MILLIMAN REPORT

Point-of-Sale Rebate Study for Colorado House Bill 22-1370

Commissioned by the Colorado Division of Insurance

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Executive Summary

On May 18, 2022, Colorado Governor Jared Polis signed House Bill 22-1370 (HB-1370) into law.[1] This bill includes a variety of provisions related to prescription drug coverage in the state of Colorado. In particular, the law directs health insurers to maximize the use of manufacturer rebates to reduce member cost-sharing at the point-of-sale (POS), to the extent that it will not increase premiums, starting in 2024. The Colorado Division of Insurance (DOI) engaged Milliman to complete an actuarial study analyzing the effects of POS rebates on customers in Colorado's Individual health insurance market. This report summarizes the results of our study, focusing on the impact of POS rebates on (a) premium and (b) actuarial value (AV) in the Individual market.

Pharmaceutical manufacturers negotiate with Pharmacy Benefit Managers (PBMs) to cover and/or prefer their drugs in various health insurance markets. Some manufacturers will provide rebates, or volume-based incentive payments, to PBMs to offer preferred placement of their medications (through lower cost-sharing or fewer restrictions). In our experience, PBMs share manufacturer rebates with health insurers in the Individual health insurance market.

We modeled the financial impact of passing through rebates at the POS for five existing benefit designs in Colorado's Individual health insurance market, representing a range of popular drug benefit designs. This analysis reflects drug-level POS rebates using estimated manufacturer rebate information the DOI received from SSR Health.[2] This approach aligns the POS price concession for each member with the rebates for each drug that the health insurer receives for that member. For the purpose of this analysis, we assume rebates are 100% passed through at the POS, decreasing allowed cost on a dollar-for-dollar basis. We also discuss and present results for an alternate approach, required by HB-1370, to pass through rebates at the formulary tier-level in the "Results" section of this report; this approach produced similar results. Please refer to the "Methodology" section of this report for additional detail.

Figures 1 and 2 summarize the estimated premium and AV impacts of passing through drug level rebates at the POS for each benefit design analyzed. Our analysis indicates the following:

- **Premium Impact.** We estimate premium increases in the range of +$0.40 to +$5.00 per-member-per-month (PMPM) due to POS rebates in Colorado's Individual market for the five tested plan designs. The largest changes are for lean benefit designs with a high deductible and/or coinsurance (e.g., Bronze plan), while rich copay-based designs (e.g., Gold plan) see a more limited impact. We estimate a dollar-for-dollar increase in plan costs to offset member cost-sharing decreases from POS rebates, resulting in higher premiums. This change shifts rebates from a reduction to premium for all beneficiaries to a reduction in cost-sharing for beneficiaries taking certain drugs.
- **Actuarial Value Impact.** AV measures the benefit richness for an insurance plan, reflecting the proportion of gross healthcare costs that insurance covers at the POS (with the member covering the remainder). Passing through rebates at the POS decreases both gross healthcare costs and member cost-sharing, shifting additional cost to the health insurer. However, AV is based on gross healthcare costs, and using Milliman's actuarial projection model, we estimate that the health insurer's share of gross healthcare costs would decrease by 0.5% to 1.3% for all tested benefit designs. We did not use the Federal AV Calculator because it does not explicitly account for POS rebates. We expect health insurers would use the Federal AV Calculator, which would result in no changes to a plan's AV or metal level. However, if health insurers manually adjust the inputs or outputs of the Federal AV Calculator to reflect AV changes similar to our study, these impacts could cause a plan to no longer meet metallic level AV requirements.

Figure 1
Colorado Division of Insurance
Estimated 2024 Premium Impacts of Passing-Through Rebates at the Point-of-Sale at Drug Level (PMPM)

Premium PMPM	Bronze	Silver	Gold	Silver 87 CSR	CO Option
Baseline	$505.30	$423.40	$581.50	$688.40	$462.50
POS Rebate Scenario	$510.30	$425.90	$583.40	$688.80	$465.00
POS Rebate Impact	$5.00	$2.50	$1.90	$0.40	$2.50
% Change	1.0%	0.6%	0.3%	0.1%	0.5%

Figure 2
Colorado Division of Insurance
Estimated 2024 Actuarial Value (AV) Impacts of Passing-Through Rebates at the Point-of-Sale at Drug Level

Actuarial Value	Bronze	Silver	Gold	Silver 87 CSR	CO Option
Baseline	72.2%	71.5%	87.0%	89.9%	71.3%
POS Rebate Scenario	71.3%	70.2%	86.5%	89.3%	70.0%
POS Rebate Impact	-0.9%	-1.3%	-0.5%	-0.6%	-1.3%

