

September 2015

Emergence and Impact of Pharmacy Deductibles:

Implications for Patients in Commercial Health Plans



Introduction

Commercial insurance provides coverage for about half of the total U.S. population and is a critical element of the healthcare system. The design of health insurance plans has evolved over the past decade, especially as employers have sought to manage rising costs. Premiums, employee contributions and cost-sharing provisions have all been subject to redesign, with a growing range of choices available to employers and employees from commercial payers.

The introduction of the Affordable Care Act has also stimulated many changes in insurance design, including mandated provisions for coverage of specified preventive services, requirement to offer coverage for those with pre-existing conditions, elimination of lifetime caps, and limits to out-of-pocket costs. These changes directly and indirectly affect the design of commercial insurance.

The objective of this report is to bring forward insights on the extent to which pharmacy deductibles are becoming a more common aspect of health plan design, and the impact they have on patient behavior related to pharmaceutical use. We believe that close monitoring of these dynamics is critical in light of the further near-term changes that are expected in health plan insurance design. Measuring the impact on patient behavior – and linking that to health outcomes and costs – will provide important input to the assessment of this aspect of our healthcare system.

This report was undertaken independently by the IMS Institute for Healthcare Informatics as a public service and without external funding. In addition to the authors, Mason Tenaglia and Marcella Vokey, the contributions provided by the IMS Health Managed Markets Strategy team are gratefully acknowledged.

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Background

Some health benefits are designed with deductibles that apply to both medical and pharmacy benefits (also known as integrated deductibles). Other designs implement separate deductibles for medical and pharmacy. Until recently, three-quarters of plans did not implement a deductible for pharmacy costs. In benefit designs with a deductible, patients pay full cost until the deductible amount is reached.

Insurers with a high proportion of at-risk accounts, meaning the insurer pays for health expenses and not the employer, are incentivized to pass initial costs along to the patient. As a result, they often offer lower premiums in exchange for selecting a deductible design. High deductible health plans (HDHPs) typically refer to health benefits with deductibles of at least \$1,000 for an individual and \$2,000 for families. Employers may then pair HDHPs with some version of a savings option, such as a Health Savings Account (HSA) or a Health Reimbursement Account (HRA). In these instances, at least a portion of the higher costs associated with a deductible are offset by an employer benefit.

Depending on their employer, patients may either opt into a deductible plan, reaping some savings from the lower premium, or select a low to no-cost deductible benefit design. In other cases, however, patients may not have any choice regarding their health benefits. For these reasons, patients with high deductibles are a mix of self-selected individuals with presumably low health costs and higher cost patients.

We are able to observe patients and their cost exposure in the longitudinal prescription claims dataset, Formulary Impact Analyzer (FIA). FIA calculates the coordination of benefits by grouping multiple claims for a given patient, product and day. The result provides unique insight into the cost patients are initially exposed to before the use of co-pay cards or discount programs (primary co-pay) as well as the cost patients ultimately pay to purchase a product (final out-of-pocket).

The Affordable Care Act (ACA) has two policies that impact deductibles in commercial health plans. In 2015, the ACA's out-of-pocket maximum requirement started to take effect. The requirement stipulates that insurance members should pay no more than \$6,850 for individuals or \$13,700 for families in 2016. This maximum applies across both medical and pharmacy benefits. This policy compelled insurers to invest in technology that combines payment data from these two facets of healthcare coverage and gave plans the capability to apply integrated deductibles.

BACKGROUND

The ACA is also positioned to enforce a high-cost plan tax (known as the “Cadillac tax”), which is a 40% excise tax on healthcare benefits that exceed a certain value threshold. In 2018, upon the policy’s initial implementation, the thresholds will be \$10,200 for individuals and \$27,500 for families. Premiums account for most of a plan’s value, but health savings options and employer-sponsored flu shots will also count towards the benefit.

Employers would thus face high taxes (estimated to be more than \$2,000 per affected patient between 2018 and 2024) on a previously untaxed benefit – much like when the tax exemption on retiree drug subsidy (RDS) plans was repealed. In 2013, RDS plans were no longer eligible for a tax exemption which would have resulted in \$500 or more in additional costs per RDS member per year. To avoid the costs, employers moved members into employer group waiver plans (EGWPs), in which members are primarily funded by Medicare and also receive coverage gap assistance from manufacturers.

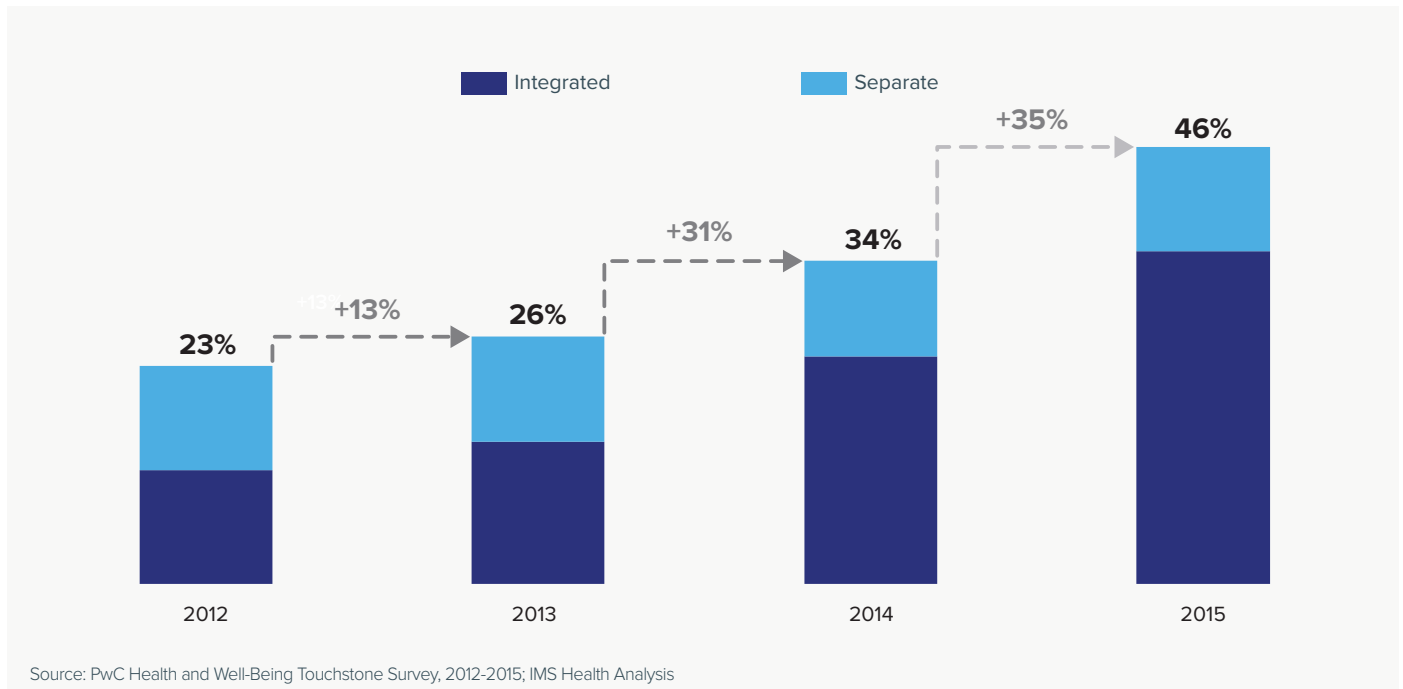
The emergence and expansion of deductibles in pharmacy benefits

The design of commercial health plans shifted further toward those with deductibles for pharmacy benefits in 2014 and the impending implementation of the “Cadillac tax” is expected to accelerate this movement by 2018

- The proportion of plans that offer benefits with a pharmacy deductible (either a separate deductible or an integrated deductible that applies to medical and pharmacy costs) has grown from 23% to 46% since 2012, partially driven by the ACA’s out-of-pocket maximum requirement, which compelled employers and insurers to integrate their medical and pharmacy benefits.
- Over 20% of workers with employer-based insurance are now enrolled in high deductible plans (those with a deductible of at least \$1,000 for individual and \$2,000 for family coverage), up from 10% five years ago.
- The impending implementation of the “Cadillac tax” could result in a sizable expense for about 30% of employers in 2018, and should employers respond to the excise tax with the same level of response taken to the removal of the tax exemption for retiree drug subsidy plans, enrollment in high deductible plans could increase by nearly 80% from current levels, or 28 million new enrollees, by 2018.

A growing share of health plans incorporate pharmacy deductibles

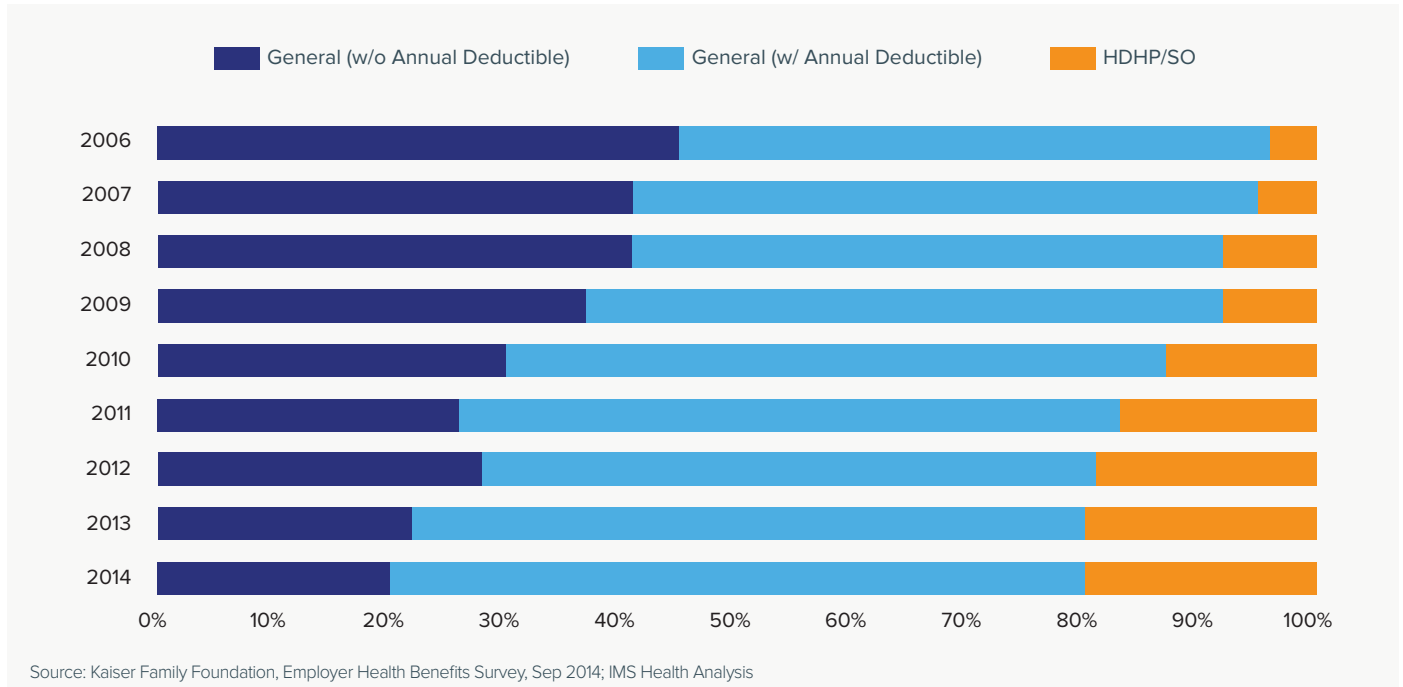
Percent of Plans with Deductibles on Pharmacy Benefit, 2012–2015



- The proportion of plans that offer benefits with a pharmacy deductible has grown from 23% in 2012 to 46% in 2015.
- Plans with newly adopted pharmacy deductibles fall into an “integrated deductible” category, where the deductible applies to medical and pharmacy costs.
- About 10% of all plans carry a separate pharmacy deductible, which is the patient’s responsibility and is independent of medical benefit spending.
- Most of the growth in patients facing pharmacy deductibles results from their enrollment in plans carrying an integrated deductible.

Enrollment in high deductible plans is also increasing

Percent Covered Workers by Plan Type, 2006–2014



- The percent of people enrolled in a HDHP/Savings Option (SO), has increased from 4% in 2006 to 20% in 2014.
- The percent of covered workers with an average annual deductible, but not a HDHP/SO has also increased from 51% to 60%.
- Only 20% of workers now have a health plan without an annual deductible, down from 45% in 2006.
- Offering a deductible plan can reduce the annual premiums paid by the employer and employee.

