

THE BIG PINCH

Findings on Changing
Insurance Coverage of
Prescription Drugs

GoodRx Research Team

Anna Wells, Tori Marsh, MPH, Amanda Brooks, MPH,
Diane Li, Jeroen van Meijgaard, PhD, Amanda Nguyen,
PhD, and Thomas Goetz, MA, MPH

OVERVIEW

Conventional wisdom holds that Americans can't afford their medications simply because prices are high, and climbing. Headlines scream about unaffordable gene therapies, and Congress and the White House jostle to do something about escalating drug costs.

This argument isn't wrong — drugs are expensive. Since 2014, the list price for all brand and generic medications has increased by 33.7%, far outpacing the rate of inflation. This year, we saw the second million-dollar drug, and the 20 most expensive drugs each have a list price of at least \$28,000, with some stretching well above \$50,000.

But these high-price-tag drugs for relatively rare conditions don't explain the struggle that so many Americans face in affording their prescriptions.

For most Americans, the struggle with affordable medications isn't over the ones that cost thousands of dollars. It's about affording routine drugs for chronic conditions, and finding that their insurance doesn't cover what it used to.

In other words, Americans are paying more out of pocket. They are carrying more of the cost burden as prescription insurance coverage gets more complex and more restrictive. And they are caught in a Big Pinch as fewer drugs are being covered by insurance and more restrictions are placed on the drugs that are covered.

OUR THREE MAIN FINDINGS

This paper presents updated analysis of formulary data from Medicare Part D insurance plans and highlights 3 worrisome trends in insurance coverage:

01

Insurance plans are covering fewer drugs.

02

Insurance on covered drugs is getting more restrictive.

03

The patient's share of cost through copays, coinsurance, and deductibles is rising.

INSURANCE PLANS ARE COVERING FEWER DRUGS

Drug formularies, set by pharmacy benefit managers (PBMs), are lists of drugs that an insurance plan will pay for, or cover. Formularies ultimately determine how much a patient will pay out of pocket for their medication. These lists change frequently as PBMs add and remove medications based on the drug's effectiveness, price, popularity, and available alternatives.

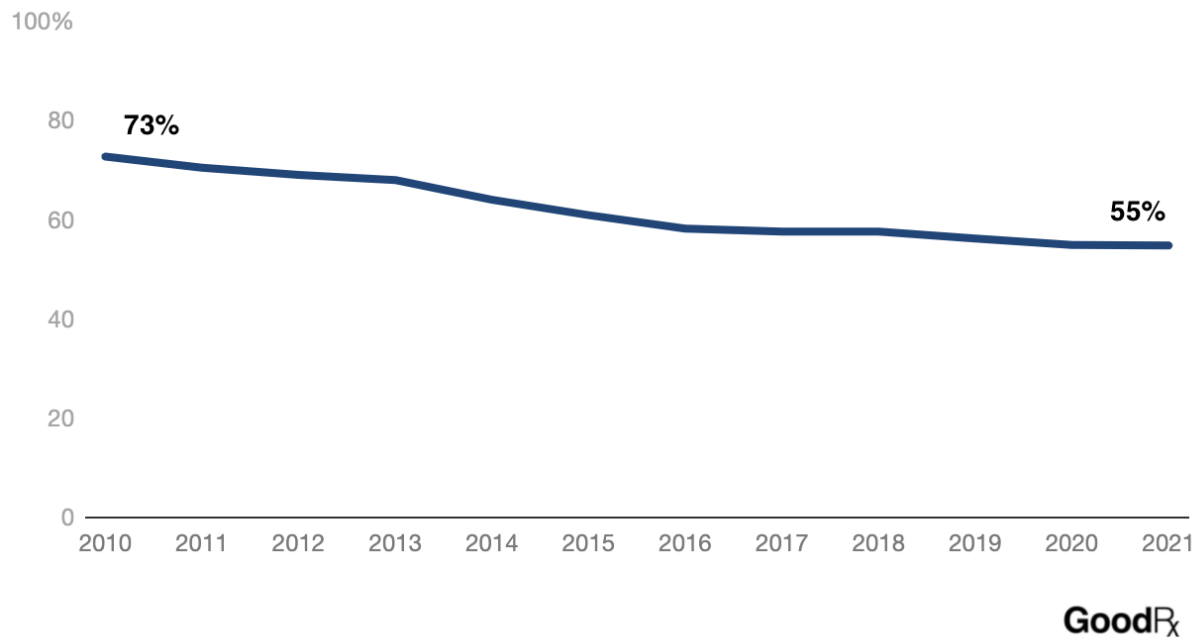
But as it turns out, these formularies are shrinking, leaving people with few options to obtain their drugs.

