



Prescription Drug Spending and Rebates in Delaware



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OFFICE OF VALUE-BASED
HEALTH CARE DELIVERY
DELAWARE DEPARTMENT
OF INSURANCE

TABLE OF CONTENTS

01 Executive Summary

03 Background

- 03. Rising Costs Attract Attention
- 05. State and National Policymakers Take Action
- 06. Market Solutions Emerge
- 07. Purpose of Analysis
- 07. Data Collection and Analysis Process

08 Five Key Findings

- 08. Finding 1: Prescription Drug Spending Increasing
- 09. Finding 2: Cost Per Prescription Increasing
- 10. Finding 3: Member Cost Share Decreasing
- 10. Finding 4: Specialty Medication Costs Increasing
- 11. Finding 5: Rebates Increasing

13 The Rebate Debate

- 14. Impact of Rebates on Consumer Cost Share
- 16. Role of Consumer Coupons

17 Deep Dive into Key Cost Drivers

- 17. Antineoplastics
- 20. Blood Glucose Regulators
- 23. Immunological Agents

26 Conclusion

27 Glossary

29 Bibliography



EXECUTIVE SUMMARY

Spending on prescription drugs increased a cumulative 77% nationally from 2010 to 2020, making it one of the fastest growing components of healthcare spending, according to one recent study.¹ Delawareans' recent experience reflects these national trends. Commercial prescription drug spending increased an average of 4.9% among Delaware's largest PBMs each year from 2018 to 2020, on a per member, per month basis. This growth is net of rebates, a form of price concession paid by a pharmaceutical manufacturer to the health plan sponsor or the pharmacy benefit manager.²

Policymakers, regulators, health care purchasers and consumer advocates recognize the critical role medications play in improving and maintaining health. They also recognize the unsustainability of its rising costs and are taking action. Their efforts primarily aim to infuse more transparency into the business practices of pharmacy benefit managers (PBMs), the companies that administer pharmacy benefits on behalf of health insurance carriers and other plan sponsors.

In Delaware, a series of recently passed laws provide the Department of Insurance (DOI) with new statutory authority to study and regulate the administration of the pharmacy benefit and prescription drug supply to Delawareans. This report, prepared by the DOI Office of Value-Based Health Care Delivery (the "Office"), provides a baseline understanding of pharmaceutical spending in the state and will inform state policymakers and regulators as they consider future efforts to improve consumers' access to affordable prescription drugs.

¹ Black, 2022.

² This includes member cost sharing.



To support its analysis, the Office collected fully-insured and self-insured cost, utilization and rebate data from the state's three largest PBMs – CaremarkPCS Health, LLC, Express Scripts, Inc., and Optum Rx. Data was collected for 2018 to 2020. As part of its analysis the Office identified five key takeaways:

- 1 Prescription Drug Spending Increasing:** Prescription drug spending increased an average of 4.9%, net of rebates, among Delaware's largest PBMs each year on a per member, per month basis.
- 2 Cost Per Prescription Increasing:** The cost per prescription, net of rebates, increased an average of 5.5% per year.
- 3 Member Cost Share Decreasing:** Average member cost share was 10.7% of the cost of per prescription, net of rebates, in 2020 compared to 12.5% in 2018.
- 4 Specialty Medication Spending Increasing:** Spending on specialty brand prescriptions increased, on average, 12% each year on a per member, per month basis, net of rebates. Utilization, which increased an average of 10.7% per member, per year, drove most of this growth. Cost per prescription increased an average of only 1.4% per year.
- 5 Rebates Increasing:** Across PBMs, rebates paid back to the insurer or plan sponsor increased an average of 18.5% each year, on a per script basis. Rebates equaled nearly 23.5% of the cost per prescription, on average, among Delaware's largest PBMs in 2020.



BACKGROUND

In 2019, Senate Bill 116 of the 150th Delaware General Assembly directed the Department of Insurance (DOI) to create the Office of Value Based Health Care Delivery (the Office) to improve healthcare affordability, in part by collecting and publishing information on health care costs including pharmacy costs. The purpose of this report is to provide information on pharmaceutical costs in the state, specifically the costs of medications paid for through the pharmacy benefit.

Rising Costs Attract Attention

In 2020, pharmaceutical spending in the United States reached \$570 billion — a 77% cumulative increase from \$322 billion in 2010, according to a February 2022 report based on state and national data from the U.S. Bureau of Economic Analysis and the Kaiser Family Foundation and published by ValuePenguin³. Interestingly, the researchers found the share of those costs paid out of pocket by patients decreased over the decade, by approximately \$1 billion. Delaware had the highest average prescription drug costs per household at \$6,513, the report found. Increases in prescription drug costs combined with complex financing mechanisms motivate much of the interest in understanding cost drivers and potential ways to improve affordability.

The increasing costs have received the attention of consumers, healthcare purchasers and regulators. Consumer surveys have shown that almost eight in 10 people in the United States say the cost of prescription drugs is unreasonable, and three in 10 report they have not taken a prescription medicine as directed because of the cost.⁴ Pharmacy benefits and the prescription drug supply chain are complex. Policymakers as well as public and private purchasers are increasingly calling for more transparency in the system.⁵

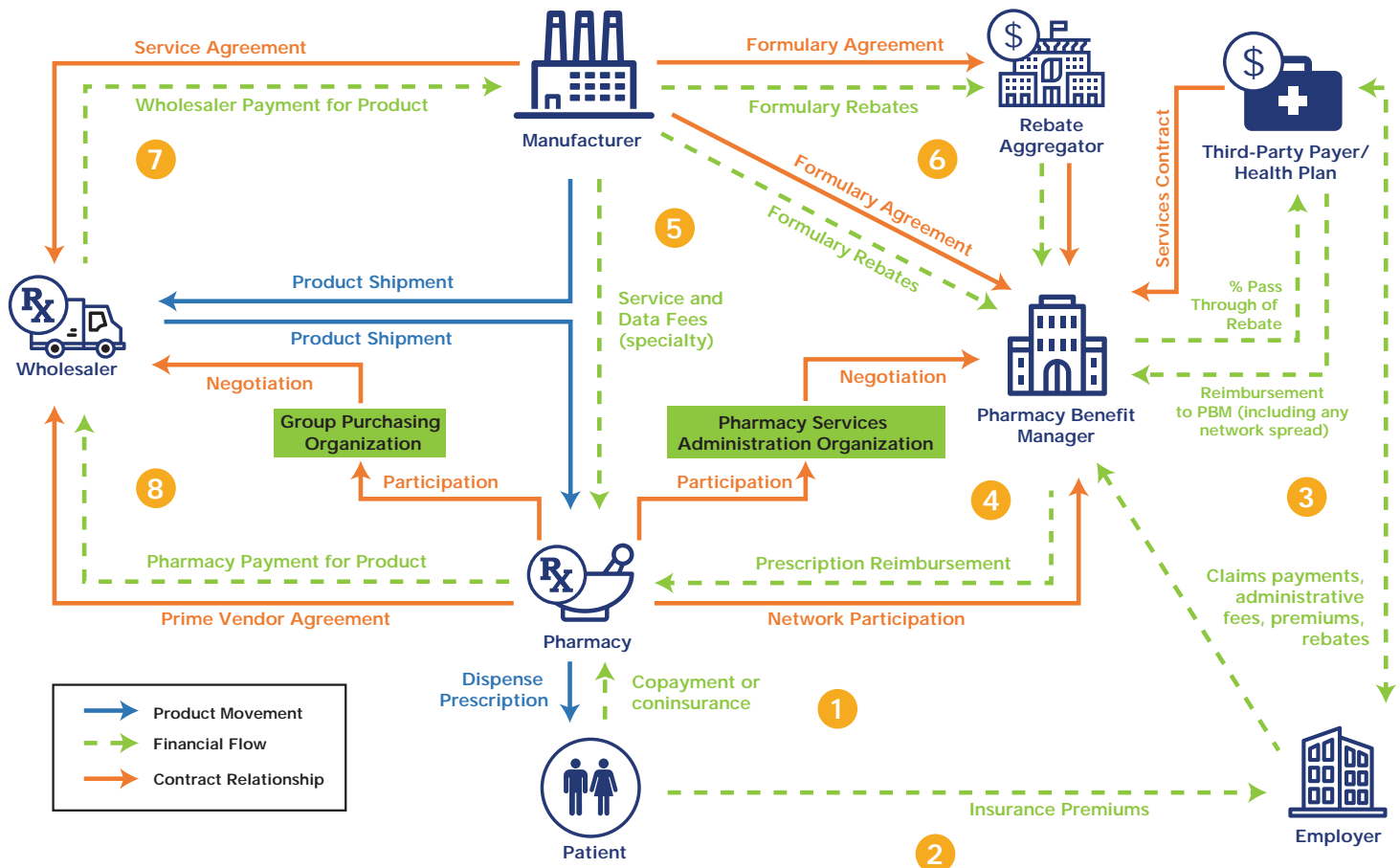
Pharmacy benefit managers, or PBMs, are companies that manage prescription drug benefits on behalf of health insurers, Medicare Part D prescription drug plans, large employers, and other payers. By serving as an intermediary responsible for negotiating with manufacturers and pharmacies, PBMs impact prescription drug costs, influence patients' access to medications, and determine how much pharmacies are paid.

