

Understanding Prescription Medicine Spending

Medicines play a central role in transforming the trajectory of many debilitating diseases, reducing mortality and improving health outcomes and quality of life for patients. For example, the HIV death rate has declined 91% since the introduction of highly effective antiretroviral therapy in the mid-1990s,¹ novel direct-acting antivirals (DAA) have increased the cure rate of hepatitis C to nearly 100%,² and the cancer death rate has declined 32% since 1991, in large part due to a new era of personalized medicine and immunotherapy.³ Additionally, America's biopharmaceutical companies have successfully researched, developed and delivered multiple vaccines and therapeutics to help halt the spread and effects of COVID-19. The introduction of COVID-19 vaccines is estimated to have saved more than 275,000 lives and averted up to 1.25 million hospitalizations in the United States alone.⁴

Today, prescription medicines account for just 14% of total health care spending.⁵ Less than half of total spending on medicines is retained by manufacturers, with the remainder going to the supply chain, the government, hospitals and other stakeholders.⁶ Discussions of prescription medicine spending need to consider the following five facts:

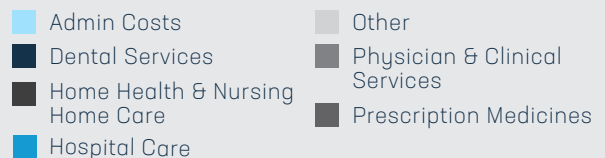
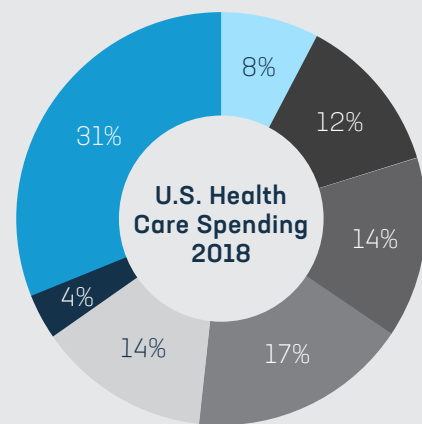
1. Medicines represent a small and stable share of total health care spending.

Per person spending on medicines has increased just 0.5% per year over the last decade after accounting for rebates, discounts and other payments.⁷ Overall, total spending on all medicines grew 0.8% in 2020, even as new products entered the market and an increasing number of prescriptions were filled.⁸ Our market-based system will continue to keep spending in check in the years ahead, with total net spending on medicines projected to grow between 0 and 3% annually through 2026.⁹

Discussions about the cost of medicines are nearly always based on a medicine's undiscounted list price, even though this amount is just a starting point for price negotiations. Pharmacy benefit managers (PBMs) negotiate significant discounts and rebates with manufacturers and leverage their purchasing power to gain increasing price concessions each year. In fact, total rebates, discounts and other payments have more than doubled since 2012, reaching \$187 billion in 2020.¹⁰ Due in part to these negotiations, net prices for brand medicines decreased by 2.9%, on average, the same year.¹¹ Looking ahead, average brand medicine net price growth is projected to be 0 to -3% annually through 2025.¹²

Over the next decade, many novel medicines will continue to transform patient care and meet current unmet needs, yet medicines are expected to remain at just 14% of total health spending.¹³ Over this same period, total spending growth for other health care is projected to be more than 6 times that of prescription medicines.¹⁴

Spending on Prescription Medicines is a Small Share of Total Health Spending



Source: PhRMA analysis of CMS National Health Expenditures data, Altarum Institute study. Results may not sum to 100% due to rounding.

2. PBMs, insurers, hospitals and others receive more than half of total spending on brand medicines.

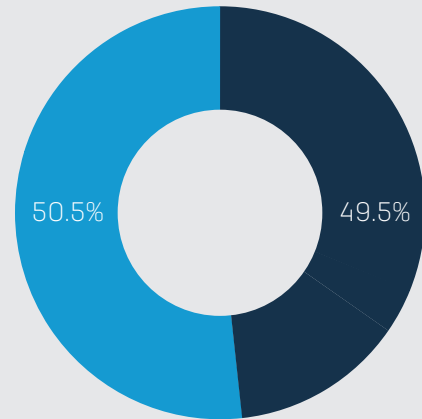
More than half of every \$1 spent on brand medicines in 2020 went to stakeholders other than the companies who researched, developed and manufactured the medicines. This marks the first year on record where non-manufacturer stakeholders – including PBMs, health plans, hospitals, the government and others – received the majority of total spending on brand medicines.¹⁵

