

COST-SHARING AND DRUG-PRICE TRANSPARENCY IN NEW YORK

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Executive Summary

The rising cost of prescription drugs has pushed the issue onto the political agenda. Various voices, including senior officials in the Trump administration, have suggested that greater price transparency may help to remedy this problem.

There is certainly much to be said for doing more to empower consumers in much of the health-care sector. But the market for prescription drugs does not allow for shopping around by patients in the way that markets for hospital or physician services do. Branded drugs, for which prices are highest, are deliberately insulated from competition by the patent system.

In New York, prescription drug cost-sharing is rigidly defined by state law for most health-insurance markets, except federally regulated employer-sponsored insurance or Medicare plans. This further reduces the scope for patients to respond to price signals.

Although drug-price transparency may be welcomed for its political effects, the disparity between list prices and those actually paid by individuals covered by various insurance plans would tend to mislead rather than inform.

Price transparency is therefore best deployed within the context of specific insurance-plan designs. Although most insurers offer price-comparison websites, few enrollees use them. To get more value from price transparency, insurers should be allowed more flexibility in designing cost-sharing so that they may provide more appropriate incentives for consumer engagement.

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The Push for Price Transparency in Health Care

Alex Azar recently announced that he was making health-care price transparency a major objective of his tenure as U.S. Secretary of Health and Human Services. As a consumer who had been frustrated by an inability to find the prices associated with medical services, Azar declared: “It’s not an exaggeration to say that just about every hospital bill in America today is a surprise bill for folks.”¹ As a matter of principle, he stated: “I believe you ought to have the right to know what a health-care service will cost—and what it will really cost—before you get that service.”²

Secretary Azar is not alone in his hunger for greater price transparency: 56% of Americans have reportedly looked for price information before seeking medical care, and 21% have sought to compare prices across several providers.³ Although this may not always be possible for those in need of emergency care, the bulk of health-care spending relates to elective procedures and services, and information about price and quality can be important for patients seeking the best value for their money.

As the sophistication and cost of health-care services have increased, the out-of-pocket share of health-care spending in the U.S. has fallen, from 52% in 1960 to 11% in 2016.⁴ With private insurers and public entitlements becoming responsible for the bulk of health-care spending, the incentive for medical providers to compete by cutting and publicizing prices has been greatly diminished.⁵ Nonetheless, following the Medicare Modernization Act (MMA) of 2003 and Affordable Care Act (ACA) of 2010, which both encouraged the purchase of high-deductible health-insurance plans, average deductibles faced by U.S. employees increased sharply, from \$303 in 2006 to \$1,221 in 2017.⁶

The result: a revival of interest in helping consumers shop around for care, as well as a hope that price transparency could generate savings for those purchasing care by reducing wasteful overspending and constraining bloated service costs.

Prescription drug spending was long seen as a modest, low-variance expense that was not covered by insurance. Medicare was slower than most plans to add coverage, doing so only after MMA created Part D. Today, despite the expansion of entitlement and insurance coverage, patients remain disproportionately exposed to prescription drug costs: whereas 2.6% of hospital inpatient spending was paid directly by patients in 2014,⁷ 13.9% of prescription drug costs were borne out-of-pocket.⁸

In spring 2018, a bipartisan group of senators led by Bill Cassidy of Louisiana, seeking to develop legislation to improve price transparency, received feedback from 130 organizations from across the health-care industry.⁹ Senator Cassidy suggested that Congress mandate price disclosures for

elective medical services and ban “gag clauses,” which drug companies use to prevent pharmacists from informing patients about drugs that would cost less to obtain by paying entirely out-of-pocket rather than through insurance.¹⁰ The Know the Lowest Price Act and the Patient Right to Know Act, which prohibit the use of gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs), were signed into law in October 2018.¹¹ Secretary Azar has also voiced his opposition to these gag clauses, and the Trump administration has floated a proposal that would require drug list prices to be posted in TV ads.¹²

Currently, 26 states require health insurers to report comprehensive data on payment for medical services to All-Payer Claims Databases.¹³ But states cannot impose such reporting requirements on Medicare Advantage plans and health-care plans that are self-funded by large employers, which are both regulated at the federal level.¹⁴ Nor does the distribution of prices for services delivered to past consumers necessarily offer much guidance to individuals under various network arrangements who are shopping for care in the present.

While enhanced reporting of the cost of specific services may help policymakers keep track of public funds used to subsidize the purchase of private insurance, such arrangements are unlikely to do much to empower consumers. Indeed, there is often a great disparity between formal list or chargemaster prices and those to which individuals under a variety of insurance arrangements may be subject. A jumble of price data relating to facility costs, practice expenses, anesthesiologist fees, lab tests, and post-acute care may also be effectively incomprehensible to patients. Indeed, emphasizing prices in isolation from information about quality may lead consumers to make inappropriate choices.

