

# 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. The HIV death rate has declined 88 percent since peaking in 1996 as a result of antiretroviral therapy, a new class of medicines has increased the hepatitis C cure rate to nearly 100 percent, and the cancer death rate has declined 26 percent since 1991 due to a new era of personalized medicine and immunotherapy.<sup>1</sup>

Today, prescription medicines account for just 14 percent of total health spending.<sup>2</sup> While brand medicine manufacturers produce 100 percent of new medicines, they account for only half of medicine spending, or 7 percent of total spending on health care.<sup>3</sup> Over the next decade, many novel medicines will further transform patient care, yet medicines are projected to remain a small and stable share of total health spending.<sup>4</sup>

Discussion of prescription medicine spending needs to consider the following five facts:

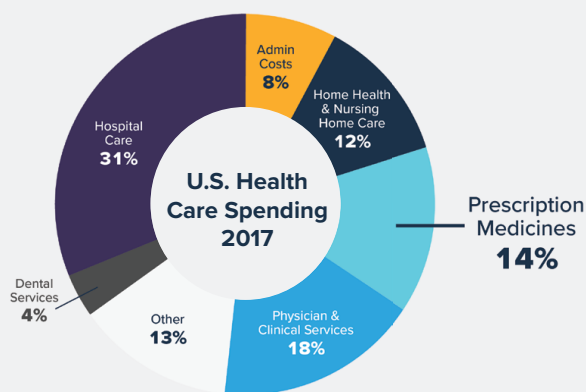
## 1. Spending on medicines is not the main driver of health care cost growth.

Per person spending on medicines—including breakthrough cancer therapies — grew just 1 percent per year over the last decade after accounting for rebates, fees, and other price concessions.<sup>5</sup> Despite technological advances, spending on retail prescription medicines accounts for the same percentage of health care spending today as it did in 1960.<sup>7</sup> And in 7 of the last 10 years, retail prescription medicine costs grew more slowly than total health care spending.<sup>8</sup>

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) often negotiate significant discounts and rebates with manufacturers and leverage their purchasing power to gain larger and larger price concessions each year. In fact, total rebates, fees and other price concessions have more than doubled since 2012, reaching \$166 billion in 2018.<sup>9</sup> After accounting for discounts and rebates, prices for brand-name medicines increased just 0.3 percent in 2018, below the rate of inflation.<sup>5</sup>

In 2018, total spending on all medicines grew 4.5 percent and our market-based system is expected to continue to keep costs in check.<sup>5</sup> Medicine spending is projected to grow just 3 to 6 percent annually between 2019 to 2022.<sup>5</sup> Meanwhile, cumulative spending growth for other health care is projected to be five times that of prescription medicines through the next decade.<sup>8</sup>

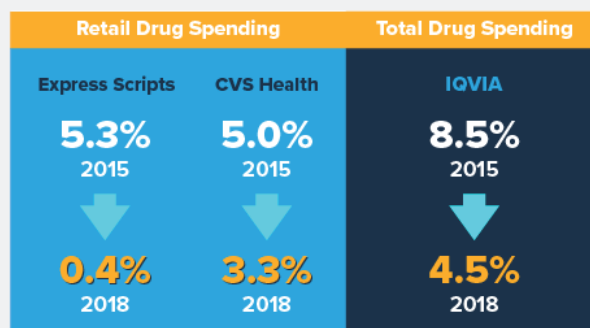
## Spending on Prescription Medicines is a Small Share of Total Health Spending



The Altarum Institute. "A Ten-Year Projection of the Prescription Drug Share of National Health Expenditures Including Non-Retail," October 2014, addendum update May 2018.

Centers for Medicare & Medicaid Services (CMS). "2017 National Health Expenditure," December 2018.

## Annual Prescription Drug Spending Growth



CVS. 2015-2018 Drug Trend Reports.

Express Scripts. 2015-2018 Drug Trend Reports.

IQVIA. Use and Spending on Medicines. April 2015 and May 2019

## 2. A large share of reported spending on medicines goes to health plans and payers or is retained by the supply chain.

On average, more than one third of the initial list price of a brand medicine is rebated back to insurers, PBMs, and the government, or retained by other stakeholders in the supply chain, and this share has been increasing in recent years.<sup>10</sup> PBMs and other middlemen are typically compensated based on a percentage of the medicine's list price, even though the list price is rarely what is paid for a medicine.