Background

Starting on January 1, 2024, health insurers in Colorado must ensure that 100% of estimated manufacturer rebates will be used to "reduce policyholder costs." This provision was enacted by Colorado HB-1370, which includes a variety of provisions related to prescription drug coverage. For the Individual market, HB-1370 states the following:[3]

> "*For Individual health benefit plans, all rebates are used to reduce consumer premiums and out-of-pocket costs for prescription drugs and that health insurers will maximize the use of rebates to reduce consumer out-of-pocket costs at the point of sale not to exceed the consumer's actual out-of-pocket costs for the prescription drug if the use of such rebates will not:*
> *(I) Increase premiums;*
> *(II) Change the actuarial value of the plan inconsistent with federal and state requirements; or*
> *(III) Otherwise result in an impact that is not in the best interest of consumers.*"

This study explores the impact of POS rebates on premiums and actuarial values in the Individual health insurance market. We provide an overview of the pharmacy supply chain, manufacturer rebates, and POS rebates below.

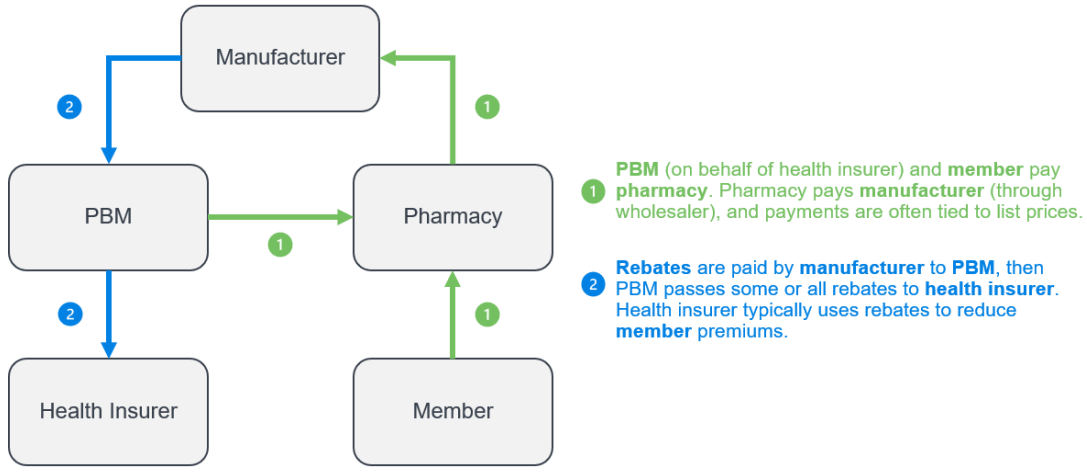
Pharmacy Supply Chain Overview

The pharmacy supply chain is complex and includes many key stakeholders. Figure 3 provides a simplified diagram visualizing the flow of funds for some of the key stakeholders in the pharmacy supply chain. This visual is highly simplified to help illustrate some, but not all, of the key relationships in the supply chain. Please note that the actual flow of funds is far more complex and includes additional stakeholders and dollar flows. The two key dollar flows highlighted in this figure include:

1. **Pharmacy reimbursement.** Both the member (through cost-sharing) and PBM (on behalf of the health insurer) reimburse the pharmacy for the cost of the drug. The pharmacy pays the manufacturer (through a wholesaler), and in the current environment, reimbursement is often tied to list prices set by manufacturers.

2. **Manufacturer rebates.** Manufacturers pay rebates to the PBM, and subject to the contract between a PBM and a health insurer, the PBM passes all or some of the rebates through to the health insurer. In our experience, the health insurer typically uses the rebates to reduce premiums for all members. The health insurer in this scenario can be any plan sponsor (e.g., employer, government entity) that facilitates healthcare benefits. In the Individual market, this is an insurance carrier.

Figure 3
Simplified Overview of Pharmacy Supply Chain Flow of Funds



Note: Illustrates rebate and cost-sharing payments only, excludes other dynamics (e.g., premiums)

Manufacturer Rebates Overview

Like most health insurance benefits, prescription drug benefits typically include a member cost-sharing component. This benefit design usually reflects a tiered approach, where members pay lower cost-sharing for less expensive drugs (e.g., generic drugs) and higher cost-sharing for more expensive drugs (e.g., brand and specialty drugs). To determine the tiering of drugs, PBMs develop formularies, which are lists of covered drugs and the applicable tier for each drug. Member cost-sharing varies for each tier, with lower tiers having lower cost sharing to incent the use of lower cost or preferred drugs. PBMs may also place utilization management (UM) requirements for specific drugs to manage access to those drugs.