Yet price transparency might help empower intermediaries, who are trained and capable of interpreting the data correctly. Only 28% of patients say that medical providers have brought up costs in their discussions of care options, and there may be value in helping clinicians to incorporate financial concerns of patients into their advice.¹⁵

Insurance plans are likely even better placed than doctors to guide patients to use price transparency effectively. Plans bear most of the costs associated with care, and they have knowledge and experience in getting value for money. They are able to design cost-sharing structures that complement provider-payment arrangements. Price transparency can bolster the effectiveness of these structures and arrangements by helping to steer patients toward the most cost-effective providers, too.

The extent to which price transparency can be effective is intertwined with the idiosyncrasies of insurance-plan design. Price transparency has less of a role to play in more aggressive forms of managed care, such as staff model health maintenance organizations (HMOs), than it does in looser network preferred provider organization (PPO) insurance plans, which have fewer supply-side tools with which to constrain expenditures. Price transparency is therefore likely to be useful to the extent to which, and in contexts in which, plans afford choice to enrollees as shoppers, rather than procuring medical services for them directly. Indeed, price transparency is likely to be an essential complement to payment innovations, such as reference pricing or balance billing, for which insurers reimburse a fixed amount for particular services and leave consumers to pay costs above that level.¹⁶

Over the past two decades, the growth of travel websites like Expedia has made it much easier for consumers to compare fares for flights. It has also forced airlines to concentrate on driving down prices. While it might be difficult for individuals to assess the value of complex medical services, it might be easier for them to compare insurance plans as a package deal. Websites such as eHealthInsurance have helped them to do so.

The Role of Cost-Sharing and Price Transparency for Prescription Drugs

Public policy on prescription drugs typically seeks to balance various, often conflicting, goals: access to treatment, innovation, and cost control. To this end, public programs and PBMs negotiate formularies and payment arrangements with drug manufacturers while establishing cost-sharing arrangements to encourage cost-conscious utilization by enrollees.

Health plans usually require cost-sharing with three goals in mind: (1) to shift the cost burden from the third-party payer to the individual enrollee; (2) to discourage overuse of medical goods and services; and (3) to encourage patients to shop around for cheaper services.¹⁷ In the case of prescription drugs in New York State, the motive of shifting costs to enrollees is relevant mostly for those enrolled in high-deductible employer-sponsored insurance (ESI), as cost-sharing is otherwise capped by state regulation or curtailed by recent legislation that has capped the “donut hole” in Medicare Part D.¹⁸

The objective of discouraging the overuse of costly health-care services by those for whom payment is covered by health insurance was most prominent in the RAND Health Insurance Experiment (conducted from 1971 to 1982, it demonstrated the sensitivity of health-care spending to out-of-pocket expenses).¹⁹ Yet in the case of prescription drugs, this objective is counterbalanced by an opposite (and possibly more prevalent) concern: to avoid underuse and ensure that enrollees complete their prescribed courses of medication.²⁰ For this reason, there is a strong case for prescription drug cost-sharing to be set artificially low relative to that for hospital and physician services.²¹

The optimal cost-sharing in this respect likely varies from drug to drug and from patient to patient, according to therapeutic benefit. In some cases, it may even be negative (i.e., with money being saved if plans *pay* enrollees to take their drugs).²² Other instruments, such as prior authorization requirements, can also be used to mitigate the risk of overuse or inappropriate use—even where cost-sharing is absent, such as in Medicaid.²³

The objective of encouraging patients to shop for cheaper substitutes thus provides the most unambiguous role for cost-sharing in prescription drugs.²⁴ As generic drugs seek merely to replicate the content of innovator drugs—and do not vary on the vast number of qualitative dimensions that hospital or physician services may differentiate themselves with—where generic drugs are available, there is less to fear (and more to be gained) by giving patients the responsibility and incentive to shop around for cheaper substitutes.²⁵

A desire to leverage consumer price sensitivity is acknowledged by New York’s regulations for Exchange and Essential Plans, which require copays for generics to be set below those for all branded drugs. Given that generic drugs average just 6% of the cost of branded drugs, this helps ensure that those paying taxes and premiums enjoy the savings possible when drugs go off patent. This indirectly serves to constrain the price of branded drugs, which helps patients who don’t switch. As a result of such cost-sharing arrangements, and mandatory generic substitution under many plans, 89% of the drugs consumed in the U.S. are generics.²⁶