An updated GoodRx analysis of Medicare Part D looked at an average of 3,707 plans from 2010 to 2021 and their coverage. We found that, on average, the share of drugs covered dropped by 18 percentage points from 2010 to 2021. Compared to 2010, when an average plan covered 73% of prescribed drugs, in 2021 just 55% of prescribed drugs were covered by the average part D plan.

These numbers are based on patient populations of 25.2 million and 41.1 million enrollees in 2010 and 2021 respectively, and they are benchmarked by the best available Medicare plan (the plan that covers the largest amount of drugs, which equals 100%). Coverage percent is calculated by summing the number of drugs covered by a plan, as a proportion of the drugs covered by the best plan. More on this analysis below.

Average Percent of Drugs Covered

GoodRx Analysis of Medicare Part D Plans (2010-2021)



Typically, the commercial insurance market mirrors what happens in Medicare plans. In fact, Medicare Part D formularies are generally better than commercial insurance formularies, mainly because Medicare plans are required to offer a set standard level of coverage.

Specifically, Medicare plans must cover at least two drugs per condition category, and they also must cover most drugs in the following classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, immunosuppressants, and anticancer.

Mandates for commercial insurance plan coverage vary state to state; so while the percentage of drugs covered by typical Medicare plans has dropped by 18 percentage points from 2010 to 2021, it's likely that commercial plans have seen an even steeper decrease.

And we've indeed seen a similar pattern in commercial insurance. In a GoodRx survey of more than 1,000 patients, 15% noted that one or more of their prescriptions had been dropped from coverage in the last year, and 26% noted that they take one or more medications that aren't covered by insurance.

Patients that can't afford the out-of-pocket price may abandon their prescription completely. This has dire long-term consequences for both the patient and the healthcare system as a whole.

INSURANCE FOR COVERED DRUGS IS GETTING MORE RESTRICTIVE

As PBMs design their formularies and decide on the drugs to add and remove, they also add restrictions to drugs they cover. Pharmacy benefit managers add these restrictions, referred to as utilization management tools, to drugs that have cheaper alternatives in an effort to save money. These restrictions are placed on nearly every aspect of healthcare, from tests to procedures to prescription medications.

For their part, PBMs assert that these restrictions control costs by limiting unnecessary care. But research has suggested that they can affect physicians' ability to care for their patients, which can end up delaying patient care and increasing overall out-of-pocket costs.

Patients face insurance restrictions on medications in the form of quantity limits (QL), step therapy (ST), prior authorizations (PA), and refill-too-soon limits. These restrictions allow insurers to evaluate the medical necessity for a patient's prescribed medication and require them to jump through hoops to receive coverage for their medication.

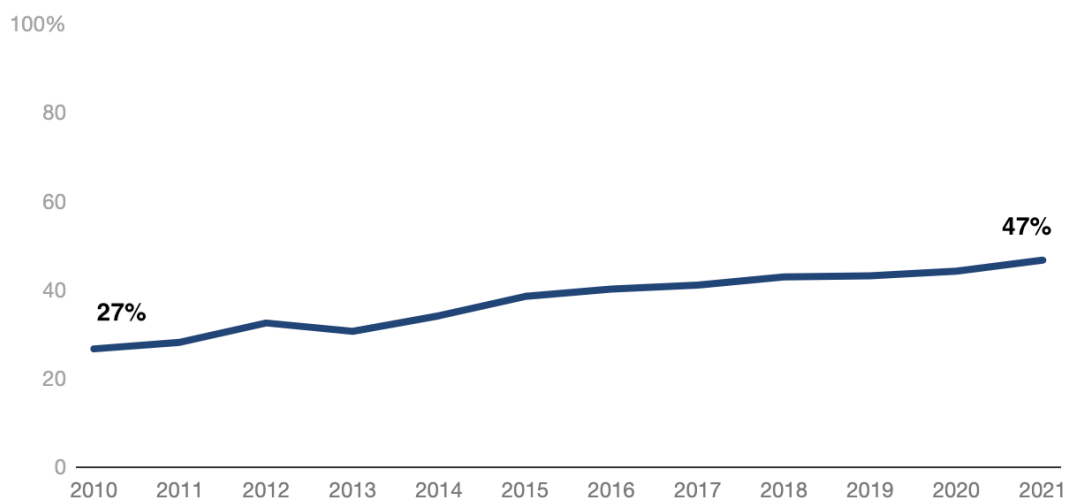
The use of these restrictions has increased substantially in past years.

Between 2010 and 2021, the average number of drugs in Part D plans with restrictions has increased by 20 percentage points, from 27% of drugs in 2010 to 47% of drugs with some form of restriction in 2021.

In other words, nearly half of all medications covered by Medicare plans have a restriction.