³ Black, 2022.

⁴ Hamel, et al., 2021.

⁵ Rae, Kamal, & Cox, 2020.

Figure 1: Prescription Drug Distribution in the United States



- 1 Individuals cover their prescription drug copays and coinsurance obligations, often referred to as “member cost share.”
- 2 Individuals pay premiums to their health insurers or other plan sponsors, such as employers.
- 3 Health insurers or other plan sponsors, such as employers, contract with PBMs to negotiate on their behalf.
- 4 PBMs negotiate with pharmacies regarding reimbursement for prescriptions and dispensing fees. Most PBMs also own pharmacy operations to support mail order business.
- 5 PBMs also negotiate prices with manufacturers, which then pays rebates to the PBM for preferred placement on a plan’s formulary.
- 6 Rebate aggregators combine the buying power of multiple PBMs to improve their rebates from manufacturers. PBMs own some rebate aggregators, which has raised concerns about conflicts of interest.
- 7 Wholesalers purchase bulk quantities of pharmaceutical products from manufacturers and store them in warehouses and distribution centers.
- 8 After purchasing the drugs from the manufacturer, the wholesaler is then responsible for safely delivering the medication to pharmacies.

Source: Adapted from the Vermont Green Mountain Care Board

State and National Policymakers Take Action

Nationally, proposed federal legislation would prohibit gag clauses in PBM contracting with pharmacies⁶. These contract provisions would bar pharmacists from informing customers that paying for medications out of pocket could be cheaper instead of using their insurance. The Build Back Better Act (BBBA), which passed the House of Representatives but stalled in the Senate, included several provisions that would impact pharmacy benefits and prescription drug supply⁷. BBBA provisions that would apply to private insurance included requirements for drug manufacturers to limit price increases for prescriptions to the rate of inflation and provide rebates for revenues collected in excess of that increase. Additionally, the BBBA would require private insurance plans limit member cost sharing for insulin products to no more than \$35 per month.

Several states have increased oversight of PBMs. Recent legislation and regulations include⁸:

- Requirements for PBMs to be licensed or registered with the state
- Requirements for PBMs to conduct fair audits of pharmacies without unduly penalizing administrative errors and seeking recoupment of payments to pharmacies based on the number of errors found
- Requirements for increased transparency of Maximum Allowable Cost (MAC) lists
- Authority to investigate spread pricing practices, where PBMs receive significantly higher reimbursements for drugs than they dispense to pharmacies filling these prescriptions
- Patient protections including additional accreditation requirements, prohibiting copay claw backs and enacting additional rules governing mail order and pharmacy delivery services

⁶ PBM Watch, 2022.

⁷ Cubanski, Neuman, & Freed, 2021; 117th Congress (2021-2022), 2021.

⁸ National Community Pharmacists Association, 2022.

In Delaware, the General Assembly has passed legislation to do the following:

- Require registration of all PBMs that wish to operate in the state
- Limit member cost sharing for drugs in specialty tiers to \$150 per month
- Cap the amount an individual must pay for insulin prescriptions at \$100
- Prohibit prior authorization in emergency situations for short term medications that are not controlled substances
- Prohibit gag clauses
- Establish a task force to make recommendations on PBM reimbursement practices
- Prohibit cost-sharing in excess of pharmacy prices⁹
- Prohibit claw backs, when pharmacy benefit managers (PBMs) instruct the pharmacy to collect an elevated copayment, such as more than the cost of the prescription to the pharmacy, and subsequently recoup the excess amount—and sometimes more—from the pharmacy
- Allow pharmacies to decline to dispense medications if the PBM's reimbursement is less than its acquisition costs
- Require PBMs to report on rebates received and distributed to insurers and patients of those insurers
- Prohibit PBMs from engaging in spread pricing and differential reimbursement for affiliated pharmacies
- Prohibit PBMs from reimbursing for ingredients lower than the national average drug acquisition cost¹⁰

Market Solutions Emerge

Capital Rx and Navitus Health Solutions are among the fastest growing PBMs offering a new model that promises more transparency and lower costs. These companies build on the work of many previous startups, some of whom have now been purchased by larger PBMs. EmsanaRx, launched in October 2021, is a PBM that was built by employers for employers and seeks to lower health care costs and increase transparency. It is operated by the Purchasers Business Group on Health (PBGH), a nonprofit coalition of nearly 40 large, private employers and public purchasers. The Mark Cuban Cost Plus Drug Company formed a PBM focused on access to low-cost versions of higher-cost generic drugs. It's starting with Albendazole, an antiparasitic drug that currently has a list price of approximately \$225 per tablet. The Mark Cuban Cost Plus Drug Company says it can make the same drug for \$13 a tablet, sell it wholesale to pharmacies for \$15 and sell it to patients for \$20. Civica Rx, which launched in 2018, is the nation's first not-for-profit generic pharmaceutical company. It announced plans in March 2022 to manufacture and distribute insulins at significantly lower prices than those currently on the market.

⁹ PBM Watch, 2022; 151st General Assembly, 2021.

¹⁰ NASHP, 2021.

Purpose

This report provides a baseline to inform Delaware policymakers and other stakeholders as they implement existing statutes and related regulations and consider further action to reduce pharmaceutical costs and improve access and affordability.

Data Collection and Analysis Process

The DOI determined the Office's data collection effort would include PBMs that provided pharmacy benefits to at least 5,000 Delawareans enrolled in fully-insured, Delaware-situated plans. Three PBMs met this threshold: CaremarkPCS Health, LLC, Express Scripts, Inc., and Optum Rx. These PBMs provided cost, utilization, and rebate data from 2018, 2019 and 2020. This information was collected under the statutory authority given to the Office under 18 Del.C. § 334.¹¹

During the data collection process, PBMs determined they could not easily disaggregate fully-insured and self-insured members and in turn, the data they provided includes Delawareans with both types of health coverage. Plan sponsor detail was not collected.

To support data collection, the Office distributed a Microsoft Excel template to the three PBMs and provided technical assistance to support completion. Information was collected by national drug code and drug name to allow the Office flexibility in analysis. After an initial review of the data sets it was determined that two of the PBMs had provided some partial benefit data that could not be used for analysis. This data was excluded and represented less than 0.8% of total expenditures.¹²

It is important to note that there are no national standard definitions for drug category, therapeutic category or other common classifications of medications. Drugs are classified differently by each PBM and sometimes even within the PBM depending on the preferences of a plan sponsor. This is particularly true for drug category, which reflects benefit design and formulary placement as well as non-subjective factors such as patent status.

After receiving the templates, the Office standardized certain categories of information including the drug name, drug category, therapeutic category, pharmacological class and formulary key drug types. Drug category was reported by the PBMs as one of four categories: traditional brand, traditional generic, specialty brand and specialty generic.¹³

Therapeutic category was reported by the PBM, and the Office standardized the definition across all data sets by applying one PBM's definition. The Office focused its analysis on the eight therapeutic categories responsible for the majority of pharmacy costs. Therapeutic category relates to chemical type of the active ingredient or the way it is used to treat a particular condition.

¹¹ 150th General Assembly, 2019.

¹² One PBM provided data for members that did not have full pharmacy benefits. Including this population would artificially deflate results. One PBM provided data for members that were only in the plan for part of 2020. Including this data would skew results.