There are no perfect substitutes for patent-protected drugs, which are subject to temporary legal monopoly. But other products may have similar therapeutic effects. Prescription drug plans may therefore still employ differential cost-sharing to steer enrollees toward cheaper branded alternatives. This incentive is generated automatically for those enrolled in plans subject to coinsurance, and it may be maintained by

a disparity in copays (as for those between Tier 2 and Tier 3) for individuals enrolled in the exchange.²⁷ Plans have used this tiered structure to encourage beneficiaries to switch toward cheaper preferred drugs.²⁸ While price transparency may be of little use to consumers if every drug in a class has the same copay, there is some evidence that a switch from tiered copays to tiered coinsurance can reduce costs, without diminishing utilization, by better transmitting price incentives to consumers.²⁹

For all market segments in New York other than ESI or Medicare Part D, the requirement for fixed copays entirely eliminates price incentives within tiers, and between preferred and non-formulary tiers for those in Medicaid, the Children’s Health Insurance Program (CHIP), and the Essential Plan (EP) with incomes below 150% of the federal poverty level. In theory, enrollees could gain further savings by purchasing prescription drugs by mail order, rather than at a pharmacy. However, state-mandated copays seek to push New Yorkers to fill prescriptions at brick-and-mortar providers, which impose higher costs on consumers.

Under such circumstances, even the best price-transparency tool for prescription drugs is likely to have little effect. Indeed, when cost-sharing structures are standardized across plans, there is little ability for individuals to shop around for a cost-sharing structure that offers them the best value for their own particular prescription drug needs, as is the case with the Medicare Plan Finder, which helps beneficiaries choose between Medicare plans.³⁰

Transparency Initiatives in Other States

In 2017, state legislatures considered 75 health-care pricing bills, of which 21 passed—most requiring reporting of drug costs and price changes. California, for instance, requires manufacturers to inform the state before raising drug prices, and requires that they provide reasons to justify the increase.³¹ Connecticut enacted a law (HB 5384) that would require manufacturers to report and justify price increases.³² Vermont enacted legislation (S 92) requiring insurers to file annual summaries of payments for drugs and their impacts on premiums; it also requires manufacturers to provide justifications of price increases and notice of costly new drug launches.³³

Maine enacted legislation (LD 1406) to commission a report on the pricing of the 25 drugs in the state

that are most prescribed, costliest, and subject to the fastest price increases.³⁴ Oregon enacted legislation (HB 4005) requiring drug manufacturers to report prices along with costs of development and marketing for prescription drugs; the state also requires insurers to report information about the impact of drug prices on premiums.³⁵

The National Academy for State Health Policy released model legislation to shed light on the activities of PBMs, including: Who gets rebates? How much are they? How is the money used? Do savings serve to reduce premiums or increase profits?³⁶ Utah (SB 208) requires PBMs to report the amount of direct or indirect remuneration related to drug sales, along with the reasons and terms associated with such payments.³⁷ Louisiana enacted legislation (SB 283) requiring PBMs to disclose aggregate data on administrative fees and rebates received from manufacturers.³⁸

From January 2017 to August 2018, 41 state legislatures considered—and 26 states enacted—laws prohibiting gag clauses for pharmacists.³⁹ Florida enacted a law (HB 351) requiring pharmacists to inform customers of generically equivalent drug products, as well as to advise customers on whether the associated cost-sharing exceeds that for prescribed drugs.⁴⁰

Cost-Sharing for Prescription Drugs in New York

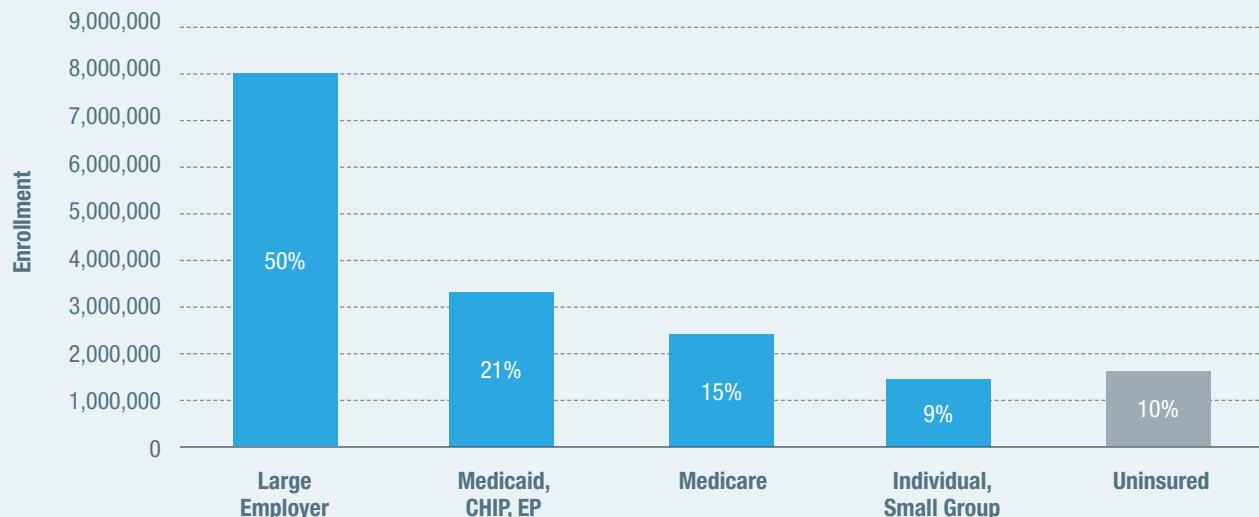
People often speak loosely as if “health insurance” is a generic item, but there is much variation between what different plans cover and the cost-sharing payments that accompany plans. This is particularly true in the case of prescription drugs, for which plans may allocate to various cost-sharing tiers and for which different market segments are subject to differing levels of public subsidies, state regulations, coverage requirements, price controls, and mandatory discounts. Under some employer plans, a deductible may apply equally to prescription drugs, hospital services, and physician services; under Medicare, prescription drugs may be entirely uncovered without the payment of a supplemental premium. Because various market segments are subject to distinct regulatory regimes, these segments must be examined distinctly.