Average Percent of Drugs Covered with Restrictions

GoodRx Analysis of Medicare Part D Plans (2010-2021)

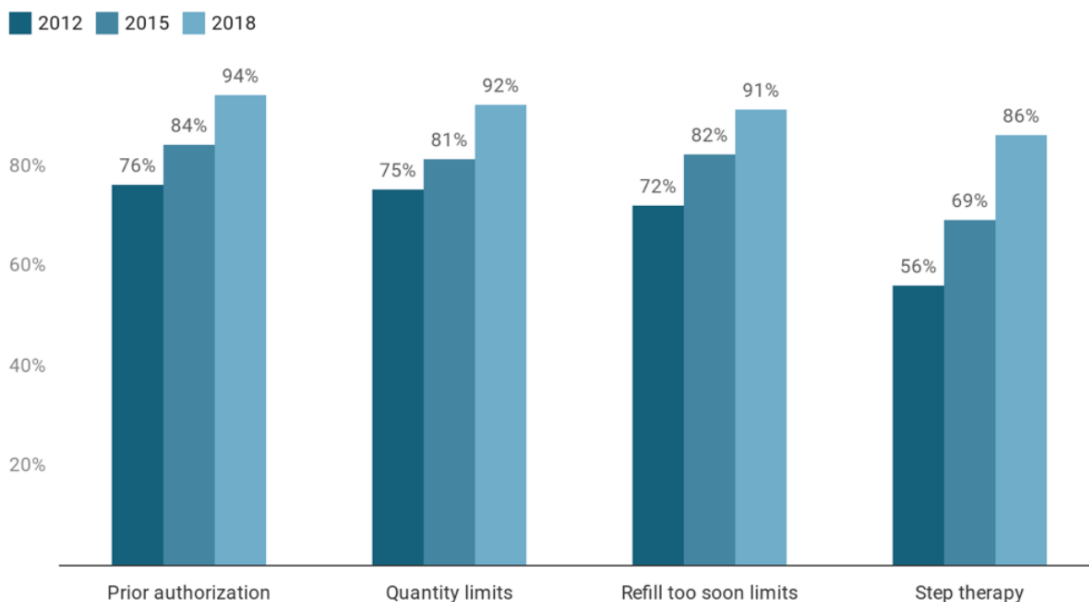


GoodRx

Restrictions on drugs in commercial plans are also on the rise. According to Takeda Pharmaceuticals' [annual report](#), from 2012 to 2018, the percentage of employers that used prior authorization in their plans increased by 18 percentage points, the use of quantity limits increased by 17 percentage points, and step therapy increased by 30 percentage points. The overwhelming majority of plans now use these restrictions.

Restrictions on Covered Drugs in Commercial Insurance Plans

Takeda Pharmaceuticals Annual Report (2012, 2015, 2018)



GoodRx

Patients who have a restriction on their medication are left with few options. While they can jump through the hoops to receive coverage for their prescription, many (1) pay entirely out of pocket for their medication or (2) delay taking or abandon their medication completely. Both options result in higher costs for the patient overall.

In cases where a patient decides to pay entirely out of pocket instead of going through their insurance, they will pay the cash price of the drug, which is typically unaffordable.

Here's an example: Many plans have a prior authorization restriction for voriconazole, an antifungal medication used to treat some infections. If patients are forced to pay out of pocket due to the restrictions, they will pay a cash price upwards of \$1,500 instead of the typical copay price of \$31.

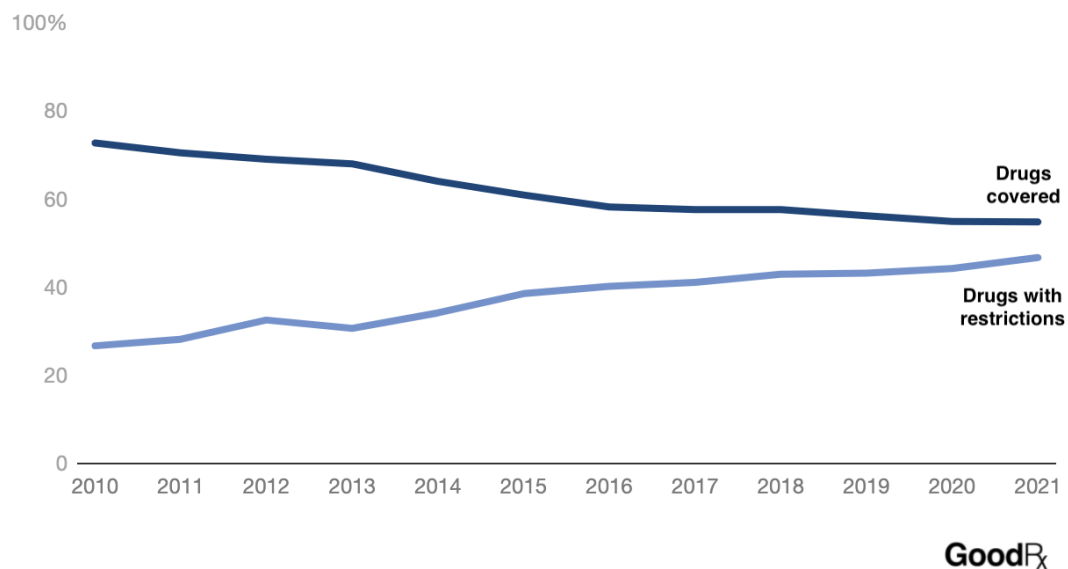
With costs like these, it's no wonder many patients end up abandoning their prescriptions. According to a survey from the American Medical Association, 79% of providers reported that prior authorizations lead to patients abandoning treatment.

