PRESCRIPTION DRUG SPENDING IN THE U.S. HEALTH CARE SYSTEM: AN ACTUARIAL PERSPECTIVE

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Agenda

1. Drivers of Growth in Prescription Drug Expenses
2. Impact of Drug Costs on Payers
3. Options to Address Spending

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Agenda

1 **Drivers of Growth in Prescription Drug Expenses**

2 Impact of Drug Costs on Payers

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Overview

- Primary drivers
  - Changes in utilization
  - Increases in the unit cost or cost per dosage
- Additional drivers

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Utilization

- Increased utilization due to many factors
  - New approved guidance for prescribing
  - Changes in disease prevalence
  - Revisions in treatment regimen
  - More effective disease identification
  - Plan design

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Overutilization

- Overutilization directly leads to higher costs
- Reasons for overutilization
  - U.S. pharmaceutical delivery system
  - Direct drug marketing

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Non-Adherence

- Patients may not follow drug treatment protocol
- Non-adherence can lead to higher medical cost from avoidable treatments

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Unit Cost

- Cost per unit generally increases over time
- Other reasons for increase
  - Brand drugs losing exclusivity
  - New brand drugs
  - New generic drugs with high unit costs
  - Generic drugs with substantial price increase
  - New therapies

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Drug Mix

- Mix of drugs directly impacts total drug spending
- Formularies used to mitigate cost increases
  - Balance cost management and comprehensive coverage
  - Reviewed by Pharmacy and Therapeutics Committee
  - Reviewed for cost-effectiveness
  - Steer member behavior using cost-sharing

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Specialty Pharmaceuticals

- One of fastest-growing cost areas of drug spending
- Include high-cost/high-complexity drugs
- Examples
  - Sovaldi
  - Disease-modifying therapies for multiple sclerosis
- May help avoid expensive medical care in future

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Additional Drivers of Drug Cost Increases

- Delays in introduction of generics
- U.S. paying more than other nations for drugs
- Numerous links in pharmacy supply chain
- Research and development

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Perception May Depend Upon Who Is the Payer

- Insurers, Government, and Other Payers
  - Includes employers
- Insured Members
- Governmental Programs
  - Medicaid, Medicare, VA Health, etc.
- Uninsured Population

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Insurers, Government, and Other Payers

Need to Balance:

Increased Drug Costs With Overall Health Costs and Better Outcomes

- Rx costs represent significant % of total payer health costs
- If higher expenditures result in lower health costs in the future, then such increases may be justified
  - True only if a stable population
  - If population churns, the entity funding the original costs will not realize savings

- If higher Rx costs do not result in equal or lower overall health expenditures, then upward pressure on budgets and premiums
- High Rx costs may not be sustainable even is they are life-saving

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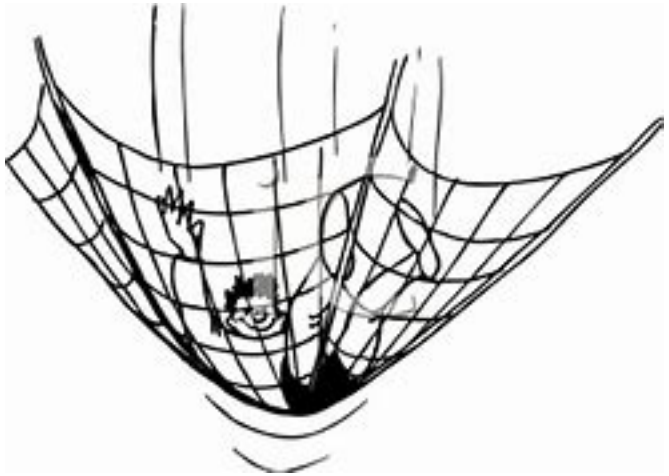
Insured Members

- ACA provides annual maximum out-of-pocket (MOOP) limits for drug and medical costs combined. Thus there is a safety net to limit insured members' expenditures
  - 2018 MOOP is $7,350 per person per year
  - Can still represent a significant percentage of income
  - Higher drug costs result in higher expenditures for those insureds who do not meet their MOOP



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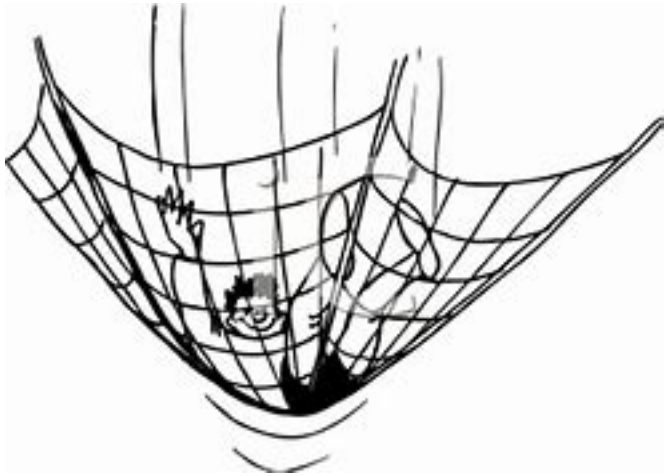
Insured Members

- Manufacturers' coupons can negate impact of formularies
  - Brand drugs may be similar or lower in cost than generic formulary to consumers, but not to payers
  - Can result in higher costs to payers, driving higher costs to insureds in the form of higher premium contributions, higher cost-sharing or employer dropping coverage