The distorted incentives within the pharmaceutical supply chain have created a dynamic where middlemen involved in distributing and paying for prescription medicines benefit from higher list prices and higher rebates.

As a result, some industry observers and government agencies have questioned whether insurers and PBMs are more focused on the size of rebates than on achieving the lowest possible costs and best outcomes for patients.

There are similar distorted incentives for medicines administered in hospitals, as the price of medicines reflects a markup charged by the hospital.

The 340B drug discount program further intensifies these distortions. The discounts manufacturers provide to 340B hospitals are not required to be passed on to patients or payers. To generate more profit through increased 340B prescriptions, hospitals acquire physician practices and shift patient care from community physician offices to settings where they are paid twice as much for administering the same medicines.<sup>11</sup> This shift in site of care increases costs for patients and the health care system as whole.<sup>12</sup> Economists have found that the 340B program may lead participating hospitals to "shift toward more expensive drugs because profit margins will in general be larger."<sup>13</sup>

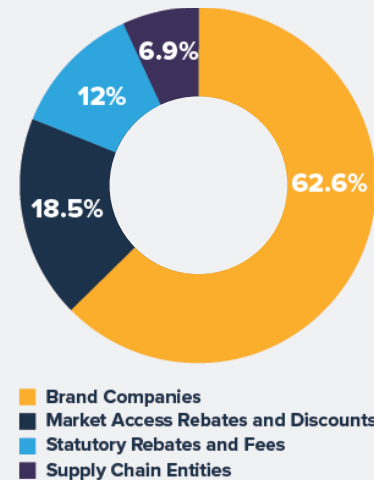
## Hospital Markups

Recent research shows that, on average, hospitals charge prices for medicines that are nearly five times higher than the amount retained by the manufacturer. Hospitals are also reimbursed two and a half times their acquisition cost of medicines, on average, by commercial insurers, more than twice the amount received by the manufacturer who developed the medicine.

The Moran Company. "Hospital charges and reimbursement for medicines: analysis of cost-to-charge ratios," September 2018.

The Moran Company. "Hospital charges and reimbursement for drugs: analysis of markups relative to acquisition cost," October 2017.

## Brand Companies Retain Just 63 Percent of Gross Spending on Brand Medicines



Berkeley Research Group, "The Pharmaceutical Supply Chain: Gross Drug Expenditures Realized by Stakeholders," January 2017.

**Nearly 1 in 5 hospitals markup medicine prices at least 700 percent.**

A 700 percent markup could result in patients being billed \$1,050 for a \$150 medicine.

### 3. Patients are facing rising out-of-pocket costs.

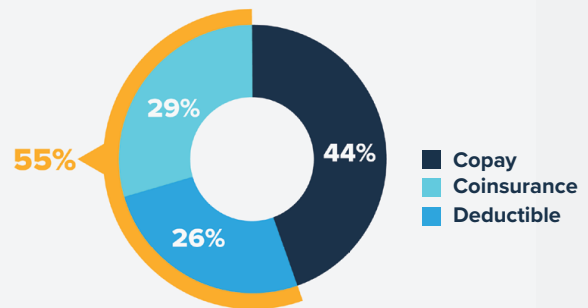
Even though payers often receive deep discounts on a brand medicine's price, they rarely directly pass along those savings to the patients obtaining those medicines at the pharmacy counter. Health plans typically use some portion of negotiated rebates to reduce premiums for all enrollees rather than to directly lower costs for patients taking the rebated medication. When patients face deductibles or coinsurance, health plans typically base patients' cost sharing on a medicine's list price, rather than the discounted price paid by the plan. Notably, more than half of commercially insured patients' out-of-pocket spending for brand medicines is based on list price.<sup>6</sup>

As actuarial firm Millman has pointed out, this results in a system of "reverse insurance" where payers require sicker patients using brand medicines to pay more out of pocket, while rebate savings are spread out among all health plan enrollees in the form of lower premiums.<sup>14</sup>

In 2017, 7 percent of claims for brand medicines had cost sharing of \$125 or more, and these claims represented more than half of total patient cost exposure.<sup>15</sup> Asking sicker patients with high medicine costs to subsidize premiums for healthier enrollees is the opposite of how health insurance is supposed to work.

Some payers, including UnitedHealth and Aetna, have taken steps to improve affordability for patients by announcing plans to share a portion of negotiated rebates at the pharmacy counter. However, much more needs to be done to address current trends and ensure patients have access to the medicines they need.