RESULT: THE BIG PINCH

Fewer drugs covered coupled with more restrictions on the ones that are covered leaves Americans in a Big Pinch. This pinch is a key contributor to the struggle that Americans face in affording their drugs.

The Big Pinch

GoodRx Analysis of Medicare Part D Plans (2010-2021)



But that's not the end of the story.

An even bigger pinch: Patients pay more, get less from health insurance

Of course, this isn't the only phenomenon at play with regards to insurance coverage. In order to understand the magnitude of the Big Pinch, it also helps to understand other trends in insurance coverage. In essence, insurance isn't what it used to be, and as a result patients are paying more out of pocket for their medications and the rest of their healthcare.

THE PATIENT'S SHARE OF HEALTHCARE COSTS IS RISING

Cost-sharing refers to the portion of healthcare covered by the patient through deductibles, copayments, and coinsurance. To PBMs, cost-sharing tactics serve an important purpose: They reduce the use of unnecessary medical expenses and encourage patients to switch to lower-cost medications.

But while cost-sharing is a common strategy used by PBMs, the landscape continues to change. In the last few years, high-deductible health plans have become more common and copayments have risen, leaving Americans to pick up more of the tab for their healthcare costs.

More high-deductible health plans and rising average deductibles

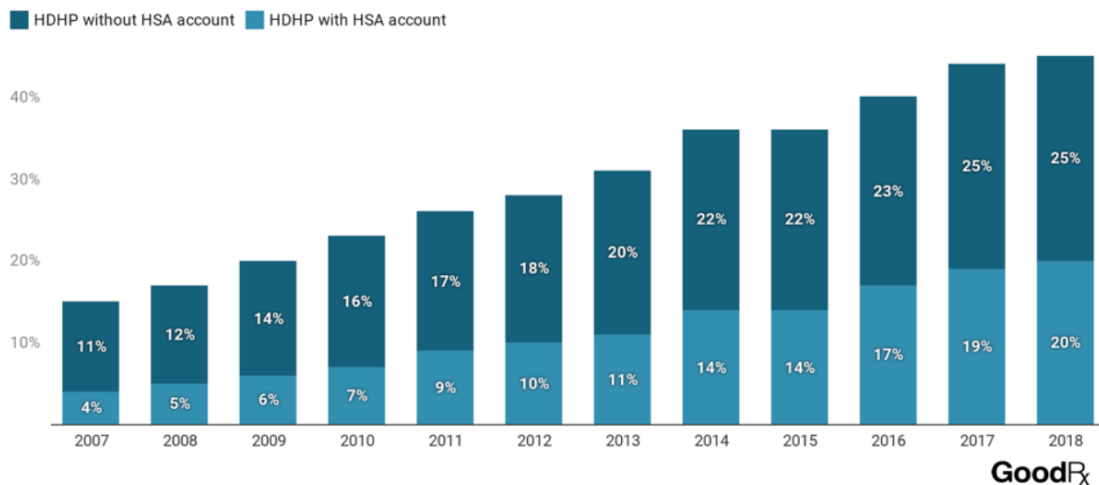
A deductible refers to the amount a patient must pay out of pocket before their insurance starts to cover in-network medical costs. For example, an annual deductible of \$1,500 means that patients must pay that amount for covered services before their insurance kicks in.

While deductibles are a common cost-sharing tactic (83% of workers have some form of deductible in their plan), high-deductible health plans are becoming increasingly more common.

Any plan with a deductible of more than \$1,400 for a single enrollee or \$2,800 for a family is considered a high-deductible health plan. And now, nearly half of Americans with employer-sponsored insurance are enrolled in one. According to the National Center for Health Statistics, from 2007 to 2018, the share of covered workers with a high-deductible plan increased from 15% to 45%.

