The impact of California's prescription drug cost-sharing cap

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EXECUTIVE SUMMARY

In 2016, a per-prescription cost-sharing cap was introduced for non-catastrophic plans offered on the Patient Protection and Affordable Care Act (ACA) health exchange in California's individual and small group markets. Beginning in 2017, the cap was required for all non-grandfathered individual and small group plans. In this report, we analyze the impact of this regulation on projected prescription drug spending across the California individual and small group markets.

Our analysis looks at two components of a premium increase related to this benefit change. First, spending may increase because members may utilize more prescription drugs if the cost sharing is lower. We were able to evaluate this by looking at total prescription drug spending, measured by allowed costs, which is the sum of the plan-paid and member cost-sharing amounts. Second, the plan will pay a larger share of the prescription drug spending if the cost sharing is lower. We analyzed the impact of this component through the net plan paid costs using Milliman's prescription drug pricing model (RxRM).

IMPACT ON TOTAL SPENDING (ALLOWED COSTS)

We compare allowed cost projection factors from the 2017 Uniform Rate Review Templates (URRTs) in California to those from states that did not mandate prescription drug cost-sharing restrictions. The projection factors in the 2017 URRTs represented insurers' expectations for spending changes from 2015 (prior to the cap) to 2017 (after the cap).

Our analysis suggests that California insurers did not project higher increases in pharmacy spending than insurers in states without a cost-sharing cap. Figure 1 shows the results of the URRT projection factor analysis for the individual and small group markets. We found that the prescription drug spending increases implied by the projection factors are similar for California insurers and for insurers from other states.

Figure 1: Projected 2015 to 2017 Change in Prescription Drug Spending Based on Projection Factors in Insurer URRTs

	Individual Market	Small Group Market
California Annualized Spending Increase	12.5%	8.6%
Non-California* Annualized Spending Increase	13.4%	11.4%
California Spending Increase, Compared to Other States	-0.9%	-2.8%

* Non-California states are those that do not have prescription drug cost-sharing restrictions and met certain data availability criteria for the analysis. See Appendix A for included and excluded states, and reason for exclusion.

The similarity of California's projected pharmacy spending increases to non-California projected pharmacy spending increases suggests that carriers did not project much, if any, change in total spending due to induced demand resulting from the cost-sharing cap. However,

changes in premiums may result from changes in the insurer's portion of spending ("net paid costs") caused by lower prescription drug cost sharing.

IMPACT ON INSURERS' SHARE OF SPENDING (NET PAID COSTS)

We used Milliman's prescription drug pricing model to quantify the impact of the cost-sharing cap on the insurer's share of prescription drug costs based on 2017 standard silver plans in California's individual and small group markets, and found that premiums would increase by approximately 1% due to the increased plan responsibility for pharmacy benefit costs. The impact of this premium increase assumes no other changes to plan designs and no induced utilization, as suggested by Figure 1.

Insurers may choose to offset the increases in their paid claims by making other changes in copays, deductibles, or out-of-pocket maximums. Thus, increases in net paid costs do not necessarily translate to observed premium increases. In the case of Covered California, the ACA health exchange in California, benefits are standardized and cannot be modified by individual insurers. Covered California made several benefit design changes between 2015 and 2017, although we did not attempt to assess whether these changes may have offset the impact of the prescription drug cost sharing cap.

While we estimated, at most, a small premium impact for the average member, members who use high-cost drugs may see a large reduction in out-of-pocket spending. For members with high medical and pharmacy expenses that are expected to hit the annual out-of-pocket maximum, total cost sharing and plan liability may be unchanged, but patient out-of-pocket costs may be spread more evenly throughout the year, instead of concentrated in the first few months.

The reader should note that the URRT represents information required by federal regulation and may represent a simplification of the way insurers develop cost estimates. As the cost-sharing cap was not fully implemented until 2017 and actual experience for 2017 is not yet available, we used data from 2017 URRTs. We did not adjust for unique features of California's insurance market, such as its status as a state-based marketplace (SBM) and its requirement that plans sold on its exchange have standardized benefits. Results for specific plans, states, or patients will vary with their own circumstances.

This report was commissioned by the Biotechnology Innovation Organization (BIO), a trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and internationally. This report should not be interpreted as an endorsement of any particular legislation by Milliman or the authors. Dieguez, Pyenson, and Bochner are members of the American Academy of Actuaries and meet the qualification standards to produce this report. Because extracts of this report taken in isolation can be misleading, we ask that this report be distributed only in its entirety.