Employer-Sponsored Insurance

Most New Yorkers, like most Americans, receive health insurance from their employers (**Figure 1**).⁴¹ There is also great variation in the benefit structures of ESI: self-insured employer plans, for example, are excused from ACA’s essential health-benefit requirements and

FIGURE 1.

Health-Insurance Enrollment in New York State, 2016



Source: American Community Survey, U.S. Census Bureau

are exempted from state regulation by the Employee Retirement Income Security Act (ERISA). Although ESI is a category of health insurance, any two ESI plans may have as little in common as plans from any two other market segments. It is therefore hard to generalize about the nature of ESI benefit structures. (One caveat: while ESI plans exist with similar benefit structures to those of any other kind of plan, the exemption of ERISA plans from ACA and state regulations means that ESI plans exist with much greater cost-sharing and looser coverage requirements than other market segments.)

The absence of regulatory standardization also means that ESI benefit structures can only be characterized statistically. The Kaiser Family Foundation’s 2017 Employer Health Benefit survey is not limited to the State of New York, but it still provides a good overview of the nature of plan designs.⁴² Nationwide, 99% of those with ESI enjoyed prescription drug coverage, with 91% being subject to tiered cost-sharing (**Figure 2**). ESI enrollees in high-deductible health plans (28%) were more likely to be exempt from cost-sharing for prescription drugs after the deductible was met, while those with a separate annual deductible for prescription drugs (15%) faced average deductible levels of \$149.

Individual and Small Group Market

The individual and small group market in New York, including exchange and off-exchange plans, is subject to state and federal regulation under ACA. New York prohibits short-term limited-duration insurance, so only ACA-compliant plans are available for purchase by individuals. These are subject to ACA’s regulations on essential benefits, premiums, and cost-sharing; state regulations further narrow the options that insurers can offer.

With respect to prescription drugs, state law mandates a specific cost-sharing structure for prescription drugs for each segment of the individual market (**Figure 3**). New York law prohibits specialty tiers, prohibits cost-sharing from exceeding the actual costs of drugs, and allows eligible consumers to opt out of “step therapy” requirements to try lower-cost drugs first.⁴³ Copays for retail pharmacies are specified for each tier, with copays for mail-order drug purchases required to be set at 250% of these levels.⁴⁴

FIGURE 2.

Prescription Drug Cost-Sharing Under ESI

	Tier 1 (Generics)	Tier 2 (Preferred)	Tier 3 (Non-Formulary)	Tier 4 (Specialty)
No Cost-Sharing	7%	<1%	<1%	2%
Copay	81% (avg.: \$11)	71% (avg.: \$33)	67% (avg.: \$59)	48% (avg.: \$110)
Coinsurance	10% (avg.: 17%)	28% (avg.: 25%)	30% (avg.: 35%)	40% (avg.: 28%)

Averages are for the 77% of ESI enrollees in plans with three tiers or more.

Source: Kaiser Family Foundation

FIGURE 3.

Prescription Drug Cost-Sharing on Individual Market

	Tier 1 (Generics)	Tier 2 (Preferred)	Tier 3 (Non-Formulary)	Deductible (Incl. Medical)
With Cost-Sharing Reduction Subsidies (100%–150% of Federal Poverty Level) (94% Actuarial Value)	\$6	\$15	\$30	\$0
CSR (150%–200% of FPL) (87% AV)	\$9	\$20	\$40	\$0
CSR (200%–250% of FPL) (94% AV)	\$10	\$35	\$70	\$0
Catastrophic (aged under 30)	\$0	\$0	0	\$7,150 (single adult)
Bronze (60% AV)	\$10	\$35	\$70	\$4,000 (single adult)
Silver (70% AV)	\$10	\$35	\$70	\$0
Gold (80% AV)	\$10	\$35	\$70	\$0
Platinum (90% AV)	\$10	\$30	\$60	\$0

Source: New York State Department of Health

FIGURE 4.