Share of Employees Covered by a High-Deductible Health Plan (HDHP)

National Center for Health Statistics (2018)

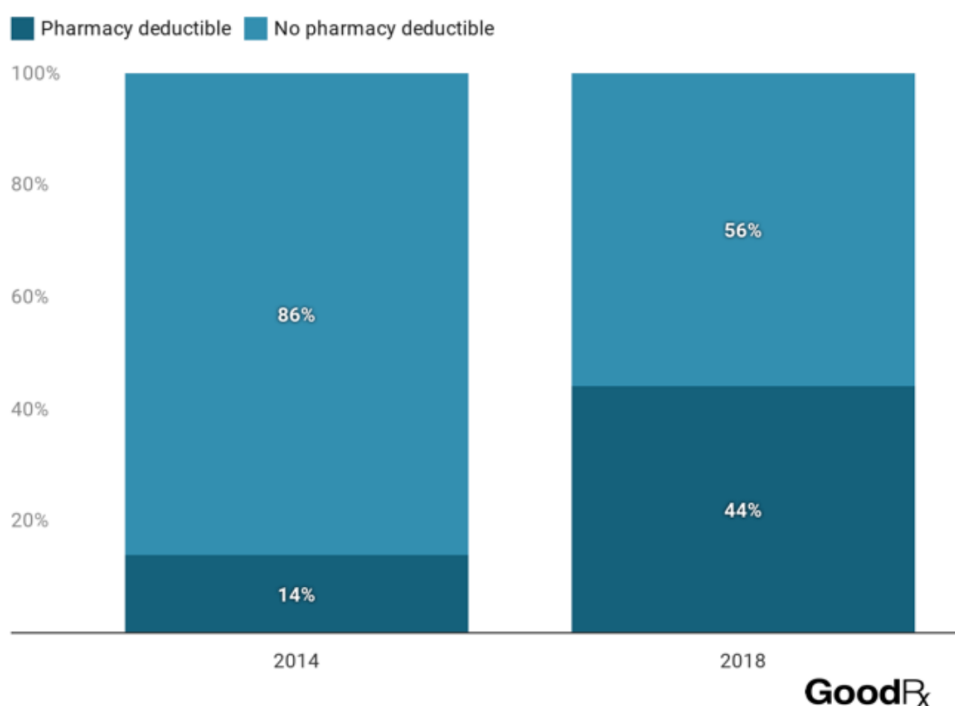


On top of that, a growing number of Americans also have a separate deductible applied only to prescription medications, referred to as a pharmacy deductible. Pharmacy deductibles can be anywhere from \$134 per month to \$465 per month, and only prescription medications can count toward it.

These deductibles are on the rise, too: In 2014, 14% of commercial plans had a separate pharmacy deductible, and now 44% of plans have one, according to Takeda Pharmaceuticals' Annual Report.

Commercial Plans That Use a Pharmacy Deductible

Takeda Pharmaceuticals Annual Report (2014, 2018)



As the number of plans that use deductibles rise, so does the average deductible. Over the last 10 years, the average deductible for a single enrollee almost doubled, from \$917 to \$1,644.

What's more, deductible relief day, the day that the average commercially insured patient will satisfy their deductible, continues to get later every year. In 2019, the average commercially insured patient fulfilled their deductible on May 19, nearly 3 months later than deductible relief day in 2006.

When patients are in the deductible phase, they pay the full negotiated price, a price that is substantially higher than a typical copay. For instance, brand-only drug Xarelto, used to treat blood clots, has an average copay of \$43, but patients in the deductible phase pay the negotiated price of \$456 for a 30-day supply. A similar trend exists for generic medications. Generic Adderall (amphetamine salt combo), used to treat ADHD, has an average copay of \$15, but patients in the deductible phase will pay around \$93.

Copayments and coinsurance are rising

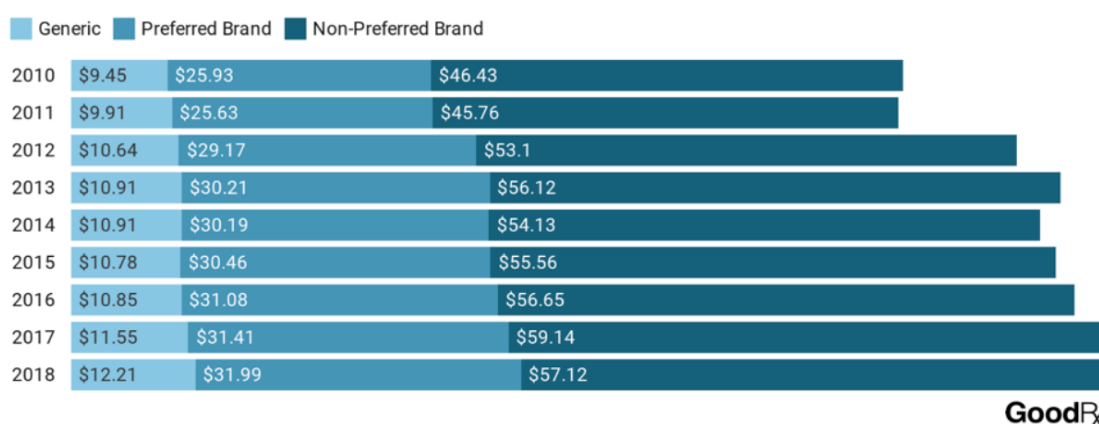
As PBMs design formularies, they divide medications into different tiers, also referred to as levels of coverage. Each tier has a defined out-of-pocket cost through either a copay (a fixed price for a drug), or coinsurance (a defined percentage of the cost of a drug that the patient pays).