BACKGROUND

Tiers in insurance prescription drug benefits are used to vary patient cost sharing for different covered drugs. In commercial health plans, drug benefits often use three or four tiers with increasing patient cost sharing for higher tiers. These tiers typically consist of generics (lowest cost sharing), preferred brands, non-preferred brands, and specialty drugs (highest cost sharing), the latter of which may be combined with non-preferred brands in three tiered plans. As the use and prices of specialty drugs have increased, benefit designs with four or more tiers have become more common. More expensive drugs are often placed on the highest tiers, where patients may be required to pay a percentage of the cost of the drug (coinsurance) rather than a flat dollar copayment amount.[1] Changes in benefit design, increasing prices, and broader use of more expensive drugs have all contributed to higher patient out-of-pocket spending on prescription drugs.

In recent years, a number of states have implemented regulations that limit patient cost sharing for prescription drugs in commercial fully insured health plans. Delaware, Louisiana, and Maryland have limited patient cost sharing per 30-day supply of specialty drugs. Maine and Vermont have set limits on annual out-of-pocket spending on all drugs. Colorado and Montana have required certain insurers to offer plan options with drug copays that are $250 or less.

In California, carriers selling on Covered California must offer only standard plans, and, in 2016, Covered California required a per-prescription cap on cost sharing on all of its non-health savings account (HSA) standard plans. In 2017, per-prescription cost-sharing caps were required for all non-catastrophic plans (i.e., platinum, gold, silver, or bronze) offered in California's individual and small group markets, both on and off the exchange.[2] The requirement mandated that member cost sharing per 30-day script could not exceed $500 for bronze plans and $250 for silver, gold, and platinum plans. In this report, we analyze the impact of the 2017 California regulation on average projected prescription drug spending across the California individual and small group markets.

The 2017 cost-sharing cap may have affected premium rates in two ways: 1) it may have increased patient use of prescription drugs by reducing the patient's financial burden of filling some expensive drugs, and 2) it may have increased insurers' costs per drug due to reduced patient cost sharing.

To estimate the impact of the cost-sharing cap on the use of prescription drugs, we analyzed 2017 URRTs to determine if cost projections by insurers in California were different from projections filed by insurers in states without a cost-sharing cap. The 2017 URRT forms contain projection factors showing insurers' estimates of prescription drug spending increases from 2015 (the baseline experience period, pre-cap) to 2017 (the projected rating period, after the implementation of the cap).

[1] Kaiser Family Foundation (November 13, 2015). Patient Cost-Sharing in Marketplace Plans, 2016. Retrieved January 9, 2018, from https://www.kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016.
[2] California Legislative Information (2015-2016). AB-339 Health Care Coverage: Outpatient Prescription Drugs. Retrieved January 9, 2018, from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB339.

In addition, we used Milliman's prescription drug pricing model (RxRM) to quantify the impact of the cap on the insurer's share of prescription drug costs. Assuming no other changes, the introduction of the cap would have increased the premium levels proportionally to the increase in the insurer's share of total costs (not just prescription drug costs). However, this effect would not necessarily pass through premium rate increases; an insurer may offset reductions in patient-pay amounts such as caps on cost sharing with increases in cost sharing for other benefits to avoid a premium increase or to meet actuarial value (AV) requirements.

FINDINGS

IMPACT ON TOTAL SPENDING (ALLOWED COSTS)

We compared projection factors in California filings to those in other states without prescription drug cost-sharing regulations to determine whether insurers in California expected higher spending increases for prescription drugs than insurers in other states. The comparison for the individual and small group markets is shown in Figure 2. Detailed results are shown in Appendices B and C.

Figure 2: Projected 2015 to 2017 Change in Prescription Drug Spending From Insurer URRTs

	Individual Market		Small Group Market	
	Member Months (millions)	**Annualized Increase in Rx Spending**	**Member Months (millions)**	**Annualized Increase in Rx Spending**
California	22.8	12.5%	13.1	8.6%
Non-California*	66.8	13.4%	73.5	11.4%
California Increase, Compared to Other States		-0.9%		-2.8%

* Non-California states are those that do not have prescription drug cost-sharing restrictions and met certain data availability criteria for the analysis. See Appendix A for included and excluded states, and reason for exclusion.