Chart notes:

High deductible plans with a savings option (HDHP/SO) are defined as health plans with a deductible of at least \$1,000 for individual and \$2,000 for family coverage offered with a health reimbursement arrangement (HRA) OR meet the federal legal criteria for a HSA-qualified HDHP.

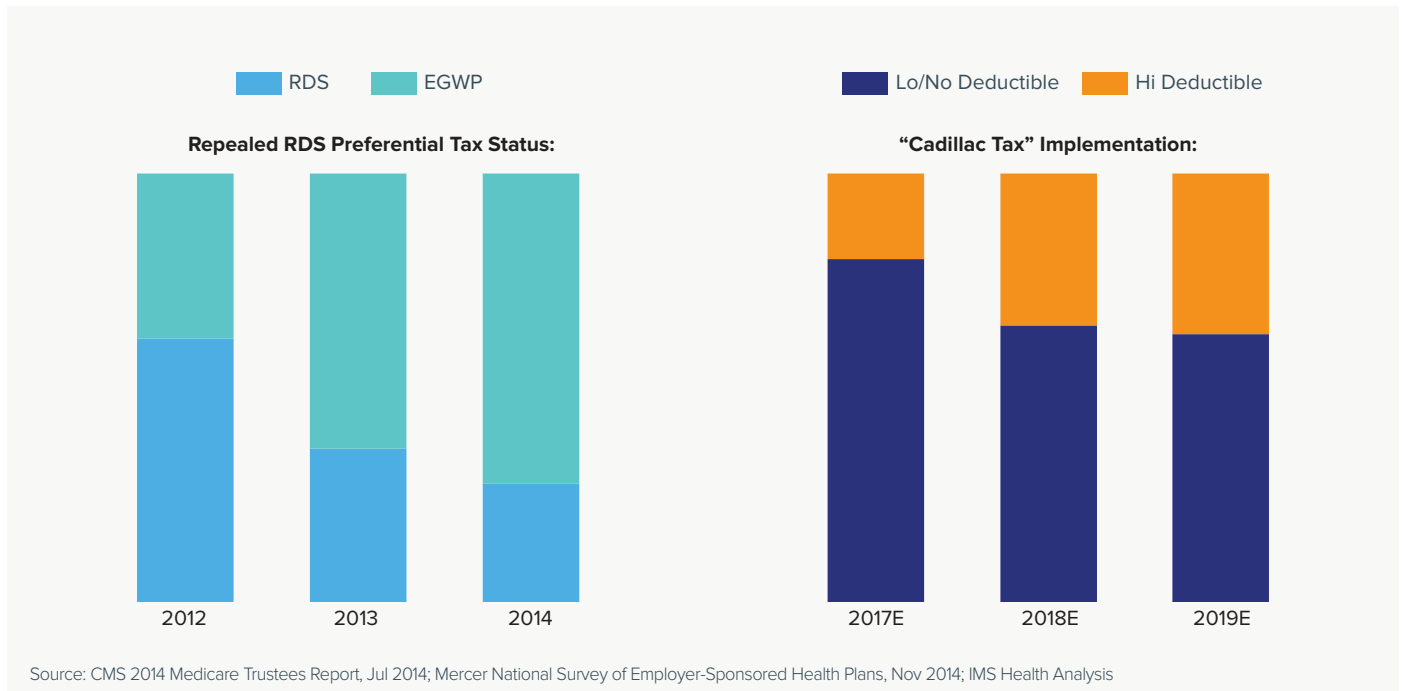
Plan types classified as “General” include health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS), and HDHP/SO.

For the purpose of this graph, HDHP/SO was carved out of the general deductible category.

The percent of covered workers with a deductible is estimated using Kaiser’s percent of workers with an annual deductible for single coverage minus the percent of covered workers in an HDHP/SO.

“Cadillac tax” could cause a surge in high deductible plan enrollment

Percent Patient Enrollment by Benefit Type, Actual and Estimated



- The loss of a tax exemption in 2013 for Retiree Drug Subsidy (RDS) plans resulted in an immediate response by employers and led to 2.4 million enrollees shifting to Employer Group Waiver Plans (EGWPs).
- The percentage of retirees in RDS plans fell from 62% to 28% over a two-year period.
- The impending “Cadillac tax” implementation could mean a significant expense beginning in 2018 for an estimated 30% of employers.
- Should employers respond to the excise tax with the same severity as the removed tax exemption from RDS plans, high deductible plans could see an enrollment increase of nearly 80% (roughly 28 million patients) in 2018.

Chart notes:

The 28 million patient estimate uses 2013 enrollment data from the Kaiser Family Foundation and US Census population growth estimates. Deductible enrollment shifts are modeled with the assumption that excise-tax-affected commercial plan sponsors will face comparable, if not higher, costs than RDS sponsors (refer to the Buck Consultants’ EGWP brochure and the American Health Policy Institute’s excise tax report).

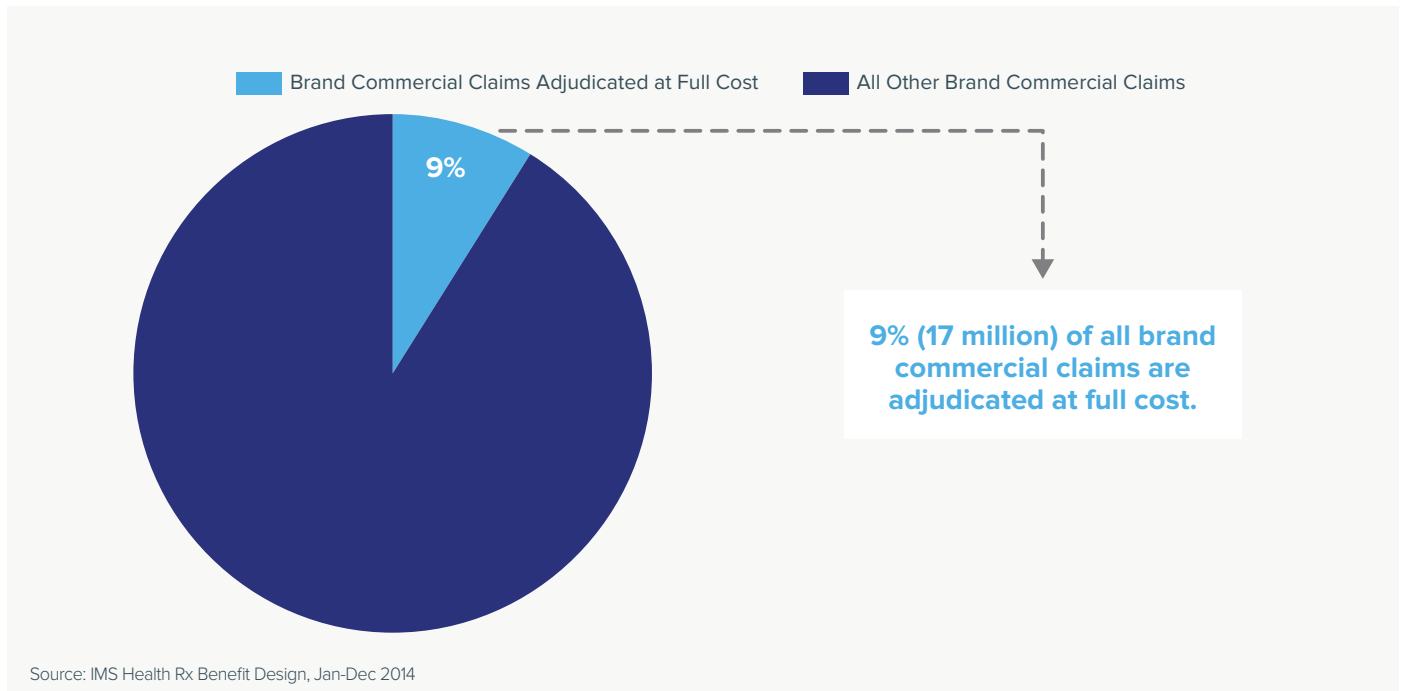
Prevalence of deductibles in pharmacy claims

While only about 9% of total branded commercial insurance pharmacy claims were filled at full cost in 2014, there is significant variation across the country, by payer type and through the course of the year

- Across the top 20 commercial payers, about 8% of all branded pharmacy claims filed in 2014 were for prescriptions filled by patients at full cost because they had yet to meet their deductible threshold.
- Among commercial payers, the share of brand claims at full cost ranged between 3% and 19%, with regional insurers typically having a higher proportion of at-risk business than larger, national payers and therefore, more likely to have greater enrollment in deductible plans that carry lower premiums.
- Variation in the proportion of full cost claims is significant across the country and also within large states such as California, Texas and Florida.

Approximately 17 million commercial brand pharmacy claims were filled at full cost

Proportion of Brand Commercial Pharmacy Claims Adjudicated at Full Cost, 2014



- In 2014, 17 million commercial claims were adjudicated at full cost across all brands.
- These claims account for 9% of branded commercial transactions in which patients were exposed to and filled at the highest possible cost for a given drug.

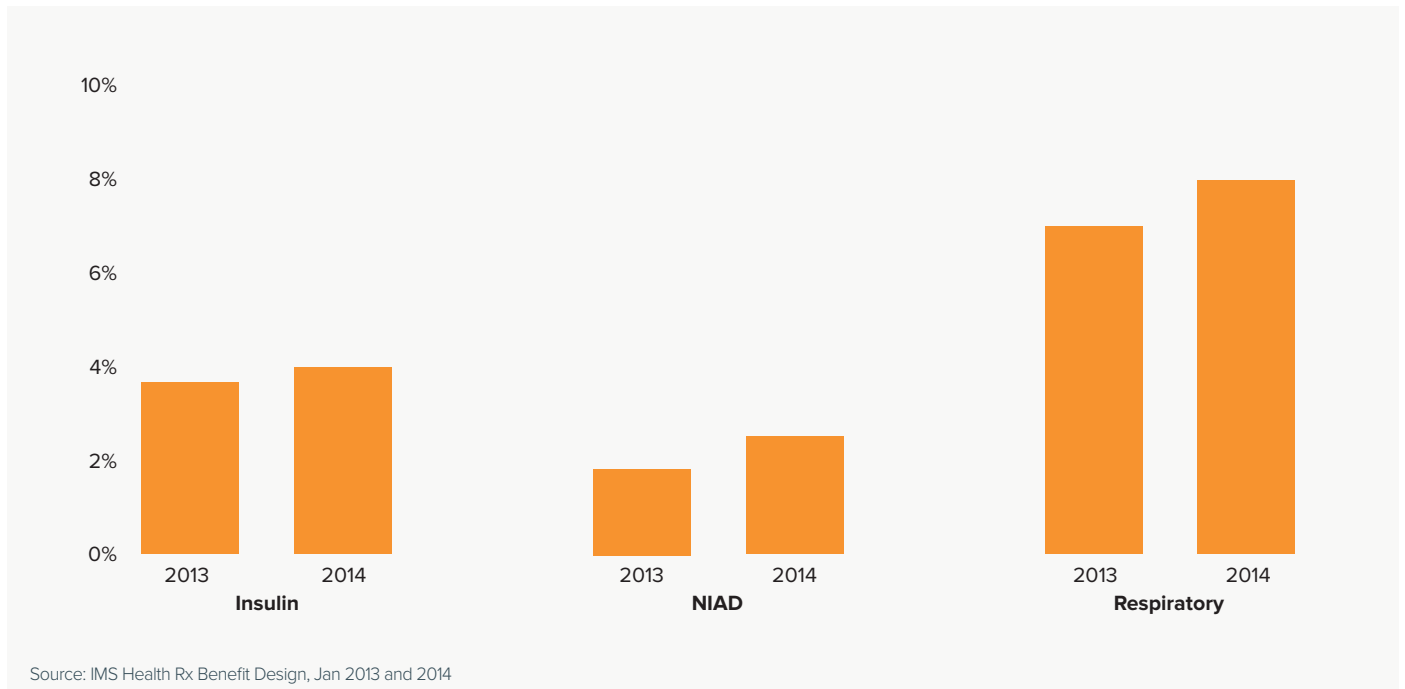
Chart notes:

Calculations are limited to commercial, brand claims with known out-of-pocket costs.

Percent of commercial claims is calculated across all brands available in the RxBD dataset.