In general, low-tier drugs, like tiers 1 and 2, consist of affordable generics while higher tiers, like tiers 4 and 5, include more expensive brand-only and specialty drugs. Over the past few years, the landscape around tiering, copayments, and coinsurance has changed, and the result is more medications with higher copays.

From 2010 to 2018, average copays increased by about 30% for commercial insurance plans, according to a report done by Takeda Pharmaceuticals. The average copay for a 30-day supply of low-tier generics jumped from \$9.45 in 2010 to \$12.21 in 2018, while the average copay for a 30-day supply of high-tier brand medications jumped from \$46.43 to \$57.12 during the same time period.

Average Copay for a Typical 30-Day Supply

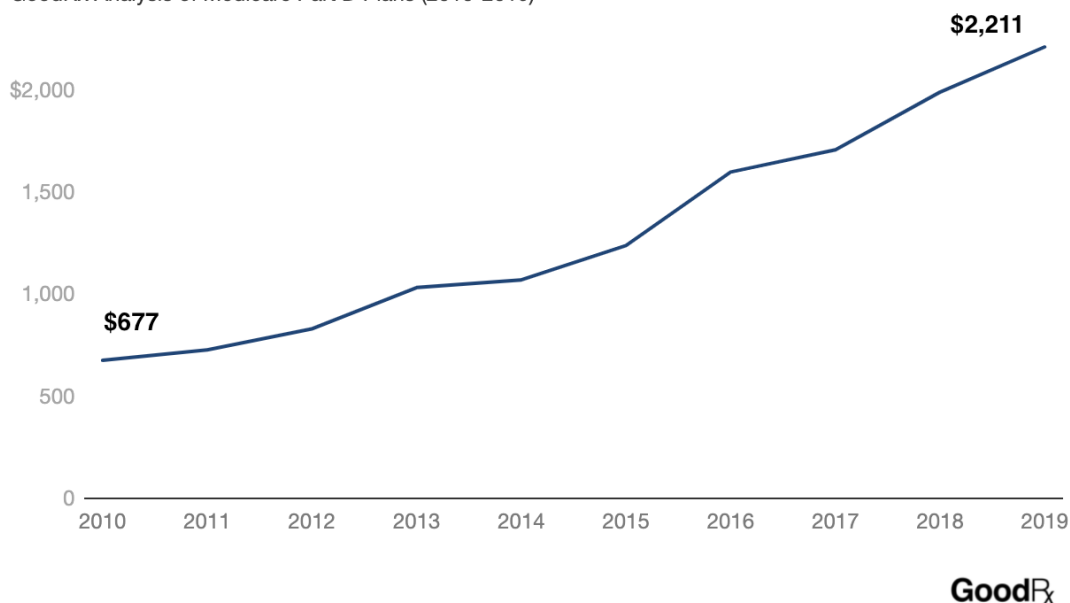
Takeda Pharmaceuticals Annual Report (2018)



A similar trend has happened for Medicare plans. In 2010, the average copay or coinsurance for the highest insurance tiers was \$677. That number increased to a whopping \$2,211 in 2019.

Average Copay and Coinsurance for Highest-Tier Plans

GoodRx Analysis of Medicare Part D Plans (2010-2019)