¹³ Drug categories were assigned using one PBM's definitions. There were times when one drug had multiple drug categories. In these instances, the category with the greatest expenditures was assigned.



FIVE KEY FINDINGS

1. Prescription Drug Spending Increasing

Prescription drug spending gross of rebates increased an average of 7.6% among Delaware's largest PBMs each year from 2018 to 2020, on a per member, per month basis. These costs reached \$156 per member, per month in 2020. After subtracting rebates, spending increased an average of 4.9% during the same period to \$119 per member, per month.

The increase was driven by a combination of increases in the average price of medications and the “mix” of medications purchased, specifically specialty brand medications comprising a greater proportion of those purchased. Prices increased an average of 2.5% per year, net of rebates. Changing mix across drug categories drove an average of 2.9% of the increase each year. Utilization, defined as prescriptions per member per year, was largely flat, decreasing an average of 0.5% per year from 2018 to 2020.

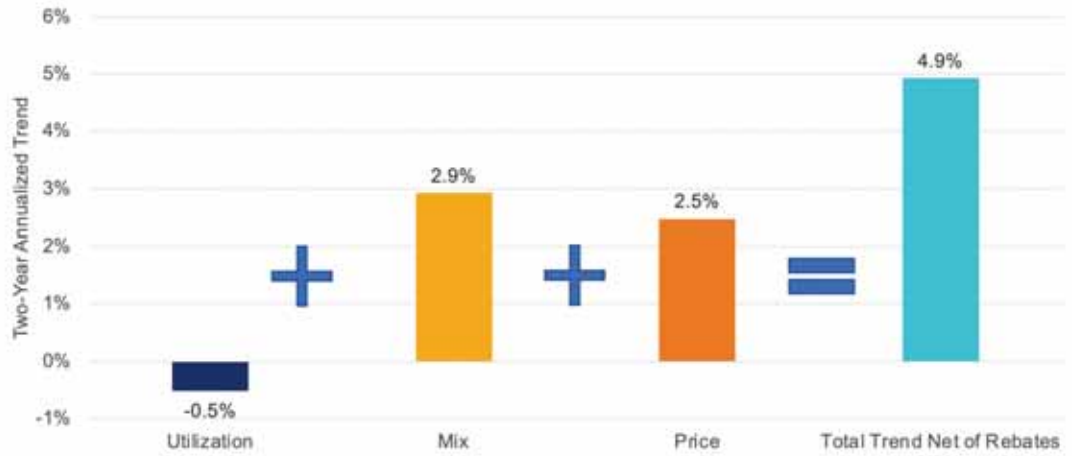
Comparatively, on a national basis, CaremarkPCS Health reported a national trend of 2.9% in 2020 and 1.4% in 2019 across all lines of business¹⁴. Evernorth, which is part of Express Scripts, reported a 4% increase in total cost in 2020 and a 2.3% increase nationally in 2019 for its commercial clients¹⁵. These national cost trend figures reported by the PBMs are net of rebates. CaremarkPCS Health and Express Scripts reported higher utilization trends of 1% to 3% each year.

¹⁴ Lotvin, 2020; Lotvin, 2021

¹⁵ Evernorth, 2021.

Figure 2. Changes in Delaware Commercial Prescription Drug Utilization, Price and Mix, Net of Rebates, 2018- 2020

**The Total Trend Net of Rebates is calculated using the following formula:
 $(1 + \text{utilization trend}) * (1 + \text{mix trend}) * (1 + \text{price trend})$*



Changing mix across drug categories – specifically, specialty brand medications comprising a greater proportion of all medications purchased – drove an average of 2.9% of the 4.9% increase in costs each year.

2. Cost Per Prescription Increasing

Cost per prescription, net of rebates, increased an average of 5.5% per year from 2018 to 2020.

Cost per prescription is defined as the plan paid plus the member paid, net of rebates divided by total prescriptions. Nationally, CaremarkPCS Health and Express Scripts report unit price trend instead of cost per prescription. In 2020, Express Scripts reported its unit cost trend has remained under 1% for the previous four years. Unit price trend for CaremarkPCS Health was -0.1% in 2019 and 1.2% in 2020.

Figure 3. Rebates Offset Rising Prescription Drug Costs

**Total Gross Cost per Prescription*



The amount health insurance carriers paid per prescription increased an average of 6.6% per year, net of rebates, while members' cost share remained flat. Rebates per prescription increased an average of 17% per year, each year.

3. Member Cost Share Decreasing

Average member cost share was 10.7% of the cost of per prescription, net of rebates, in 2020 compared to 12.5% in 2018.

Members paid an average of \$15 per script in 2018 compared to \$14 per script in 2020. This is consistent with national data showing decreases in member cost sharing.

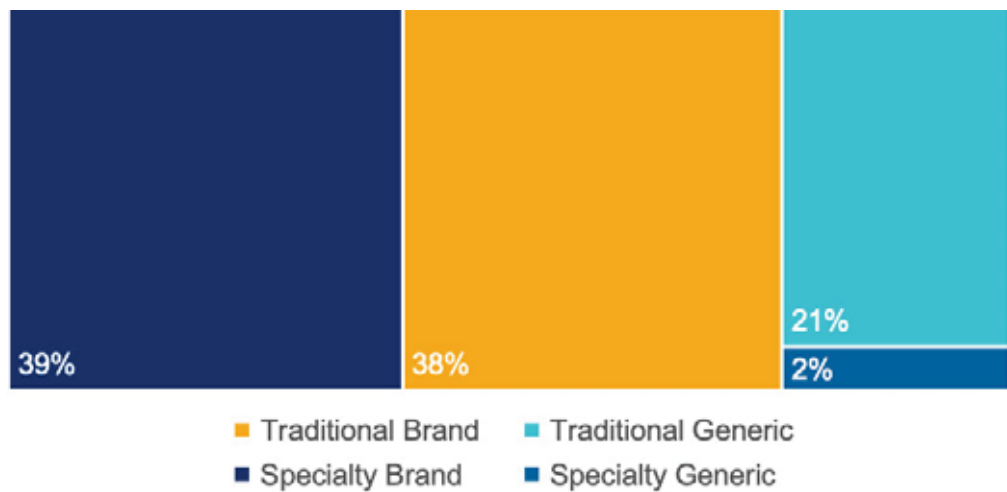
4. Specialty Medication Costs Increasing

Spending on specialty brand prescriptions increased, on average, 12% each year, on a per member, per month basis, net of rebates.

Utilization, which increased an average of 10.7% each year on a per member, per year basis drove most of the growth in spending. Cost per prescription increased only 1.4% per year. In 2020, across all three PBMs, specialty brand medications accounted for 1% of total utilization and 39% of total spending, net of rebates. These prescriptions cost an average of \$5,073 net of rebates for a 30-day supply. Members paid, on average, \$176 of that cost in 2020.

Rebates for specialty brand medications increased nearly 19% each year on a cost per prescription basis, reaching more than \$1,100 per script in 2020. Utilization of specialty brand medications increased an average of 10% per year, on a prescription per member, per year basis.

Figure 4. Proportion of Total Costs, Net of Rebates, by Drug Category in 2020



Though nearly 80% of total spending on prescription drugs went toward traditional brand and specialty brand medications, these medications comprised only 16% of the prescriptions purchased.

Figure 5. Proportion of Total Prescriptions by Drug Category in 2020



Conversely, traditional generic prescriptions accounted for 83% of total utilization and 21% of total spending, net of rebates. These prescriptions cost an average of \$33 net of rebates for a 30-day supply with members paying, on average, \$7 of that cost in 2020. The cost of traditional generic prescriptions decreased, on average, nearly 4% percent each year. Rebates for generic prescriptions are low, averaging just a few cents per script. Utilization of generic medications was steady over the period.

Traditional brand medications comprised 15% of total utilization and 38% of total spending, net of rebates in 2020. These prescriptions cost an average of \$338 net of rebates for a 30-day supply. Members paid, on average, \$42 of that cost in 2020. Spending on traditional brand prescriptions increased, on average, 3% percent each year on a per member, per month basis. Cost per prescription increased an average of 7.1% per year. Rebates for traditional brand medications increased an average of nearly 15% per year, reaching \$196 per script in 2020. Utilization of traditional brand medications declined an average of nearly 4% each year.