PBMs are typically compensated based on a percentage of a medicine's list price, even though the list price is rarely what is paid for a medicine. Experts believe this may lead PBMs to favor medicines with higher list prices and larger rebates.¹⁶ According to a Senate Finance Committee investigation, "PBMs have an incentive for manufacturers to keep list prices high, since the rebates, discounts and fees PBMs negotiate are based on a percentage of a drug's list price – and PBMs retain at least a portion of what they negotiate."¹⁷ As a result, some industry observers and government agencies have questioned whether health plans and PBMs are more focused on the size of rebates than on achieving the lowest possible costs for patients.¹⁸

There are similar distorted incentives for medicines administered in hospital outpatient departments to patients with commercial insurance, as the cost to health plans reflects a markup charged by the hospital. On average, hospitals charge commercial insurers 250% more than what they paid to acquire a medicine. Due to these markups, hospitals make 20 times more from administering the same medicine to a commercially insured patient than to a Medicare beneficiary.¹⁹

The 340B drug discount program further intensifies these distortions. Today, large hospitals buy deeply discounted 340B medicines and then turn around and charge both uninsured patients and insurers higher prices, pocketing the difference with no requirement that they use profits to help patients. Hospitals can generate even more profit by acquiring physician practices and shifting patient care from community physician offices to hospital outpatient departments where they are paid twice as much for administering the same medicines.²⁰ This shift in site of care increases costs for patients and the health care system with no commensurate benefit for patients.²¹

Percent of Total Spending on Brand Medicines Received by Manufacturers and Other Stakeholders, 2020



■ Other Stakeholder Received ■ Brand Manufacturer Received

Source: Berkeley Research Group, 2022.



3. Despite declining medicine price growth, many of the sickest patients continue to face high out-of-pocket costs.

Even though health plans and PBMs often negotiate rebates from manufacturers that significantly reduce brand medicine prices, most patients with deductibles and coinsurance do not benefit directly from these savings at the pharmacy counter. Notably, half of commercially insured patients' and 92% of Medicare Part D beneficiaries' out-of-pocket spending for brand medicines is based on undiscounted list price.²²

Health plans typically use some portion of negotiated rebates to reduce premiums for all enrollees rather than to directly lower cost sharing for patients taking the rebated medication. As experts have pointed out, this results in a system of "reverse insurance" where insurers require sicker patients using brand medicines to pay more out-of-pocket, while rebate savings are used to lower premiums, disproportionately benefiting the healthy.²³ Asking sick patients with high medicine costs to

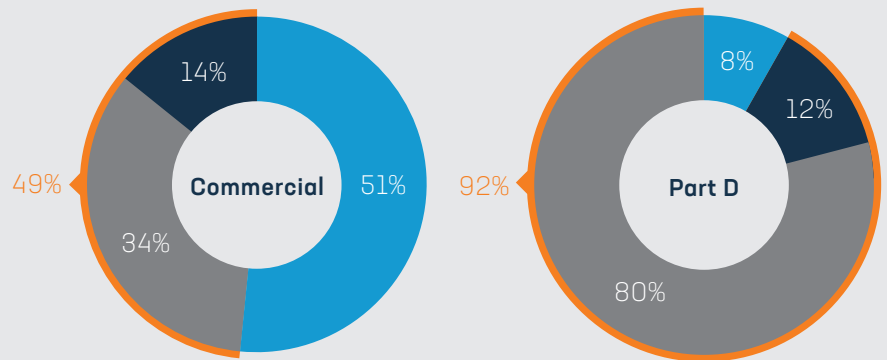
subsidize premiums for healthier enrollees is the opposite of how health insurance is supposed to work.

Policies to ensure rebates are used to lower patient out-of-pocket costs at the pharmacy counter and to delink supply chain entity compensation from the price of medicines would help the system work better for patients. For example, sharing rebates directly with Medicare patients with diabetes is expected to save \$40 billion due to fewer hospitalizations.²⁴ In the commercial market, some insurers have already begun sharing rebates directly with patients, resulting in lower out-of-pocket costs and higher adherence rates.²⁵ However, more needs to be done to address current trends and ensure patients have access to the medicines they need. In the absence of reform, rebates will continue to lower costs for PBMs and health plans rather than directly benefiting patients.

Half of commercially insured patients' and 92% of Medicare Part D beneficiaries' out-of-pocket spending for brand medicines is based on a medicine's undiscounted list price.

