Rebates at the Point of Sale

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Actuarial Perspectives on Prescription Drug Financing
Initiative 18|11 explores prescription drug rebates and their impact on consumer pharmacy spend Deana K. Bell and Karen L. Nixon May 2020

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As the United States continues to struggle and question the high cost of health care, the fact that drug manufacturers issue rebates to prescription benefit managers (PBMs) and health plans (payers) has moved from industry-insider information to the public spotlight. In light of this, payers have considered sharing their rebates with the consumer at the point of sale (POS). The Society of Actuaries' (SOA's) Initiative 18|11 is exploring all areas of the U.S. health care system to find ways to control spending. One of these areas is prescription drug rebates. This article examines how rebates at the POS might affect the consumer.

How Drug Rebates Work Today

Rebates on prescription drugs are a significant part of the complex drug distribution chain. Health plans and PBMs develop a list of drugs that are covered at various levels of consumer out-of-pocket costs. This list is referred to as a formulary, and the various levels

of coverage are referred to as formulary tiers, where “preferred” status of a drug is a lower cost to the consumer and “nonpreferred” status is a higher cost to the consumer. The health plan (and the government, in Medicare) is responsible to pay the net balance of the drug costs after the consumer portion is paid.

Health plans and PBMs negotiate drug rebates with drug manufacturers to try to get the lowest net cost drugs[1] on their formularies, especially in the preferred tiers, as those will likely be the most utilized drugs. Drug manufacturers are willing to partake in these types of negotiations because it allows their drugs to be more affordable to consumers (and therefore, more highly utilized) if a health plan or PBM covers a portion of the cost.

Drug rebates are paid retrospectively to the plan based in part on the number of prescriptions that were utilized by the plan’s members. Payments may occur at the end of each month or quarter depending upon the contract terms. However, there can be nine or more months between the POS and rebate payment associated with a specific claim. In the current environment with high drug cost trends, many payers use the anticipated savings from rebates to reduce plan costs. For these plans, all members, using rebated drugs or not, may receive the benefit from rebates in the form of lower premium rates or lower employee contribution rates than they would likely have had in the absence of the drug rebates (see Figure 1).

Figure 1: Rebate/Cost-Share Example

	Rebate = 5%	**No Rebate**
(a) Drug cost	$100	$100
(b) Coinsurance (20%)	$100 * 20% = $20	$100 * 20% = $20
(c) Rebate	$100 * 5% = $5	$100 * 0% = $0
(d) Net cost to plan (a – b – c)	$100 – $20 – $5 = $75	$100 – $20 – $0 = $80
(e) Premium = net cost to plan (d) / minimum medical loss ratio	$75 / 80% = **$93.75**	$80 / 80% = **$100**
(f) Coinsurance as % of premium (b / e)	$20 / $93.75 = 21%	$20 / $100 = 20%

Note: This example has been simplified to provide a high-level, directional view of how rebates could impact premium.

In addition to drug manufacturer rebates, there can be rebates that are paid from pharmacies to health plans by participating in preferred networks. A preferred pharmacy network is a group of pharmacies identified by the plan, and usually there is lower cost-sharing at preferred pharmacies to encourage members to use the network. Preferred pharmacies may have different contracting terms with the plan, compared to all other pharmacies, and pharmacies may negotiate rebates (also called price concessions) with PBMs and health plans in order to participate. In the end, there may be higher discounts and other price concessions (i.e., pharmacy rebates) paid to the plan by the preferred pharmacy and vice versa.

POS Rebates

Given the competitive nature of health plan premiums and therapeutically appropriate drug alternatives, specific rebate information has historically been kept proprietary. This lack of transparency has been a driving force to develop alternative, more transparent methods of passing rebates on to consumers. Currently, rebates are passed through to all members in the form of lower premiums, but there are new plans where rebates are passed through directly to consumers using specific rebate-eligible drugs. There are two alternative rebate payment methods that have been considered for this direct-to-consumer approach: POS aggregated rebates and POS rebates by drug.