Proportion of pharmacy claims adjudicated at full cost varies by therapeutic area

Commercial Pharmacy Claims Adjudicated at Full Cost by Year and Therapeutic Area, Brands 2013–2014



- Pharmacy claims adjudicated at full cost can be assumed to fall within a health plan member’s deductible.
- Among the top 20 commercial payers, about 8% of all branded pharmacy claims in 2014 were filled at full cost.
- The percent of claims adjudicated at full cost varies by therapeutic area e.g. from 2.5% for non-insulin anti-diabetics (NIAD) to 7.9% for respiratory brand claims.
- Variations by therapy area may reflect decisions by patients to avoid deductible plans if they have known chronic conditions and would face economic hardship reaching the deductible threshold.
- The proportion of full cost claims increased by 1.6 percentage points from 2013 to 2014 across major therapeutic areas.

Chart notes:

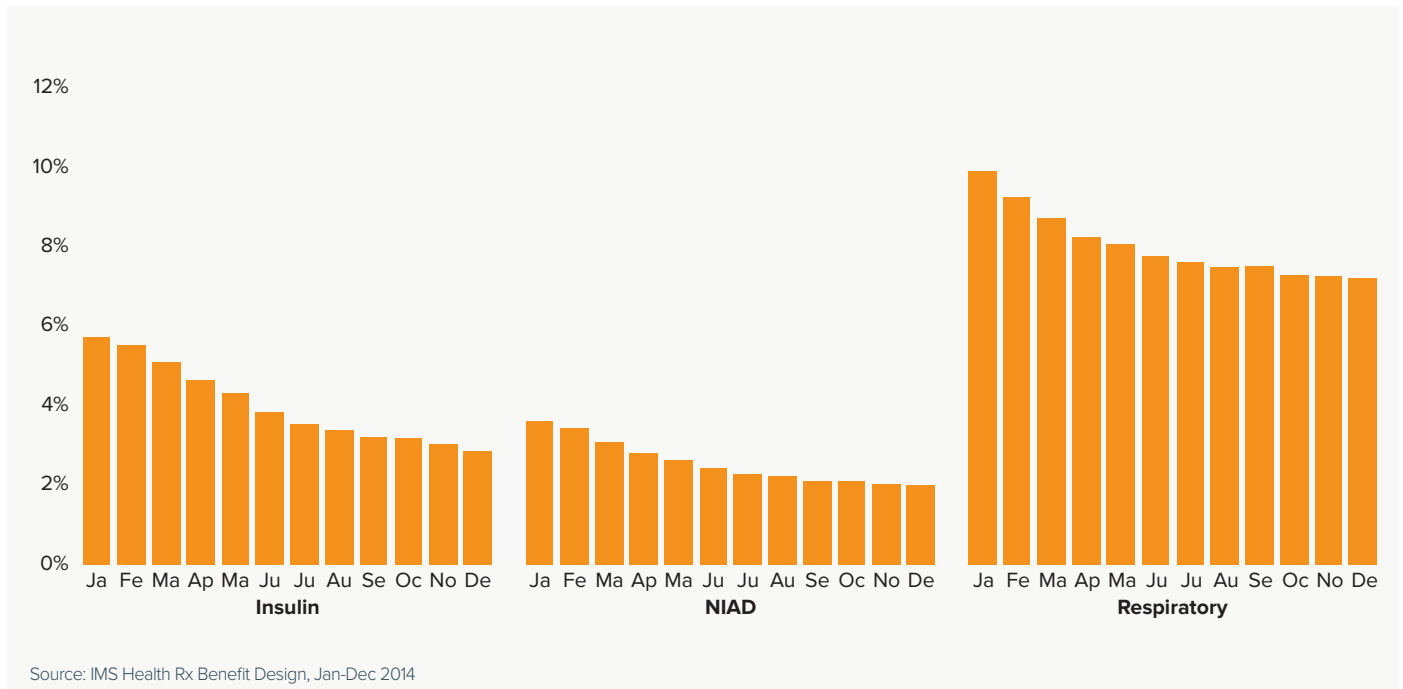
Calculations are limited to commercial, brand claims with known out-of-pocket costs.

Percent of commercial claims is calculated across three major therapeutic areas: respiratory, insulin and NIAD.

Overall averages are calculated across all therapeutic areas.

The proportion of full cost pharmacy claims declines over course of year

Commercial Pharmacy Claims Adjudicated at Full Cost by Month and Therapeutic Area, Brands 2014



- Across therapeutic areas, the proportion of full cost claims decreased over the calendar year.
- On average, the proportion of full cost claims declined by 2.7 percentage points between January and December 2014.
- Most of this decline occurs in the first half of the year.
- This decrease in full cost claims is likely a mix of responses, including patients who reach their deductible threshold and thereafter do not face the full prescription cost, and patients who no longer adhere to therapy because of the cost.

Chart notes:

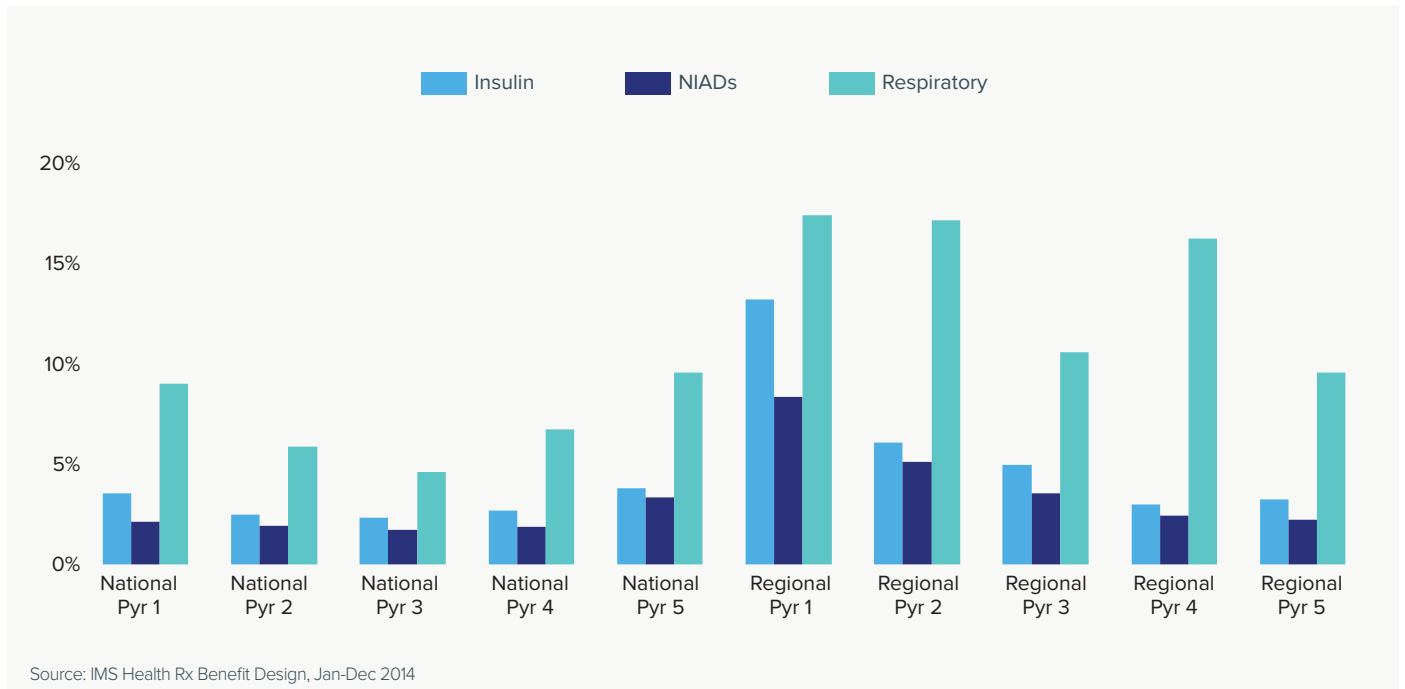
Calculations are limited to commercial, brand claims with known out-of-pocket costs.

Percent of commercial claims is calculated across three major therapeutic areas: respiratory, insulin and NIAD.

Overall averages are calculated across all therapeutic areas.

Proportion of full cost pharmacy claims varies by payer

Commercial Pharmacy Claims Adjudicated at Full Cost by Therapeutic Area and Payer, Brands 2014



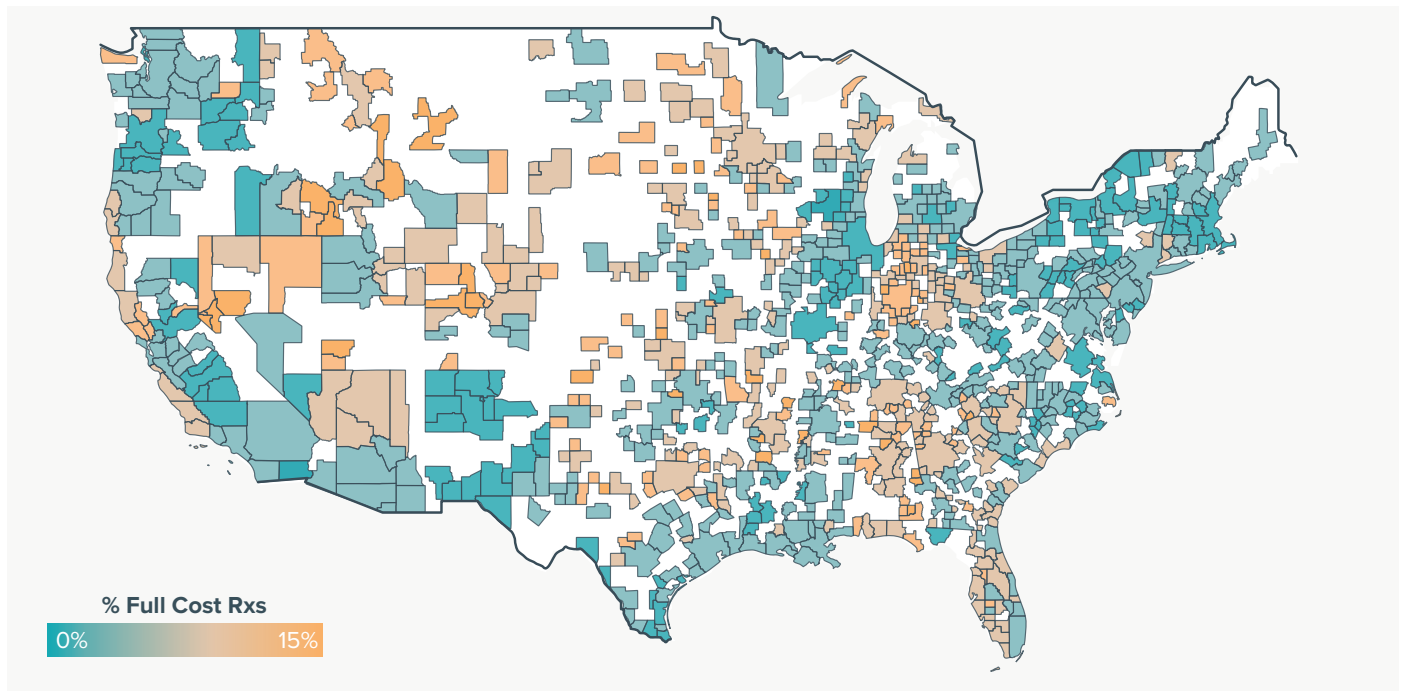
- Across the top 20 commercial payers, the percent of all brand claims adjudicated at full cost range from approximately 3% to 19%.
- Large commercial payers such as PBMs and national insurers demonstrate a relatively low incidence of full cost claims – averaging 8% brand claims at full cost in the top 5 five national payers.
- Top commercial, regional payers such as the Blue Cross Blue Shields have an average of 13% brand claims adjudicated at full cost.
- Regional insurers have a higher proportion of at-risk business than national payers and are thus more likely to offer plans with lower premiums but higher out-of-pocket costs for members.

Chart notes:

Calculations are limited to commercial, brand claims with known out-of-pocket costs.
 Percent of commercial claims is calculated across three major therapeutic areas: respiratory, insulin and NIAD.
 Overall averages are calculated across all therapeutic areas.
 Payers are grouped according to IMS Health’s proprietary Contract Entity classifications.

Proportion of full cost pharmacy claims varies by geography

Percent of Commercial Pharmacy Claims Adjudicated at Full Cost by CBSA, Brands 2014



- Most of the core based statistical areas (CBSAs) with high full-cost incidence are clustered in the middle and southern regions of the country.
- States such as California, Texas and Florida are not uniform in full cost exposure at the CBSA level.

Chart notes:

Calculations are limited to commercial, brand claims with known out-of-pocket costs.