■ Copay ■ Deductible ■ Coinsurance

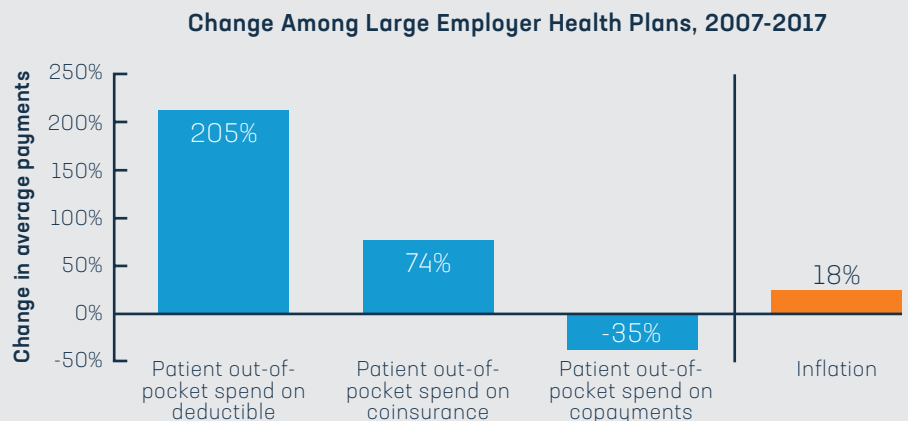
Source: IQVIA, 2020; PhRMA, 2021. Results may not sum to 100% due to rounding.



Patient Cost-Sharing Trends

Trends in health plan benefit design – including higher deductibles, increasing use of coinsurance and decreasing use of copayments – have shifted costs to patients at a higher rate than inflation. As patients using prescription medicines are exposed to increasing out-of-pocket costs, health plan coverage becomes less generous.

Source: Peterson-KFF Health System Tracker, 2019.



4. Medicines play a crucial role in controlling future health care costs and improving patients' lives.

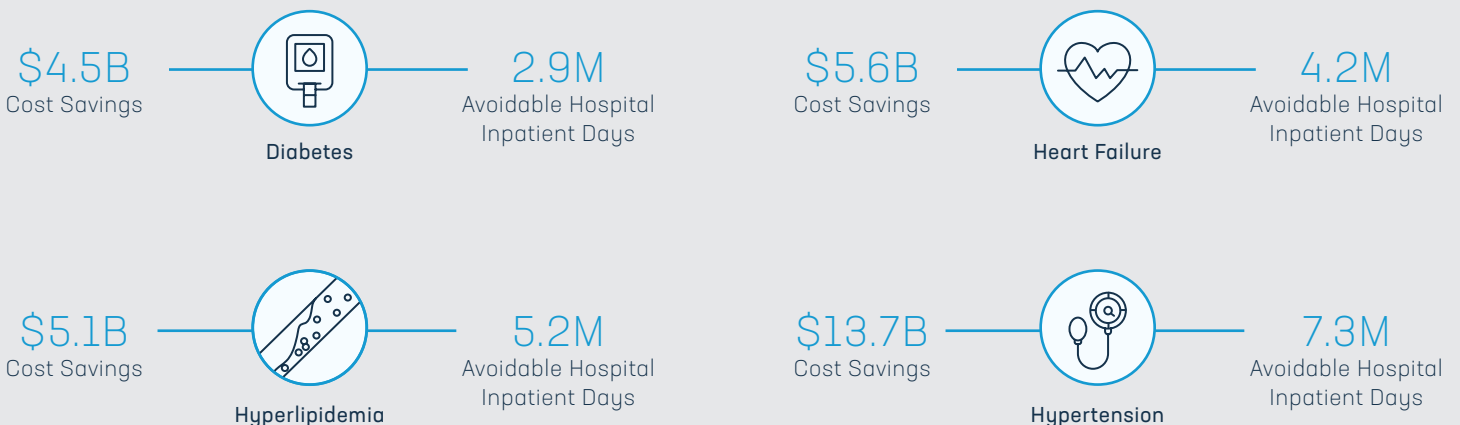
A study by Harvard University researchers found that 35% of the increase in U.S. life expectancy from 1990 to 2015 was attributable to prescription medicines, more than twice the amount attributable to other medical care.²⁶ Prescription medicines have been shown to improve patients' health, quality of life, productivity and reduce overall health care costs for many conditions.²⁷ For example, every additional dollar spent on medicines for adherent patients with congestive heart failure, high blood pressure, diabetes and high cholesterol generates \$3 to \$10 in savings in avoidable health care costs.²⁸ Better use of medicines can also help patients and their families lead more productive lives.²⁹ Research suggests that innovative medicines increase worker productivity by 4.8 million days and \$221 billion in wages per year.³⁰