- **POS aggregated rebates** can be estimated as the portion of rebates that plans anticipate receiving each year that are provided to members filling rebate-eligible drugs (the estimate can be done in aggregate or by rebatable drug class—see Figure 2). This amount does not directly reflect the actual rebates that are paid for that drug from the manufacturer and therefore keeps negotiated rebate values proprietary as is the case right now.
- **POS rebates by drug** reduce the cost of a drug by the actual rebate amount provided by the manufacturer (see Figure 3). This would affect cost-sharing for utilizing members in the deductible phase and when coinsurance is applied. This would not affect members utilizing drugs subject to a copay as long as the net cost of the drug is greater than the copay or members purchasing drugs that are not subject to a rebate. This would enable negotiated rebate levels to become public knowledge. However, due to the lag between incurred claims and rebate payments, this makes POS discount payments challenging to make available to consumers.

Figure 2: POS Aggregated Rebates Impact on Consumer POS Cost Example

	Current Rebates	**POS Aggregated Rebates**

(a) Drug cost	$100	(a) Drug cost	$100
(b) Coinsurance (a * 20%)	$100 * 20% = **$20**	(b) Estimated total rebate % of all drugs[#]	$100 * 5% = $5
Note that rebates are used to decrease premiums, not coinsurance out-of- pocket costs for specific consumers		(c) Net drug cost (a – b)	$100 – $5 = $95
		(d) Coinsurance (d * 20%)	= $95 * 20% = **$19**

[#]This would be the overall rebate amount estimated to be received by the payer throughout the year divided by the estimated total drug spend.

Figure 3: POS Rebates by Drug Impact on Consumer POS Cost Example

	POS Rebates by Drug (Drug A: 10% Rebate)	**POS Rebates by Drug (Drug B: 0% Rebate)**
(a) Drug cost	$100	$100
(b) Rebate for specific drug[##]	$100 * 10% = $10	$100 * 0% = $0
(c) Net drug cost (a – b)	$100 – $10 = $90	$100 – $0 = $100
(d) Coinsurance (c * 20%)	$90 * 20% = **$18**	$100 * 20% = **$20**

[##]This value would vary by the specific drug being dispensed and would be specific to the contract negotiated between health plans, PBMs and drug manufacturers.

Either of these methods may result in potentially higher premiums for all members, all else being equal, because utilizing members would pay less of the cost-share, resulting in a higher liability for the plan sponsor.

Commercial Market: Health Plans Adopting Rebates at the POS

Traditionally in the commercial market, drug manufacturers issue rebates to PBMs (or directly to payers) based on rebate-eligible drugs dispensed. Over time, rebates have influenced the commercial market. For example, many payers, via their PBMs, leverage the

financial benefit of rebates by creating rebate-driven drug formularies (as opposed to drug formularies that drive utilization toward lower-cost drugs).

In 2019, some health insurers in the commercial market began sharing a portion of their rebates with consumers at the POS. Because the PBMs do not receive drug manufacturers' rebates until weeks or months after a drug is dispensed, any amount issued to the consumer at the POS can only be an estimate or projection on the part of the health insurer. Actual rebates are determined by the contract between health insurer/PBM and the drug manufacturer; projecting what that rebate will be poses an element of risk for plan sponsors. Will health insurers underestimate rebate dollars or inflate premiums to account for risk? There is significant pressure from employer sponsors to keep premiums low because they are ultimately covering much of the benefit and employees are sensitive to plan premium. There may not be enough incentive for plan sponsors to change from the current environment.

However, if there is disruption to the current environment, it may affect the behavior of the consumer and employer as well as PBMs and plan sponsors. Drug manufacturers issue rebates on brand and specialty drugs only, not on generic drugs. With few exceptions, brand and specialty drugs are more expensive than generic drugs. In response to a visible decrease in their out-of-pocket costs, consumers may choose to purchase brand over generic drugs to save money. This could result in health plans raising premiums to cover the increased utilization of higher-cost drugs. Health plans may also increase premiums to replace rebates that they are sharing with consumers.