Manufacturers typically negotiate with PBMs to (a) have their drugs covered by health insurers, (b) limit the number of restrictions applied to their drugs, and (c) secure preferred formulary placement / lower member cost-sharing. For manufacturers, these negotiations can improve member access to drugs, increasing the volume of prescriptions that they sell. Some manufacturers will offer rebates during these negotiations as a financial incentive for PBMs to cover their products, particularly for brand and specialty drugs in competitive therapeutic classes where multiple alternative treatments exist.

In our experience, PBMs pass some or all manufacturer rebates along to their health insurer clients. These payments are usually retrospective, driven by the historical volume of prescription drugs where the PBM has negotiated a manufacturer rebate. Generally, these payments do not affect member cost-sharing, which is typically tied to drug list prices as well as pharmacy reimbursement set by the PBM. As such, manufacturer rebates provide a direct offset against health insurer costs, reducing their prescription drug claim payments and liabilities. In our experience, these cost savings are explicitly factored into health insurance premium rate development and are passed along to health plan members through reduced premiums.

In the individual market, the Centers for Medicare and Medicaid Services (CMS) provides a standardized template for summarizing a health insurer's experience and premium development, called the Unified Rate Review Template (URRT). In the instructions for this template, CMS describes how to report prescription drug claims experience, noting specifically, "This amount should be net of rebates received from drug manufacturers."[4]

Because manufacturer rebates are paid retrospectively, future manufacturer rebates are unknown. Health insurers need to estimate rebates when developing forecasts or setting premiums, and actual rebates could emerge higher or lower than expected. In our experience, estimated rebates directly offset estimated plan costs in premium rate development, consistent with the guidance from CMS noted above. However, health insurers cannot predict rebates with certainty, making it challenging to pass through 100% of actual rebates to health insurance premiums. If manufacturer rebates emerge more favorably than expected, health insurers will see an improvement in profits/surplus, while if rebates emerge less favorably, profits/surplus will decrease. This dynamic is consistent with deviations in any key assumption in premium rate development (e.g., claim trends, membership forecasts, provider contracting changes).

Manufacturer rebate contracts are considered highly confidential for competitive reasons, with few publicly available sources summarizing rebate levels. There are a few state and federal requirements for health insurers to report aggregate manufacturer rebates received from PBMs. These sources provide state and federal regulators with insight into historical, aggregate rebate levels, and in some cases, projected aggregate rebates affecting premium rate development. These sources include the following:

1. **Colorado-Specific Requirements.** As a result of HB-1370, health insurers in Colorado will be required to report their actual and estimated manufacturer rebate amounts with their premium rate development provided to state regulators beginning in 2024.

2. **Statutory Financial Statements.** Health insurers are required to report rebates received from their PBM in their statutory financial statements. In their financial statements, health insurers report rebates as an offset to prescription drug claims and summarize total rebates received in a supplemental exhibit or in the notes to the financial statements.

3. **Medical Loss Ratio (MLR) Rebate Reporting.** Federal instructions require health insurers to subtract rebates from claim payments for Medical Loss Ratio (MLR) rebate calculations.[5] If a health insurer's net claim payments are less than 80% of premiums in the individual market over a three-year period, health insurers are required to refund members a portion of their premiums through a Medical Loss Ratio (MLR) rebate.

Our analysis assumes 100% of rebates received by health insurers are used to reduce premiums. This assumption is based on (a) our experience in developing premium rates, (b) the language in the URRT instructions from CMS to net out rebates, and (c) the requirements to report rebates in both statutory financial statements and for MLR rebates.

Point-of-Sale Rebates Overview

An alternative approach to PBMs passing manufacturer rebates to health insurers is to share rebates with members at the point-of-sale. Several PBMs offer this as a voluntary option, and there have been regulations proposed or enacted in the Medicare Part D market that would require rebates to be passed through at the POS.[6,7,8,9] With POS rebates, member cost-sharing may decrease as it is tied to the gross drug cost net of rebates, as opposed to the gross drug cost (which aligns closer to the list price).

Figure 4 illustrates the impact of POS rebates to health insurer and member costs in a scenario with a $500 drug, $150 rebate, and two different benefit designs ($50 copay vs. 25% coinsurance). In both scenarios, the POS drug price decreases from $500 to $350. These examples assume no deductible or maximum out-of-pocket (MOOP) apply for simplicity. These examples show:

