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What Can Large Corporations Do To Lower Drug Prices ?

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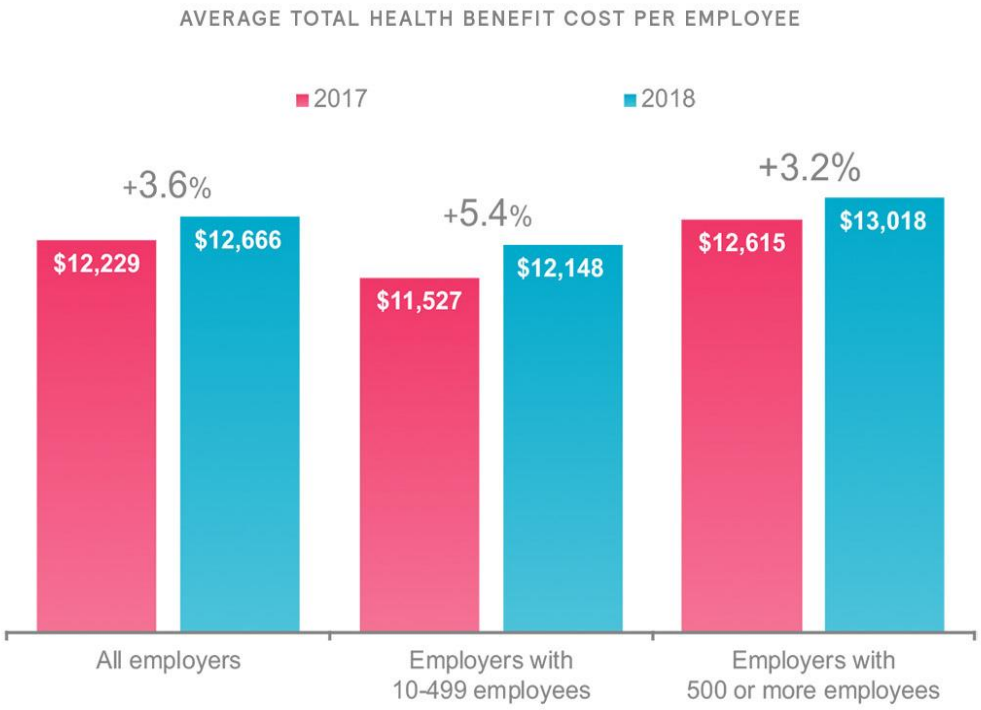
Protecting Health, Saving Lives—*Millions at a Time*

Large and Medium Size Companies Spent An Average of $13000 on Health Benefits

- Small employers were hit with a 5.4% increase in 2018.
- Midsized and large employers (those with 500 or more employees) held cost growth to 3.2%



SOURCE: Mercer's National Survey of Employer-Sponsored Health Plans 2018

Drugs Represent 21% Of Employee Health Benefit Spending

- Real drug spending per person has doubled since 2000
  - Drug spending averaged $2730 per employee in 2018
- Most of the recent spending increases are due to new brands, higher prices for existing brands, fewer patent expirations, not greater utilization
- Prices for common generic drugs have dropped by 37% since 2014, but prices for branded drugs have increased by over 60%

Source: https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#item-nominal-and-inflation-adjusted-increase-in-rx-spending_2017