Prescription Drug Cost-Sharing in Medicaid, CHIP, and EP

	Tier 1 (Generics)	Tier 2 (Preferred)	Tier 3 (Non-Formulary)
Medicaid (non-dual)	\$0	\$0	\$0
CHIP (children <400% of FPL) ⁴⁵	\$0	\$0	\$0
Essential Plan 1 (150%–200% of FPL) ⁴⁶	\$6	\$15	\$30
Essential Plan 2 (138%–150% of FPL) ⁴⁷	\$1	\$3	\$3
Essential Plan 3 (100%–138% of FPL) ⁴⁸	\$1	\$3	\$3
Essential Plan 4 (<100% of FPL) ⁴⁹	\$0	\$0	\$0

Source: New York State of Health

Medicaid, CHIP, and the Essential Plan

New York’s state-operated, means-tested, entitlement programs function with minimal cost-sharing. Medicaid and CHIP require no out-of-pocket payments for prescription drugs, while EP requires more than nominal copays only for individuals earning more than 150% of the federal poverty level (**Figure 4**). EP also does without specialty tiers or deductibles for prescription drug coverage.

Medicare

The Medicare Part D prescription drug benefit, only in its second decade, has already evolved an enormously complex set of cost-sharing rules. Prescription drug coverage under Medicare is not mandatory but was still chosen by 76% of New York’s Medicare beneficiaries in 2016.⁵⁰ Of these, 55% received prescription drug coverage as a stand-alone drug plan, while 45% received drug coverage as part of a Medicare Advantage plan.⁵¹ Nationwide, the 2017 median monthly premium for

FIGURE 5.

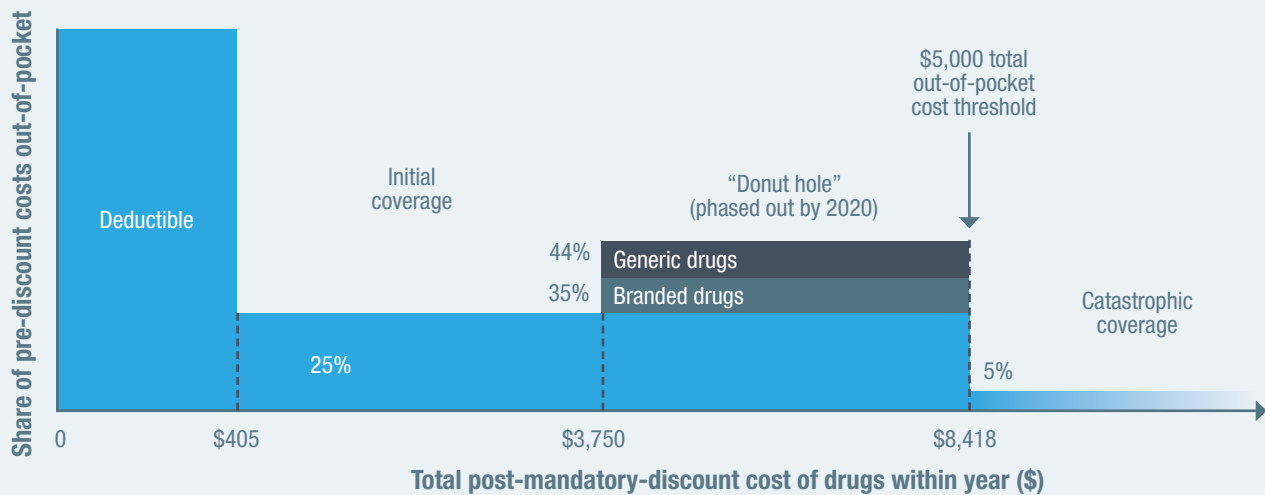
Prescription Drug Cost-Sharing in Medicare Part D

	Total Drug Spending Level (Threshold)	Tier 1 (Generics)	Tier 2 (Preferred)	Tier 3 (Non-Formulary)	Tier 4 (Specialty)
Deductible	\$0–\$405	100%	100%	100%	100%
Initial Coverage	\$405–\$3,750	25%	25%	25%	25%
Donut Hole	\$3,750–\$8,418	44% in 2018; 25% from 2020	35% in 2018; 25% from 2020	35% in 2018; 25% from 2020	35% in 2018; 25% from 2020
Catastrophic Coverage	\$8,418+	Greater of 5% or \$3.35	Greater of 5% or \$3.35	Greater of 5% or \$8.35	Greater of 5% or \$8.35

Source: National Council on Aging

FIGURE 6.