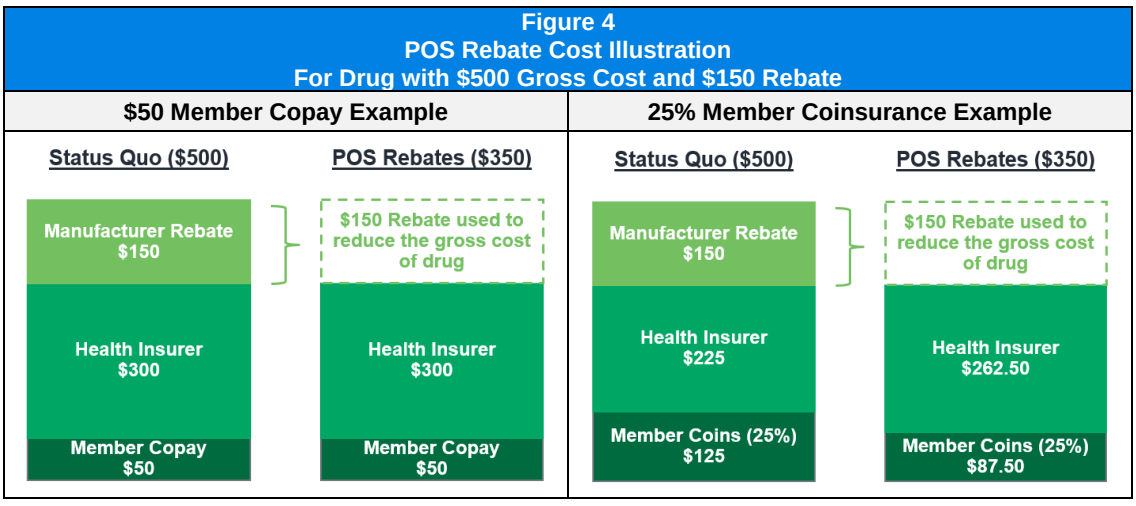
1. **In a fixed $50 copay scenario**, the member's cost remains unchanged, as the drug price still exceeds the copay amount. As a result, the health insurer's cost remains unchanged as well.

2. **In a 25% coinsurance scenario**, the member's cost decreases, as the coinsurance now applies to a lower price. The member's savings are shifted to the health insurer, increasing their share of the total drug cost.

In these examples, we expect that POS rebates would drive premium increases for coinsurance-based designs, while driving limited-to-no premium changes for copay-based designs. This finding is consistent with other actuarial studies on this topic across different market segments.[10,11,12] To the extent that members taking high-cost, high rebate drugs tend to favor copay-based designs over coinsurance-based designs, they may see a limited reduction to their cost-sharing as a result of POS rebates. We expand on this dynamic in the "Results" section of this report.

Members with a deductible would see a dollar-for-dollar decrease in their cost-sharing due to POS rebates before they meet their deductible. For example, if a member has a $500 deductible and takes a drug with a $500 gross cost and a $150 rebate, their cost-sharing would decrease from $500 to $350 with POS rebates. For members that exceed their deductible, POS rebates would still decrease the drug costs applied to the deductible, but those costs could be replaced by other claims where the deductible applies (e.g., other medical or drug spend). However, we expect, in general, members with a deductible will see lower cost-sharing due to POS rebates. Members that exceed their MOOP will similarly see a decrease in costs and cost-sharing applicable to the MOOP; however, they may see limited-to-no overall cost-sharing impact from POS rebates if the reduction in cost-sharing is offset by other healthcare costs (e.g., other medical or drug spend).

Figure 4
POS Rebate Cost Illustration
For Drug with $500 Gross Cost and $150 Rebate



Results

Figure 5 summarizes the premiums, actuarial values, and member cost-sharing estimated for each benefit design tested. Please refer to the "Methodology" section for additional detail on the benefit designs selected and our underlying assumptions. Our analysis estimates these values under three separate scenarios:

- **Baseline.** The baseline scenario reflects the current environment, where we assume that rebates passed from PBMs to health insurers directly reduce premiums. We reflect an adjustment to list prices for insulins in our baseline scenario, given recent announcements from the three largest insulin manufacturers for 65%-78% list price discounts effective 1/1/2024.[13,14,15] We assume no rebates in 2024 for the insulin products.

- **POS Rebates at Drug Level.** This scenario assumes rebates are passed through at the point-of-sale at the drug level. Drug level rebates are estimated using data from SSR Health. We assume the allowed cost reduction due to POS rebates is equal to the value of post-POS rebates reflected in the Baseline scenario.

- **POS Rebates at Tier Level**. This scenario assumes rebates are passed through at the prescription drug tier level. We apply a uniform gross cost reduction to each drug on a tier, independent of the rebates received for each drug. This approach affects member cost-sharing when tied to the gross drug cost (e.g., deductible, coinsurance), but not affecting member cost-sharing when using fixed copays, similar to the prior scenario.

POS rebates at the drug level is the most common approach in the industry to pass rebates through at the POS. Based on a requirement in HB-1370, we also tested a scenario where rebates are passed through at the formulary tier level. The aggregate results of this scenario are similar to the drug-level impact, with slightly lower premium increases. However, the impact at the member level will vary materially, with members taking drugs that receive low or no rebates seeing a greater reduction in cost-sharing, and members taking drugs with high rebates seeing a lower reduction in cost-sharing, relative to the drug-level POS rebate approach.