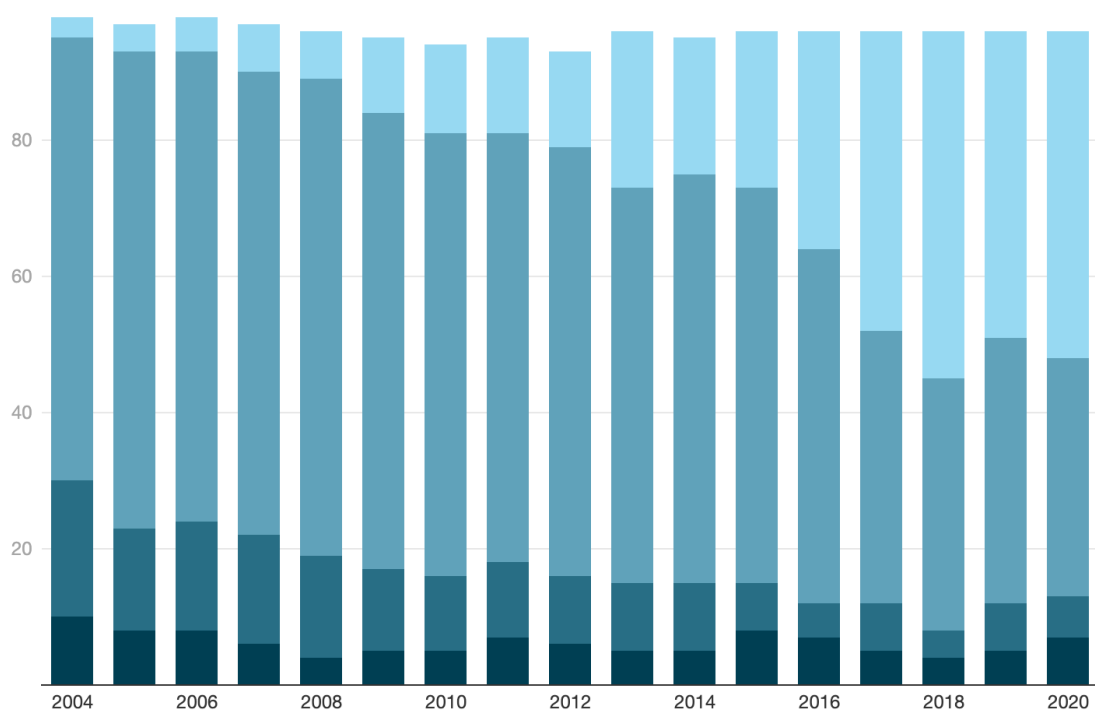
Some of this increase in average copays can be explained by the changes in tiering. Years ago, most formularies only had 3 tiers — a tier for preferred generic drugs, a tier for preferred brand drugs, and a third tier for expensive specialty medications. But in recent years, plans have created additional tiers to account for more expensive medications, and more tiers simply means higher costs.

In 2004, more than 50% of commercial insurance plans had only 3 tiers, but now the majority of plans are four-tier plans that have higher copays.

Percent of Formulary Tiers Under Employer-Sponsored Insurance

Kaiser Family Foundation Employer Health Benefits Survey, 2020

One tier Two Tier Three Tier Four+ Tier



GoodRx

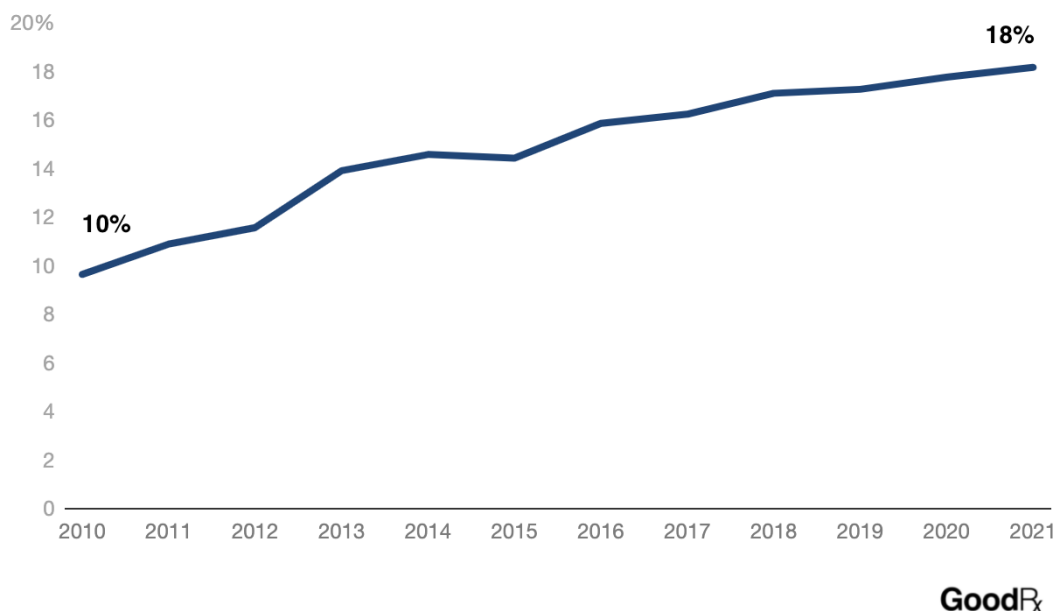
According to the [Kaiser Family Foundation](#), the average copay for third-tier drugs in 2020 was \$62, while the average copay for fourth-tier drugs was \$116. To put this in perspective, nowadays, more than half of patients will pay over \$100 for their fourth-tier medication for a drug that used to cost only \$62 on the third tier.