### Type of Cost Sharing as a Percentage of Total Patient Out-of-Pocket Spending, 2017

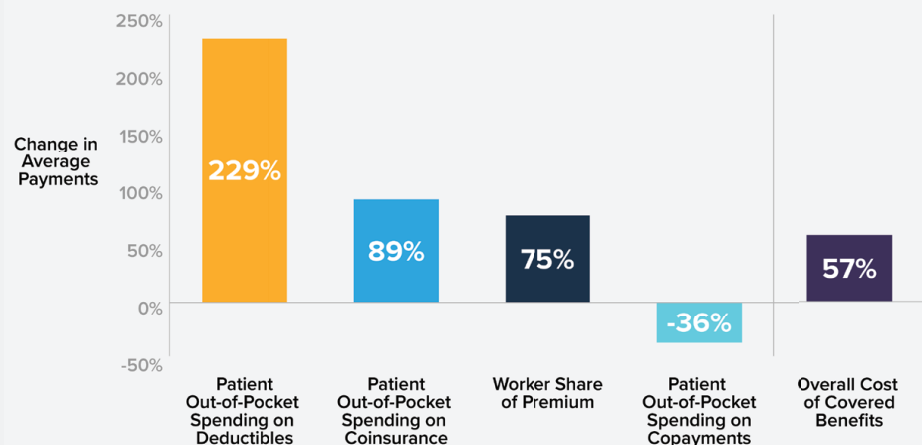


IQVIA. "Patient Affordability Part One: The Implications of Changing Benefit Designs and High Cost-Sharing," May 2018.

### Patient Cost-Sharing Trends

Trends in health plan design—including higher deductibles and coinsurance — have shifted costs to patients, so much so that growth in out-of-pocket spending has out-paced increases in overall health plan costs. As health plans become less generous, more costs are shifted to sick patients, particularly those using prescription medicines. In the last five years, the share of plans that subject medicines to a deductible has doubled.

### Change in Spending Among Large Employer Health Plans, 2005–2015



PwC. "Health & Well-Being Touchstone Survey Results," June 2017.

Kaiser Family Foundation. "2018 Employer Health Benefits Survey," October 2018.

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

Prescription medicines have been shown to be powerful tools to improve health and reduce overall health care costs for many conditions. 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 dollars in savings on emergency room visits and inpatient hospitalizations.<sup>16</sup> Better use of medicines can also help patients lead more productive lives. New research suggests that innovative medicines increase worker productivity by 4.8 million work days and \$221 billion in wages per year.<sup>17</sup>

As trends in increasing out-of-pocket costs continue to disproportionately impact the sickest patients, higher cost-sharing on medicines may cause patients to be less adherent to treatment or abandon medications altogether.<sup>18</sup> Abandonment and non-adherence lead to poor health outcomes and drive up overall health costs. Better use of medicines could eliminate \$213 billion in U.S. health care costs annually, amounting to 8 percent of the nation's spending on health care.<sup>19</sup>

#### 5. Targeted solutions can lower costs and drive value for patients today, while promoting continued medical innovation in the future.

In this era of breakthrough therapies and cures, understanding the complex dynamics in the prescription medicine market is more important than ever if we hope to continue to incentivize the vital research needed for continued progress and avoid practices and policies that restrict patients' access to medicines. Too often patients must fight to access medicines that are revolutionizing how we fight disease.

We agree the status quo is not working in the best interest of patients and that our health care system needs to change. Today, PBMs and other entities in the supply chain have incentives to favor medicines with high list prices and large rebates. When list prices go up, the entire supply chain benefits. This hurts patients and increases costs. The biopharmaceutical industry has taken a bold new stance on how payments should change in the supply chain, including advancing policy reforms that prevent PBMs and other entities in the supply chain from being paid off the list price of a medicine. Instead, such entities should be paid a flat fee based on the value their services provide.

Another way to address patient affordability is requiring insurers to share more of the discounts and rebates with patients at the point of sale. Sharing negotiated discounts could save certain commercially insured patients with high deductibles and coinsurance between \$145 and \$880 annually while affecting premiums by about 1 percent or less.<sup>20</sup> And finally, we can improve patient access and affordability by moving toward a system that prioritizes results for patients. Biopharmaceutical companies are working with insurers to develop innovative and flexible ways to pay for medicines that focus on results and value, lower out-of-pocket costs, and enable patients to access the right treatments the first time. Many companies have begun to pilot these approaches, and participation in novel payment arrangements is expected to double over the next five years.<sup>6</sup> Policy changes to allow further development of results-based contracting and other innovative, patient-centered payment approaches would be a positive step toward improved patient access, better outcomes, and more manageable health care costs.