Percent of commercial claims is calculated across three major therapeutic areas: respiratory, insulin and NIAD.

CBSA averages are weighted across three major therapeutic areas.

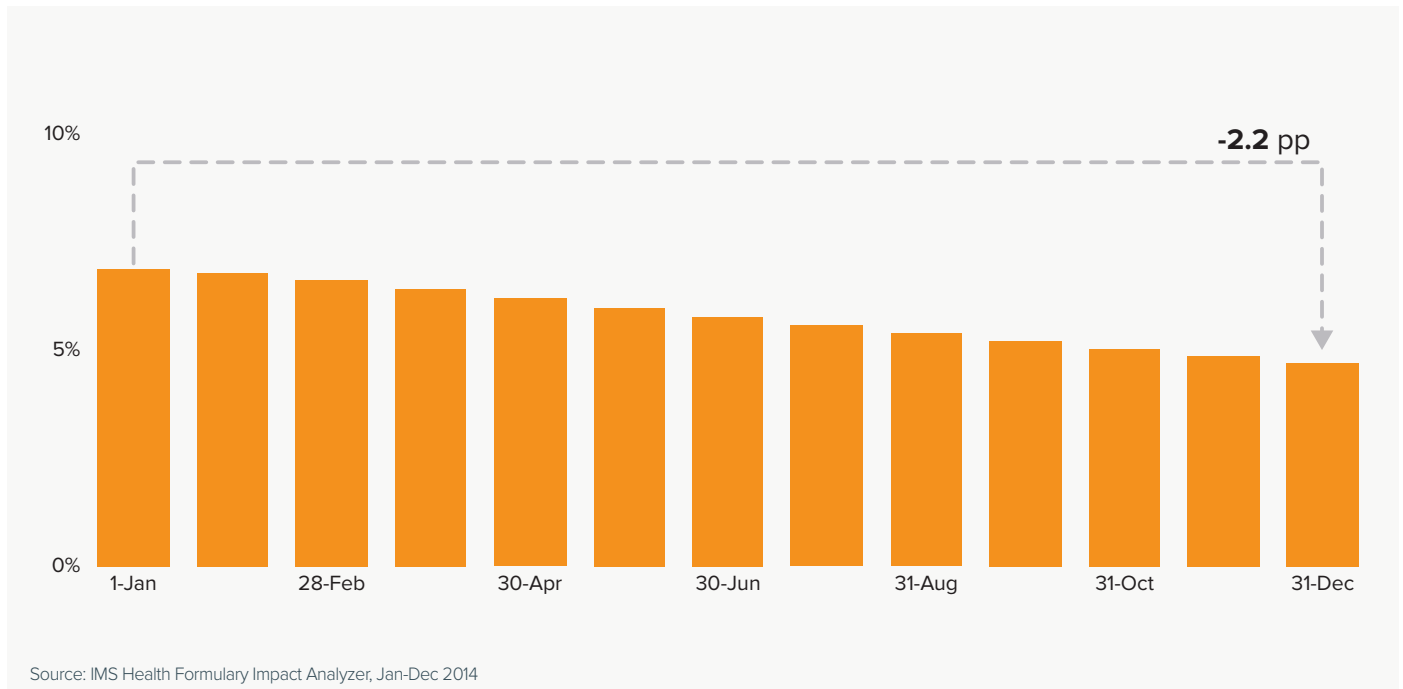
Cost sharing for deductible patients

Most patients in deductible plans reach their deductible limit during the course of the year and are much more likely to face prescriptions costing over \$100 than those in standard plans without a deductible

- Approximately one-third of the patients in deductible plans reached their deductible limit in 2014, which mostly occurred in the second or third quarter of the year.
- Deductible pharmacy spending ranges from under \$300 to more than \$3,000, and 83% of patients in 2014 spent \$1,000 or less while in their deductible phase.
- Across adjudicated claims for all drugs, 86% of claims under standard plans carried a co-payment of \$20 or less, compared to 71% of claims under deductible plans.
- For patients using branded drugs, 32% of claims under deductible plans carried a co-pay in excess of \$100, compared to 8% of claims under standard plans.

Nearly a third of patients in deductible plans reach their deductible limit by year end

Percent of Commercial Patients In Deductible Phase Throughout Year, 2014



- Approximately 7% of classified patients are in a deductible, starting in January 2014.
- By the end of December 2014, less than 5% of pharmacy deductible patients are still paying full cost for their prescriptions.
- Nearly a third of patients in deductible plans exited their deductibles by the end of the year while the remaining two-thirds continued to pay full cost.
- The exit of patients from their deductibles is mostly gradual, with the fewest number of patients exiting in Q1 and most patients exiting in Q2 or Q3.
- Patients who did not exit their deductibles may have filed fewer prescription claims, used less expensive prescriptions, or dropped their use of more expensive therapies.

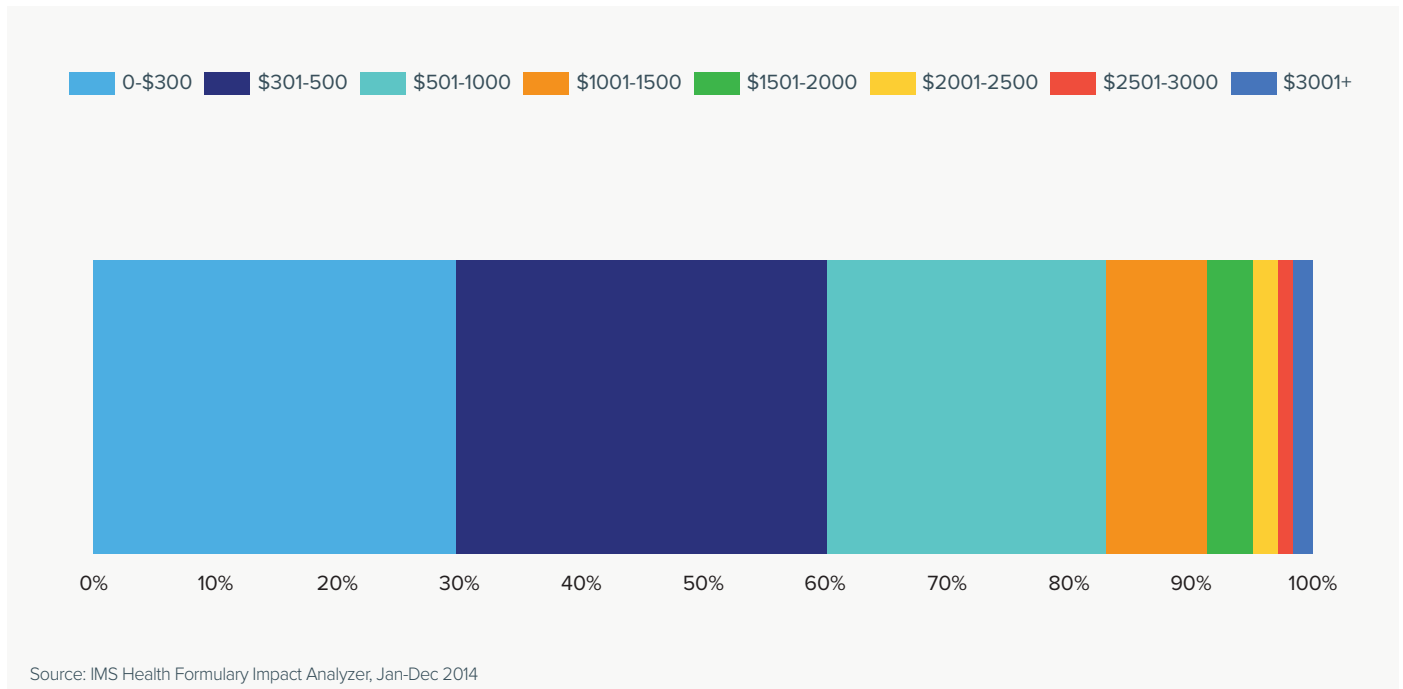
Chart notes:

Pharmacy deductible patients are identified as paying full cost for the first \$200 of pharmacy expenses.

Pharmacy deductible patients who exit their deductibles no longer pay full cost at some point in the calendar year, instead paying less than 80% of full cost.

Pharmacy spending varies across deductible patients

Distribution of Patients by Pharmacy Deductible Spending, 2014



- Pharmacy spending by patients who exited their deductible ranges from under \$300 to more than \$3,000, indicating substantial variation across plans and the deductible population.
- Among pharmacy deductible patients who have exited their deductible, 30% had out-of-pocket pharmacy spending less than or equal to \$300 during their deductible phase.
- 83% of patients spent \$1,000 or less in their deductible phase.

Chart notes:

Sample is limited to patients who have exited their deductibles.

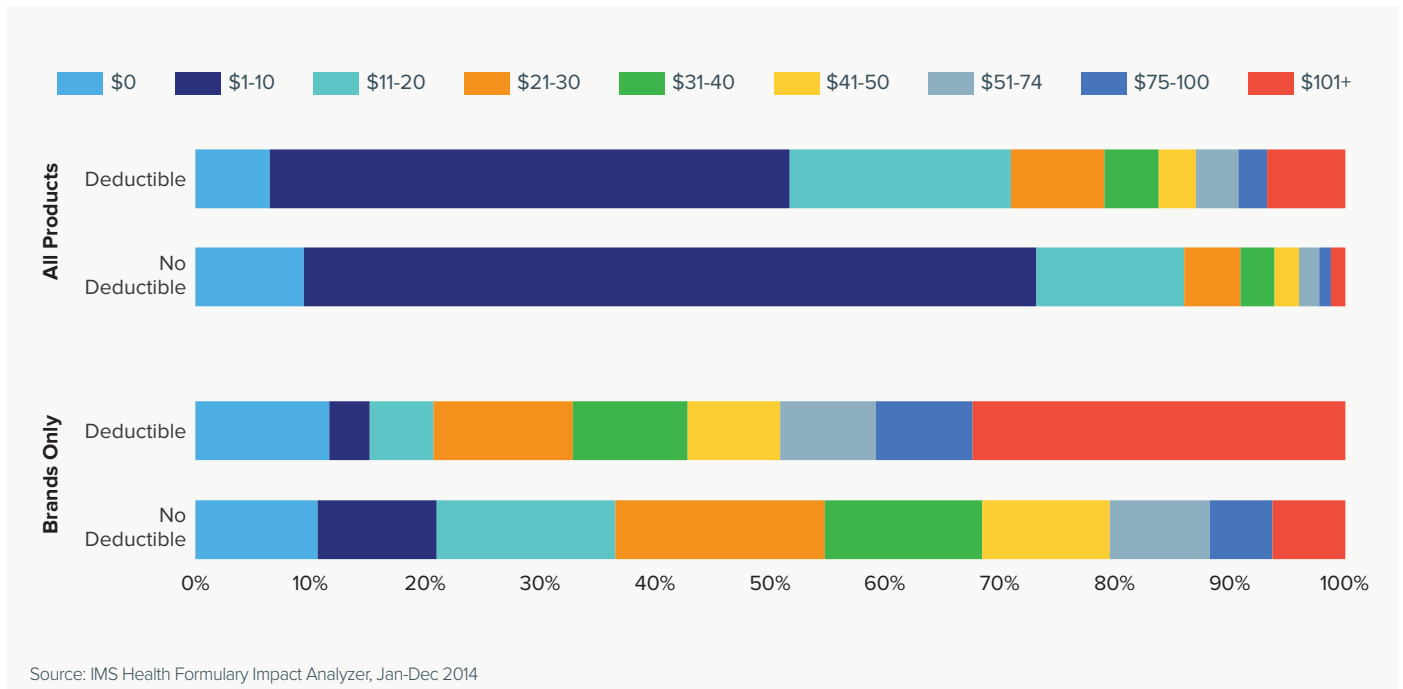
Pharmacy deductible patients are identified as paying full cost for the first \$200 of pharmacy expenses.

Pharmacy deductible patients who exit their deductibles no longer pay full cost at some point in the calendar year, instead paying less than 80% of full cost.

Total costs are calculated as the sum of final out-of-pocket costs across all adjudicated, commercial claims within the deductible phase.

Co-pays for patients in deductible plans trend higher for branded products

Distribution of Claims by Primary Co-Pay and Plan Type, 2014



- Across all adjudicated claims in deductible or standard patients, co-pays are predominately under \$20.
- This proportion is smaller for claims filled through pharmacy deductible plans (71%) than non-deductible plans (86%).
- The disparity between patient categories becomes more pronounced for claims from branded products only.
- Across branded claims in deductible patients, 21% of claims are under \$20; 37% of claims are under \$20 among non-deductible patients.
- 32% of branded claims are over \$100 in deductible patients – this is only 6% in non-deductible patients.