The projection factor comparisons indicate that Covered California insurers did not expect the cost-sharing cap to increase allowed prescription drug spending beyond the increases in other states. This is the case for both the individual and small group markets. In the individual market, California insurers projected that pharmacy spending would increase approximately 12% annually from 2015 to 2017, while insurers in the individual market in other states projected an approximate 13% annual increase. Similarly, small group insurers in California projected approximately a 9% annual increase in pharmacy spending from 2015 to 2017 compared to an approximately 11% annual increase projected by insurers in other states. These results suggest that California insurers did not expect a larger spending impact from the prescription drug cost-sharing cap than insurers in other states.

IMPACT ON INSURERS' SHARE OF SPENDING (NET PAID COSTS)

We also used Milliman's internal prescription drug pricing model to measure the impact of the cost-sharing cap on 2017 Covered California individual and small group market standard silver plans. Both plans had copays under $250 for Tiers 1 to 3 (and thus the cap had no impact) and 20% coinsurance for Tier 4 with a $250 cap per prescription after deductible. We estimated pharmacy paid claims for the 2017 Covered California individual and small group market standard silver plans with and without the $250 per-script cost-sharing cap, holding utilization and other cost-sharing features constant. The results are shown in Figure 3.

Figure 3: Impact of Cap on 2017 Covered California Net Paid Costs Individual and Small Group Silver Plans

Paid Claims Impact		
	Individual	**Small Group**
Pharmacy Paid Claims PMPM without $250 Cap on Rx *	$49.98	$47.13
Pharmacy Paid Claims PMPM with $250 Cap on Rx*	$54.10	$51.10
Impact of Cap on Insurer Paid Claims PMPM**	$4.12	$3.97
Premium Impact		
	Individual	**Small Group**
Age 40 Average Premium Rate PMPM***	$375.29	$408.87
Age 40 Estimated Average Paid Claims PMPM******	$319.00	$347.54
Impact of Cap as a Percent of Premium	1.3%	1.1%

* Calibrated to the average projected 2017 utilization and allowed cost per member per month (PMPM) for carriers in the California individual and small group markets.
** Assumes no changes in other benefits and no increased prescription drug spending due to the cap, as suggested in Figure 2 above.
*** Average of 2017 California Department of Managed Healthcare age 40 silver premiums, weighted by regional membership. The maximum age 40 silver premium was $705.61 and minimum age 40 premium was $249.03 for the individual market, and $909.26 and $314.53 for the small group market, respectively.
**** Assumes 85% loss ratio.

According to our pricing models, the cap results in an increase in insurer-paid claims of approximately $4 per member per month (PMPM) for both the individual and small group market plans—assuming Covered California made no other changes. This estimate assumes

no increase in spending due to induced utilization, as suggested by Figure 2. Instead, it reflects only the increase in the insurer's portion of paid claims as a result of reduced member cost sharing. As shown in Figure 3, the impact of the cap for a 40-year-old member would be approximately 1%, but this will vary depending on each plan's circumstances, including its contracts with providers and pharmacies. This impact could also vary for plans that enroll older or younger members.

Premium increases caused by the introduction of the cap would take into account both the total increase in pharmacy spending (Figure 2) and the increase in the insurer's portion of spending (Figure 3). AV rules under the ACA require that plans stay within the allowed AV range (e.g., 66% to 72% for silver in 2018), and insurers or Covered California (for standard plans) can reduce some benefits to offset the cost of increases in other benefits to stay compliant with the AV range or for other reasons. Thus, the estimated premium increases shown in Figure 3 above do not necessarily translate to observed premium increases. Rather, insurers may choose to offset the increases in their paid claims by making other changes in copays, deductibles, or out-of-pocket maximums. In the case of the Covered California standard plans, several benefit design changes were made between 2015 and 2017. The out-of-pocket maximum increased for gold, silver, and bronze standard plans, and the deductible increased for bronze and silver plans, among other changes. We did not attempt to assess whether these changes offset the impact of the cap.

While we estimated, at most, a small premium impact for the average member, we expect that members who use high-cost drugs will see a large reduction in out-of-pocket spending. In a previous Milliman report[3] we quantified the impact of different pharmacy benefit limits on members taking specific types of drugs. For instance, families enrolled in a silver Covered California standard plan with at least one household member taking Imatinib or Lenalidomide for blood cancer were projected to see an annual decrease in cost sharing of $586 for each family member under a $200 per-prescription cap. Results were similar for families with at least one member taking Adalimumab for rheumatoid arthritis, with a projected annual savings of $683 per family member. For members hitting the annual out-of-pocket maximum, total cost sharing may be unchanged, but patient out-of-pocket costs will be spread more evenly throughout the year. Members with no or low spending on high-cost drugs will likely not see any reduction in their cost sharing. Some members may also see their cost sharing increase for other benefits.