Medicare Part D Cost-Sharing Structure



Source: New York State Department of Health

a stand-alone drug plan was \$36, while that for drug coverage under Medicare Advantage was \$0.⁵² Medicare Advantage plans subsidized Part D coverage by an average of \$360 per beneficiary with savings from the delivery of other medical services.⁵³

On average, Medicare beneficiaries consumed \$2,904 in Part D drugs in 2013, with \$384 borne out-of-pocket.⁵⁴ Unlike the market segments regulated by the State of New York, Medicare drug plans usually include deductibles, coinsurance, and specialty drug tiers.⁵⁵ Medi-

care Part D cost-sharing must be actuarially equivalent to a standard defined structure within threshold levels of drug spending—i.e., the average proportion of out-of-pocket spending between thresholds is fixed, but plans can widen, or narrow, the disparities in cost-sharing levels between tiers (Figures 5 and 6). Plans may place drugs on specialty tiers if their average costs exceed \$670 per month.⁵⁶ Coinsurance is capped at 25% for preferred brands, 50% for non-preferred brands, and 33% for specialty tiers.⁵⁷

FIGURE 7.

Prescription Drug Cost-Sharing for Dual Eligibles

	Tier 1 (Generics)	Tier 2 (Preferred)	Tier 3 (Non-Formulary)	Tier 4 (Specialty)	Deductible
Long-Term Care Duals with Low-Income Subsidy ⁵⁹	\$0	\$0	\$0	\$0	\$0
Full Duals LIS (<100% of FPL) ⁶⁰	\$1.20	\$3.70	\$3.70	\$3.70	\$0
Partial Dual LIS (100%–150% of FPL) ⁶¹	\$3.30	\$8.25	\$8.25	\$8.25	\$0 to \$82.00

Source: National Council on Aging; people who are “dual eligible” are eligible for both Medicare and Medicaid.

The federal government provides additional subsidies to reduce prescription drug cost-sharing for low-income Medicare beneficiaries (Figure 7). Some 35% of New York’s Medicare beneficiaries with prescription drug coverage received such low-income subsidies in 2016.⁵⁸

Cost-Sharing Approaches by Other States and Payers

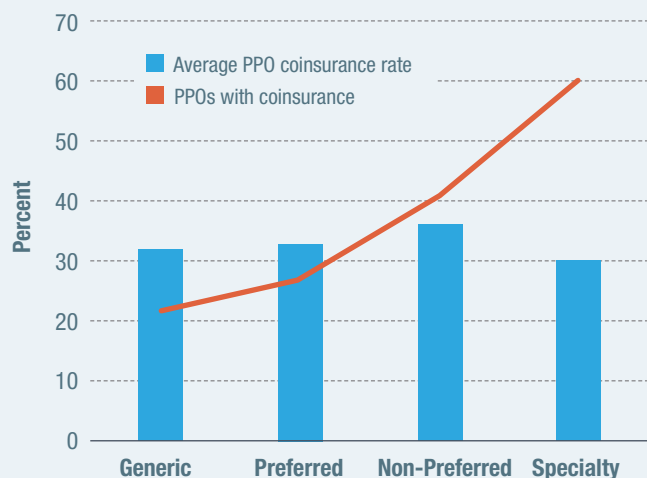
In 2017, the nationwide average silver plan deductible on the exchanges established by ACA was \$3,572 for individuals and \$7,474 for families.⁶² Two-thirds of exchange plans exempt drugs from medical deductibles.⁶³ Yet whereas cost-sharing levels for hospital and physician services on the exchange were similar to those under ESI, out-of-pocket expenses associated with prescription drugs were twice as high.⁶⁴

Federal regulations and subsidies limit aggregate out-of-pocket expenses as a proportion of insurance costs. The details of how cost-sharing must be distributed between different medical services are left for states to regulate (Figure 8). This potentially deters appropriate use of prescription drugs. It may also be used by plans to select a healthier group of enrollees, which ACA’s community rating regulations make highly profitable.⁶⁵

Approaches to managing cost-sharing vary greatly, from state to state and from plan to plan (Figure 9).⁶⁷ Some states, such as California, require a specific pre-

FIGURE 8.

Coinsurance, Exchange Silver Plan



Source: Buttorff et al.⁶⁶

scription drug cost-sharing structure for each “metal” tier.⁶⁸ New York has been even more prescriptive about the design of cost-sharing for prescription drugs (Figure 10). But this has come at the cost of further inflating cost-sharing for other services. It has also contributed to giving New York some of the highest health-insurance premiums in the U.S.⁶⁹

FIGURE 9.