Our modeling does not reflect stakeholder behavioral changes, which could significantly increase or decrease the estimated POS rebate premium impact and lead to other knock-on effects. Specifically, we did not assume (a) higher utilization due to lower prescription drug costs for members, or (b) increased administrative expenses due to greater operational complexity with POS rebates, which would both drive larger premium increases due to POS rebates. We also did not reflect potential health insurer strategies that would mitigate some of the cost increases, such as changes in formulary strategies or health plan contracts with PBMs.

We discuss the impact of POS rebates on premiums, actuarial values, and member cost-sharing below. In addition to these changes, we expect that POS rebates could affect Advanced Premium Tax Credits and the state reinsurance program in the Colorado Individual market offered through a section 1332 waiver program. We did not model the impacts to these programs explicitly, but we discuss them in the "Discussion" section of this report.

Figure 5
Estimated 2024 Impacts of Passing-Through Rebates at the Point-of-Sale (PMPM)

Scenario	Bronze	Silver	Gold	Silver 87 CSR	CO Option
Premium (PMPM)					
Baseline	$505.30	$423.40	$581.50	$688.40	$462.50
Drug Level POS Rebates	$510.30	$425.90	$583.40	$688.80	$465.00
Tier Level POS Rebates	$509.60	$425.40	$582.70	$688.70	$464.40
Drug Level Impact	$5.00	$2.50	$1.90	$0.40	$2.50
Tier Level Impact	$4.30	$2.00	$1.20	$0.30	$1.90
Actuarial Value					
Baseline	72.2%	71.5%	87.0%	89.9%	71.3%
Drug Level POS Rebates	71.3%	70.2%	86.5%	89.3%	70.0%
Tier Level POS Rebates	71.1%	70.1%	86.4%	89.3%	69.9%
Drug Level AV Difference	-0.9%	-1.3%	-0.5%	-0.6%	-1.3%
Tier Level AV Difference	-1.1%	-1.4%	-0.6%	-0.6%	-1.4%
Member Cost-Sharing (PMPM)					
Baseline	$177.60	$154.00	$78.30	$69.20	$169.60
Drug Level POS Rebates	$172.60	$151.50	$76.40	$68.80	$167.10
Tier Level POS Rebates	$173.30	$152.00	$77.10	$68.90	$167.70
Drug Level Impact	-$5.00	-$2.50	-$1.90	-$0.40	-$2.50
Tier Level Impact	-$4.30	-$2.00	-$1.20	-$0.30	-$1.90

Premiums

POS rebates increase premiums across all tested benefit designs in our modeling. Premiums increase due to sharing rebates directly with members through lower cost-sharing, shifting costs to the health insurer. The POS rebate premium impact varies based on benefit design. For example, we estimate high deductible health plans (HDHPs) and plans with coinsurance would see the largest premium increases, consistent with our modeled results for the Bronze and Silver benefit designs tested. Conversely, members with copay-based prescription drug benefit designs and/or lower MOOPs would see a more limited premium impact, as their fixed dollar copays are largely unaffected by passing through rebates at the POS, consistent with our modeled results for the Gold, Silver 87 CSR, and Public Option benefit designs.

HB-1370 requires health insurers to pass through rebates at the POS to the extent that it does not increase premiums. Certain copay-based plans could see limited-to-no premium increases if they have low, fixed dollar copays, such as the Silver 87 CSR benefit plan tested. However, for members in these copay-based plans, passing through rebates at the POS would also offer limited-to-no benefit, as member cost-sharing would remain the same (or similar).

Actuarial Values

AV measures the benefit richness for an insurance plan as the proportion of gross healthcare costs that insurance covers at the POS. The AV estimated using the Federal AV Calculator determines the metal level of each plan. We estimate POS rebates will decrease the AVs across all plans based on calculated paid-to-allowed ratios (e.g., proportion of gross healthcare costs that are paid by the health insurer at the POS) from our actuarial projection model. We did not use the Federal AV Calculator, which does not explicitly consider POS rebates and would compute no change in AVs due to POS rebates. Federal regulations allow users to reflect a unique plan design for material benefit provisions that are not compatible with the Federal AV Calculator's existing structure.[16] This provision would allow users to adjust the input or output of the AV Calculator to account for POS rebates, but it would be non-standard and would require manual user adjustment.