[3] Pyenson, B., Ziomek, B., & Simon, K. (March 5, 2015). Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations. Milliman Client Report. Retrieved January 9, 2018, from http://www.hivdent.org/_medicare_/2015/Milliman-Report-on-Prescription-Cost-Sharing-Limits-for-Exchange-Plans.pdf.

METHODOLOGY AND SOURCES

We examined several data sources for our analysis. We analyzed historical URRTs filed by insurers for the 2016 through 2018 plan years. These forms contain projection factors that show insurers' estimates of spending changes for certain service categories (such as prescription drugs and inpatient hospital services) from the baseline experience period to the projected rating period. We focused on the 2017 URRTs, which show projected pharmacy spending increases from 2015 to 2017 and should incorporate the anticipated impact of the cost-sharing cap effective in 2017 relative to 2015. We examined URRTs from carriers in the individual and small group markets in order to identify how the factors associated with prescription drug spending changed between 2015 and 2017. These carrier rate filings are publicly available through the Center for Consumer Information and Insurance Oversight (CCIIO).

The projection factors in the URRT include cost trends, utilization trends, population morbidity, and other adjustments. In our analysis, we excluded the population morbidity factor because it contains adjustments for members' medical and pharmacy spending related to factors such as the health status and illness burden for the insured members of the state.[4] Our analysis shows that carriers rarely vary the morbidity factor among service categories, and thus this factor would be unrelated to the per-prescription cost-sharing cap. We analyzed the other three projection factors to determine whether cost projection factors by insurers in California were measurably different from those of marketplaces in other states, after weighting by membership and normalizing for differences in member plan selection across years (i.e., the mix of platinum, gold, silver, and bronze plans). The Centers for Medicare and Medicaid Services (CMS) describes what each of these factors represents in the 2018 Unified Rate Review instructions, as follows:

- **Cost trend**: The annualized trend in cost per service. This should not reflect expected changes in the mix of services provided, nor should it contain large changes in networks (such as adding a new network) or changes in manufacturer rebates for prescription drugs. However, it should contain changes in network mix.
- **Utilization trend**: The annualized trend in utilization per 1,000 members. This should not reflect changes in health status of the population. It should reflect changes in service mix, product mix, and any impact of selection.
- **Population risk morbidity**: The two-year change (i.e., not annualized) in population health status from the experience period to the projection period. This factor should treat the demographic and product mix as fixed, and not apply any adjustments for trends or contract changes.
- **Other**: The two-year change for any adjustments not related to a change in population health status, a trend in costs or utilization, or a change in product mix or network mix. This may include significant network changes, changes in manufacturer rebates, demographic changes, and any other adjustments not included in the other projection factors.

[4] CMS (April 6, 2017). 2018 Unified Rate Review Instructions. Retrieved January 9, 2018, from https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Unified-Rate-Review-URR-Reporting-Requirements-for-Single-Risk-Pool-Plans-OMB-0938-1141-Final-2018-URR-Instructions-Parts-I-II-and-III-.PDF.

In order to account for the impact of anticipated changes in induced demand between states, we used available data to normalize for projected changes in plan mix of metallic levels between 2015 and 2017. We developed an adjustment factor separately for each insurer, state, and market based on the change in membership plan selection from the experience period to the projection period as reported in the URRT Worksheet 2. We based the adjustment on standard induced utilization factors developed using the U.S. Department of Health and Human Services (HHS) plan behavior change factors presented in the HHS Notice of Benefit and Payment Parameters for 2014, and expanded for the Massachusetts alternate risk adjustment application released in January 2013.[5] We adjusted induced demand for cost-sharing reduction (CSR) enrollees using the "Induced Utilization Factors for Purposes of Cost-Sharing Reduction Advance Payments" published in the HHS Notice of Benefit and Payment Parameters for 2014, along with CSR distributions by state found in the open enrollment period public use files (PUFs) published by CMS.

We excluded states that had already instituted regulations on prescription drug cost sharing in order to compare California's market to states that do not impose any similar limitations. In the individual market we excluded any states that did not report their CSR member distribution information in the open enrollment reports published by CMS. These state were not excluded in our analysis of the small group market, as CSR plans are not offered there. A full list of states included in the individual and small group analyses are listed in Appendix A.