Exchange Cost-Sharing Tiers by State

State	Cost-Sharing via Copays	Tier 2 Copay	Tier 4 Coinsurance	With Joint Deductible	Drug-Specific Deductible
California ⁷⁰	100%	\$50 fixed	Max \$250	0%	\$250 (avg.)
Texas ⁷¹	89%	\$49 (avg.)	38% (avg.)	63%	\$586 (avg.)
Florida ⁷²	97%	\$39 (avg.)	26% (avg.)	34%	\$1000 (avg.)
New York ⁷³	100%	\$35 fixed	n/a	0%	n/a
Pennsylvania ⁷⁴	74%	\$47 (avg.)	47% (avg.)	69%	\$417 (avg.)

Source: PhRMA

Increased Price Transparency Is No Cure-All

Cost-sharing and price transparency draw attention to difficult trade-offs, and they allow individuals to make decisions for themselves that otherwise would have been made for them behind closed doors. By better aligning the knowledge, interest, and responsibility for making cost-conscious decisions, cost-sharing and price transparency attempt to promote a more efficient allocation of scarce health-care resources and funds.

The ability of patients to choose effectively—when given the opportunity and incentive to shop for hospital and physician services—is often unfairly denigrated. The need for consumer control to check inflated medical costs is similarly underappreciated. However, the value of consumerism with respect to prescription drugs is mitigated by the fact that the grant of monopoly power to inflate prices is a deliberate goal of drug policy. Whereas one may seek to encourage consumers to avoid costly hospitals for the sake of discouraging facilities from becoming overstaffed or overcapitalized, drug prices have little to do with marginal costs of production, which are trivial. This is not to say that drug prices should be set at marginal costs. Patent protections serve an important function by allowing drugmakers to profit from billion-dollar investments in bringing valuable new therapies to market.

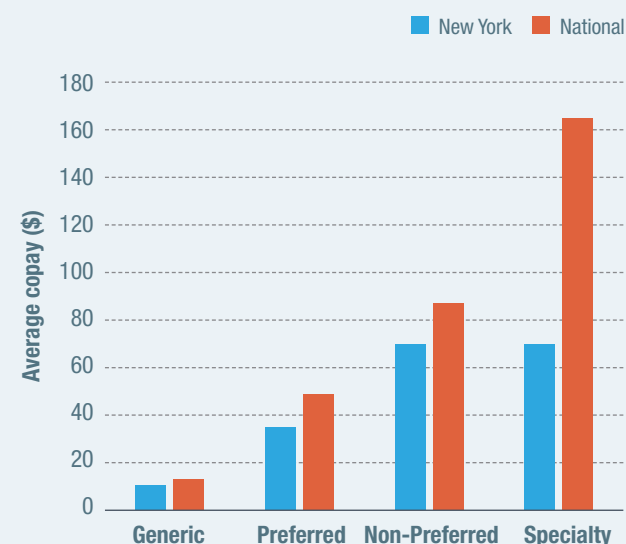
Still, the monopoly power granted by the patent system is not absolute. First, it is a temporary monopoly lasting only 20 years from the initial filing of an application (this may be extended by market-exclusivity provisions, in some cases).⁷⁵ Second, patent protections do

not preclude distinct therapies from being developed and serving as substitutes. Competition between drugs covered by patents usually involves some difference in therapeutic effects, but between-patent competition also serves to constrain pricing.⁷⁶

However, to the extent that the prices of branded drugs are constrained by the availability of substitutes, it is primarily in negotiations between payers (privately or publicly managed plans) and manufacturers. For most of the market, direct consumerism is auxiliary to that dynamic. Instead, consumerism is greatly shaped

FIGURE 10.

Prescription Drug Cost-Sharing, Exchange Silver Plan



Source: Avalere

by the form in which price disparities are passed on through cost-sharing.

There are two big exceptions to this situation: the uninsured (who lack comprehensive drug coverage) and individuals with ESI (whose unified medical deductible may be so substantial that their drug coverage pays for little of their expenses). While most individuals do not undergo major medical procedures in a given year, most adults (particularly those past midlife) have ongoing drug prescriptions. As a result, much drug consumption must be financed entirely out-of-pocket.

There is little doubt that higher cost-sharing for prescription drugs will reduce spending on drugs. But, as noted, any benefit resulting from an increased incentive to seek out cheaper substitutes may be overwhelmed by the effect of disrupting adherence to prescribed courses of treatment.

The requirement for some markets (such as New York's exchange) to fix copays for prescription drugs and to exempt prescription drugs from deductibles may impose opposite evils. At any fixed cost-sharing tier (e.g., "silver," at 70% actuarial value), covered aggregate medical expenditures on prescription drugs may be so substantial that overall cost-sharing must be increased proportionately on nonroutine expenses. The result: the insurance product fares poorly at its primary function of protecting enrollees from major medical costs, such as hospitalizations. Rather than skewing plan design for substantial cost-sharing for prescription drugs with high-deductible insurance plans or against it with mandated copays, policymakers should instead allow plans flexibility to craft "value-based insurance designs," which allow for nuanced attempts to balance conflicting goals.⁷⁷

With hospital and physician services, there are qualitative considerations for which individuals may wish to pay more, such as being treated at a hospital that is nearer to home or by a physician with whom they have a good rapport. In such cases, cost-sharing serves an important role—reconciling the need to control costs within well-managed provider networks with the idiosyncratic preferences of consumers for out-of-network providers for which they would be happy to pay more. However, such subjective considerations play much less of a role in the case of prescription drugs—products that are uniform.