### Mounting Evidence Demonstrates the Potential for Savings and Improved Outcomes



#### HYPERTENSION

Better treatment and adherence to anti-hypertensive medicines could save nearly 200,000 lives and avert more than 1 million hospitalizations.



#### MENTAL HEALTH

Better treatment and adherence to treatment for mental health can save \$22.8 billion annually.



#### CONGESTIVE HEART FAILURE

Improving adherence to congestive heart failure medicines could result in federal savings of \$22.4 billion over 10 years.

Cutler DM, Long G, Berndt ER, et al. *Health Affairs*. 2007;26(1):97-110.

Jha A, Aubert RE, Yao J, et al. *Health Affairs*. 2012;31(8):1836-46.

IHS Markit. "Burden of mental illnesses in the US: model implementation plan for anxiety, Alzheimer's, bipolar and schizophrenia," October 2016.

Dall TM, Blanchard TD, Gallo PD, et al. *Am J Managed Care*. 2013;19(6 Suppl):S97-S100.

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<sup>1</sup> CDC, National Center for Health Statistics. "Health, United States, 2016: With Special Feature on Racial and Ethnic Health Disparities." June 2018.; PhRMA. "A Decade of Innovation in Chronic Diseases: 2006-2016." February 2016.; American Cancer Society. "Cancer Facts & Figures 2018," August 2018.

<sup>2</sup> The Altarum Institute. "A Ten Year Projection of the Prescription Drug Share of National Health Expenditures Including Non-Retail," October 2014, addendum update May 2017.

<sup>3</sup> Berkeley Research Group, "The Pharmaceutical Supply Chain: Gross Drug Expenditures Realized by Stakeholders," January 2017.

<sup>4</sup> The Altarum Institute. "Projections of the Prescription Drug Share of National Health Expenditures Including Non-Retail," May 2018.

<sup>5</sup> IQVIA. "Medicine Use and Spending in the US: A review of 2018 and Outlook to 2023." May 2019.

<sup>6</sup> IQVIA. "Medicine Use and Spending in the U.S.," April 2018.

<sup>7</sup> CMS. "NHE," December 2017.

<sup>8</sup> The Altarum Institute, "A Ten Year Projection of the Prescription Drug Share of National Health Expenditures Including Non-Retail," October 2014, addendum update May 2017.; CMS. "NHE," December 2017.

<sup>9</sup> Fein, Adam J., The 2019 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute, 2019.

<sup>10</sup> Berkeley Research Group. "The Pharmaceutical Supply Chain: Gross Drug Expenditures Realized by Stakeholders," 2017.

<sup>11</sup> Milliman. "Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014," 2016.

<sup>12</sup> Parente ST, Ramlet M. "Unprecedented Growth, Questionable Policy: The 340B Drug Program." University of Minnesota.

<sup>13</sup> Conti RM, Bach PB. "Cost Consequences of the 340B Drug Discount Program." *JAMA*. 2013;309(19):1995-1996.

<sup>14</sup> Girod CS, Hart SK, Weltz S. 2017 Milliman Medical Index. May 2017. <http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2017-milliman-medical-index.pdf>

<sup>15</sup> IQVIA. "Patient Affordability Part One: The Implications of Changing Benefit Designs and High Cost-Sharing," May 2018.

<sup>16</sup> Roebuck MC et al. "Medical Adherence Leads to Lower Health Care Use and Costs Despite Increased Drug Spending." *Health Affairs*, January 2011.

<sup>17</sup> Chen AJ, Goldman DP. "Productivity benefits of medical care: evidence from US-based randomized clinical trials." *Value in Health*. March 2018.

<sup>18</sup> IQVIA. "Patient Affordability Part Two: Implications for Patient Behavior and Therapy Consumption., May 2018.; Goldman DP, Joyce GF, Escarce JJ, et al. "Pharmacy benefits and the use of drugs by the chronically ill." *JAMA*. 2004;291(19):2344-2350.

<sup>19</sup> IMS Institute for Healthcare Informatics. "Avoidable Costs in US," June 2013.

<sup>20</sup> Milliman. "Point of Sale Rebate Analysis in the Commercial Market: Sharing Rebates May Lower Patient Costs and Likely has Minimal Impact on Premiums," October 2017.