Specialty generic medications were the fastest growing drug category with utilization increasing an average of 15% per year and total spending, net of rebates, increasing an average of 20% each year. Despite this growth, specialty generic medications still only represented less than 1% of all prescriptions filled and approximately 2% of total spend, net of rebates. Specialty generic medications cost an average of \$290 per prescription, net of rebates for a 30-day supply in 2020. Members paid an average of \$12 of that cost. Similar to traditional generic medications, most specialty generic medications were not eligible for rebates.

Nationally, more of the prescription drug spend is going to specialty medications. For example, in 2020, Evernorth reported 51% of its total pharmacy spend went toward specialty medications compared to 49% toward traditional brand and generic drugs.

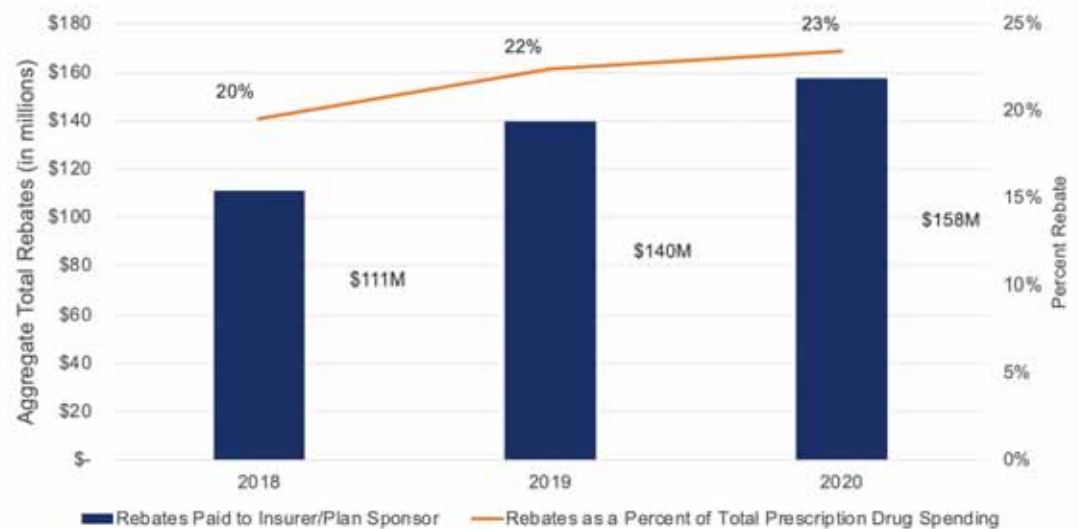
5. Rebates Increasing

Across PBMs, rebates paid back to the insurer or plan sponsor increased an average of 18.5% each year, on a cost per prescription basis.

Rebates equaled nearly 23.5% of the cost per prescription, on average, among Delaware's largest PBMs in 2020. This percentage varied widely depending on whether the drug was a traditional brand, specialty brand or generic medication. For example, rebates accounted for 37% of the cost of traditional brand medications and 18% of the cost of specialty brand medications but less than 1% of the cost of traditional and specialty generics. Rebates also varied by therapeutic category.

There is considerable discussion regarding whether rebates result in lower or higher prescription drug costs and for whom. The following section will focus on these questions.

Figure 6. Growth in Prescription Drug Rebates and Percentages



In aggregate, rebates paid back to the insurer or plan sponsor increased an average of 18% each year, on a per member, per month basis. By 2020, rebates received by health insurers or other plan sponsors were equal to 23% of total prescription drug spending.

THE REBATE DEBATE

Rebates are payments from prescription drug manufacturers typically to PBMs, health plans and other plan sponsors. Manufacturers generally offer rebates in exchange for prompt payment, purchasing volume or loyalty for a single medication or multiple medications produced by the manufacturer¹⁶. The loyalty typically translates to placement on a preferred tier of the formulary, a listing of medications and treatments that defines a member's level of cost sharing and whether prior authorization or other steps are needed before coverage begins. Medications on preferred tiers are more likely to be purchased by consumers because they typically require fewer approvals and lower cost sharing than similar medications on lower tiers. Drug rebates are paid retrospectively to the plan based in part on the number of prescriptions purchased by the plan's members.

For manufacturers, rebates mitigate the risk associated with selling to a relatively concentrated market of buyers. Nationally, three PBMs –CaremarkPCS Health, LLC, Express Scripts, Inc., and Optum Rx – controlled more than 80% of the market share in 2021¹⁷. These PBMs also dominate the Delaware market. As noted previously, they are the only PBMs operating in the state that serve more than 5,000 fully-insured lives.

For PBMs, receiving rebates in exchange for steering patients toward a product helps them negotiate lower prices. Most prescription drugs with rebates have a competing product that generally can act as a substitute. Achieving the highest rebates typically requires placing one or more of the manufacturer's medications in preferred tiers of the formulary. This limits barriers to patient access by requiring fewer prior authorizations and lower cost sharing. Conversely, it also requires

¹⁶ Stomberg, 2021; Federal Trade Commission.

¹⁷ Health Industries Research, 2021.



putting other competitors to those preferred medications on non-preferred tiers with more barriers to patient access. If these decisions were based predominantly on value and if all medications worked equally as well for all patients, rebates might face little controversy. The challenge is that rebates tend to be based on a variety of factors, including but not limited to, comparative value. Further, some patients respond better to certain medications. Some health plans prefer more open access with fewer prior authorization restrictions and less powerful copay incentives to steer patients among products. These formularies have less potential to generate rebates from manufacturers. Formularies with closed access and tight formulary restrictions can generate more significant rebates due to their greater ability to steer patients.

In Delaware and nationally, nearly all rebates are paid from the PBM to the plan or plan sponsor, not the consumer. In some states and regions, the trend is slowly beginning to shift with plan sponsors electing to share rebates with patients at the point of sale. In 2019, some commercial health insurers began suggesting plan sponsors share a portion of their rebates with consumers. Uptake has been limited. In Delaware, 96% of rebates were paid from the PBM back to the health plan or plan sponsor in 2020, which was consistent over the three-year period.

A relatively new market entrant, known as a rebate aggregator, is making it more difficult to understand the percent of rebates not retained by the PBM. Typically, PBMs are contractually bound to return the majority of manufacturer rebates to health plans, employers and plan sponsors. Rebate aggregators combine the buying power of multiple PBMs to improve their rebates from manufacturers. This can be helpful to smaller PBMs who otherwise may not have sufficient buying power to negotiate a competitive price. However, many PBMs also have ownership stakes in rebate aggregators. Since rebate aggregators' business model is to be paid via a portion of the negotiated rebates, it becomes harder to understand the total rebates received by the PBM. PBMs negotiate prices on behalf of the insurer. Therefore, if PBMs receive significant revenue via rebates, they may have an incentive to negotiate arrangements with manufacturers based on the rebate, rather than the overall price and value of the drug.

Impact of Rebates on Consumer Cost Share

In theory, rebates should ultimately offset the cost to the consumer. For fully-insured plans, the plan realizes lower prescription drug costs and passes those savings to consumers through lower future premiums. Considering the high cost of prescription drugs today, many payers use the anticipated savings from rebates to reduce plan costs and in turn, make their plans more attractive to customers and potential customers. However, this cycle takes time. Payments from manufacturers may occur at the end of each month or quarter depending upon the contract terms. Rebates may not be reflected in the premiums for one or more plan years and during that time, the population enrolled in the plan is likely to shift.

There are also equity issues across consumers. When consumers pay a greater portion of their total cost sharing obligation at the point of care, there are several downstream impacts.

- **A greater proportion of consumers' collective share of the cost is paid by those who use services or in this case, buy prescriptions.** Health insurers and plan sponsors consider the relative cost burden placed on two groups of patients when developing premiums and tiered formularies: those who are most likely to use care – in this case, buy prescriptions – and those who are not. Their goal is to arrive at an equitable distribution, recognizing that those who use more care will pay more but this use will be subsidized by those who do not use as much care. With rebates retrospectively lowering the cost to health plans and other plan sponsors, achieving balance becomes more difficult.

