

## What's Driving Prescription Drug Costs?

by Heather Burns, Charles Beever, and Robert Hutchens

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# What's Driving Prescription Drug Costs?

Spending on prescription drugs is one of the biggest contributors to the unrelenting rise in the cost of health care for business. Critics of rising drug costs are quick to blame pharmaceutical companies' advertising and aggressive sales practices for the problem. In fact, the real culprit is a third-party reimbursement system that undermines economic incentives to control costs.

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**T**he cost of health-care benefits has continued its unrelenting rise this year: Premiums are up 13.9 percent between May 2002 and May 2003, according to an annual survey of nearly 3,000 companies by the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust. This marks five consecutive years of increases above 5 percent and the highest jump since 1990, and parallels a persistent uptick in overall U.S. health-care spending, which almost doubled between 1990 and 2000, from \$655 billion to \$1.2 trillion. The biggest contributor to this increase was spending on drugs, which tripled during that time from \$40 billion to \$122 billion, or from 6 percent to 9 percent of health-care expenditures.

These trends have many companies rethinking the generous health-care benefit packages they

have used to attract and keep talent in a highly competitive economy. But the more fundamental questions are, Why are drug prices going up so fast, and what can and should employers do about it?

### Third-Party Problem

Critics of rising drug costs in the media, in government, and elsewhere blame aggressive marketing

consumers to pressure their doctors to prescribe unnecessary or inappropriate drugs. But the truth is more complicated. In fact, there's an institutional force that's harder to control and reform: It's the third-party reimbursement system, led by employers, insurance companies, and government programs (collectively referred to as the "payers"), that erodes patients' personal

**"Spending on drugs is the biggest contributor to the unrelenting rise in the cost of health-care benefits."**

by big pharmaceutical companies, pointing to "mega" sales forces calling on physicians and the persuasive television ads the critics say compel

accountability for their health-care decisions and distorts doctors' treatment decisions.

The evidence has long suggest-

ed that third-party payments significantly affect health-care spending. The proportion of medical care expenditures covered by third parties, including government programs, rose to almost 70 percent from roughly 48 percent between 1960 and 1980. In that period, medical costs as a percentage of GNP nearly doubled, to 9 percent from 5 percent. Although factors other than third-party reimburse-

increased diagnosis of common diseases like asthma and diabetes, innovative new treatments for such conditions as osteoporosis and anemia, more cost-effective applications of drug therapies, and the pharmaceutical industry's spending on sales and marketing. Nevertheless, the growing role of third-party reimbursement provided the fertile soil in which the healthy growth in drug expenditures took place.

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ment (e.g., 25 percent population growth and a 50 percent increase in the number of people over 65) also drove up medical care spending, these factors don't explain the magnitude of the increase.

During those 20 years, 1960 to 1980, expenditures on pharmaceuticals as a percentage of overall health-care spending actually fell by half, from 10 percent to 5 percent, mainly because most consumers paid for drugs out of their own pockets. Since the beginning of the 1990s, however, there has been a dramatic shift to third-party payment for pharmaceuticals. In 1992, third parties covered only 38 percent of full-time employees' spending on medicines; in 2001, it reached 88 percent.

To be sure, drug spending wouldn't have ballooned so quickly without other trends, such as

Third-party reimbursement distorts how patients and physicians make pharmaceutical and other treatment decisions, because those decisions are actually in the hands of payers and their agents (pharmacy benefit managers, or PBMs). In plans without patient co-payments, for example, patients and physicians are entirely insulated from the economic consequences of their choices. Payers can and are shifting costs back to patients using co-pays. But the payers and their agents still decide which products merit low co-pays, and they negotiate the prices with manufacturers. For example, prescription drug benefit plans commonly sort co-pay amounts in three tiers, with co-pays of roughly \$10, \$15, or \$20 per prescription. The tier a drug is on (and therefore the size of its co-pay) depends on whether it is “preferred”

by the plan. To qualify a drug for a lower co-pay, pharmaceutical companies offer discounts to benefit plans. Such arrangements are now used in more than 70 percent of prescription benefit plans.

Co-pay programs are also typically designed to influence unit volume (the number of prescriptions) more than prices. Because the patient pays a fixed co-pay no mat-

the hands of patients and physicians. Rather than pay for health care on a prescription-by-prescription or visit-by-visit basis, the employer contributes a fixed sum that employees can spend as they see fit.

Some argue that individual employees lack the power of large health plans to push back on pharmaceutical price increases. But our research suggests otherwise. A recent

## “Consumer-directed plans place the decision about the “right” level of pharmaceutical spending where it belongs — in the hands of patients and physicians.”

ter what the price of the prescription, there is no incentive for the patient to select a less expensive alternative. Payers theoretically should want to push for lower prices. But their incentive to do so is usually attenuated because they do business through PBMs that make their money by capturing some portion of the discounts drug companies offer in exchange for co-pays.

### Consumer Power

So how can companies that want to continue to provide attractive health benefits give their employees a more direct economic stake in their health-care choices and moderate the upward rise in drug prices? In our view, defined-contribution or consumer-directed health plans are part of the solution. What consumer-directed plans do is place the decision about the “right” level of pharmaceutical spending where it belongs — in

Booz Allen Hamilton survey of health plans shows little or no correlation between the size of the plan and the discounts it receives from pharmaceutical companies. Instead, discounts are triggered mostly by the plan’s ability to shift market share from one drug to another.

As patients begin to vote with their wallets and select prescription medicines based not only on performance but also on price, pharmaceutical companies will respond. As drug companies compete to make their case directly to patients and physicians, there will be more market pressure to temper rising prices and indirect pressure to lower marketing and advertising expenditures. Pharmaceutical prices and spending may or may not drop as a result, but at least it will be the patients and physicians who are making the choice. +

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