Chart notes:

Pharmacy deductible patients are identified as paying full cost for the first \$200 of pharmacy expenses.
 Non-deductible patients are identified as consistently paying less than 80% of the full cost of pharmacy expenses.
 Primary co-pay reflects patient cost before the offset of a coupon or other savings program.
 Sample is limited to adjudicated, commercial claims.

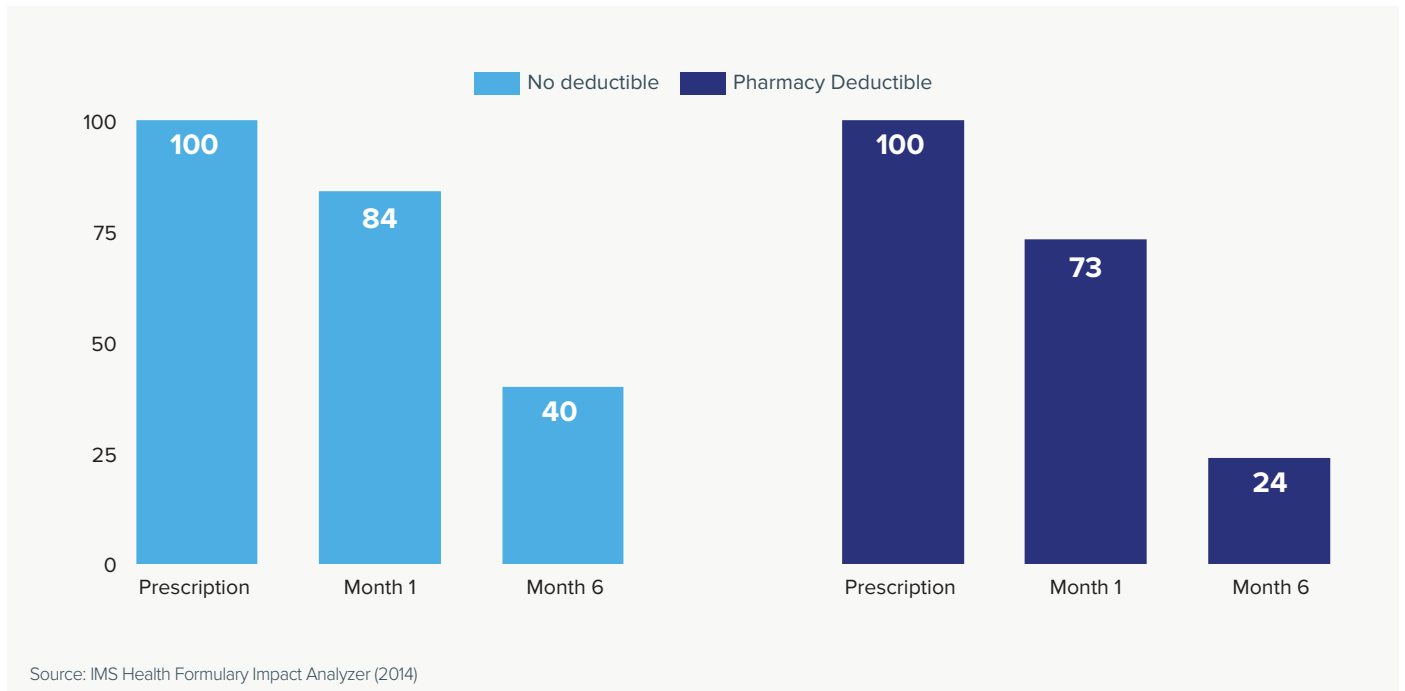
Impact of deductible plans on patient behavior

Patients in deductible plans have higher abandonment rates and lower adherence levels than patients in standard plans, and these differences are much greater for branded drugs and when out-of-pocket costs exceed \$50 per prescription

- Only about one quarter of initially prescribed patients in plans with pharmacy deductibles are likely to be maintaining their use of branded prescription medicines after six months, compared to about 40% of patients in standard plans.
- Abandonment rates – the rate at which patients do not pick up from pharmacies the medicines that are prescribed for them – are 60% higher for new patients prescribed branded drugs in deductible plans than for those in standard plans.
- Abandonment rates when a patient faces a new out-of-pocket cost that is more than \$50 above the cost of their previous prescription are double the levels that occur when the cost increase is less than \$50
- The use of co-pay cards to offset out-of-pocket costs for branded drugs is similar for patients in each type of plan at about 8% of prescriptions.
- Patients who were active users of medicines for diabetes and respiratory disease are significantly less adherent to their medications after switching to a deductible plan in 2014, and this impact is seen as early as January when fill rates were 7% lower for patients switching to a deductible plan than for those remaining in a standard plan.

New patients with pharmacy deductibles are much less likely to maintain therapy over six months

Patients on Therapy after 100 New Rx's by TA and Plan Type, Brands 2014



- DPP-4s and GLP-1s combined make up approximately 10% of diabetes market volume in TRxs.
- Out of 100 new patients receiving a branded GLP-1 or DPP-4 prescription in a non-deductible plan, about 40 will maintain their therapy after six months.
- In the case of 100 patients in a plan with a pharmacy deductible, only 24 will maintain their therapy after six months.

Chart notes:

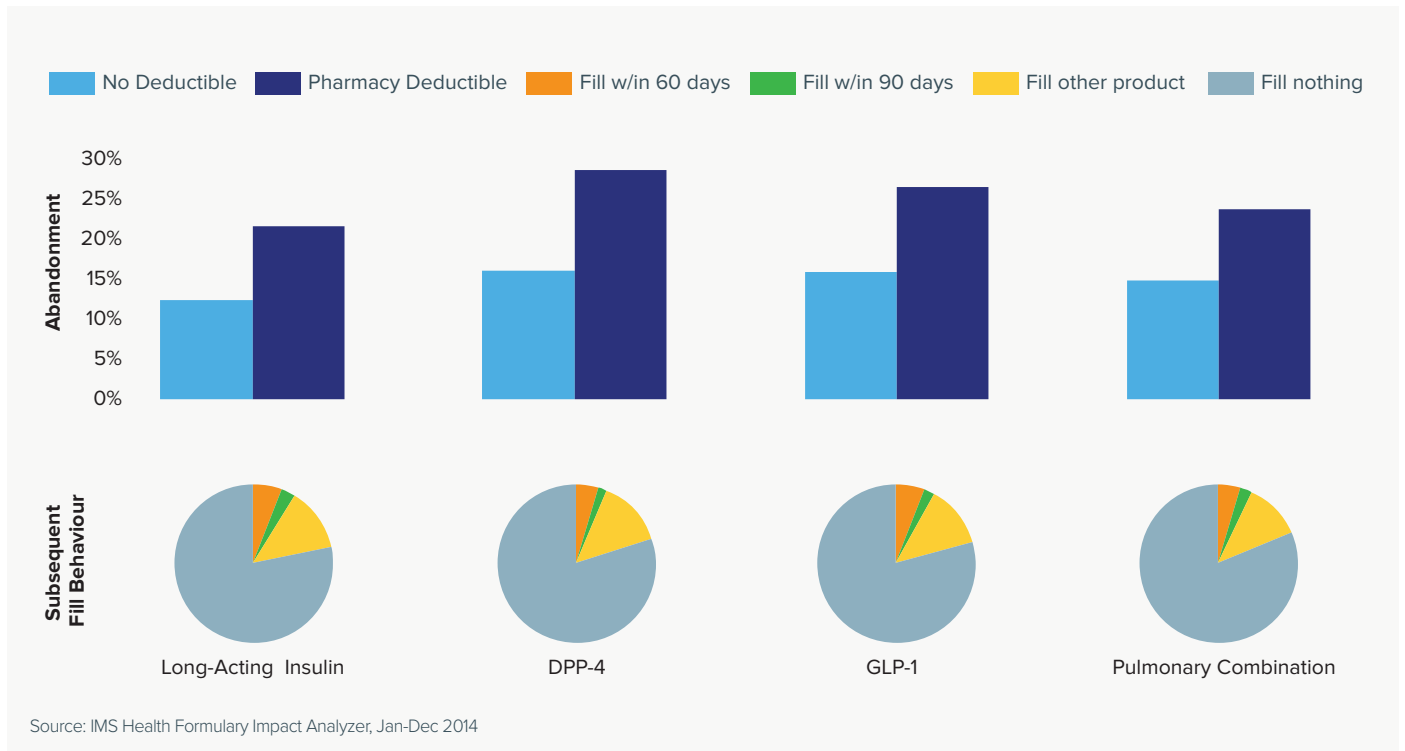
New patients are identified as having a first transaction for a given product, using a 3-4 quarter look-back.

Patients who initially abandon but fill the prescription within 30 days are counted as a paid claim.

Continuing fill behavior uses a 180-day look-forward period across both standard and deductible patients.

New patients with deductibles are more likely to abandon a first claim for a branded drug

New Patient Abandonment by Plan Type and Subsequent Fill, Brands 2014



- New patient abandonment rates are more than 60% higher for patients in deductible plans compared to those without a pharmacy deductible.
- More than 75% of patients who abandon a prescription do not fill any therapy within 90 days, suggesting treatment has not been initiated as intended by their physician.

Chart notes:

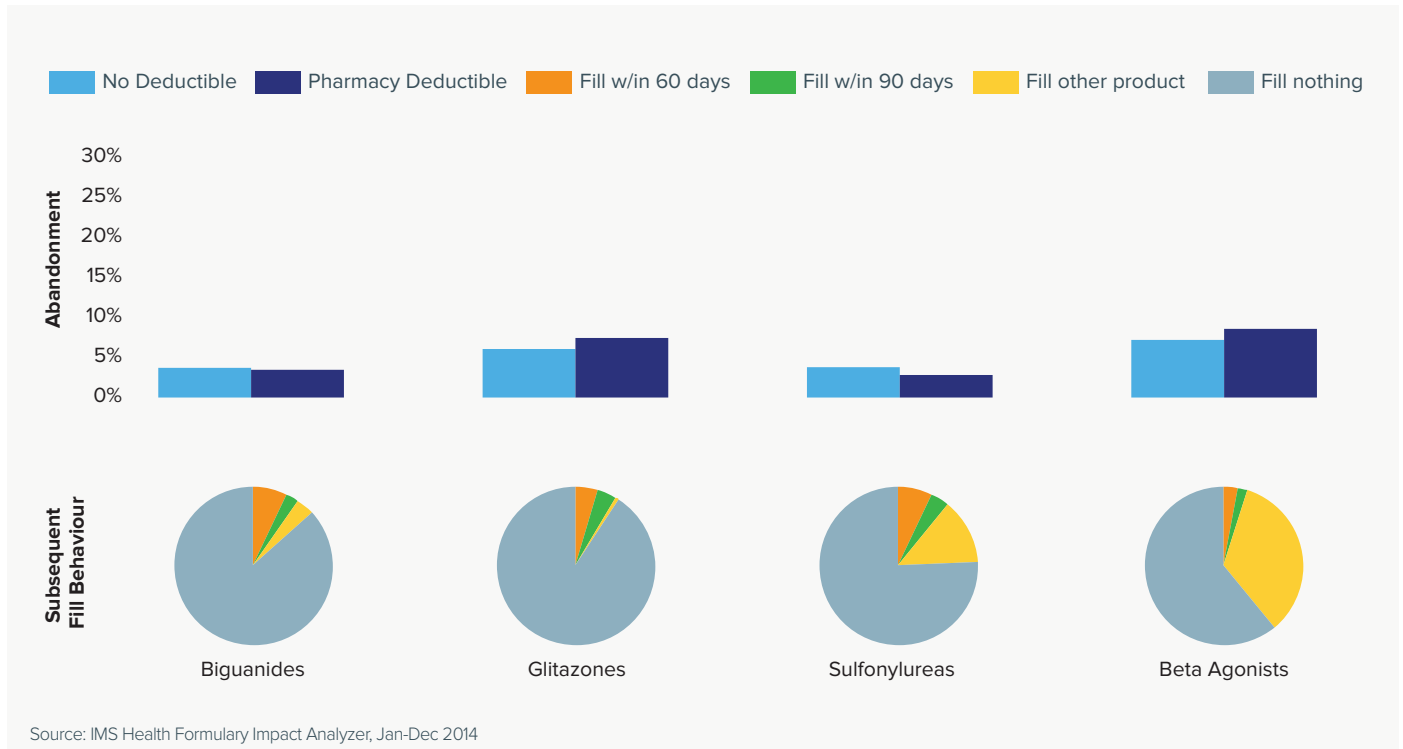
New patients are identified as having a first transaction for a given product, using a 3-4 quarter look-back.