Changes in AVs could affect whether or not a plan qualifies to be offered under its current metal level. Our actuarial projection model estimates that POS rebates would decrease AVs, while the Federal AV Calculator, which does not explicitly consider POS rebates, would result in no AV changes due to POS rebates. We expect health insurers would use the Federal AV Calculator, which would result in no changes to a plan's AV or metal level. However, if health insurers manually adjust the inputs or outputs of the Federal AV Calculator to reflect AV changes similar to our study, these impacts could cause a plan to no longer meet metallic level AV requirements.

The decrease in AVs computed in our modeling occurs as total allowed cost (i.e., gross cost before member cost-sharing) decreases, but member cost-sharing decreases by a smaller proportion. POS rebates directly reduce allowed costs, but the lower allowed cost is often split between insurers and members (depending on plan design). This dynamic results in insurance covering a lower portion of the new allowed cost, reducing the overall actuarial value. These results are counterintuitive relative to the premium changes, as a lower AV generally indicates that the health insurer pays a lower portion of the overall healthcare benefit. All else equal, insurers pay more (net of rebates) in a POS rebate environment than they do assuming they solely receive rebates after the POS, which drives the premium increases shown above.

Our calculated paid-to-allowed ratios are higher than the AVs for each metal level. For example, a Bronze plan typically has an AV of approximately 60%, while our estimated Bronze paid-to-allowed ratio exceeds 70%. This dynamic is not uncommon, where paid-to-allowed ratio estimates calculated by insurers (such as the AVs carriers may calculate when setting premiums) can vary materially from results produced by the Federal AV Calculator.

Member Cost-Sharing

We estimate member cost-sharing decreases across all tested benefit designs due to POS rebates. As illustrated in Figure 5, these cost-sharing decreases drive a dollar-for-dollar increase in the estimated premiums, as members pay less and insurance pays more. Consistent with the premium changes, the largest impacts are to members with an HDHP or coinsurance-based design.

The values illustrated in Figure 5 reflect averages and can vary widely by member. Members that take no drugs or generic drugs could see no cost-sharing reduction due to POS rebates but would see a premium increase. Members that take brand or specialty drugs with rebates could see material cost-sharing decreases with POS rebates (if they have a benefit design with a deductible and/or coinsurance), which could more than offset the premium impact. In the Drug Level POS Rebate scenario, members taking drugs with high rebates would experience the largest changes, while in the Tier Level POS Rebate scenario, members taking any drug on a brand or specialty drug formulary tier would see a uniform cost reduction. This could create more uniform cost-sharing reductions for all members taking specialty and brand drugs, even after accounting for premium increases.

Stakeholder Behavior Changes

We assumed no stakeholder behavior changes as a result of this change in law. Changes in stakeholder behavior (e.g., members taking more / less / different drugs, PBMs and/or health insurers negotiating more or less rebates, changes in formularies / drug coverage / preferred drugs) would affect the results of our analysis. The effect of behavior changes could be significant. We also assumed no stakeholder behavior changes because of insulin list price changes other than our assumption of no rebates on these drugs on an ongoing basis. Future member behavior may not conform precisely to the behavior exhibited in our data.

Discussion

Point-of-sale rebates could affect a variety of other related programs or aspects of the pharmacy supply chain and Individual Health insurance market. We discuss some of the key considerations below.

- **Advanced Premium Tax Credits (APTCs).** The premium impacts illustrated in this report represent total Individual market premium impacts, before accounting for APTCs. The APTCs subsidize premiums for certain beneficiaries that select on-exchange Individual plans. To the extent the benchmark plan (i.e., second lowest cost silver plan) premium in the market were to increase, this would also increase APTCs. Net premium impacts to members will vary based on their plan selection and the premium for the benchmark plan.

- **Section 1332 Waiver Reinsurance.** Colorado also operates a state-based reinsurance program in the Individual Market through use of a Section 1332 Waiver.[17] If rebates are passed through at the point-of-sale, this could decrease reinsurance payments associated with high-cost members taking drugs with a rebate, due to lower point-of-sale spend. If there are no changes to the reinsurance parameters (e.g., increase the maximum threshold where reinsurance would apply), this reduction in reinsurance payments could result in reinsurance having a reduced impact on premiums due to POS rebates.

- **Member Behavior.** POS rebates could drive changes in member behavior in Colorado's Individual market. For example, lower drug costs could lead to more utilization of brand and specialty drugs, due to both higher adherence for existing users and more members starting new therapies. In the long-term, lower financial barriers to accessing these medications could lead to improved health outcomes and lower medical costs / fewer acute episodes (e.g., fewer emergency room visits). If premiums were to increase, it could also drive member plan selection changes. For example, we expect leaner designs, such as HDHPs, would see the largest premium increases, which could cause some members on an HDHP to switch to a different benefit design. Conversely, a HDHP could be more appealing to members taking brand and specialty drugs that have previously opted for a benefit design with fixed copays, given the lower cost-sharing due to POS rebates.