We also excluded certain carriers from our analysis. To maintain a consistent set of carriers across years, we excluded any carrier that did not file rates in their respective states and markets (i.e., individual or small group) for all three years (2016, 2017, and 2018). Additionally, we excluded any carriers that assigned their experience 0% credibility in any year, or who had fewer than 100 member months across all plans in any single experience year. This would indicate that these carriers did not have credible experience to project forward, and thus their projection factors would not be suitable for our purposes. Some states did not have any carriers meeting these requirements in a particular market, and these states were thus excluded from the analysis. These states are noted in Appendix A.

We also used Milliman's prescription drug rating model (RxRM[6]) to isolate the impact of the cap on insurer paid claims. We calibrated the RxRM to the projected 2017 utilization and allowed cost PMPM for carriers in the California individual and small group markets that were included in our URRT analyses, and rated the 2017 Covered California standard individual and small group silver plan designs.[7] We estimated insurer-paid claims for each plan with and

[5] Massachusetts Health Connector (April 2013). Notice of Benefit and Payment Parameters 2014: Risk Adjustment Methodology and Operation. Retrieved January 9, 2018, from https://betterhealthconnector.com/wp-content/uploads/reports-and-publications/Risk_Adjustment/MANoticeofBenefitPaymentParameters.pdf.

[6] The RxRM is part of Milliman's Health Cost Guidelines™ (HCGs). Milliman's HCGs provides a flexible but consistent basis for the determination of health claims costs and premium rates for a wide variety of health plans. The HCGs is developed as a result of Milliman's continuing research on healthcare costs.

[7] Covered California (June 16, 2016). 2017 Standard Benefit Plan Designs. Retrieved January 9, 2018, from http://hbex.coveredca.com/stakeholders/plan-management/PDFs/2017_Standard_Benefit_Plan_Designs_FINAL_Board-approved_2016-04-07.pdf?v=2.0.

without the $250 per-prescription cost-sharing cap. To isolate the insurer cost-sharing impact, we excluded any potential induced utilization as a result of the cap.

To illustrate the insurer cost impact in the context of member premiums, we captured minimum, maximum, and average premium rates for 40-year-old members enrolled in silver tier plans in California for the 2017 plan year, separately for the individual and small group markets, from carrier rate filings from the Department of Managed Healthcare[8]. For each market, the average premium rate was estimated by first calculating the straight average of age 40 silver premiums within each California rating region, and then weighting these averages using membership by rating region.[9][10] We converted these values from premiums to estimated paid claims in order to compare on an equivalent basis with the paid claims impact of the cap. We assumed an average loss ratio of 85% based on 2015 Minimum Loss Ratio form filings[11].

[8]California Department of Managed Healthcare (2017). Search Rate Review Filings. Retrieved September 7, 2016, from wpso.dmhc.ca.gov/premiumratereview/FilingList.aspx.

[9] Covered California (September 1, 2017). Active Member Profile, September 2017. Retrieved January 9, 2018, from http://hbex.coveredca.com/data-research/library/active-member-profiles/12-13-17/CC_Membership_Profile_2017_09.xlsx (download).

[10] Center for Consumer Information and Insurance Oversight (June 30, 2017). Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year, Appendix B, Department Of Health & Human Services. Retrieved January 11, 2018, from www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-B-2017-Summary-Report-GCF.xlsx (download).

[11] CMS.gov Centers for Medicare & Medicaid Services (2017). The Center for Consumer Information & Insurance Oversight Medical Loss Ratio Data and System Resources. Retrieved December 28, 2017, from www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

LIMITATIONS

We acknowledge several study limitations. First, the Unified Rate Review Template (URRT) represents information required by federal regulation to be provided in support of the review of rates, for certification of qualified health plans and for certification that the index rate is developed in accordance with federal regulation and used consistently and only adjusted by the allowable modifiers. However, the URRT does not necessarily correspond to the rate development process used by insurers. We assumed the URRTs were accurate, but we had no independent way of judging their accuracy. In addition, regulators require changes to rate filings for a variety of reasons, and the involvement of regulators varies from state to state. Regulatory actions may have impacted insurer's projection factors in the URRTs.

We quantified how insurers perceived the cost-sharing cap would impact pharmacy spending and estimated the cap's potential impact on insurer cost sharing. However, we did not use actual claims data to assess the impact as this data was not available to us following implementation of the regulation effective in 2017. Nor did we attempt to address whether the regulation had an impact on patient access to prescription drugs due to potential changes in formularies.