Higher-tier plans are also associated with more coinsurance, which also exposes patients to higher out-of-pocket costs. In fact, among commercial plans with three or more tiers, 35% of fourth-tier drugs and 33% of third-tier drugs have coinsurance.

Unlike copayments, coinsurance is greatly affected by rising prices. For instance, Afrezza, used to treat diabetes, increased in price by 7% this year, meaning that the out-of-pocket cost for patients with a typical fourth-tier coinsurance of 28% increased by just over \$30 this year alone.

As the number of high-tier plans increases, so does the number of drugs on high tiers. According to an analysis of Medicare Part D plans, more than 18% of drugs are on the highest tier of the plan. That number is up from 10% in 2010.

Average Percent of Drugs on Highest Tier



As average copays rise in line with the number of drugs on high tiers, the result is more drugs with higher out-of-pocket costs.

WHAT CAN BE DONE?

For years, insurance has been seen as the best way to help Americans access and afford their medications and healthcare. But this is no longer the case. Cost-management tactics have reached a point where it is common for patients to find that their necessary drug is no longer covered, or that there are more restrictions inhibiting coverage for the drugs they take.

In addition, prior authorizations, step therapy, and other restrictions delay treatment, and high costs lead to patients skipping or putting off taking their medications. All of this leads to sicker patients and higher healthcare expenses for the country as a whole.

Instead of automatically turning to insurance when buying prescription medications, patients can explore other savings options. For the top 100 most popular medications, GoodRx users pay less than the average insurance copay 37% of the time, with savings up to 54%.

Other ways to cut prescription drug costs besides GoodRx include filling a 90-day supply, discussing more affordable alternatives with providers, or seeing if there's a patient assistance program or manufacturer copay card available for the drug.

Reducing out-of-pocket costs for patients is good for the country as a whole. Lower healthcare expenses lead to a greater likelihood that patients will take their medications. This prevents poor health outcomes and the development of additional health conditions, and it can even lower insurance costs overall.

METHODOLOGY

Medicare Part D analyses:

All Medicare analyses use the Centers for Medicare & Medicaid Services Prescription Drug Plan Formulary, Pharmacy Network, and Pricing Information Files. These data include specific formulary structures, benefits, plans, and networks, and they are updated monthly and quarterly. All analyses related to Medicare Part D plans use first quarter data of each year between 2010 and 2021. Our analysis does not include National PACE plans, employer-sponsored plans, and demonstration plans per Medicare's documentation.

Medicare Part D covering fewer drugs:

For all Medicare Part D plans in each year, we took the total number of unique drugs covered by all formularies in that year for drugs in the GoodRx database. We deem the prior the "best plan" in each year. To calculate the drug coverage for each plan in each year, we calculated the number of drugs covered on that plan as a proportion of the drugs covered on the "best plan." To summarize for each year, we then took the weighted average of all plans' drug coverage, weighted based on the number of enrollees on the plan.

Medicare Part D covered drugs getting more restrictive:

For all Medicare Part D plans in each year, we looked at drugs on formularies for drugs in the GoodRx database. For each plan in each year, we calculated the proportion of drugs that have any coverage restrictions (quantity limits, prior authorization, step therapy) of all drugs on that plan. To summarize for each year, we then took the weighted average of all plans' proportion of drugs that have any coverage restrictions, weighted based on the number of enrollees on the plan.

Medicare Part D average copay/coinsurance on highest tier:

For all Medicare Part D plans in each year, we looked at the highest tier on all formularies. We evaluated each Medicare Part D plan's highest tier using the cost file; in particular, we used cost information for a 30-day supply of a drug at preferred pharmacies. The cost file details if a tier on a plan is copay or coinsurance. If a plan's highest tier is a copay tier, the average cost of that plan's tier is the copay. If a plan's highest tier is a coinsurance tier, we pulled in pricing information for all National Drug Codes (NDCs) in that tier using the pricing file. We then multiplied the coinsurance percentage with the price of the drug to get the coinsurance price for the drug. We then averaged all the coinsurance prices in the plan's highest tier to get the average cost of that plan's tier. To summarize for each year, we took the weighted average of all plans' highest tier average cost, weighted based on the number of enrollees on the plan. This portion of the analysis is only updated until 2019 due to changes in the structure of the pricing data.

Medicare Part D percent of drugs on highest tier:

For all Medicare Part D plans in each year, we looked at the highest tier on all formularies. We then calculated the proportion of drugs on the highest tier of all drugs on that plan. To summarize for each year, we took the weighted average of all plans' proportion of drugs on the highest tier, weighted based on the number of enrollees on the plan.