Abandonment is calculated using a 30-day look-forward period; patients who initially abandon but fill the prescription within 30 days are counted as a paid claim.

Subsequent fill behavior uses a 90-day look-forward period and includes both standard and deductible patients.

Abandonment rates for generic drugs are much lower and similar for all patients

New Patient Abandonment by Plan Type and Subsequent Fill, Generics 2014



- Across major generic markets, abandonment is roughly equal.
- Generics do not present as substantial a cost burden to deductible patients.
- Even so, more than half of all patients who abandon their first claim do not fill within 90 days.

Chart notes:

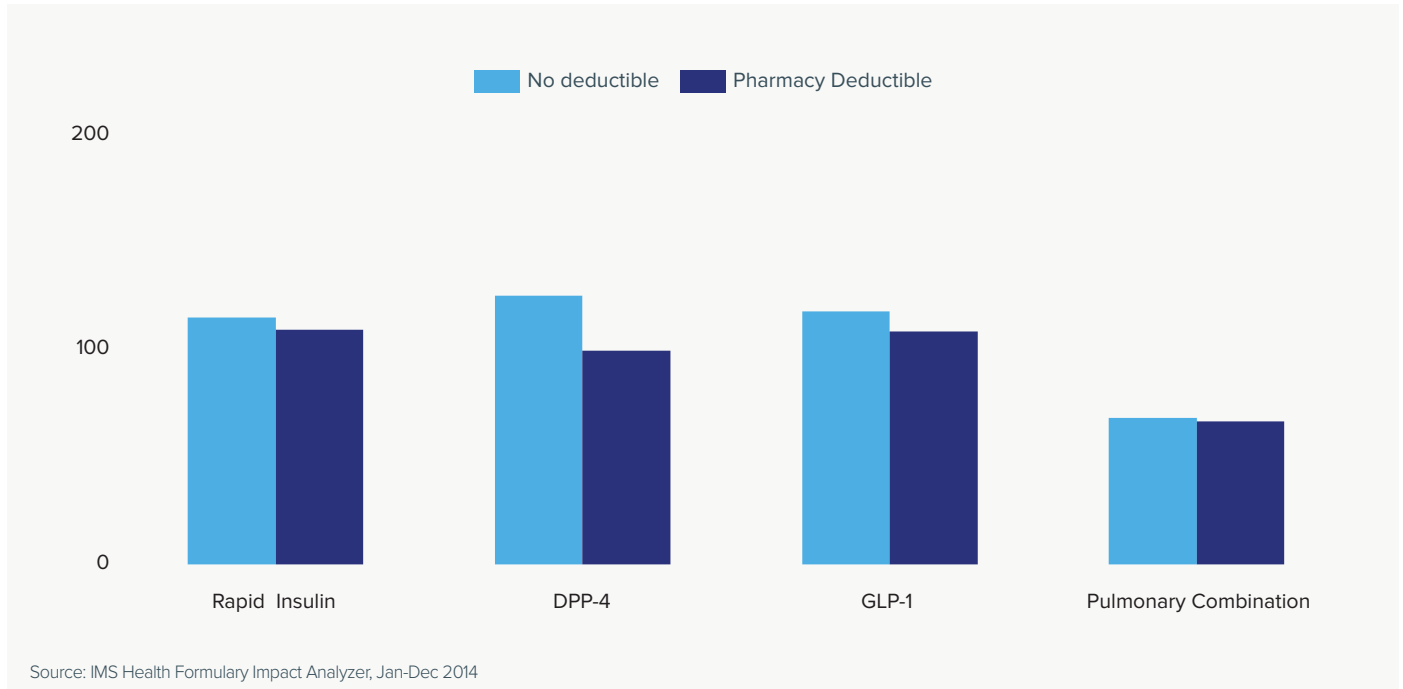
New patients are identified as having a first transaction for a given product, using a 3-4 quarter look-back.

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Subsequent fill behavior uses a 90-day look-forward period and includes both standard and deductible patients.

New patients in deductible plans are slightly less adherent when using branded drugs

Average New Patient Days of Therapy in 6 Mos by Therapy Area and Plan Type, Brands 2014



- The average number of therapy days for newly-treated patients ranges from 65 to 123 days during the six months since an initial pharmacy claim was made.
- In all therapy areas reviewed, this measure of adherence was higher for patients in non-deductible plans than it was for patients in pharmacy deductible plans by 2 to 25 days.

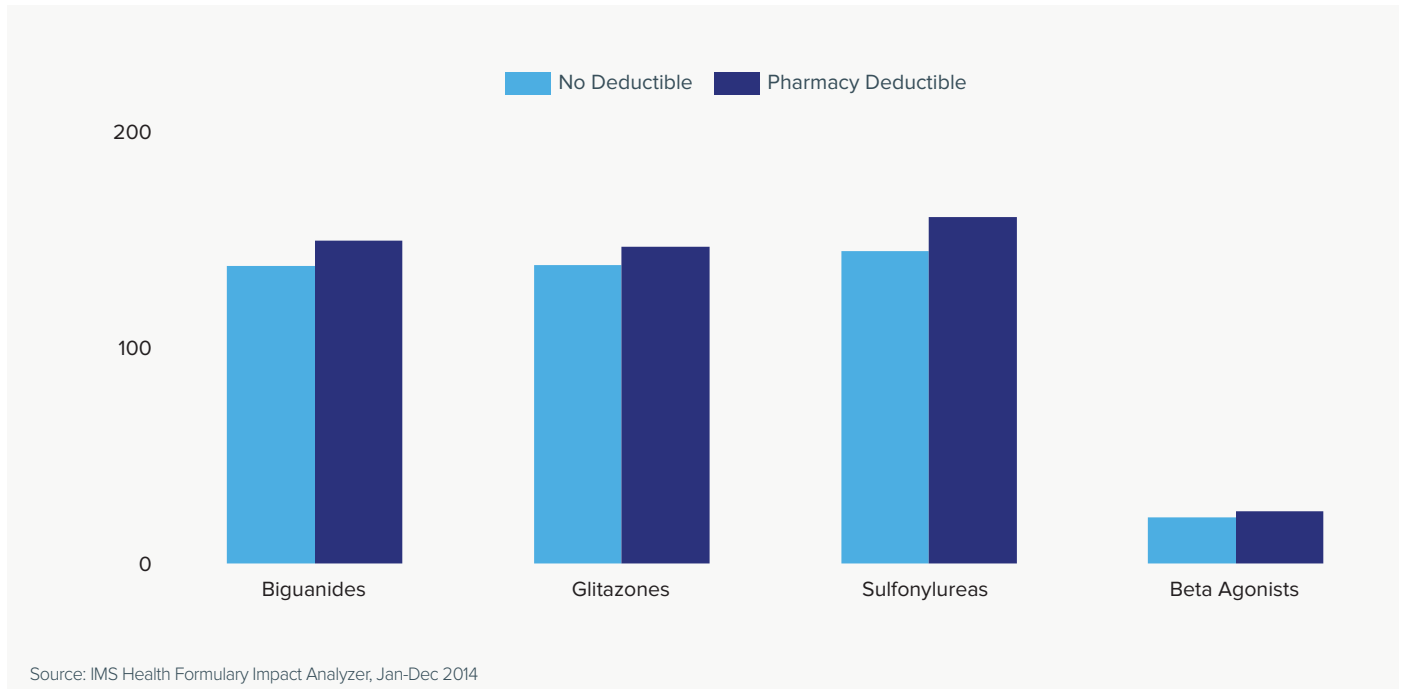
Chart notes:

New patients are identified as having a first transaction for a given product, using a 3-4 quarter look-back.

Adherence is calculated as the average total days of therapy across all new patients for their first six months on a given drug.

Adherence rates for generics are higher for patients in both plan types

Average New Patient Days of Therapy in 6 Mos by Therapy Area and Plan Type, Generics 2014



- Across four major generic markets, new patients with a deductible are about 10% more adherent than their non-deductible counterparts.
- In both deductible and standard benefit designs, at least 80% of generic co-pays cost less than \$20.
- While patients who abandon tend not to return to therapy, patients who do fill their first transaction seem to remain on therapy equally.
- Beta agonists are used as a “rescue therapy” and therefore acute patients fill fewer prescriptions.

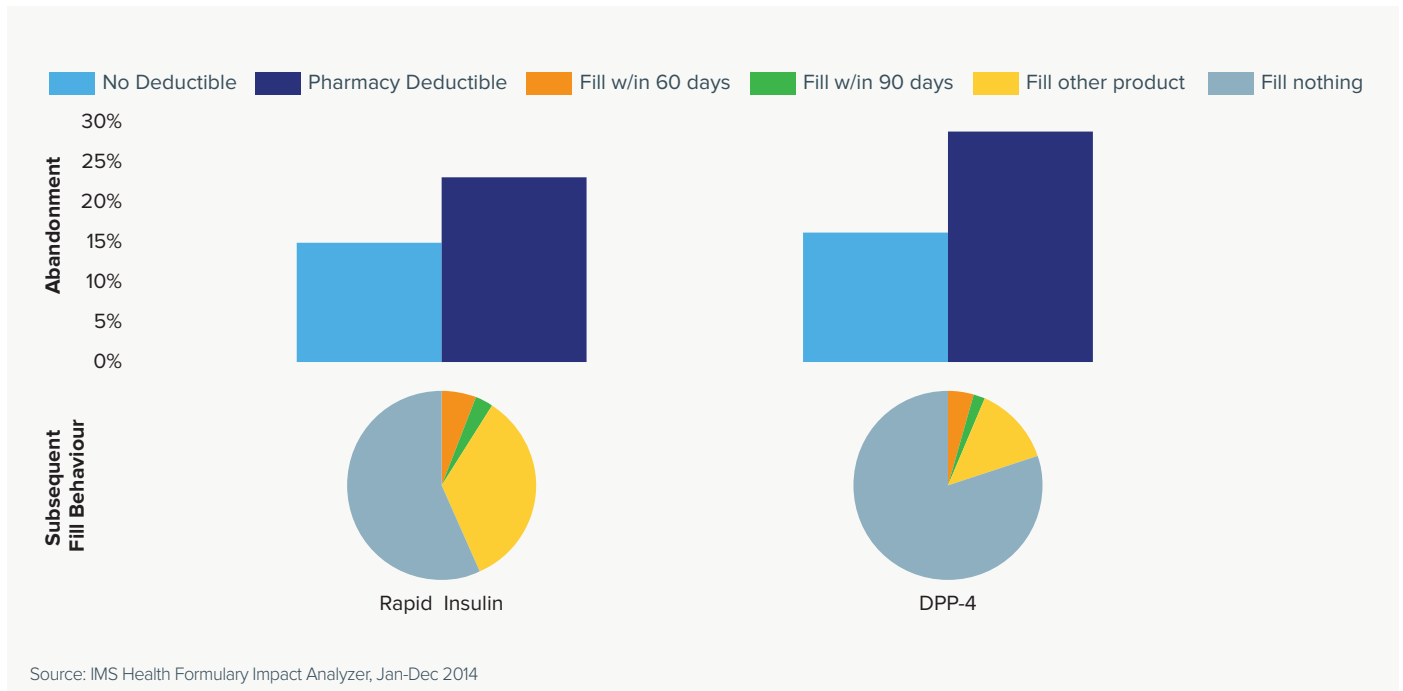
Chart notes:

New patients are identified as having a first transaction for a given product, using a 3-4 quarter look-back.

Adherence is calculated as the average total days of therapy across all new patients for their first six months on a given drug.

Patients taking maintenance drugs are more susceptible to price sensitivity than those using emergency therapies

New Patient Abandonment by Plan Type and Subsequent Fill, Brands 2014



- Deductible patients are 8 percentage points more likely to abandon a rapid insulin claim when compared to standard commercial – this difference is 12 percentage points in DPP-4s.
- 43% of abandoned rapid insulin claims are filled by some form of therapy within 90 days while less than 20% of abandoned DPP-4 claims are ever filled.