Government Proposals for Discontinuing the Current Rebate System

In Medicare Part D and managed Medicaid, two recent proposals sought to remove rebates from the drug financing system:

- On Nov. 30, 2018, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule that included changes to pharmacy price concessions (pharmacy rebates) paid from pharmacies to Medicare Part D plan sponsors.[2] This particular proposal was to change pharmacy rebates, or pharmacy price concessions,[3] only which are separate and distinct from drug manufacturer rebates. Although pharmacy rebates are a much smaller piece of the total rebate pie (and a lot smaller than drug manufacturer rebates), they are still an important tool that Part D plan sponsors have used to reduce plan premiums. The proposal was to change the technical definition of the "negotiated price" of a drug in that it disallowed incentive-based pharmacy rebates paid from pharmacies to plan sponsors after the POS. CMS was concerned that the Part D beneficiary was not benefiting from lowered drug costs at the POS due to pharmacies paying rebates to plan sponsors, and this may have been distorting drug prices in a similar way as drug manufacturer rebates. With the release of the final rule in May 2019, this proposal was not finalized. As of early 2020, the latest version of the Senate's Prescription Drug Pricing Reduction Act included a section that would require pharmacy price concessions to be at the POS in Medicare Part D.[4] The government is still interested in pursuing this concept through legislation.
- On Jan. 31, 2019, the Department of Health and Human Services' Office of Inspector General (HHS-OIG) released a proposed rule that would outlaw post-POS drug manufacturer rebates in Medicare Part D and managed Medicaid. This was one of the most impactful regulations put forth as part of the release of the Trump Administration's American Patients First, a blueprint to lower drug prices and reduce out-of-pocket costs.[5] On July 11, 2019, the White House announced that this proposal was no longer being considered.[6]

Removing pharmacy rebates from Medicare Part D could lead to the deterioration of preferred pharmacy networks[7] because any negotiated cost differences would need to be handled through discounts at the POS instead of pharmacy rebates. Pharmacy rebates are much smaller in magnitude compared to drug manufacturer rebates and pharmacy rebates also affect all types of drugs, not just rebate-eligible brand drugs. If plan sponsors and pharmacies are not able to achieve a meaningful net cost differential between preferred pharmacies and all others, then there may not be a case to maintain a preferred network with lower cost-sharing to steer consumers.

There is no consensus regarding what may happen if drug manufacturer rebates are no longer allowed in Part D. CVS Caremark offered a plan that mirrored the POS rebates proposal in 2019[8] and did not offer it after the first year due to low demand from consumers. Because of the competitive bidding process in Part D and the standardized payments from CMS, CVS had to charge a much higher monthly premium than a typical plan. This case showed that consumers were sensitive to this premium differential. This may have worked out differently if all Part D plans were required to offer rebates at the POS.

If drug prices are unchanged, plans will need to negotiate POS discounts with manufacturers to have similar net drug costs before the removal of rebates. Stakeholders in favor of eliminating rebates believe that more transparency of the flow of costs in the drug channel may immediately lower prices for consumers at the counter, and in order to keep premiums low (after losing rebates), health plans may steer consumers toward lower-cost drugs.

Others believe that the HHS-OIG proposed rule may not lead to lower drug costs because some rebates may not be converted to lower prices or higher discounts. As a result, drug manufacturers may realize benefits from disrupting the current rebate system. As mentioned previously, rebates at the POS may lead to significant reductions in cost-sharing for consumers taking rebate-eligible drugs, which could lead to increased utilization of higher-cost drugs. Part D beneficiaries that receive low-income subsidies will most likely not realize any impacts from changes to rebates in Part D because they already benefit from very low copays for both generic and brand drugs. All beneficiaries paying a monthly premium may see their premiums increase, unless there are changes to how plans manage drug costs and through their formularies and other cost management activities.

Deana K. Bell, FSA, MAAA, is a principal and consulting actuary at Milliman Inc.
Karen L. Nixon, MBA, is a partner and the CEO at Nixon Benefits.
Note: The Society of Actuaries' (SOA's) Initiative 18|11 is exploring all areas of the U.S. health care system to find ways to control spending. This initiative is not affiliated with the authors' employers nor does the content reflect employer opinion.

References:

1. 1. The drug net cost to a payer is usually the average wholesale price minus any applicable discounts and rebates. ↩
2. 3. Incentive-based pharmacy price concessions are common in preferred pharmacy networks, where pharmacies have arrangements with plans where they may be subject to pay health plans as part of being in the plan's preferred pharmacy network. ↩
3. 7. A drug benefit plan may have a preferred network of pharmacies that offer lower cost-sharing compared to other pharmacies covered by the plan. ↩