- **Drug Discount Cards.** There has been a rise in members using drug discount cards, such as GoodRx, to be cash-paying customers instead of using insurance over the last several years.[18] These programs are mostly used for generic drugs, but some companies have been exploring options to offer brand drugs as well. POS rebates could alter that trend, resulting in more prescriptions being filled under the insurance benefit.

- **Copay Assistance Programs.** Many manufacturers offer copay assistance programs for brand and specialty drugs that help subsidize member cost-sharing. As a result, many members are currently insulated from the full cost of their drugs. For members using these programs today, cost-sharing may not decrease due to POS rebates. In addition, health insurers and PBMs are using these copay assistance funds to reduce their premiums through copay accumulator and maximizer programs, where copay assistance is used to reduce member cost-sharing, but it does not accumulate to a member's deductible or MOOP. Passing through rebates at the POS could reduce the amount of copay assistance that health insurers receive through copay accumulator and maximizer programs, which could, in turn, increase premiums.

- **Insulin Prices and List Price Changes.** In March 2023, the three largest insulin manufacturers decreased their list prices by 65% to 78%, effective beginning in Q4 2023.[19,20,21] Several other pharmaceutical manufacturers may change their list prices as they could be facing financial pressures from recent legislation, such as the American Rescue Plan Act and the Inflation Reduction Act. If manufacturers remove or reduce rebates on lower list price drugs, this could mirror a POS rebate environment. We included the announced insulin list price changes in our baseline scenario and assume no rebates for these drugs in 2024.

- **Colorado Option Plan.** Colorado Option plans must meet specific premium decrease targets in the next few years. If the decrease target is not met, Colorado has the authority to reduce provider reimbursement to achieve the required decrease. To the extent POS rebates increase premiums for Colorado Option plans, this increased cost could ultimately be shifted to providers. The premium impact was relatively limited for the Colorado Option plan we tested, given it reflects a primarily copay-based design.

- **Operational Challenges.** Implementing a POS rebate program may require operational changes for PBMs and pharmacies. For example, the correct discount at the pharmacy counter needs to be identified for each member. That discount will vary by drug for each carrier and formulary offering. The discount could change throughout the year as PBMs continue to negotiate rebates in response to market events. Rebates are also paid retrospectively, so the health insurer will need to bear the cash flow risk before the rebate is received. This increased operational complexity could increase PBM and health insurer administrative expenses, which could further increase plan premiums.

Methodology

To perform this analysis, we relied on medical and prescription drug claims data from Milliman's Consolidated Health Cost Guidelines™ Sources Database. We limited the claims data to members in the Individual market and used Milliman's Claim Simulation Model to estimate changes in health insurer and member costs. This model projects costs in a seriatim fashion at the claim level, allowing our analysis to capture drug-level impacts from POS rebates. We selected five distinct benefit designs representing a range of results (as described below).

In our baseline scenario, we project the historical claims data forward using assumed utilization and unit cost trends by service category and drug type from Milliman's Health Cost Guidelines™. We then calibrate the projected claims for each benefit design to align with the corresponding 2023 premiums reported in CMS's Unified Rate Review (URR) data (which compiles information from the carrier rate filings).[22] We also adjusted the Silver and Silver 87 Cost Sharing Reduction (CSR) plan premiums, as in the current environment, these are loaded for the additional cost associated with the CSR benefit designs. We made this adjustment to align the premiums with the actual benefits modeled for these members (i.e., a typical Silver plan benefit and an enriched Silver plan with an 87% AV, respectively). We then adjust the prescription drug experience for a subset of insulins at the claim-level to account for material price reductions of 65%-78% announced by pharmaceutical manufacturers in March 2023 to form our baseline scenario.

With the calibrated dataset and baseline scenario, we applied two separate POS rebate scenarios. In both scenarios, we assume 100% of rebates are passed through on a dollar-for-dollar basis at the POS and assume no changes in utilization as a result of member cost-sharing decreases.

- **POS Rebates at Drug Level.** This approach relies on the estimated non-Medicaid rebate rates from the SSR Health data at the drug level. We calibrate the rebates by drug to align with our estimates for each drug type (40% for brand and 20% for specialty drugs), which are informed based on industry experience and Milliman's internal studies. These average rebate levels are applied before the change in list prices for insulins that have announced price reductions, and we assume no rebates for these specific insulin drugs in 2024.

- **POS Rebates at Tier Level**. This approach applies an average rebate assumption by formulary tier to all drugs on that formulary tier. We apply assumptions consistent with the rebate levels from the drug level approach: 40% for brand and 20% for specialty drug tiers (before accounting for insulin list price changes). We apply a uniform price reduction to all drugs on these tiers, as opposed to the drug-specific assumptions in the prior scenario. We assumed a standard four-tier benefit design, as illustrated in Figure 6 below.