On average, member cost share was 8% per member, per month of total gross prescription drug costs in 2020. Net of rebates, member cost share increased to nearly 11% per member, per month of total gross prescription drug costs in 2020. When health plans and other plan sponsors recoup rebates, the savings may be shared through future premium reductions, but those savings are not proportionally distributed based on the number of prescriptions the member purchased. Therefore, a system that relies heavily on rebates tends to transfer more member responsibility burden to those who buy prescriptions.

- **Higher cost share at the point of purchase has been shown to reduce adherence, or the likelihood patients take their medications as prescribed, even for high value medications¹⁸.** A National Bureau of Economic Research (NBER) study of the impact of increased cost sharing for prescriptions among Medicare beneficiaries reported increased rates of mortality for patients who filled fewer prescriptions. Further, they were able to show that patients were less likely to fill prescriptions when out of pocket costs were higher. The study found that on average, out of pocket cost increases of 33% or about \$10 per drug is associated with nearly 23% utilization decreases. The NBER study, published in February 2021, found that the cycle occurred across life-saving, high value categories of medications including statins to lower cholesterol, ACE inhibitors and beta blockers to lower blood pressure, medications to regulate blood sugar and inhalers to treat acute exacerbations of emphysema and asthma.
- **Several states and the federal government are considering policies to address how consumer cost share at the point of care may be contributing to health inequities.** Communities of color, particularly non-Hispanic Black individuals, are more likely to be diagnosed with chronic conditions including chronic pain, diabetes, high blood pressure, and HIV. They also are more likely be diagnosed with multiple chronic conditions. For many of these chronic conditions, effective treatments exist but member cost sharing may be high. As discussed above, high-cost sharing contributes to lower adherence to treatment plans, particularly for individuals on multiple prescriptions and among those with lower incomes. About 30% of Black Americans and 42% of Hispanics report being unable to afford their

¹⁸ Chandra, Flack, & Obermeyer, 2021.

medications, compared to 25% of White Americans. The compounding factors of higher rates of disease and less ability to afford treatment risks further deepening health inequities. To address part of this issue, eleven states have adopted legislation to limit member cost sharing for insulin.

Other states, including Delaware, are addressing adverse tiering, which occurs when health insurers and other plan sponsors structure drug formularies to require substantial out of pocket cost sharing for all drugs in a certain category, particularly for expensive-to-treat conditions such as HIV/AIDS. The plan design discourages patients needing those drugs from selecting that plan and puts a hefty financial burden on those who do. Adverse tiering can cost HIV-positive individuals, nearly 90 percent of whom were Hispanic, Black or of multiple races in 2018, an additional \$3,000 each year, a recent article by the National Academy for State Health Policy found.

Role of Consumer Coupons¹⁹

Consumer coupons are one way patients can reduce the cost of prescription drugs. Consumer coupons are often provided by manufacturers to encourage patients to access medications with higher cost sharing. Researchers estimate that these coupons can reduce point of purchase, out of pocket costs for privately-insured consumers for brand name drugs by about 70%. Prescription drug coupons are currently allowed in all 50 states for commercially-insured patients. Federal health insurance programs, such as Medicare, Medicaid, Tricare and Veteran's Administration, prohibit the use of coupons based on federal anti-kickback statutes.

One concern regarding the coupons is they will drive patients towards higher cost drugs when equally appropriate lower cost therapeutic alternatives may be available. Conversely, coupons may also make patients more likely to begin or continue a necessary therapy that they could not otherwise afford. While these coupons reduce consumer costs at the point of purchase, they may result in some combination of higher premiums, lower health plan profits, and less generous formularies.

¹⁹ Health Policy Commission, 2020.



DEEP DIVE INTO KEY COST DRIVERS

Therapeutic categories offer one way to classify prescription drugs. A therapeutic category is a group of similar medications classified together because they are intended to treat the same medical conditions. The Office took a focused review of the three therapeutic categories with the highest proportion of spending. These therapeutic categories – antineoplastics, blood glucose regulators and immunological agents – are discussed in more detail below.

Antineoplastics

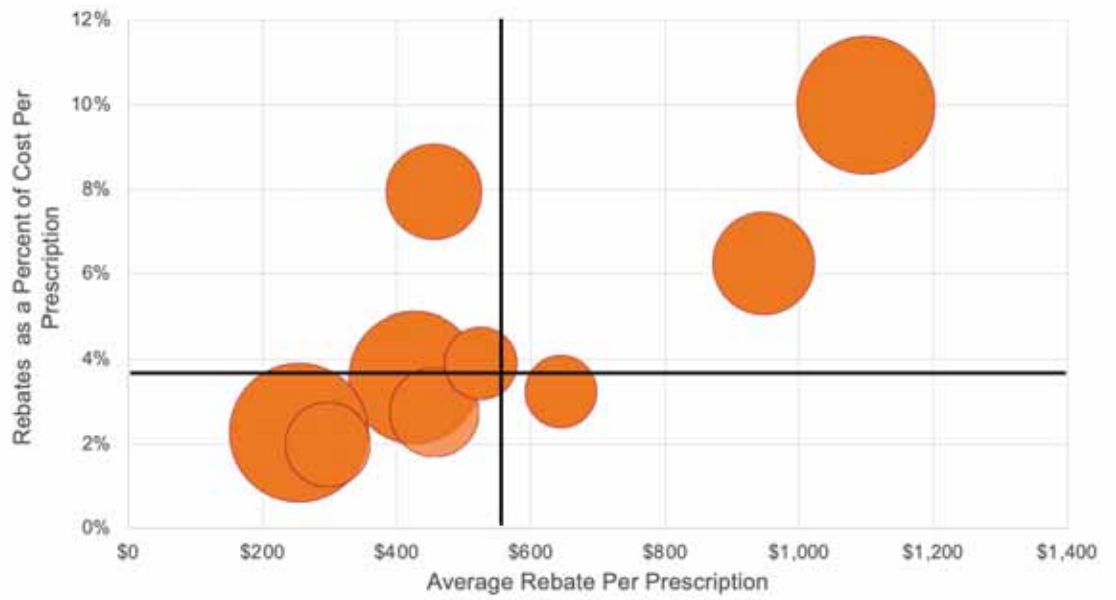
Antineoplastic drugs slow or stop the growth of tumors by interfering with cell metabolism or reproduction. Antineoplastics are often used to treat cancer. In 2020, antineoplastics accounted for less than 1% of all prescriptions filled and 11% of all prescription drug costs after subtracting rebates, which accounted for about 4% of the cost of a prescription. The cost per prescription net of rebates increased an average of 8% per year. The average cost of a prescription in this category was \$1,900 in 2020, net of rebates. The average member cost share, however, was just under \$15.

Medications in this category fall on both ends of the cost spectrum. Allopurinol, a generic medication commonly used to treat gout, comprised 47% of the prescriptions in the category. It costs about \$11 for a 30-day supply, including the member portion and the plan portion. The antineoplastic category also included 36 medications each costing more than \$10,000, net of rebates, for a 30-day supply. These 36 medications were responsible for 10% of the prescriptions purchased in the antineoplastic category and 76% of total spending in the category in 2020.



Figure 7. Variation in Rebates for the Most Common Antineoplastics with Rebates

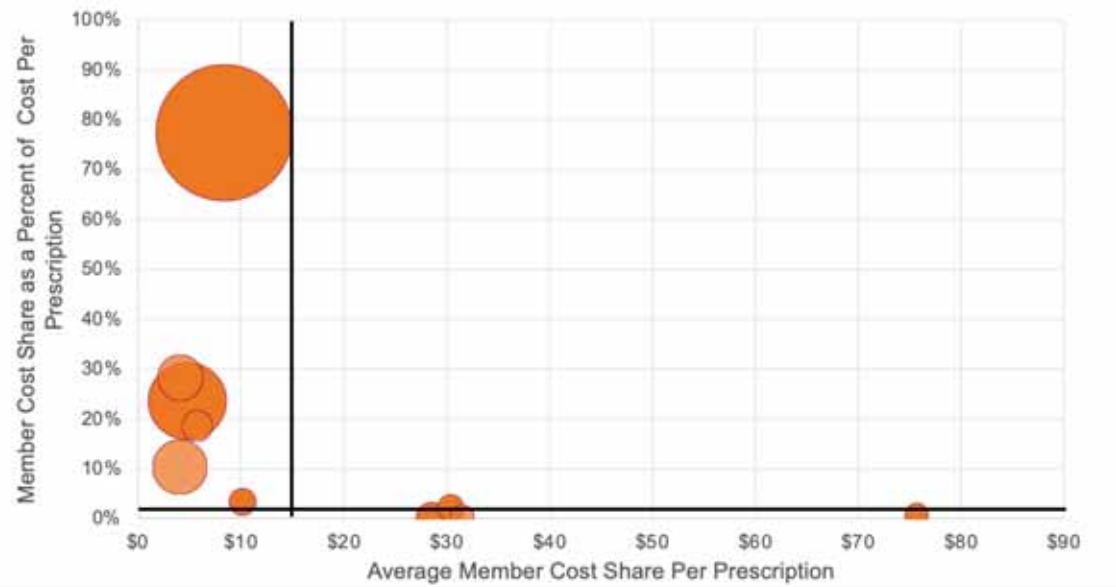
Note: For this series of bubble charts, the size of the bubbles represents the number of prescriptions purchased in 2020 across all three PBMs. The dark axes represent the average of the variation in rebates.



