Pharmacy Cost Trends and System Impacts

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Healthcare costs in the United States have exceeded those of other developed countries for years. The rate of growth has recently slowed, but costs continue to rise and are still a significant portion of the gross domestic product.[1] Importantly, the proportion of total costs attributed to pharmaceuticals has risen. Costs and volume of both generic and specialty drugs are now a major driver of overall healthcare expenditures. While the United States is a leading nation in pharmaceutical innovation, both public and private payers have opportunities to improve pharmaceutical management and improve health outcomes. This fact sheet reviews trends in pharmacy costs, reasons for increasing pharmacy expenditures, impact of drug costs on state budgets and opportunities for improvement, and potential policy implications.

OVERVIEW

Trends in Pharmacy Costs

Between 1990 and 2014, total healthcare costs in the United States rose by approximately 320 percent, while prescription drug costs rose 638 percent. In the same time period, the share of total healthcare costs attributed to drugs rose from 5.6 percent of total costs in 1990, to 9.8 percent of total costs in 2014 (see Table 1).[1] Following a recent period of limited growth due to patent expirations and the emergence of generic substitutes, consumer spending increased in 2014 by 12.2 percent compared to the year before.[2] This increase was due in part to the introduction of higher-priced patent-protected brand named drugs for the treatment of chronic conditions including autoimmune conditions, new cancer therapies, and infections such as hepatitis C.[3]

Table 1: National Health Care Expenditures

	1980	1990	2000	2014
Type of Expenditure	**Amount in Billions**			
Overall Nat. Health Expenditure	**$255.3**	**$721.3**	**$1,369.7**	**$3,031.3**
Prescription Drugs	**$12.0**	**$40.3**	**$121.0**	**$297.7**
Hospital Care	**$100.5**	**$250.4**	**$415.5**	**$971.8**
Physician/Clinical	**$47.7**	**$158.4**	**$288.7**	**$603.7**
Other	**$95.1**	**$272.2**	**$544.5**	**$1,158.1**

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

The pharmaceutical industry receives patent protection on newly developed drugs and/or new combinations of existing drugs for a period of 20 years following their introduction. Upon patent expiration, manufacturers of generic substitutes frequently provide lower cost substitutions for the brand named drug.[4]

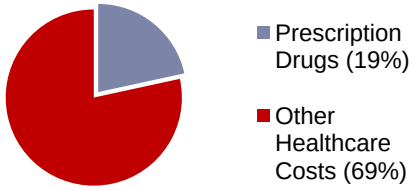
Table 2. Factors Influencing Higher Pharmaceutical Costs

Research and Development Costs	◆ Introduction of a new drug into the market is costly due to research costs and staged safety studies required to achieve US Food and Drug Administration approval. According to the Tufts Center for the Study of Drug Development, the "average pre-tax industry cost per new prescription drug approval is estimated to be $2.5 billion."[5] The same study noted the clinical approval rate of new drugs has also decreased.
Regulatory Limitations	◆ In the 1980s, the Hatch-Waxman Drug Price Competition and Patent Term Restoration Act (Act) intended to increase the presence of generic drugs and increase market competition by restricting new drug introduction for conditions with existing pharmaceutical treatments. The Abbreviated New Drug Application (ANDA) was meant to accelerate new generic drug approval if chemically equivalent to its brand-name counterpart.[6] The Act has had limited impact due to provisions allowing brand manufacturers to impede generic drug development, increasing reliance on costlier branded drugs.[7]
Growth of Specialty Drugs	◆ Specialty drugs represent classes of medications with high costs for a single course of treatment, often used to treat rare conditions or conditions requiring intricate therapeutic management. While specialty drugs represent a small percentage of overall written prescriptions, they accounted for 32% of total drug expenditures in 2014.[8]
Lack of Price Control	◆ While pharmaceutical access through Medicare and Medicaid has progressively improved, these programs have federal limits on their ability to negotiate prices set by drug manufacturers. Private insurers are also limited in negotiating set prices due to formulary necessities.[9]

Impact of Rising Pharmacy Costs on States and Opportunities

Growth in drug spending is unsustainable despite legislation meant to lower costs by increasing market competition. Managing pharmacy costs is now a key issue for state-funded health plans and programs. Overall Medicaid prescription drug spending has risen 3 percent since 2013, with higher spending expected in expansion states after 2017.[10] In 2013, nearly a quarter of the estimated $31 billion spent on public employee insurance was used for prescription drug coverage (See Figure 1).

Figure 1: Prescription Drug Costs for Public Employer Health Plans in 2013



*Source: National Academy for State Health Policy

The Arkansas Employee Benefits Division (EBD) has partnered with the UAMS College of Pharmacy's Evidence-Based Medicine Program for pharmaceutical review and analyses aimed at improving quality and reducing plan costs. This partnership has led to an estimated cost avoidance of $20 million through the implementation of reference pricing in 2014. As more recent findings indicate, anti-inflammatory agents, anti-diabetic agents, antineoplastic/oncology drugs, antivirals, and anticoagulants represent drugs with the highest cost increases for EBD for the first quarter of 2016 when compared to the previous year. The Arkansas Health Reform Legislative Task Force recently highlighted the potential of targeting pharmacy costs to reduce Medicaid spending. Like other states, Arkansas Medicaid has seen increased costs of hepatitis C drugs which have led some programs to enact approval processes for use of the drug.

POLICY IMPLICATIONS

Several options exist for public and private payers to improve patient outcomes while controlling the cost of pharmacy spending and overall healthcare costs. Pharmacy management can contribute to a more efficient plan and healthier population by streamlining the prescription process and promoting coordination of care across settings and providers. Examples of payer strategies include:

- Tiered Formularies—Patients are given options for treatments and drug choices. Lower-tier co-payments are less costly and typically associated with generic options with lower prices negotiated by the purchaser.
- Reference-Based Pricing—Plans typically provide a lower-cost option within a drug category and require plan members to pay for any cost-differences should they choose a more expensive alternative.
- Pharmacy Benefit Management (PBM)—PBMs act as third-party administrators for public and private plans. Various states have outsourced pharmacy management strategies to reduce costs in public programs, including Medicaid and state employee health plans.

Value-based payment strategies provide an opportunity to test the health and economic outcomes promised by drug studies. Pharmaceutical manufacturers should be considered a care delivery participant in total cost-of-care arrangements and outcomes assessments. In considering options for pharmacy management, policymakers must weigh the need to maintain appropriate access, available resources, and any unintended adverse effects of pharmacy-related policy decisions. Cost-control could shift costs to consumers resulting in reduced pharmaceutical compliance and potential unintended exacerbations of medical conditions. Consumers may also face challenges understanding changes to prescriptions to which they previously have had access. Options should be aimed at improving access while incentivizing providers and patients to make informed decisions about the need, intended use, and cost of their pharmaceutical resources.

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