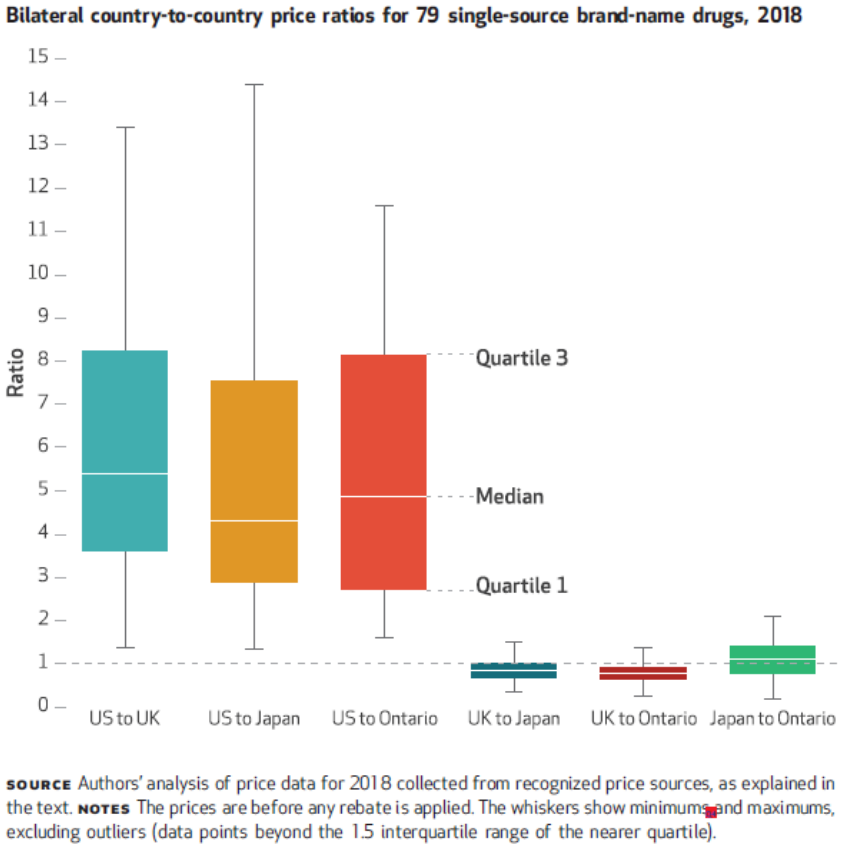
Drug Coverage By Large Employers

- >99% of large employers have drug coverage
- 92% have tiered cost sharing
- 88% have 3 or more tiers
- Cost sharing varies by tier
  - $11 in tier 1
  - $33 in tier 2
  - $59 in tier 3
  - $105in tier 4
- 52% have a specialty tier for very expensive drugs

Source; https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-9-prescription-drug-benefits/

International Price Comparisons

- The US pays 3-4 times what other industrialized countries pay for the same branded drugs
- The main benefit is that the US may get them a year or two earlier than other countries



SOURCE Authors' analysis of price data for 2018 collected from recognized price sources, as explained in the text. **NOTES** The prices are before any rebate is applied. The whiskers show minimums and maximums, excluding outliers (data points beyond the 1.5 interquartile range of the nearer quartile).

Using External Reference Pricing In Medicare Part D To Reduce Drug Price Differentials With Other Countries. Kang SY, DiStefano MJ, Socal MP, Anderson GF. Health Aff (Millwood). 2019 May;38(5):804-811.

Paying For Drugs at International Rates Instead of Domestic Rates

- Prices would decline by 2/3rds
- The longer the branded drug has been on the market the higher the price is relative to other countries
  - In other countries the price goes down while in the US the price increases
  - The US does not have mechanisms to lower prices over time

US Pays Higher Prices For All Medical Care Services Not Just Drugs

- The US pays much higher prices for hospital and physician services than other countries
- Current system not oriented to getting the lowest prices

It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt. Anderson GF, Hussey P, Petrosyan V. Health Aff (Millwood). 2019 Jan;38(1):87-95.

Large Corporations Have Little Market Power in Health Care

- In spite of having a large number of employees, most large corporations have little market power
  - Most large corporations have employees spread across the US so they do not have significant market power in any one community
  - Most large corporations have their headquarters in a large city with many other large corporations and therefore do not have market power without working together
- One or two dominant providers in a community have considerable market power

Corporations Pay Twice as Much as Medicare for Hospital and Physician Services

- 15 years ago the prices were similar
- Now corporations pay 2 times Medicare prices nationally and in some locations 3 times Medicare prices
- Major determinant is the concentration of providers in the community
- This is not true for drugs
  - Companies and Medicare pay about the same price
  - The same PBMs negotiates for companies and Medicare

When Companies And Medicare Try to Get Lower Drug Prices For Branded Drugs

- Branded drug companies have patent and market exclusivities that effectively give them a monopoly to sell their product
- There are 3 large PBMs that control 80+% of the market and most large companies do not change PBMs so little competition across PBMs
- PBMs retain a significant and unknown percent of the savings when they negotiate with the drug companies
  - Unclear how much of savings goes to the employees or the company
  - PBMs favor rebate-generating products in their formularies, sometimes with minimal clinical value

PBMs

- PBM profits have increased dramatically in recent years
- Most of the profits come from rebates which are the difference between the list price and the transaction price
- Rebates are typically paid by branded drug companies to get favorable placement for their drugs

IDEAS AND OPINIONS

Annals of Internal Medicine

Pharmacy Benefit Managers, Brand-Name Drug Prices, and Patient Cost Sharing

Ge Bai, PhD, CPA; Aditi P. Sen, PhD; and Gerard F. Anderson, PhD

When prescription drugs became a new insurance benefit in the 1960s, companies known as pharmacy benefit managers (PBMs) started helping insurance companies manage the pharmaceutical part of the insurance business. The PBMs decided which drugs would be in the formularies, administered drug claims, and negotiated with drug manufacturers and pharmacies on behalf of insurers. Through these activities, PBMs offered value by containing drug spending.