Most medications in the antineoplastic class that have rebates are expensive. Rebates per prescription ranged from \$255 to \$1099 per prescription and represented between 2% and 10% of the total cost of the drug.

Figure 8. Variation in Member Cost Share for the Most Common Antineoplastics

Note: The size of the bubbles represents the number of prescriptions purchased in 2020 across all three PBMs. The dark axes represent the average of the total cost share.



Average member cost share in this therapeutic class was low, as the medications in the class with the greatest utilization also tended to be the least expensive.

Revlimid was the medication with the highest total spending in this category, comprising 18% of spending net of rebates and 2% of the antineoplastic prescriptions in 2020. Revlimid is used to treat multiple myeloma, a cancer of the blood in which the bone marrow produces a high number of cancerous cells. There is no cure but medications including Revlimid have been found to slow its progression. In 2019, the Institute for Clinical and Economic Review flagged the medication for steep price increases but after review found they were supported by new evidence of its effectiveness.²⁰

Exciting advances in antineoplastics have made new drugs that are more effective in attacking cancers while having fewer side effects. Truly life-saving drugs are good values even at high prices; drugs offering marginal or even no improvement in care are not.

²⁰ Rind, Agboola, Kumar, Borrelli, & Pearson, 2019.

²¹ Rajkumar, 2022.



OLIVIA'S STORY²¹

An avid bowler, Olivia noticed she was experiencing pain in her right arm — her bowling arm. She thought it was a pulled muscle or another injury, but the pain wouldn't go away.

Olivia went to see her primary care doctor. An X-ray of Olivia's right arm showed destruction of bone in her right arm. Olivia's primary care doctor referred her to an oncologist. Olivia's oncologist ordered a blood test and performed a bone marrow biopsy. The tests confirmed Olivia had multiple myeloma.

Olivia's oncologist said multiple myeloma is typically not curable, but it is treatable. She explained that since current therapy rarely cures the disease completely, most people go through many treatment regimens throughout the course of their life.

To begin, Olivia was prescribed a three-drug regimen that includes a proteasome inhibitor called Velcade, an immunomodulatory drug called Revlimid, and a corticosteroid, dexamethasone. Olivia knows the medications and other treatments will be very

expensive. Olivia's oncologist said after a few months on these medications, she likely will need a stem cell transplant.

Olivia's biggest concern is that she will no longer be able to work, which is the source of her insurance coverage. She turns 65 in six months and will be eligible for Medicare. For now, Olivia's employer is allowing her to reduce her hours and work from home. She's grateful for the support, but nervous about how Medicare will cover her medication regimen.



Blood Glucose Regulators

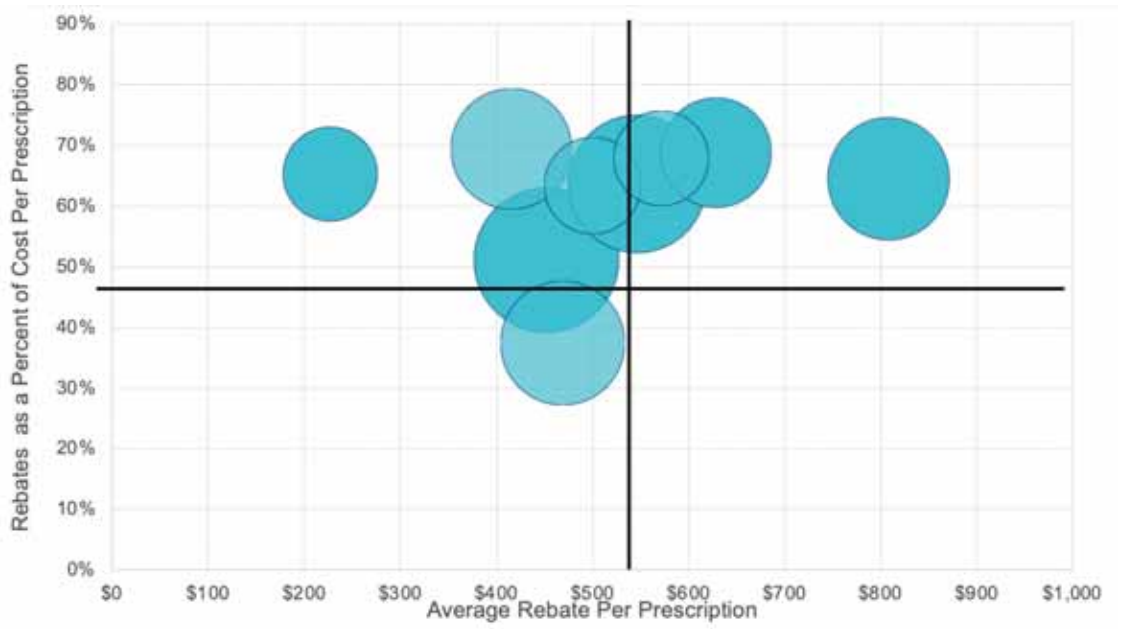
Blood glucose regulators, including insulins and oral medicines, act on sugar metabolism to keep blood sugar levels normal. Most are used to lower blood sugar for patients with diabetes, though some are used to raise blood sugar and treat hypoglycemia. In 2020, blood glucose regulators accounted for 5% of all prescriptions filled and 10% of all prescription drug costs net of rebates. Rebates have a dramatic impact on the cost of blood glucose regulators, reducing the cost of each prescription an average of 51% in 2020. Spending on blood glucose regulators rose slightly during the period, an average of 11.4% per year, on a per member, per month basis. Costs per prescription in this category decreased an average of 7.3% each year.

Metformin was most commonly prescribed drug in this therapeutic category, accounting for nearly a third of all prescriptions in the category in 2020. It is a relatively inexpensive, generic medication, costing an average of \$25 in 2020. The member's average 2020 cost share was approximately \$4. Metformin has been used successfully as a treatment for many patients with Type 2 diabetes since the 1950s. Metformin can also be used in combination with other medications to lower glucose levels.



Figure 9. Variation in Rebates for the Most Common Blood Glucose Regulators with Rebates

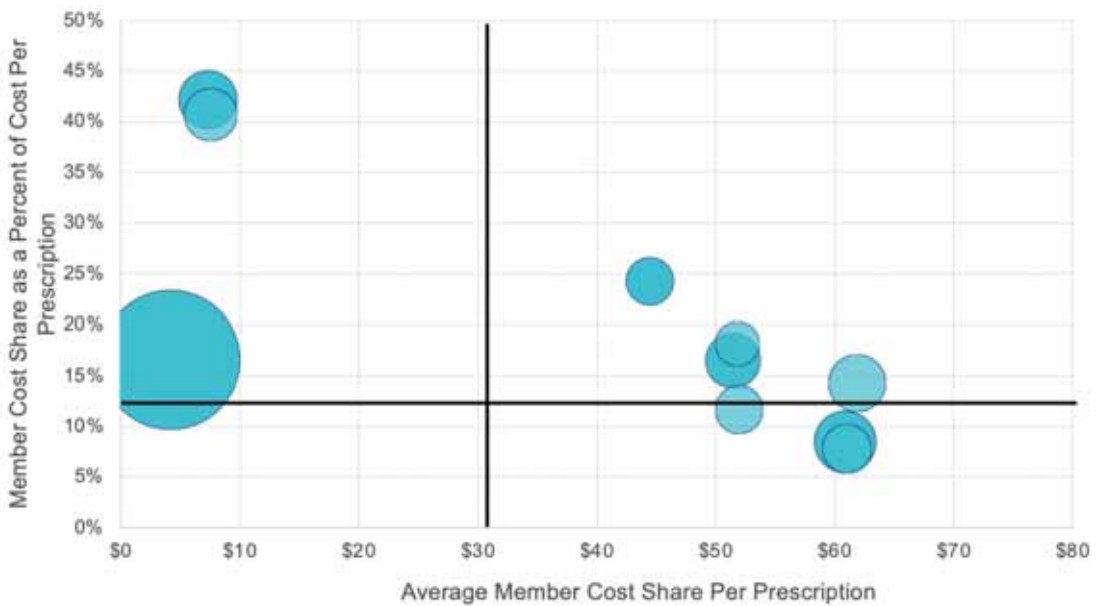
Note: The size of the bubbles represents the number of prescriptions purchased in 2020 across all three PBMs. The dark axes represent the average of the variation in rebates. *Graph only includes medications where a rebate was paid.



