



Prescription Policy Choices

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Drug Prices Rise Faster than Health Care Costs

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The US Government Accountability Office has released a report showing drug prices in the US are rising faster than overall healthcare costs. Specifically, the GAO reported annual increases from 2006 to the first quarter of 2010 of 8.3% for selected popular selling brand name drugs and 2.6% for generics,¹ compared to an annual increase in overall health care costs of 3.8%. *The Wall Street Journal* reported on the analysis by Barclays Capital investment bank, which showed an average increase of 6.9% for the 130 top selling drugs in 2010, on top of annual increases of more than 4% to 6% during the past decade.²

The increase in drug prices precedes the expiration of a number of brand-name drug patents on several of the world's best-selling drugs, including Lipitor and Plavix. As patents expire, consumers and health plans have much to gain in terms of costs savings, as do providers who hope lower prices will significantly reduce the number of people who jeopardize their health because they can't afford the medicine they need. The question is whether the savings achieved will be passed onto consumers through lower copayments and insurance premiums.

Evidenced-based recommended drugs improve quality and control costs

As prescription drug costs continue to rise and many patents near expiration, policymakers, advocates, employers, and consumers would be well served by promoting greater use of evidenced-based prescription drugs to improve health care quality, preserve benefits, and contain costs. Evidenced-based prescribing can provide payers and consumers with the best choices for the effective use of limited health care resources. Value-based drugs are recommended by sources independent of the drug industry including the Drug Effectiveness Review Project, the Agency for Health Research and Quality, and *Consumer Reports Health Best Buy Drugs*TM. Recommendations are based on unbiased, objective evidence and information regarding drug effectiveness, safety, and cost-effectiveness.

¹ Melofchik, K, Drug Prices Rising Faster than Healthcare Costs in US, *The Oncology Pharmacist*, www.theoncologypharmacist.com, 3/22/11 and GAO-11-306R Prescription Drug Price Trends, 2/10/11.

² Rockoff, J, Drug Prices Rise Despite Calls for Cuts, *The Wall Street Journal*, 3/17/11.

Government drug spending increasing

The value of promoting greater use of recommended drugs can't be understated as a means to improve access to affordable, quality health care and rein in costs. The Kaiser Family Foundation reported last May that the government's share of prescription drug spending increased from 18% to 37% between 1990 and 2008.³ To ensure public dollars spent on prescription drugs are used wisely, it is critical that drug choices are based on the best available evidence--even in the face of manufacturer discounts on brand name drugs. These discounts may look appealing in the short run but can still end up costing more over time. This is especially true in cases when a discount causes a brand name drug to be selected over a safer, more effective option that still costs far less than even the discounted brand name.

Dubious discounts

For example, consumers approaching the doughnut hole under Medicare Part D are steered toward more expensive drugs with the lure of 50% discounts on brand name drugs, while discounts of up to 7% on generics are being phased in over time. To the extent that such discount offers distract consumers from choosing an evidence-based generic option, they set both consumers and payers up to pay more while getting less.

Rebates provided by drug companies for more expensive drugs are often cited as reasons for giving brand name drugs preferred status on formularies or preferred drug lists under public health programs, even though payers may still end up paying far more for the brand name than they would for a generic, evidence-based alternative.⁴ It's important to remember that a drug listed as "preferred" does not necessarily translate into it being the most effective or safest drug in its treatment category. Effective prescription drug policies can close that gap and help ensure that public programs steer consumers to the safest and most effective drugs and not lose sight of that basic principle in the face of manufacturer discounts and rebates. The good news for consumers--and payers--is that the best available drugs are more often than not affordable generics rather than high cost brand names.

Employers can preserve benefits and create savings

A study of Minnesota health plans indicated that increasing utilization of evidence-based drugs could yield costs-savings of more than 50% for most of the drug categories studied. The savings could be achieved through formulary and preferred drug changes that incentivize value-based utilization of

³ Prescription Drug Trends, 5/10, Kaiser Family Foundation

⁴ Silverman, E, The Cost of Prescription Drugs Just Keeps Rising, Pharnalot, 3/17/2011.

evidence-based prescription drugs.⁵ This was the equivalent of nearly \$6.5 million in savings for one private, employer-sponsored plan covering approximately 36,000 members.

By encouraging broader use of recommended drugs, growth in government and private health program spending on prescription drugs can be controlled. Savings can instead be used to expand access, avoid cuts to programs and benefits, mitigate patient cost-sharing, improve reimbursement for primary care or other services, and reduce insurance premiums.

Evidenced-based Prescription Drug Information Resources

Drug Effectiveness Review Project/Effective Health Care Program:

<http://www.effectivehealthcare.ahrq.gov/index.cfm>

Drug Effectiveness Review Program:

<http://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/derp/index.cfm/>

Consumer Reports Health Best Buy Drugs™

<http://www.consumerreports.org/health/best-buy-drugs/index.htm>

⁵ Kjos, A, et al, A Comparison of Drug Formularies and the Potential for Cost-savings. *American Health & Drug Benefits*, Vol 3, No 5 (Sept/Oct 2010), pps 321-330.