Chart notes:

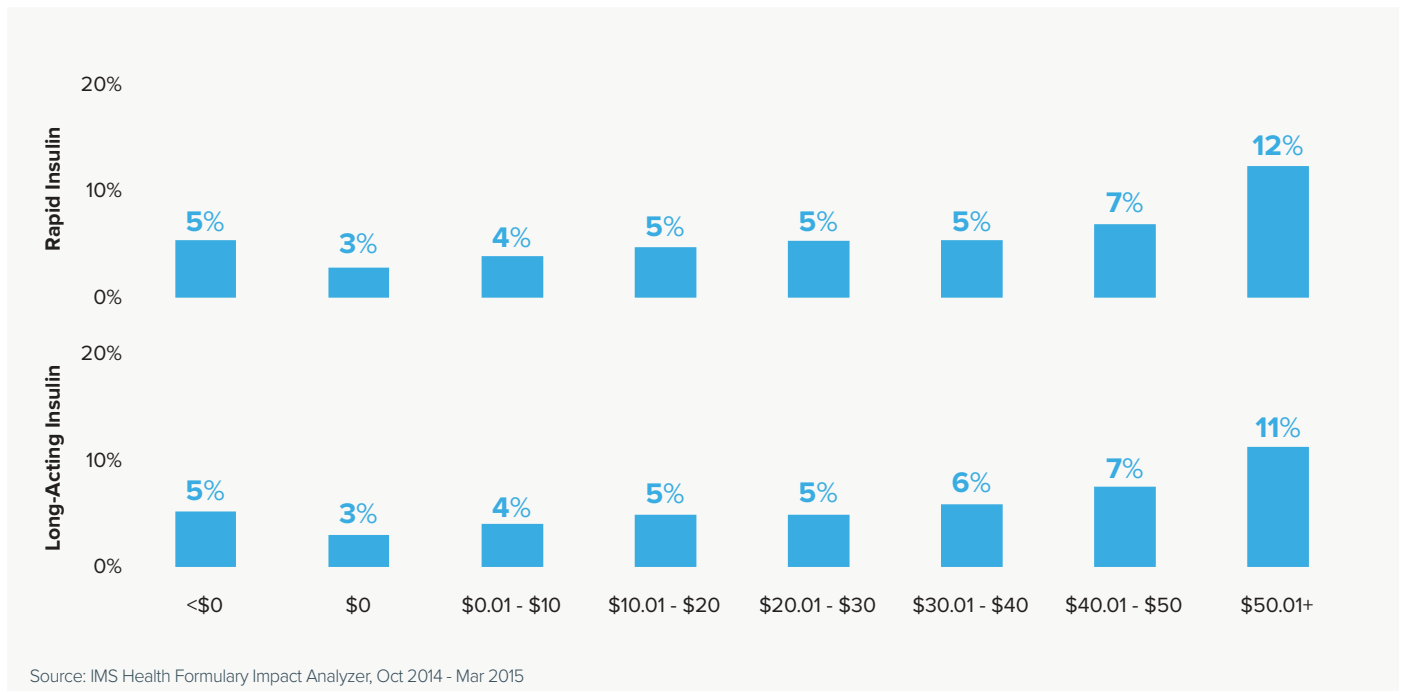
New patients are identified as having a first transaction for a given product, using a 3-4 quarter look-back.

Abandonment is calculated using a 30-day look-forward period; patients who initially abandon but fill the prescription within 30 days are counted as a paid claim.

Subsequent fill behavior uses a 90-day look-forward period across both standard and deductible patients.

Continuing patients abandon prescriptions when faced with cost increases

Continuing Patient Abandonment by Cost Change in Insulins, Brands 2015



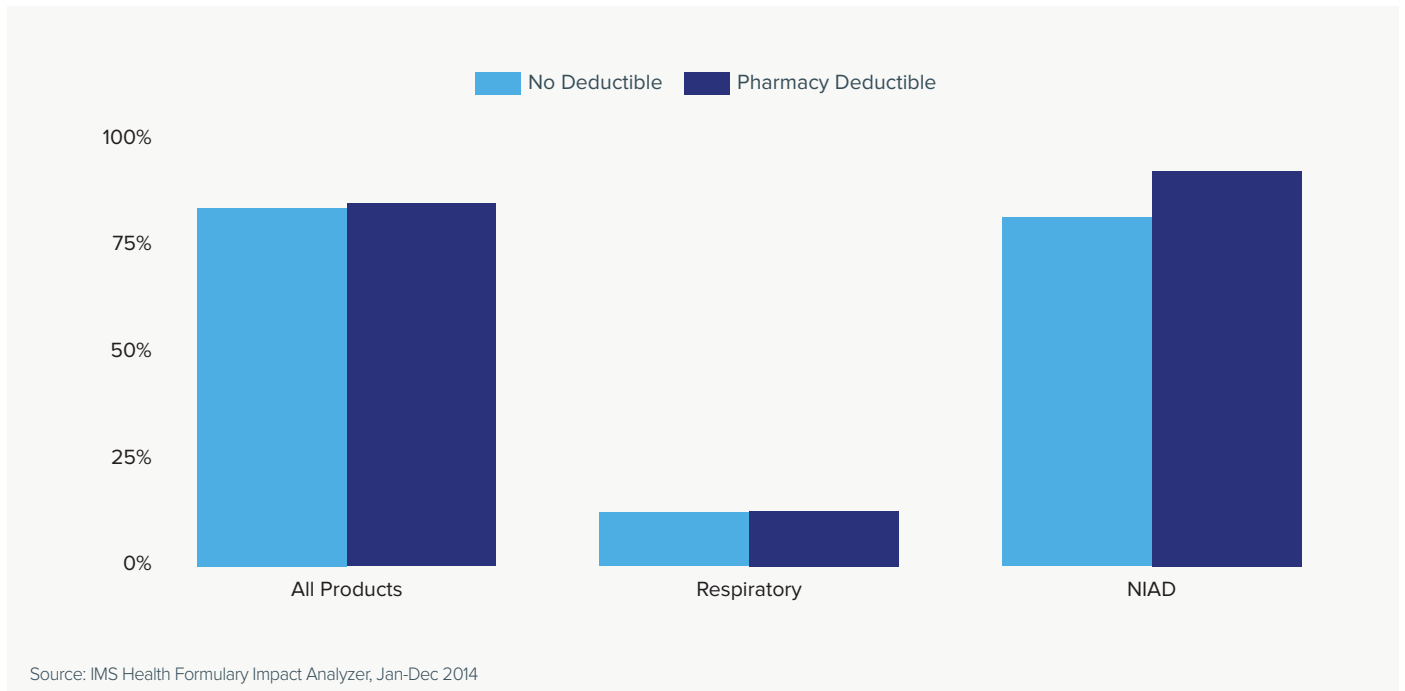
- Abandonment rates reached 11-12% when patient out-of-pocket costs increased by more than \$50 in the first claim of 2015 compared to the last claim of 2014.
- Among patients facing no increase in out-of-pocket costs, abandonment rates in January 2015 were 3% for both insulin types studied.

Chart notes:

Continuing patients are identified as having a filled claim in Q4 2014 and been approved (fill or abandon) in Q1 2015. Co-pay change is calculated as the difference in final costs between the last claim of 2014 and the first claim of 2015. A 14-day look-forward period is applied to abandoned claims, ensuring their immediate durability.

Patients in deductible plans utilize slightly more generics

Generic Fill Rate by Therapeutic Area and Plan Type (2014)



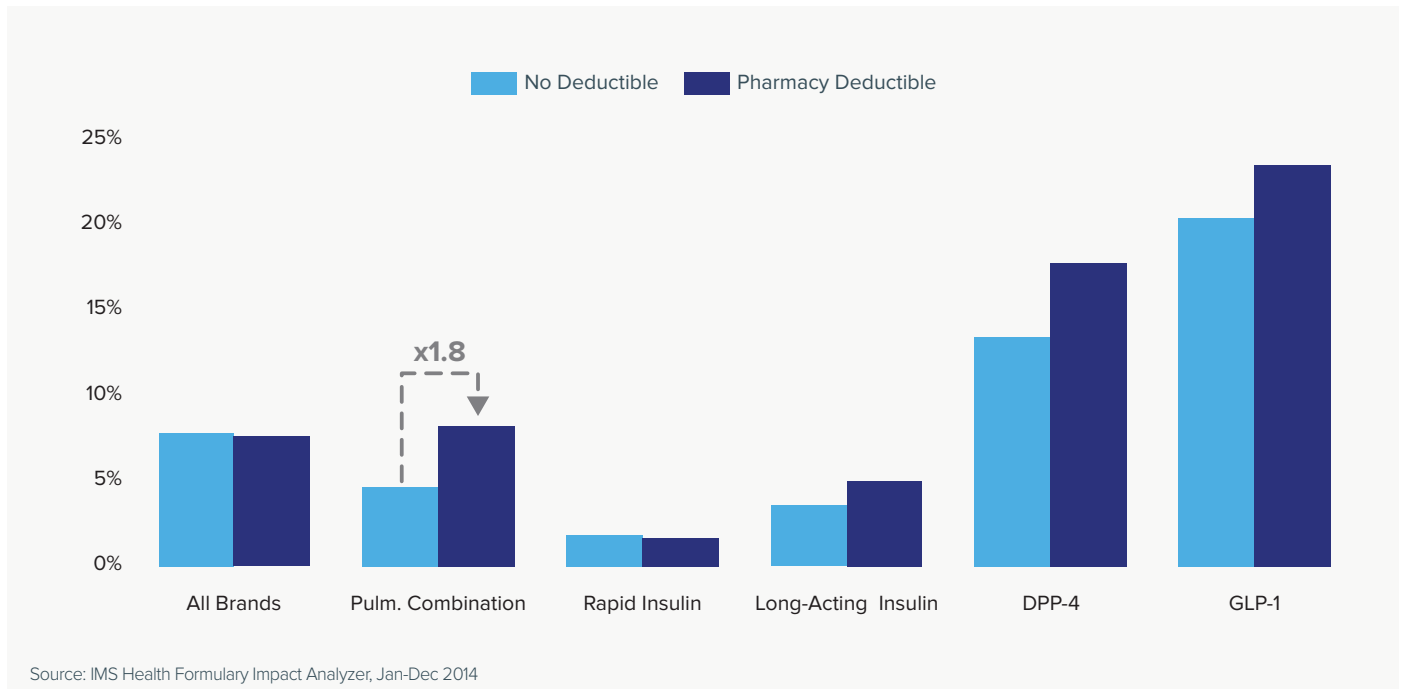
- Across all products, pharmacy deductible patients exhibit a slightly higher generic fill rate (83%) than non-deductible patients (82%).
- The difference in generic fill rate between patient cohorts is more pronounced in the NIAD market, where deductible patients fill generics at a rate of 90% and standard patients only fill 80% generics.
- Generic fill rates are nearly identical (12%) for both patient groups in respiratory, where fewer generic options are available.

Chart notes:

The Non-Insulin Anti Diabetic (NIAD) market basket includes DPP-4s, GLP-1s, biganuides, sulfonylureas, glitazones and any combinations thereof. The Respiratory market basket includes anticholinergics, beta agonists, pulmonary monotherapies and combinations.