Over time, PBMs became larger and took on new roles. In the 1990s, drug manufacturers acquired certain PBMs but later spun them off, because the Federal Trade Commission raised concerns about conflicts of interest. Since the 2000s, however, mergers and acquisitions have created market giants. The 3 largest PBMs—Express Scripts (an independent company), the pharmacy service segment of CVS Health, and OptumRx (the pharmacy service segment of UnitedHealth Group)—now have more than 180 million customers and control approximately 80% of the market (1). The combined operating profits of these 3 PBMs increased from $3.4 billion in 2007 to $12.4 billion in 2016 (2). The PBMs also are providing new products in today's market. For example, they have created pharmacy networks and now offer mail-order pharmacy and disease management services. The combination of increased size and scope expansion has prompted concerns that the business practices of PBMs may be contributing to higher list prices for brand-name drugs and thus a higher cost-sharing burden for patients, which may reduce their access to prescribed medications and lead to less adherence and worse health outcomes (3).

How the business practices of PBMs may lead to higher list prices is complicated. These companies represent insurers when they negotiate prices with the manufacturers of brand-name drugs. Those negotiations also result in the manufacturer giving rebates and discounts and paying fees to PBMs, all of which constitute some of the PBMs' profits. For example, the pharmaceutical manufacturer determines a drug's list price. However, the amount of money the manufacturer actually receives is reduced by the size of the rebate it negotiates with the PBM. The drug manufacturer emphasizes how desirable the drug is, which is measured by the drug's clinical effectiveness and the share of the overall market, and the PBM emphasizes the volume of business it can deliver to the manufacturer. At the end of this negotiation, the rebate for some therapeutic classes may be more than 50% of the manufacturer's list price (4). The size of the rebate rarely is disclosed to private insurers or the public. Under current market conditions, PBMs often can retain 10% to 15% of the rebate as profit while passing the remainder on to the insurer, which indicates that a higher list price might generate more revenue for PBMs (5).

The PBMs also benefit from the discounts drug manufacturers provide to specialty pharmacies, which handle high-cost, highly complex drugs (6). The 3 largest PBMs own 3 of the 4 largest specialty pharmacies in the United States. A PBM profits when it owns a specialty pharmacy that buys drugs from a manufacturer at a discount and then passes a smaller discount, or no discount at all, on to the insurer. In addition, drug manufacturers pay fees to PBMs for contracted services and programs, such as conducting market research and replacing a drug with another drug in the same therapeutic class. In most cases, PBMs retain those fees.

How these payments affect patient cost sharing is explained by the relationship between drug prices and cost sharing. The cost borne by the patient typically is a fixed proportion of the price established by the manufacturer (the list price). The higher the list price, the more the patient is likely to pay out of pocket. As discussed earlier, when a PBM negotiates with the manufacturer to pay a rebate, the size of the rebate may increase with the drug's list price. This rebate incentive is probably at least partially responsible for the faster increase in list prices than in the amounts received by drug manufacturers (net prices). In the United States, between 2011 and 2016, list prices for brand-name drugs rose 10.9% annually while net prices increased 5.5% per year on average; in 2016, list prices increased 9.2% while net prices rose 3.5% (7). In turn, these increases in list prices mean that patients are paying more in cost sharing. They are especially problematic when the patient's insurance coverage is in the deductible phase, and the growing popularity of high-deductible plans with high coinsurance rates has only intensified this effect.

Because of confidentiality clauses written into contracts, we cannot know how much these payments to PBMs affect prices for specific drugs; thus, we cannot be certain that these payments are causing the price increases. However, some insurers have filed lawsuits claiming that PBMs are partially responsible for the higher prices. In addition, some employers are avoiding PBMs and instead are creating their own formularies and negotiating directly with drug manufacturers (8, 9). Further, some states are developing legislation that would require PBMs to disclose more financial information.

Many observers believe that additional policy interventions should be considered. For example, some policy analysts want any rebates to be passed directly

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Pharmacy Benefit Managers, Brand-Name Drug Prices, and Patient Cost Sharing. Ge Bai, PhD, CPA; Aditi P. Sen, PhD; and Gerard F. Anderson, PhD. *Ann Intern Med.* 2018;168:436-437.