For each scenario, we summarized the plan costs, net of rebates, and calculated a premium for each benefit design using an average PMPM retention (administrative expenses + profit margin). We rely on a retention assumption of 16% in the baseline scenario, as informed by the average retention observed in the Individual market from the URR data, and we assumed the same PMPM retention values apply in each scenario.[23] We then compared the premiums and actuarial values computed in each scenario relative to the baseline to determine the impact of POS rebates.

We relied on five illustrative benefit designs based on some of the most popular plans in the Colorado Individual market. Figure 6 summarizes the key benefit design features used in each scenario. We modeled additional detail on the medical benefit, based on the actual benefit design for each representative plan, but excluded that information from this exhibit for brevity. The Colorado Option plan reflects one of the Bronze benefit designs for CY2023.

Figure 6
Colorado Division of Insurance
Modeled Benefit Designs for POS Rebate Study

Benefit Feature	Bronze	Silver	Gold	Silver 87 CSR	CO Option Bronze
Integrated Benefits					
Deductible	$7,450	$5,500	$0	$800	$7,000
Coinsurance	n/a	25%	20%	0%	50%
Maximum Out-of-Pocket	$7,450	$9,100	$7,000	$2,800	$9,100
Pharmacy Benefits by Formulary Tier					
Tier 1 (Generics)	n/a	$25	$15	$0	$30
Tier 2 (Preferred Brands)	n/a	$90	$65	$60	$200
Tier 3 (Non-Preferred Brands)	n/a	50%	$300	$120	$350
Tier 4 (Specialty)	n/a	50%	$350	$180	$700

Caveats and Limitations

We, Kevin Pierce, FSA, MAAA, Jeremy Siborg, ASA, MAAA, and Nicole Grieco, FSA, MAAA, are actuaries for Milliman. We are members of the American Academy of Actuaries, and we meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

This report has been prepared for the specific purpose of analyzing the impact of point-of-sale rebates on premiums, actuarial values, and member cost-sharing in Colorado's Individual health insurance market due to Colorado HB-1370. This information may not be appropriate, and should not be used, for any other purpose. Milliman does not intend to benefit, and assumes no duty or liability to, third parties receiving this work product. We are not legal professionals, and any third-party recipient of this work product desiring professional legal or other guidance should not rely upon Milliman's work product but should engage qualified legal and other professionals for advice appropriate to its own specific needs. Any releases of this report to a third party should be in its entirety.

Milliman developed certain models to review and apply the methodology described in this report. The intent of the models was to estimate the impact of point-of-sale rebates on health insurance premiums and actuarial values. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models, including all input, calculations, and output may not be appropriate for any other purpose.

The models rely on data and information as input to the models. We relied on guidance from the Colorado Division of Insurance as well as data and other information from Milliman's proprietary sources. We have not audited or verified this data and other information but reviewed it for general reasonableness. To the extent that the underlying data or information is inaccurate or incomplete, the results of our analysis could likewise be inaccurate or incomplete. Specifically, we relied on estimated non-Medicaid Rebate Information from SSR Health and publicly available benefit design information for Individual health insurance plans in Colorado. We also relied on Milliman's Consolidated Health Cost Guidelines™ Sources Database for prescription drug and medical claims data experience for the Individual market.

There are several key sources of uncertainty that could affect the results of our analysis, including:

- We assumed no stakeholder behavior changes as a result of this change in law. Changes in stakeholder behavior (e.g., members taking more / less / different drugs, PBMs and/or health insurers negotiating more or less rebates, changes in formularies / drug coverage / preferred drugs) are uncertain and difficult to predict and would affect the results of our analysis. Future member behavior may not conform precisely to the behavior exhibited in our data.

- We tested five different benefit designs in our analysis. Different benefit designs will have varying levels of impacts in the Individual market. We assumed no changes in the underlying plan designs in our modeling. POS rebates change benefit richness and could result in offsetting changes in plan designs offered by health insurers. We expect the Federal AV Calculator would estimate the same AVs with and without POS rebates due to its current methodology (which does not account for rebates).

- We reflected the insulin list price changes for manufacturers that have announced changes for 2024. If additional manufacturers of highly rebated drugs announce price changes, this would decrease the premium impact of POS rebates (as these changes would affect plan costs and premiums regardless of HB-1370). We assumed no stakeholder behavior changes because of insulin list price changes other than our assumption of no rebates on these drugs.

- We relied on average rebate assumptions, informed by our experience and internal research. Actual rebates will vary by carrier and plan, which will affect the impact of POS rebates.

References

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