High cost sharing on medicines may prevent patients from adhering to treatment or cause them to abandon medications altogether.³¹ In 2020, more than half of commercially insured patients did not fill their new brand prescription when out-of-pocket costs exceeded \$250.³² A substantial body of evidence shows that medicine abandonment and non-adherence leads to poor health outcomes for patients and drives up overall health costs.³³ Better use of medicines could eliminate \$213 billion in U.S. health care costs annually, amounting to 8% of the nation's spending on health care.³⁴ Addressing disparities in access and adherence to medicines can also play a key role in advancing health equity.

Mounting Evidence Demonstrates the Potential for Savings and Improved Outcomes from Better Use of Medicines

Billions of dollars in cost savings from avoided hospital stays can result from improved adherence to medicine among Medicare beneficiaries.

Outcomes With Improved Adherence



Source: Lloyd JT, Maresh S, Powers CA, et al. "How much does medication nonadherence cost the Medicare fee-for-service program?" *Med Care*. 2019;57(3): 218-224.

5. We must build a better health care system that ensures scientific advances are accessible and affordable to everyone who needs them.

In this era of transformative therapies and cures, including authorized and approved vaccines and treatments to fight a once-in-a-century global pandemic, understanding the complex dynamics in the prescription medicine market is crucial for ensuring that we continue to incentivize vital research and avoid practices and policies that restrict patients' access to medicines.

Several targeted, patient-centered policies, which focus on creating a stronger, more resilient, affordable and equitable health care system, would offer immediate relief for patients struggling to access their medicines.

- **Cover more medicines from day one.** Insurers are increasingly requiring people to pay high deductibles before receiving coverage of their medicines. This can cause patients to ration or never fill their prescriptions, which can result in devastating consequences to their health and higher overall health care costs. Policymakers can immediately help patients by requiring that some medicines, such as those used to treat certain chronic conditions, be covered by all insurance from day one – without being subject to a deductible.
- **Make cost sharing more predictable.** High and unpredictable cost sharing is a barrier to prescription medicine access, especially for patients with chronic, disabling or life-threatening conditions. Insurers' increasing use of coinsurance and deductibles can leave patients with sticker shock at the pharmacy counter. One potential solution is to encourage the use of fixed-dollar copays instead of coinsurance. Placing a limit on the maximum amount a patient will be asked to pay for medicines per prescription, per month and/or annually would also help.
- **Make coupons count.** Due to high out-of-pocket costs, patients with commercial insurance are increasingly turning to manufacturer cost-sharing assistance to help them afford their medicines. In some cases, commercial insurers do not allow the assistance that manufacturers provide to patients to count toward deductibles or a patient's annual out-of-pocket limit, meaning patients could be paying thousands more at the pharmacy than they should be. We need to end this practice so that patients with commercial insurance get the full benefit of the programs meant to help them afford their medicines.
- **Share the savings.** If health plans and middlemen don't pay the full price for medicines, patients shouldn't either. The rebates and discounts negotiated on medicines should be directly used to lower patient costs at the pharmacy counter.
- **Require standardized plans.** On the Exchanges, standardized plans often have lower and more predictable cost sharing for critical items and services than non-standardized plans and can make health care more accessible and affordable. They also aid consumer choice by allowing for apples-to-apples comparisons across health plans.
- **Preserve 340B.** We must pursue policies that preserve 340B for patients that need it through greater oversight and transparency into the program to ensure that hospitals and other entities are using the discounts to serve needy patients and not siphoning resources away from patients. This could help put the program back on solid footing by curbing program abuses and preventing further manipulation.

We agree the status quo is not working in the best interest of patients and our health care system needs to change. We stand ready to do our part.