There may be cases in which particular individuals respond unusually well to specific branded drugs instead of substitutes. Yet these costs may be better managed through prior authorization and step therapy, rather than through cost-sharing. The distinguishing

feature of prescription drugs—as opposed to over-the-counter medications—is the need for expertise and some paternalism. We trust individuals to pick their doctors and hospitals in a way that we do not trust them to shop for prescription drugs.

A prohibition on gag clauses may yield some benefits—particularly for those in New York who are enrolled in Medicare Part D or ESI and who are therefore not subject to state-regulated copays. However, consumers should also be alerted that paying for drugs out-of-pocket may increase exposure to other out-of-pocket expenses before they reach their deductibles and out-of-pocket maximums.

Price transparency is often discussed within the context of consumer behavior. But the disclosure of prices necessarily has political as well as economic effects. In theory, the perfect dissemination of information may lead to optimal political decision making. In practice, the information that is disclosed will be partial; and information promoted by political actors is likely to be skewed.⁷⁸ Selectively increasing the salience of some information will tend to reduce the salience of other, unacknowledged, dimensions.

Individuals pay different amounts for the same drugs depending on which insurance plan they are enrolled in. Many of the uninsured are eligible for patient assistance discounts directly from the manufacturer. As a result, public disclosure of a singular list price is likely to have only the loosest relationship with the prices that individuals actually pay after rebates. Although it may stoke political controversy, such disclosure of list prices may serve more to mislead than to enlighten policy debates.

The bottom line: increased transparency does not *necessarily* improve policy outcomes. Jacob Gersen and Matthew Stephenson of Harvard University have rightly noted that "over-accountability" may yield flaws in decision making, including pandering, posturing, persistence in error, populism, and political correctness.⁷⁹ In the context of health-care policy, which is replete with a vast array of delicate trade-offs between cost, quality, access, and innovation, the clamorous politicization of prices is likely to impede appropriate decision making.

Drug policy is particularly vulnerable to demagoguery, given the relationship between the billion-dollar sunk investments associated with drug development and the trivial marginal costs associated with manufacture.⁸⁰ Price-reporting requirements may create political pressure for immediate savings through price controls that politicians might find hard to resist, while the associ-

ated cost of reduced benefits from innovation is borne many years after politicians leave office. As a result, sunshine laws could undermine the ability of policymakers to credibly commit through the patent system to allow drugmakers to recoup profits generated by investments.⁸¹ Bills to monitor and publicize details of internal PBM operations, activities, and payment structures are similarly likely to induce harmful consequences.

To get value for money, it is, of course, helpful for public payers to know the prices of drugs that they are purchasing. But mandatory disclosure of the prices of privately purchased drugs may induce policy feedbacks that serve to constrain consumers rather than to empower them.

Enhanced price transparency, *by itself*, is unlikely to have the transformative effect on the health-care system that its most enthusiastic advocates claim. Still, it can play a useful role if its objectives are more modest. The following three reforms would also serve to make price transparency more beneficial.

1. Deregulate cost-sharing. Because 98% of health-insurance plans offer transparency tools, but only 2% of enrollees use them, making available even a good price-transparency tool does not, by itself, reduce health-care spending.⁸² Price-transparency tools will do little to reduce costs so long as consumers lack the incentive to use them.⁸³ This could be achieved with higher prescription drug copays for

state-regulated markets, although this may come at the cost of medication adherence. A better approach would be to simply deregulate cost-sharing arrangements and to allow insurers and PBMs more flexibility to set cost-sharing arrangements according to principles of value-based insurance design. The continued existence of actuarial value regulations would suffice to ensure that such flexibility does not increase consumers' overall exposure to out-of-pocket costs.

2. Inform regulators. Mandatory disclosure of information can sometimes be problematic; but under certain circumstances, it can aid regulators in weighing trade-offs. For instance, if PBMs are merely providing rebates for the purpose of manipulating reinsurance payments (the case with Medicare Part D), it can be helpful to policymakers to understand the nature and circumstances under which rebates are provided.

3. Eliminate barriers to competition. Usable and effective price transparency is a consequence, not a cause, of competition. Restaurants post their prices outside their doors to attract customers, not because they are forced to do so by regulators. Prices are a prominent feature of advertising in most highly competitive industries. Regulatory reforms to reduce barriers to entry for generic drugs or therapeutically equivalent competitors may generate price transparency as part of price competition.



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