Impact of Drug Prices

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OVER THE PAST FEW months, the price of drugs has gotten a lot of attention. It was an issue on Capitol Hill, on the campaign trail, and in newspapers, magazines, and television. We're all familiar with the names Shkreli and Bresch. With all this discussion, there are still no easy answers. Pharmacists are often on the front line, dealing with patients who may be surprised when the cost of their medication has risen, often drastically, since the last time it was filled, or patients who may abandon a first fill because they can't afford it. The most expensive medication is the one the patient doesn't take.

While items considered "specialty" drugs often get more attention due to their higher costs, patients are also struggling to pay for those medications that are less expensive, but still out of reach. With pharmacy benefit plan designs more frequently including higher deductibles, patients may be responsible for the first several thousand dollars in costs per year. Prescriptions that may be several hundred dollars per month, or per fill, are not always attainable for patients.

Public pressure is likely to continue, and we'll have to wait and see what the new Congress and administration choose to do to address this public health issue. Some companies are not waiting to respond. Allergan and Novo Nordisk recently announced their commitment to limit the size and frequency of their price increases.

According to an article published in late summer 2016 in the LA Times (see link on next page):

- When you have a generic drug with eight suppliers you would expect the prices to go down," said Dana Goldman, director of USC's Leonard D. Schaeffer Center for Health Policy & Economics.
- Unlike nearly every other developed nation, the U.S. allows drug manufacturers to set their own prices, a policy that has resulted in overall medicine costs being far higher than elsewhere. Increasingly, insurers are passing the cost along to patients through higher deductibles .
- According to the federal Health and Human Services Department, prescription drugs now account for almost 17% of personal healthcare expenditures — up from about 7% in the 1990s . . .
- Brand-name medicines are protected from competition by their patents, and they are still the primary driver of rising drug spending. When the patents expire, other companies can sell the medicines as generics, which in the past has usually caused the price to plummet.
- Instead, today the price of an increasing number of generic drugs with multiple manufacturers is rising.
- For example, eight of the 10 drugs that had the biggest percentage price hikes in 2014 were generic medicines made by multiple manufacturers, according to information published by the federal Medicare program.

As with other elements in healthcare, drug pricing has gotten more complicated.

The manufacturer may have invented the product, or paid for the intellectual property that allows it to sell the product. It will want to recover development costs, and cover the costs associated with producing and marketing the product, maintaining regulatory compliance, etc. Beyond covering costs, the desire and pressure for increased revenue and profit continues to grow, often driven by stockholders. As seen during recent Congressional testimony, there is a visceral reaction to frequent and significant price increases without a corresponding rationale, such as the cost of raw goods.

The manufacturer will invest in marketing its product. Years ago, that marketing occurred directly to the prescriber. Today, manufacturers are building brand awareness not just with prescribers, but also with patients, via direct-to-consumer advertising, websites, and support services. Many manufacturers offer patient assistance programs (coupons, co-pay cards) to help offset patients' out-of-pocket expenses. They are also marketing their product to the payer. Obtaining preferred formulary status is a key priority for most manufacturers, as it helps to drive market share. Offering rebates is one way to achieve preferred status. The rebates are paid to the pharmacy benefit manager (PBM), and may or may not be shared with the plan sponsor (e.g., health plan, employer); the patient rarely, if ever, is able to directly benefit from the rebate dollars.

So now that the manufacturer has made

the product, and marketed it to prescribers and payers, it has to get to the patient. There are companies that serve as wholesalers/distributors that assist in that process. These companies ensure that the product gets from the manufacturer's production facilities to the pharmacy for dispensing to the patient. Pharmacies often have a preferred distributor that they work with, or may be contractually obligated to work with (usually for chains or pharmacy services administrative organizations [PSAOs]).

Once the product is in the pharmacy, the price it's actually "sold" for is dependent on a number of factors: the price the manufacturer charges, plus any fees the distributor assesses and the fees the pharmacy is able to add (e.g., dispensing). The claim submitted to the payer results in the price to be charged to the patient (assuming the patient has and uses insurance coverage). If the price presented to the patient, whether the pharmacy's usual and customary charge or the price determined by the payer, is more than the patient can afford, the cost to the healthcare system is much greater. The patient who doesn't take his or her medication is likely to have other, more expensive interactions with the healthcare system.

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As pharmacists, what can we do? Obviously, dispense a generic whenever possible. Suggest therapeutic alternatives to the prescriber, especially if the prescriber has selected a product that isn't on the formulary. Let your patients know that there may be financial assistance available, either through coupons or discount cards, or through foundations that provide assistance based on need. While there are restrictions for government program (Medicare and Medicaid) beneficiaries, it is worth exploring. Most (brand-name) manufacturers offer some sort of program for their products, even if it isn't a "specialty" medication.

It's worth keeping in mind that if you use a coupon to assist a patient, there's potentially an additional transaction fee associated with submitting that "claim," as well as the cost of time to submit, plus any time spent researching the coupon. And payers are starting to realize that they don't know if a patient uses a coupon — and they want to have that information. They view it as impacting the patient's true out-of-pocket expense, and will likely explore ways to reconcile that information, similar to the TrOOP (total out-of-pocket) processes in place for Medicare Part D beneficiaries. **CT**

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