Lowering Prescription Drug Costs

The NCHC Fact Sheet Series

Americans face serious health care challenges: rising costs, barriers to access and affordability, and real gaps in care quality, especially for certain chronic diseases. While these challenges affect all of us, they are most acute when we are at our most vulnerable, such as when we confront old age, face disability, weather economic hardship, or reside in communities afflicted by health disparities. Amidst the sometimes heated debates around health care and the federal deficit, ordinary citizens and health care advocates alike need to be informed and engaged. This fact sheet is one of a series examining the policy choices before us.

Background

Prescription drug coverage is a critical part of the security that health insurance provides whether through public programs like Medicare and Medicaid or through private insurance. But drug coverage also plays a more complex role in efforts to hold down costs to Medicare and its beneficiaries. On one hand, appropriate use of prescription drugs is a powerful way to manage beneficiaries' health while restraining costs. Successful models of care coordination for beneficiaries with multiple chronic conditions rely on greater adherence to evidence-based drug regimens to avoid costly hospitalizations and other services. On the other hand, annual prescription drug spending in 2011 amounted to $320 billion, which represents an increase of about $50 billion since 2006 and $125 billion since 2002. Given the scale of this growing investment, finding savings in prescription drug spending without undermining their capacity to improve care and save money over the long run, is essential. This fact sheet explores several strategies under discussion in Washington to reduce the cost of prescription drugs.

Encourage generic use in the low-income subsidy population

Certain Medicare beneficiaries (i.e. dually eligible beneficiaries who are eligible for both Medicaid and Medicare, those who receive Supplemental Security Income (SSI), or those who earn less than 150% of poverty) are eligible for a subsidy to defray the cost of premiums, deductibles, and copays for Medicare prescription drug coverage. Although Part D plans have used lower copays to increase utilization of generic alternatives among other Medicare enrollees, recipients of this low-income subsidy (LIS) continue to utilize brand name drugs at a higher rate.[3]

MedPAC's March 2012 Report to Congress recommends that Congress direct the US Department of Health and Human Services (HHS) to eliminate copays for generic drugs and increase copays for brand name drugs. MedPAC has estimated that this policy would save $17 billion in federal spending over 10 years. In implementing any such policy, it would be critical to provide special appeal mechanisms that ensure patients who have a legitimate medical need for brand name drugs have access to them.

Pros

This approach would produce an estimated $17 billion in federal savings.[4] Its supporters argue that those savings would be achieved without shifting costs or cutting necessary coverage, and they could be used to sustain Medicare and other vital programs. Additionally, LIS Medicare beneficiaries who purchase generics would benefit from lower prices and greater access.

Cons

Increased cost sharing for brand name drugs in certain low-income populations may lead to non-adherence rather than generic substitution, perpetuating socioeconomic health disparities.[5]

[1]National Coalition on Health Care. (2012). Curbing Health Care Costs, Improving Quality: Care for High Cost Beneficiaries in Medicare and Medicaid. (Policy Paper #9)- forthcoming. Washington, D.C.

[2]IMS Health Institute for Health Care Informatics. (2012, Apr). The Use of Medicines in the United States: A Review of 2011. Retrieved from http://www.imshealth.com/deployedfiles/ims/Global/Content/Insights/IMS%20Institute%20for%20Healthcare%20Informatics/IHII_Medicines_in_U.S_Report_2011.pdf.

[3]Medicare Payment Advisory Commission. (2012, Mar). Report to Congress: Medicare Payment Policy. Retrieved from http://medpac.gov/documents/Mar12_EntireReport.pdf.

[4]Medicare Payment Advisory Commission. (2011, Oct 14). Letter to the Congressional Super-Committee. Retrieved from http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf.

[5]Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. J Gen Intern Med. 2008;23(8):1131–1136. doi: 10.1007/s11606-008-0614-0.

[6]U.S. Department of Health and Human Services. (2013, Apr 10). Fiscal Year 2014 Budget in Brief. Retrieved from http://cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf.

[7]Generic Pharmaceutical Association. (2012, July). Generic Drug Savings in the U.S. Retrieved from http://www.gphaonline.org/sites/default/files/IMS%20Study%20Aug%202012%20WEB.pdf.

[8]Kesselheim, A., Murtagh, L., Mello, M. N. (2011, Octr 13). "Pay for Delay" Settlements of Disputes over Pharmaceutical Patents. The New England Journal of Medicine. Engl J Med 2011; 365:1439-1445.

NATIONAL COALITION ON HEALTH CARE

Part D rebates

Federal law requires that pharmaceutical manufacturers pay a minimum rebate on medication purchased by state Medicaid programs. Drug manufacturers currently provide 15% rebates for prescription drugs to Medicaid, and in 2014, the Affordable Care Act will increase these rebates to 23.1%.