Co-pay cards are used more frequently by patients in deductible plans

Coupon Penetration by Therapeutic Area and Plan Type, 2014



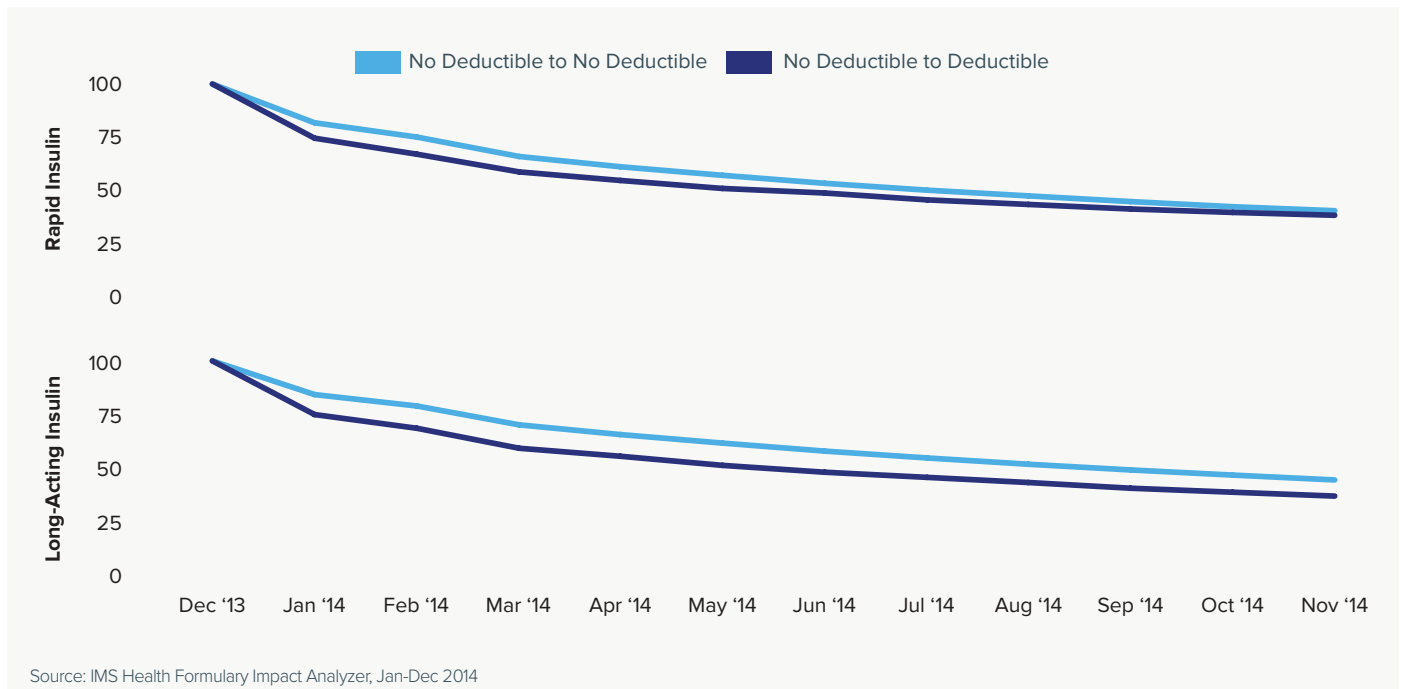
- Across all branded products, average co-pay card or coupon use is about 8% of all commercial claims with similar levels of use by patients in plans with or without a pharmacy deductible.
- At approximately 2%, co-pay card penetration is also equal between patient cohorts in the rapid insulin market.
- In markets where coupon use is more prevalent, such as pulmonary combinations, DPP-4s and GLP-1s, pharmacy deductible patients demonstrate higher use of coupons.
- Pharmacy deductible patients use nearly double the proportion of coupons for pulmonary combinations than standard patients, with penetration rates of 8% and 5%, respectively.

Chart notes:

Sample is limited to brand products and commercial claims in 2014 where patients have been classified as pharmacy deductible or standard. Coupon penetration is calculated as the percent of all commercial claims with a known coupon offsetting patient costs.

Patients switched to deductible health plans are immediately less compliant

Continuing Patient Persistence by Plan Type in Insulins, Brands 2014



- Patients who switched or were switched from a non-deductible to a deductible plan on January 1, 2014 were seven percentage points less persistent in January than those who remained on a standard plan.
- Persistence among long-acting insulin patients was ten percentage points less by January, maintaining an approximately equal difference throughout the year.

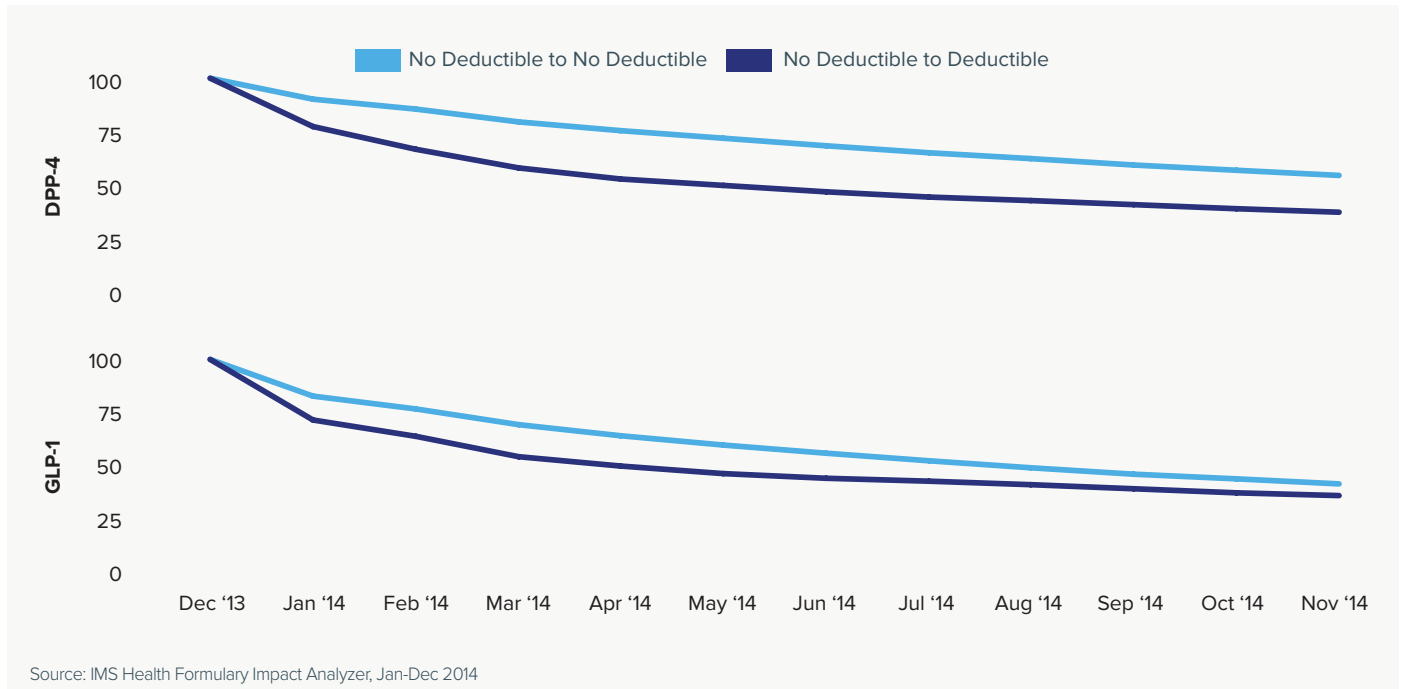
Chart notes:

Patients who filled a minimum of three prescriptions in Q4-2013 were identified as continuing and persistent.

Patients were observed over 390 days; if the days between a patient's filled claims exceeded days supply plus a 30-day grace period, that patient was classified as non-compliant; if the patient no longer filled any claims, also non-compliant

An immediate gap in persistence for branded drugs occurs when patients switch plan type

Continuing Patient Persistence by Plan Type in NIADs, Brands 2014



- DPP-4 patients who switched or were switched from to a deductible plan were 13 percentage points less persistent in January 2014 and 18 percentage points less persistent by November.
- The difference in persistence rates in the case of patients filling GLP-1 prescriptions closed somewhat over the course of the year.

Chart notes:

Patients who filled a minimum of three prescriptions in Q4-2013 were identified as continuing and persistent.

Patients were observed over 390 days; if the days between a patient's filled claims exceeded days supply plus a 30-day grace period, that patient was classified as non-compliant; if the patient no longer filled any claims, also non-compliant

Notes on Sources

This report is based on the IMS Health services detailed below.

IMS Formulary Impact Analyzer (FIA) provides insight into what impact utilization-control measures enforced by managed care organizations have had on prescription volumes including the dynamics that affect patient behavior in filling and/or refilling prescriptions. Formulary measures include tiered copay benefit designs, prior authorization restrictions, and often result in non-preferred prescriptions being rejected or switched at the pharmacy. FIA offers visibility to claims rejected for other reasons such as contraindications as well as those attempted to be refilled too soon. FIA sources include national and regional chains, independent pharmacies and a claims coordination switch company providing a comprehensive view of retailers and across geographies.

IMS Rx Benefit Design (RxBD) provides prescription retail claims (TRxs) by benefit design and further segments by plan and type of insurance including Medicare Part D, Medicaid (Managed Medicaid plans only), and Commercial Third Party. RxBD TRxs are projected and assigned to an adjudicated cost cohort (tier). Through IMS Health's partnership with Milliman, projected claims within a given plan are also categorized by benefit design.

References

American Health Policy Institute (2014), New Study Finds Excise Tax Will Dramatically Impact Employees. Retrieved from http://www.americanhealthpolicy.org/Content/documents/resources/a14-13_PR_Excise_Tax.pdf

Henry J. Kaiser Family Foundation (2014). Employer Health Benefits Survey. Retrieved from <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>

Henry J. Kaiser Family Foundation (2013). Health Insurance Coverage of the Total Population. Retrieved from <http://kff.org/other/state-indicator/total-population/#>

Internal Revenue Service (2015). Notice 2015-16. Retrieved from <http://www.irs.gov/pub/irs-drop/n-15-16.pdf>

Mercer (2014). National Survey of Employer-Sponsored Health Plans. Retrieved from <http://www.mercer.com/content/mercerglobal/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html>

Peterson Center on Healthcare & Henry J. Kaiser Family Foundation (2015). Peterson-Kaiser Health System Tracker. Retrieved from <http://www.healthsystemtracker.org/>

PricewaterhouseCoopers LLP (2012-15). Health and Well-being Touchstone Survey results. Retrieved from <http://www.pwc.com/us/en/hr-management/publications/index.jhtml>

US Census Bureau, Population Division (2014). Projections of the Population and Components of Change for the United States: 2015 to 2060. Retrieved from <http://www.census.gov/population/projections/data/national/2014/summarytables.html>

US Bureau of Labor Statistics (2015). CPI Detailed Report. Retrieved from <http://www.bls.gov/cpi/tables.htm>

Xerox and Buck Consultants (2014), Employer Group Waiver Plans. Retrieved from http://www.xerox.com/downloads/usa/en/buck/brochures/hrc_brochure_egwp.pdf

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Mason Tenaglia is responsible for advancing the IMS Institute’s payer and managed care thought leadership, as well as engaging with key leaders in the healthcare industry, academia and government.

Previously, Mason was a Vice President of the IMS Managed Markets Strategy team and former Managing Partner of the Amundsen Group, an IMS company. He has worked with major pharmaceutical, biotechnology, consumer health, and pharmacy benefit management companies for more than 30 years with a focus on access issues. Mason is a leading authority on understanding the impact of the Affordable Care Act on the healthcare industry and is a frequent author and speaker on the topic. He is a member of the Pharmaceutical Executive Editorial Advisory Board, and serves as its advisor for Managed Care. Mason began his consulting career at McKinsey & Company. He holds a BS degree in International Economics from the Walsh School of Foreign Service at Georgetown University and an MBA in Finance and International Business from the University of Chicago.



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About the Institute

The IMS Institute for Healthcare Informatics leverages collaborative relationships in the public and private sectors to strengthen the vital role of information in advancing healthcare globally. Its mission is to provide key policy setters and decision makers in the global health sector with unique and transformational insights into healthcare dynamics derived from granular analysis of information.

Fulfilling an essential need within healthcare, the Institute delivers objective, relevant insights and research that accelerate understanding and innovation critical to sound decision making and improved patient care. With access to IMS Health's extensive global data assets and analytics, the Institute works in tandem with a broad set of healthcare stakeholders, including government agencies, academic institutions, the life sciences industry and payers, to drive a research agenda dedicated to addressing today's healthcare challenges.

By collaborating on research of common interest, it builds on a long-standing and extensive tradition of using IMS Health information and expertise to support the advancement of evidence-based healthcare around the world.

Research Agenda

The research agenda for the Institute centers on five areas considered vital to the advancement of healthcare globally:

The effective use of information by healthcare stakeholders globally to improve health outcomes, reduce costs and increase access to available treatments.

Optimizing the performance of medical care through better understanding of disease causes, treatment consequences and measures to improve quality and cost of healthcare delivered to patients.

Understanding the future global role for biopharmaceuticals, the dynamics that shape the market and implications for manufacturers, public and private payers, providers, patients, pharmacists and distributors.

Researching the role of innovation in health system products, processes and delivery systems, and the business and policy systems that drive innovation.

Informing and advancing the healthcare agendas in developing nations through information and analysis.

Guiding Principles

The Institute operates from a set of Guiding Principles:

The advancement of healthcare globally is a vital, continuous process.

Timely, high-quality and relevant information is critical to sound healthcare decision making.

Insights gained from information and analysis should be made widely available to healthcare stakeholders.

Effective use of information is often complex, requiring unique knowledge and expertise.

The ongoing innovation and reform in all aspects of healthcare require a dynamic approach to understanding the entire healthcare system.

Personal health information is confidential and patient privacy must be protected.

The private sector has a valuable role to play in collaborating with the public sector related to the use of healthcare data.

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