Sources

- ¹ CDC, NCHS. "Deaths: Final Data for 2007." Vol. 58, #19, May 2010.; CDC, NCHS. "Fast Stats, AIDS and HIV."
- ² PhRMA analysis of approved Hepatitis C drug labels available on Drugs@FDA.
- ³ Siegel M, et al. "Cancer Statistics, 2021," CA CANCER J CLIN, 2021; 71:7-33.
- ⁴ Galvani A, et al. "Deaths and Hospitalizations Averted by Rapid U.S. Vaccination Rollout," Commonwealth Fund, July 2021.
- ⁵ Altarum. "Projections of the Non-Retail Prescription Drug Share of National Health Expenditures," September 2020.
- ⁶ Brownlee A. "The Pharmaceutical Supply Chain, 2013-2020," Berkeley Research Group, January 2022.
- ⁷ IQVIA. "The Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025," May 2021.
- ⁸ Ibid.
- ⁹ IQVIA. "The Global Use of Medicines 2022," January 2022.
- ¹⁰ Fein A. "The 2021 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute, March 2021.
- ¹¹ IQVIA. "The Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025," May 2021.
- ¹² Ibid.
- ¹³ Altarum. "Projections of the Non-Retail Prescription Drug Share of National Health Expenditures," September 2020.
- ¹⁴ PhRMA analysis of Altarum Institute. "Projections of the Non-Retail Prescription Drug Share of National Health Expenditures," September 2020.; Centers for Medicare & Medicaid Services (CMS). "National health expenditure (NHE) data. NHE projections 2019-2028," February 2020.
- ¹⁵ Brownlee A. "The Pharmaceutical Supply Chain, 2013-2020," Berkeley Research Group, January 2022.
- ¹⁶ Senate Finance Committee. "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug," 2021.
- ¹⁷ Ibid.
- ¹⁸ Ibid.
- ¹⁹ Silverman E. "How much? Hospitals mark up some medicines by 250% on average," STAT, 2021.
- ²⁰ Milliman. "Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014," 2016.
- ²¹ Parente ST, Ramlet M. "Unprecedented Growth, Questionable Policy: The 340B Drug Program," University of Minnesota.; Conti RM, Bach PB. "Cost Consequences of the 340B Drug Discount Program," JAMA. 2013;309(19): 1995-1996.
- ²² IQVIA. "Medicine Spending and Affordability in the U.S.," August 2020.; PhRMA. "Trends in Out-of-Pocket Spending for Brand Medicines in Medicare Part D," May 2021.
- ²³ Girod CS, Hart SK, Weltz S. "2017 Milliman Medical Index," May 2017.
- ²⁴ Pharmaceutical Technology. "Budget impact of passing a share of negotiated manufacturer rebates to patients at POS," November 2021.
- ²⁵ UnitedHealth Group. "Successful Prescription Drug Discount Program Expands to Benefit More Consumers at Point-of-sale," March 2019.; CVS Health. "Aetna to provide pharmacy rebates at time of sale, encourages transparency from drug manufacturers," March 2018.
- ²⁶ Buxbaum JD, Chernew ME, Fendrick AM, Cutler DM. "Contributions Of Public Health, Pharmaceuticals, And Other Medical Care To US Life Expectancy Changes, 1990-2015," Health Affairs, 2020; 39(9).
- ²⁷ For example, Nittala I, Ikuma L, Thomas D. "Effects of medication adherence on healthcare services use among asthma patients," Journal of Healthcare Quality Research, 2019.; Pilon DP, et al. "Economic burden in Medicaid beneficiaries with recently relapsed schizophrenia or with uncontrolled symptoms of schizophrenia not adherent to antipsychotics," Journal of Managed Care and Specialty Pharmacy, 2021.; Ta JT, et al. "Health care resource utilization and costs associated with nonadherence and nonpersistence to antidepressants in major depressive disorder," Journal of Managed Care & Specialty Pharmacy, 2020.; Chen AJ, Goldman DP. "Productivity benefits of medical care: evidence from US-based randomized clinical trials," Value in Health. March 2018.
- ²⁸ Roebuck MC, et al. "Medical Adherence Leads to Lower Health Care Use and Costs Despite Increased Drug Spending," Health Affairs, January 2011.
- ²⁹ Chen AJ, Goldman DP. "Productivity benefits of medical care: evidence from US-based randomized clinical trials," Value in Health. March 2018.
- ³⁰ Ibid.
- ³¹ IQVIA. "Patient Affordability Part Two: Implications for Patient Behavior and Therapy Consumption," May 2018.; Goldman DP, et al. "Pharmacy benefits and the use of drugs by the chronically ill." JAMA. 2004;291(19): 2344-2350.
- ³² IQVIA. "Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025," May 2021.
- ³³ For example, Quittner AL, et al. "Pulmonary medication adherence and health-care use in cystic fibrosis," Chest. 2014;146(1): 142-151.; Feldman CH, et al. "Medication nonadherence is associated with increased subsequent acute care utilization among Medicaid beneficiaries with systemic lupus erythematosus," Arthritis Care Res. 2015;67(12): 1712-1721.
- ³⁴ IMS Institute for Healthcare Informatics. "Avoidable Costs in US," June 2013.