Rebates reduced the cost of each prescription an average of 51% in 2020. For insulin, one type of blood glucose regulator in this class, rebates reduced the cost by more than 60% to nearly 70% per prescription for the most commonly prescribed brands in 2020.

Figure 10. Variation in Member Cost Share for the Most Common Blood Glucose Regulators

Note: The size of the bubbles represents the number of prescriptions purchased in 2020 across all three PBMs. The dark axes represent the average of the total cost share.



The most commonly prescribed blood glucose regulator, metformin, is a relatively inexpensive generic with a low member cost share of \$4 per script. Patients needing insulin to control their blood sugar paid anywhere from \$32 to \$162 in cost share for a 30-day supply.

In 2020, types of insulin accounted for 20% of medications purchased in this category and 24% of the total spending net of rebates. The cost of insulin has received significant attention recently due to medical necessity, its relatively high cost sharing and the large impact of rebates on its cost. In 2020, the cost of a 30-day supply of insulin ranged from less than \$40 to more than \$1,165 net of rebates. Members cost share ranged from \$30 to \$162. Rebates reduced the cost of insulin by more than 60% to nearly 70% for the most commonly prescribed brands in 2020. Though consumers may see this benefit through lower premiums, the fact that these rebates do not help offset consumer costs at the point of purchase has raised controversy, as discussed on [page 16](#). Additionally, Delaware's General Assembly passed House Bill 263 in 2020 that requires individual, group, and State insurance plans to cap the amount an individual must pay for insulin prescriptions at \$100 per month.²²

The options for treating diabetes have exploded in recent decades. Recombinant human insulin and bioengineered insulins are widely used, as are several types of oral hypoglycemics (blood sugar-lowering drugs). Some of the new options are more effective, more convenient, or have fewer side effects than older ones. The value question is whether diabetes control or patient experience is much improved despite rapidly rising prices.

²² 150th General Assembly, 2020.



NICK'S STORY

Nick was diagnosed with Type 2 diabetes a few years ago. He's been taking metformin and it has worked well. Metformin is a pill and it's inexpensive. Recently, however, his doctor recommended he add Trulicity. Nick doesn't like that he will need to use a pre-filled pen to inject himself with Trulicity once a week. He's also worried about the cost. Nick's high deductible health insurance plan has a \$5,000 deductible including prescription medications. Therefore, Nick would need to pay the full cost of the medication for more than four months before his insurance begins to cover a portion of it.

Trulicity costs an average of about \$720 for a 30-day supply net of rebates. However, the rebates - nearly \$520 for a 30-day supply of Trulicity - are paid back to Nick's health plan, not him. Therefore, the cost to Nick at the pharmacy is nearly \$1,240 a month. Over time, Nick should see some benefit of those rebates through lower premiums, but they don't help him now. Nick did some investigating into coupons offered by Trulicity's manufacturer. Those will save him about \$150 a month.

Nick and his partner decided to postpone a vacation and borrow some money from family. At the end of the year, Nick will have the opportunity to choose a different benefit design, pay less out of pocket for his medications and have those costs more evenly spread across the year.



Immunological Agents

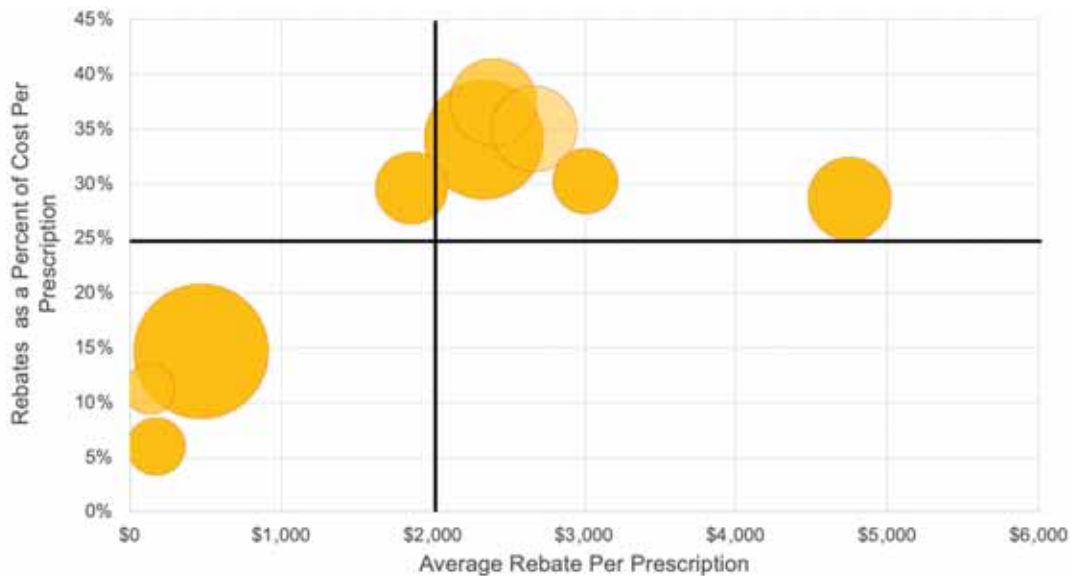
Immunological agents include vaccines and medicines to enhance or suppress the immune system. They are commonly used to treat inflammatory and autoimmune diseases (such as rheumatoid arthritis and inflammatory bowel disease) and may also treat immune deficiencies and some cancers. In 2020, immunological agents accounted for 1% of all prescriptions filled and 18% of all prescription drug costs after subtracting rebates.

Newer immunological agents have transformed the care of certain conditions, often improving lives dramatically while reducing side effects. These newer drugs are generally very expensive although the net benefit offered may vary widely. Truly life-changing or life-saving drugs are good values even at high prices; drugs offering marginal or even no improvement in care are not.



Figure 11. Variation in Rebates for the Most Common Immunological Agents with Rebates

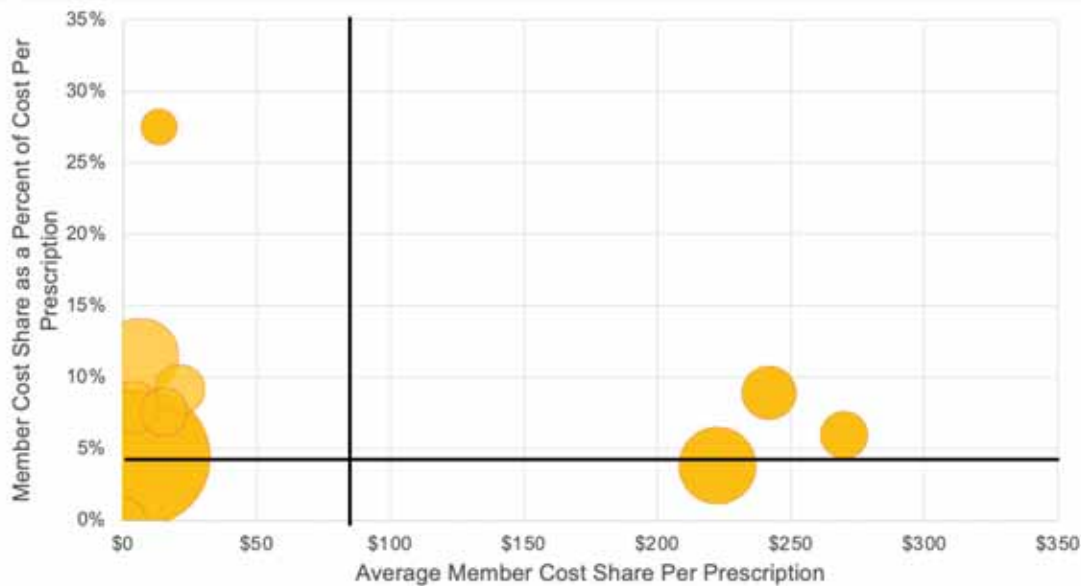
Note: The size of the bubbles represents the number of prescriptions purchased in 2020 across all three PBMs. The dark axes represent the average of the variation in rebates. *Graph only includes medications where a rebate was paid.