While we normalized for the impact of plan design differences across years, we did not adjust for other factors that may contribute to differences between 2015 and 2017, such as contractual changes and rebate shifts.

We note that California is a state-based marketplace (SBM) and that the level of regulatory oversight and consumer outreach may differ compared to those of federally facilitated marketplace (FFM) states. We also note that California requires that plans on the exchange follow standardized benefits, which limits changes from year to year. Other states may have more plan changes from year to year, which could have an impact on spending.

The values in this report represent averages based on historical projections. Actual experience for specific plans, states, or patients will differ for a number of reasons.

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APPENDIX A

States Included in Individual and Small Group Market Projection Factor Analyses

State	Individual		Small Group	
	Included?	Reason for Exclusion	Included?	Reason for Exclusion
Alabama	Yes		Yes	
Alaska	No	Limited carrier credibility	No	Limited carrier credibility
Arizona	Yes		Yes	
Arkansas	Yes		Yes	
Colorado	No	Existing Rx regulations	No	Existing Rx regulations
Connecticut	No	Data limitations	Yes	
Delaware	No	Existing Rx regulations	No	Existing Rx regulations
District Of Columbia	No	Data limitations	Yes	
Florida	Yes		Yes	
Georgia	Yes		Yes	
Hawaii	No	Data limitations	Yes	
Idaho	No	Data limitations	Yes	
Illinois	Yes		Yes	
Indiana	Yes		Yes	
Iowa	No	Limited carrier credibility	Yes	
Kansas	Yes		Yes	
Kentucky	No	Data limitations	Yes	
Louisiana	No	Existing Rx regulations	No	Existing Rx regulations
Maine	No	Existing Rx regulations	No	Existing Rx regulations
Maryland	No	Existing Rx regulations	No	Existing Rx regulations
Massachusetts	No	Data limitations	No	Merged market
Michigan	Yes		Yes	
Minnesota	No	Data limitations	Yes	
Mississippi	Yes		Yes	
Missouri	Yes		Yes	
Montana	No	Existing Rx regulations	No	Existing Rx regulations
Nebraska	No	Limited carrier credibility	Yes	
Nevada	Yes		Yes	
New Hampshire	Yes		Yes	
New Jersey	Yes		Yes	
New Mexico	Yes		Yes	
New York	No	Existing Rx regulations	No	Existing Rx regulations
North Carolina	Yes		Yes	
North Dakota	Yes		Yes	
Ohio	Yes		Yes	
Oklahoma	Yes		Yes	
Oregon	Yes		Yes	
Pennsylvania	Yes		Yes	
Rhode Island	No	Data limitations	Yes	
South Carolina	Yes		No	Limited carrier credibility
South Dakota	Yes		Yes	
Tennessee	Yes		Yes	
Texas	Yes		Yes	
Utah	Yes		Yes	
Vermont	No	Existing Rx regulations	No	Existing Rx regulations
Virginia	Yes		Yes	
Washington	No	Data limitations	No	Limited carrier credibility
West Virginia	Yes		Yes	
Wisconsin	Yes		Yes	
Wyoming	No	Limited carrier credibility	No	Limited carrier credibility

APPENDIX B

Detailed Results of Individual Market Projection Factor Analysis

Projected 2015 to 2017 Change in Prescription Drug Spending From Insurer URRTs Individual Market						
	Member Months (millions)	Projection Factors			Plan Mix Adjustment (annualized)	Annualized Increase in Prescription Drug Spending
		Other Adjustments (annualized)	Cost Trend	Utilization Trend		
California	22.8	1.017	1.064	1.037	1.002	1.125
Non-California*	66.8	0.988	1.090	1.053	1.000	1.134

* See Appendix A for included and excluded states and reason for exclusion.

APPENDIX C

Detailed Results of Small Group Market Projection Factor Analysis

Projected 2015 to 2017 Change in Prescription Drug Spending From Insurer URRTs Small Group Market						
	Member Months (millions)	Projection Factors			Plan Mix Adjustment (annualized)	Annualized Increase in Prescription Drug Spending
		Other Adjustments (annualized)	Cost Trend	Utilization Trend		
California	13.1	1.005	1.074	1.019	0.987	1.086
Non-California*	73.5	1.013	1.081	1.031	0.986	1.114

* See Appendix A for included and excluded states and reason for exclusion.