Rebates Are Part Of The Problem

- If drug companies pay a rebate they expect favorable formulary placement for their drug
- This can mean that the branded drug gets better formulary placement than the generic drug, or that the formulary allows for branded drugs with limited clinical value
- It can mean other formulary placements also
  - Preauthorization
  - Number of fills
  - Step therapy
  - Etc.
- Better formulary placements for branded drugs mean higher prices for industry and employees
- Surprisingly, large companies can’t always get the information they want from PBMs

Working with Large Companies on Biosimilars

- ERIC has asked Johns Hopkins to determine how much could be saved if the biosimilar (generic) was dispensed instead of the biologic (branded drug)

- Companies asked their PBMs for data on the prices they were paying for biologics and biosimilars and how many of their employees were taking biologics and biosimilars

- In many cases the companies were told
  - YOU CANNOT HAVE THIS INFORMATION!

Companies Participating in the ERIC Study

- Applied Materials
- AT&T
- Comcast/NBC Universal
- Fidelity Investments
- GAP
- General Dynamics
- Hyatt
- IBM
- Pepsico
- Wells Fargo

Some Results Thus Far

- Companies would have saved between 15% and 18% if used biosimilar
- One company would have saved over half a million dollars switching just one drug (Remicade)
- Savings are even more important for beneficiaries
  - Most companies charge their members a percentage fee to access these drugs
  - Members do not benefit from rebates

What Can Companies Do?

- Alter their formularies to buy the most cost effective drugs
- Often the PBMs put the less cost effective drugs on the formulary to get higher rebates

Waste Free Formularies

- If you take away the rebates you will have a different formulary
- Some companies are developing “waste free” formularies
- What does it mean?
  - Removing branded drugs when generics are available
  - Removing high-rebate drugs with low clinical value

Waste Free Formularies

- Example: Jublia®: Topical treatment for toenail fungus that is **not effective** (cure rate is <20%). Needs to be applied for 48 weeks, at a cost of **$1,031 per bottle.** The alternative, terbinafine, is twice as effective at $13 per pill.
  - Jublia also has strong DTCA and coupons
  - So patients are motivated to request drug
  - And have no out-of-pocket cost

Some Companies Have Made Strides Towards The Waste Free Formulary

- Many companies hesitate to make formulary changes
  - Changing just a few drugs can elicit backlash from PBMs & added fees for “customizing” formulary
  - Concern with member satisfaction
  - Generally assume PBM knows best
  - Generally prefer contracts with high rebates & no fees

Some Companies Have Made Strides Towards The Waste Free Formulary

- Companies that have implemented the waste-free formulary have learned that
  - Member dissatisfaction is minimal if any
  - Significant changes are possible because wasteful products have low clinical value
  - Savings can be up to 25% of total drug benefit
  - Moving towards fee-based PBM contracting actually saves money because prevents spending on high-cost high-rebate drugs

What Companies Can Do

- If a company has a no-fee contract with their PBM it is safe to assume they have some degree of wasteful drug spending
  - Should review formulary and contracts asap
  - Assess savings potential from:
    - A) removing wasteful drugs (more laborious process, may produce lower savings) or
    - B) moving to fee-based PBM contract (removes incentive for wasteful drugs). Big PBMs already offer this.
  - Hire consultants that are independent from PBMs. The 3 biggest consulting firms have agreements with PBMs - a huge conflict of interest. Ask for disclosure.

Some Drugs To Look For

- Branded drugs with available generics:
  - Nexium (esomeprazole); Crestor (rosuvastatin); Abilify (aripiprazole)

- “Combo drugs”: fixed-dose combinations of drugs that exist over the counter
  - Duexis (ibuprofen + famotidine)
  - Zegerid (omeprazole + sodium bicarbonate)
  - Vimovo (naproxen + esomeprazole)

Some Drugs To Look For

- Me-too drugs”: drugs that have been tweaked to be different from the generic
  - Dexilant (dexlanzoprazole)
  - Glumetza & Fortamet (extended-release metformin)
  - Rexulti (brexpiprazole)

- Low-value dermatological products with better alternatives
  - Jublia (efinaconazole)
  - 5% Lidocaine patch (4% is available over the counter)

There Are Also Policy Options

- Transparency
  - Requiring the price of the drug in advertisements
  - Requiring drug companies to explain the price increases
  - Requiring the drugs to make the drugs available to potential competitors after the patent has ended

More Policy Options

- Preventing pay for delay – paying generic drugs companies to not compete
- Preventing orphan drug abuses – Humira, the best selling drug in the US, also has orphan status – so do 6 of the 10 top selling drugs
- External reference pricing – making sure we know how much other countries are paying for the drug and tying our prices to international prices

More Policy Options

- Changing the rules for patient assistance programs that effectively make the drugs free
- Making it easier to manufacture biosimilars
  - 4 in US 50 in Europe
- Maryland Drug Affordability Board

Develop a Waste Free Formulary