In Medicare, on the other hand, manufacturers negotiate more limited rebates with the individual firms that sponsor Part D and Medicare Advantage plans. Because dually eligible beneficiaries currently receive their drug coverage through Medicare, the prices that Medicare pays are typically much higher than the rebated price that Medicaid pays.

The Obama administration's FY 2014 budget proposal, as well as several proposed bills in Congress, would require drug manufacturers to pay the same 23.1% rebate for drugs provided to beneficiaries receiving the Part D low-income subsidy.

Pros

This approach would produce an estimated $133.7 billion in federal savings that could be used to lower the deficit, sustain Medicare, or pay for other vital programs.[6]

Cons

Opponents warn that increasing these rebates in Medicare could actually lead to higher prescription drug prices elsewhere in the health system. According to this view, pharmaceutical companies would simply charge higher prices for their drugs in the private sector in order to make up for the loss of revenue in Medicare.

Curb pay-for-delay settlements

Before a generic drug can be sold, the generic manufacturer must prove that it does not infringe upon the original brand name drug's patent protection. Generic drug manufacturers typically engage in litigation to accomplish this goal. In recent years, a number of these lawsuits have been settled with agreements in which the generic manufacturer agrees to forego the sale of the new generic drug for a specified period of time in return for a cash payment. While generic manufacturers argue that these agreements actually help assure that more drugs make it to the market more quickly,[7] significant concerns exist that these settlements are slowing the availability of cost-reducing generics and infringing upon antitrust laws.[8]

While a recent Supreme Court decision made it easier for regulators to restrict such arrangements, proposed legislation in Congress would further limit or prohibit the use of cash payments or other inducements in these settlement agreements.

Pros

Proponents argue that restricting pay-for-delay settlements would speed more affordable generics to the patients that need them. The CBO estimates that this legislation would reduce the deficit by $5 billion over 10 years,[9] while generating further savings for private sector payers and consumers.

Cons

Opponents argue that prohibiting these settlements would have unintended consequences that could actually slow access to new generic drugs. According to this view, the expense of full litigation and the uncertainty associated with taking the case to trial would deter many generic manufacturers from challenging illegitimate or weak patents.

Curb biologic drugs costs

A two-step approach could be taken to lower the price of biologic drugs, the fastest growing element of pharmaceutical costs.[10] The first step would reduce the length of guaranteed protection of brand name biologics from generic competition from 12 to 7 years. This reduction in the exclusivity period would be intended to encourage innovation, increase market competition, and ultimately speed more affordable generics to the market.[11] The second step would change Medicare's payment for physician-administered medications, which today is based on the cost of the drug plus a percentage of that drug's cost, to a different payment structure that reconfigures the strong incentives for physicians to prescribe the higher-cost drug.[12]

Pros

Successful implementation of this two-approach would mitigate the fastest growing area of pharmaceutical costs while incentivizing development and delivery of the most effective, rather than most costly, treatments. For beneficiaries, the lower costs could make life-saving drugs more accessible to people with less generous insurance plans.[13] Medicare and other vital programs would also benefit from these lower costs; the CBO estimates that a reduced, 7-year exclusivity period for biologics and certain limited changes to payment for biologics in Medicare Part B could produce $2.9 billion in deficit reduction over 10 years.[14]

Cons

Changes to the current payment system that reduce physician reimbursements could threaten the financial sustainability of certain physician groups and outpatient facilities, including outpatient cancer centers, that face high overhead costs to purchase,

[9]Congressional Budget Office. (2012, Mar 16). Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013 - March 2012 Baseline. Retrieved from http://cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf.

[10]Generic Pharmaceutical Association. (2012, July). Generic Drug Savings in the U.S. Retrieved from http://www.gphaonline.org/sites/default/files/IMS%20Study%20Aug%202012%20WEB.pdf.

[11]Johnson, J. A. (2010, April 26). FDA Regulation of Follow-On Biologics. Congressional Research Service; 7-5700:RL34045. www.crs.gov.

[12]Robinson, JC. (2006, September). "Insurers' strategies for managing the use and cost of biopharmaceuticals." Health Affairs, 25(5), 1205-1217.

[13]Robinson, JC. (2006, September). "Insurers' strategies for managing the use and cost of biopharmaceuticals." Health Affairs, 25(5), 1205-1217.

[14] Congressional Budget Office. (2012, Mar 16). Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013 - March 2012 Baseline. Retrieved from http://cbo.gov/sites/default/files/cbofiles/attachments/44247_APB_HealthCarePrograms.pdf.