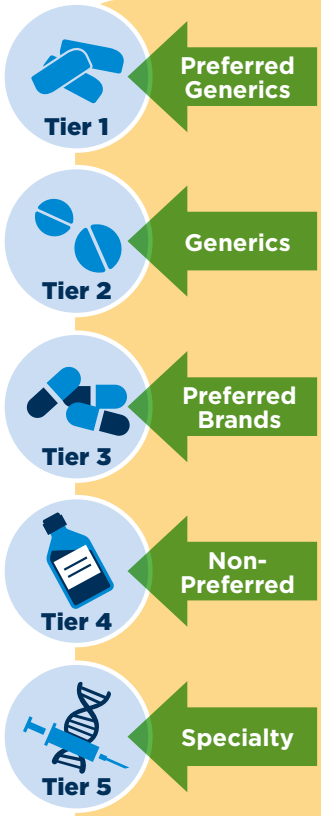
COST-SHARING CAPS DON'T SOLVE THE PROBLEM OF HIGH DRUG PRICES

Caps on Cost-Sharing Do Nothing to Hold Drug Manufacturers Accountable for High Prices

Brand manufacturers are deflecting blame for skyrocketing drug costs by falsely claiming that high costs are a "coverage" problem that requires cost-sharing caps and other restrictions on plan design.

By capping patient out-of-pocket expenses, doctors and patients will inevitably choose *more expensive* brand drugs over equally effective lower-cost generics. This will feed the cycle of price increases.



Smart benefit design stretches the health care dollar[1]

Through the use of drug tiers, health plans generally require higher out-of-pocket costs for more expensive drugs.

Cost-sharing caps disrupt the sound decision-making process plans use to provide patients with access to lower-cost — but equally effective — alternatives, including generics.

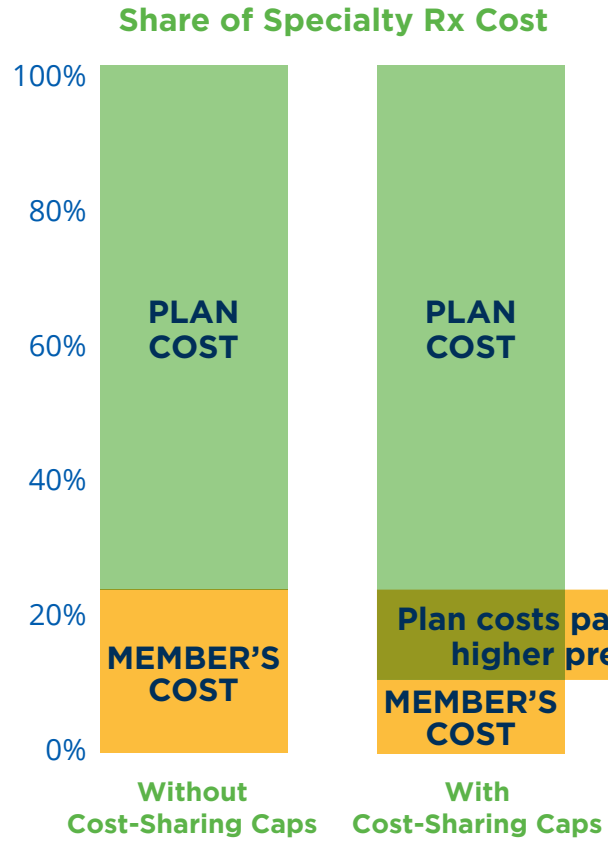
Cost-sharing caps are a windfall for brand manufacturers

Copay caps are government-set price controls that benefit brand drug manufacturers at the expense of patients and employers.

These mandates prevent payers from effectively managing drug costs, and force the public to pay more in health premiums and overall health care costs.

1 Not all health plans are designed the same way.

Shifting costs = higher premiums



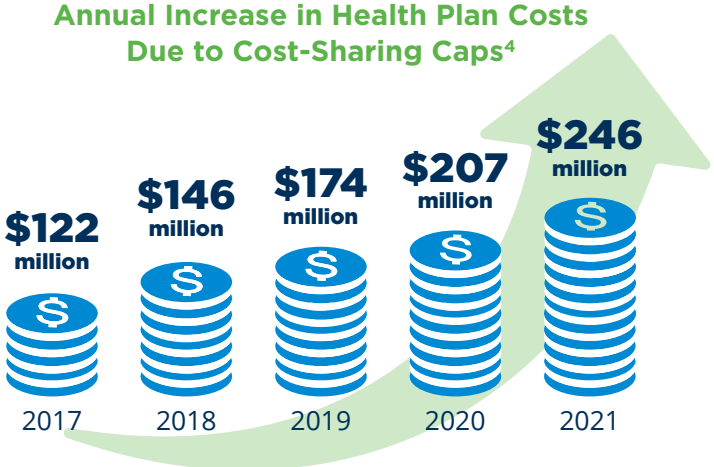
Significant changes in benefit design can affect the overall cost of a health plan, which in turn affects consumers' premiums.

Capping cost-sharing shifts cost from patients to health plans and does nothing to lower the high and rising price of drugs. This requires plans to increase premiums to compensate for higher costs. **Eventually, all members bear these higher costs through higher premium rates.**

State-mandated cost-sharing caps escalate health care costs

Example: The Kentucky Department of Insurance found that cost-sharing caps would add approximately **$13.4 million** to private market insurance premiums annually. For an average family with health coverage, these price controls would mean nearly **$150 a year** in increased premiums.[2]

Example: In the state of Washington, an independent analysis found that a $250 cost-sharing cap per 30-day script would shift costs to health plans and consumers by **$900 million** over five years.[3]



2 Kentucky Department of Insurance. (2015). Available at: http://www.lrc.ky.gov/record/15RS/SB31/HM.pdf
3 Oliver Wyman analysis for PCMA. (2016).
4 Ibid.