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Government Programs

- State and local governments have limited funds
- Recipients may see higher premiums or cost-sharing, or more rigid plan eligibility
- Some programs may consider not covering or restricting the use of some high-cost drugs

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Uninsured Population

- Rx prices are generally higher than for insured members
  - Do not benefit from payers' contracting efforts
  - May be partially offset by:
    1. Discount drug card,
    2. Manufacturers' coupons, or
    3. Subsidies provided by patient assistant programs
    4. These can result in increased cost shifting to insured population

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Options to Address Spending

- Many expensive drugs are improving patient health and quality of life
- There are options for policymakers and health care payers to address the rising costs

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Some Existing Federal Options

1	**Expedite drug approval process**	Expediting brand and generic approvals could lower research costs and administrative fees, can prevent use of more expensive treatments, and can introduce generic competition more quickly
2	**Eliminate tactics that discourage generic utilization**	Prevent brand manufacturers from paying generic companies to delay manufacturing and from using copay coupons to offset cost-sharing barriers to continue use of brand medications
3	**Import prescription drugs**	Purchasing prescription drugs from outside the U.S., where costs can be significantly lower
4	**Negotiate or regulate drug prices**	Medicare could take advantage of its size to get better pricing and rebates; regulations on price increase limits and transparency are being considered to contain costs

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Options for Health Care Payers

For health insurers, government agencies, and other health care payers, options to slow the growth of prescription drug costs include:

1. **Incorporating Value-Based Review Process**
2. **Outcomes-Based Contracting**
3. **Benefit Plan Modifications**
4. **Increasing Pricing Transparency**

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1. Incorporating Value-Based Review Process

Entities such as the ICER and DrugAbacus examine if drug prices reflect their value:

- States require similar studies for new mandated health benefits, generally focused on:
  - Medical efficacy
  - Social impact and benefit, and
  - Financial impact
- Provide a quantitative means of determining whether a price is commensurate with its value
  - Helps determine whether a particular drug should be included on a formulary
  - Drug company must demonstrate that it met the medical efficacy, social benefit and financial impact criteria

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2. Outcomes-Based Contracting

Limited success creating risk-based contracting for drugs, examples of initiatives where drug's price is dependent on patient's outcome:

- Express Scripts SafeGuardRx launched programs for diabetes, hepatitis, cholesterol, oncology
  - Diabetes Care Value Program - guarantees per-patient spending cap results in plan experiencing about half the average increase in diabetes drugs of what is forecasted for U.S. commercial payers
- Harvard Pilgrim Health Care contracted with AstraZeneca for two therapies used to treat acute coronary disease and type 2 diabetes.
  - Patient outcomes as a measure of the effectiveness of each treatment, which will be incorporated into reimbursement rates to the drug manufacturer
  - Harvard Pilgrim will monitor the number of return hospitalizations for patients treated after they are discharged from the hospital. Any reduction in return visits achieved will factor into the drug price.

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3. Benefit Plan Modifications

Modifications focused on financial factors or member behavior:

- **Partial fill programs** - allow less-than-30 day fill
  - For very-high-cost specialty drugs
  - Reduces waste if the patient can not tolerate the dosage
- **Step therapy** - patient must prove preferred drug does not work before coverage for non-preferred drug
  - Encourages cost-effective medications
  - May extend recovery time
- **Preferred Pharmacy Network** - gives the payer a larger discount, so usually have lower copays when patients choose the preferred pharmacies
- **Prior authorization** – review for medical necessity, patient-appropriate and follows clinical guidelines
  - Manages costs
  - Minimize interactions, side effects, unproven use, or overmedication
- **Reference pricing** - limits the reimbursed cost based on the national market price of equivalent drugs
  - Financial incentive to use the most cost-effective drug
  - If patient needs more expensive drug, could be penalized
  - Can combine with step therapy
- **Deductibles, out-of-pocket limits, plan designs** - becoming more complex
  - Four-, five-, and even six-tier cost-sharing structures to incent patients to use the lowest-cost drug possible
- **Specialty pharmaceuticals** - high cost/high complexity; often reduction in other medical costs with appropriate use
  - Programs focus on clinical support for the medical cost offset relative to increased pharmacy spending

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4. Increasing Pricing Transparency

- Prescription drug costs often not known by the provider or patient
  - Lower-cost drugs with efficacy at least as good as higher-priced drugs may exist
  - Better transparency can lower both patient out-of-pocket payments and premiums
- Providers with risk-sharing could benefit from cost data
  - Especially if in conjunction with a comparative effectiveness approach
  - Provider access to cost data would be especially beneficial in situations where patients have reached out-of-pocket maximums and have no incentive to use more efficient drugs
- CVS Caremark announced real-time medication costs and available lower-cost therapeutic alternatives at point of prescribing and at pharmacy
  - May help eliminate potential dispensing delays, improve patient adherence, and lower costs
- Provides more financial certainty for patients and health care payers
  - Several web-based resources help consumers find the lowest cost for drugs
  - Most insurers provide online tools to steer patients toward the lowest-cost prescriptions

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Conclusion

- The important cost drivers of high prescription drug spend are:
  - Increasing utilization driven by factors including new indications for a drug, direct marketing to consumers, and the incentives in a fee-for-service system.
  - Increasing average cost driven by factors including the exclusivity of the drug and higher prices of the newer versions of drugs.
  - Changes in drug mix that are driven by the formulary, benefit design, and availability of alternative drugs.

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Questions?

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