Rebates in this therapeutic category reduced the cost of the medications by an average of nearly 24% in 2020.

Figure 12. Variation in Member Cost Share for the Most Common Immunological Agents

Note: The size of the bubbles represents the number of prescriptions purchased in 2020 across all three PBMs. The dark axes represent the average of the total cost share.



The most commonly prescribed immunological agent, Shingrix, is a relatively inexpensive generic with a low member cost share of \$7 per script. Member cost for these treatments varied. Patients needing them paid anywhere from \$0.07 for Pneumovax to \$270 for Enbrel in cost share for a 30-day supply.

In 2020, the average cost per prescription in this therapeutic category was about \$1,800 for a 30-day supply after subtracting dollars received through rebates. Rebates in this therapeutic category are significant, reducing the cost of the medications by an average of nearly 24% in 2020. That same year, member cost share averaged nearly \$79 for a 30-day supply or about 4% of the cost of the prescription after subtracting rebates.

The top 10 medications in this category, as defined by total spending net of rebates, were responsible for nearly 82% of the spend in the category in 2020. Humira accounted for 31% of the total spending on medications in the immunological agents therapeutic category, net of rebates in 2020. Nearly \$7 or 5.8% of every member's \$119 per member, per month pharmacy cost was spent on Humira in 2020.

²³ Wong, Roth, Feuerstein, & Poylin, 2019; Wagener, 2021.



IYANNA'S STORY²³

After experiencing abdominal pain, diarrhea, weight loss, anemia, and fatigue, Iyanna was diagnosed with Crohn's disease during her sophomore year of college. Her doctor started her on antibiotics, which can help relieve symptoms by lowering the amount and change the composition of bacteria in the intestines. When she had a flare-up, her doctor wrote her a prescription for steroids to reduce the inflammation. At first, this approach worked well. Her symptoms got better, and the medications were affordable.

Over time though, her flare-ups became more common and difficult to manage. Her condition forced her to miss several important meetings for her job. Iyanna started to become depressed. Her doctor recommended she consider switching to Humira, a biologic medication that produce a more targeted response to the inflammation. Iyanna was concerned. Some patients who take Humira report side effects including upper respiratory infections, headaches and nausea. It's also expensive. Despite having insurance, the medication would cost her nearly \$100 per month.

There were also the costs of more frequent checkups and blood tests to ensure the drug was effective and not harming her kidneys.

After talking it over with her family and her physician, Iyanna decided to switch to Humira. Research suggests it will help her reduce the frequency of her flare-ups. However, she still may need surgery eventually.



CONCLUSION

Pharmaceutical spending has risen sharply in Delaware and nationally. As a result, Delaware and other states have put increased focus on PBM operations and opportunities to improve the affordability of prescription drugs.

In its analysis, the Office found costs in Delaware were increasing due to higher prices and the “mix” of medications purchased, specifically specialty brand medications comprising a greater proportion of those purchased. The Office also found a growing influence of rebates and offers some context on the potential implications of these payments. The Office took a focused review of three therapeutic categories comprising the highest proportion of total spending – antineoplastics, blood glucose regulators and immunological agents. Costs per prescription, rebates and member cost share for drugs in these therapeutic categories varied within each therapeutic category and across the categories.

DOI looks forward to continuing to monitor prescription drug spending in Delaware and work collaboratively with PBMs and health insurance carriers to better understand PBM operations and identify ways to improve affordable access to high-value prescription drugs.



GLOSSARY

Claw Backs occur when pharmacy benefit managers (PBMs) instruct the pharmacy to collect an elevated copayment, such as more than the cost of the prescription to the pharmacy, and subsequently recoup the excess amount—and sometimes more—from the pharmacy.

Gag Clauses are provisions sometimes included in contracts between PBMs and pharmacies that restrict a pharmacist from informing consumers that the drug they want to buy could be purchased at a lower cost if the consumers paid out of pocket rather than purchasing through their insurance plan.

Fully-insured health plan refers to a group health plan in which the employer pays premiums to the insurer (some of which are passed on to the employees via payroll deduction) in trade for the insurer taking on the financial risk associated with providing coverage and administering the plan. If an employee has a medical claim, the insurer – not the employer – is responsible for paying the bills (as opposed to a self-insured health plan, in which the employer is responsible for paying the bills). Fully-insured health plans are subject to state insurance regulations, whereas self-insured health plans are not – they're regulated at the federal level instead, under ERISA.

Member Cost Share is the share of a prescription drug or other healthcare cost paid by patients. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

Pharmacy Benefit Managers (PBMs) are third party companies that function as intermediaries between insurance providers and pharmaceutical manufacturers. PBMs create formularies, negotiate rebates (discounts paid by a drug manufacturer to a PBM) with manufacturers, process claims, create pharmacy networks, review drug utilization, and occasionally manage mail-order specialty pharmacies.

Prior Authorization, which is sometimes referred to as a “pre-authorization,” is a requirement from your health insurance company or pharmacy benefit manager that your doctor obtain approval from your plan before it will cover the costs of a specific medicine, medical device or procedure.

Rebates are a form of price concession paid by a pharmaceutical manufacturer to the health plan sponsor or the pharmacy benefit manager working on the plan's behalf. Proponents argue that rebates help lower overall drug costs. Critics argue that rebates sometimes encourage use of lower value medications and ultimately increase the costs patients pay out of pocket.

Situs defines the jurisdiction in which the contract is issued or delivered as stated in the contract.

Specialty Drug, as defined by Delaware Statute, is defined as a prescription drug that is prescribed for a person with:

1. A complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as multiple sclerosis, hepatitis C, and rheumatoid arthritis; or
2. A rare medical condition, defined as any disease or condition that affects fewer than 200,000 persons in the United States, or about 1 in 1,500 people, such as cystic fibrosis, hemophilia, and multiple myeloma; and
 - b. The total monthly cost of the prescription is \$600 or more; and
 - c. The drug is not stocked at a majority of retail pharmacies; and
 - d. The drug has 1 or more of the following characteristics:
 1. It is an oral, injectable, or infusible drug product.
 2. It has unique storage or shipment requirements, such as refrigeration.
 3. Patients receiving the drug require education and support beyond traditional dispensing activities.

Specialty Generic medications are similar to traditional generic medications except they are the generic versions of specialty drugs. Specialty generics are less costly than specialty brand name drugs. Specialty generics may include biopharmaceuticals, blood derived products and complex molecules.

Specialty Brand medications are high-cost prescriptions used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Specialty Brand medications sometimes require special handling and administration (typically injection or infusion), and patients using a specialty drug may need careful oversight from a health care provider who can watch for side effects and ensure that the medication is working as intended.

Spread pricing is a PBM practice of charging a payer, such as a commercial health insurance carrier or a Medicaid plan, more than they pay the pharmacy for the medication and then keep the difference or the “spread” as a profit.

Traditional Brand medications are sold by a pharmaceutical manufacturer under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Traditional Generic medications have the same active-ingredient formula as a brand-name drug. However, a generic drug can only be marketed after its brand name counterpart's patent has expired, which may take up to 20 years after the patent holder's drug is first filed with the U.S. Food and Drug Administration (FDA). Generic drugs usually cost less than brand-name drugs.

Therapeutic Category is a categorization system that groups sets of medications and other compounds that have a similar chemical structure, the same mechanism of action (i.e., binding to the same biological target), a related mode of action, and/or are used to treat the same disease.

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