Drug Pricing

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Issue

We recently experienced the largest increase in drug spending in over ten years.[4] According to the IMS Institute for Healthcare Informatics when compared to spending on other "therapeutic classes" of drugs in the United States, dermatologic, oncologic, and autoimmune drugs have remained in the top twenty classes since 2010.[5] Patients are experiencing an increasing cost burden as well with average out of pocket costs for brand medications from commercial plans rising "by more than 25% since 2010."[6] If the patient is not able to afford the drug this can lead to a lowering in adherence to the treatment plan. In 2013 9% of medications were either not approved by a health carrier or never filled by the patient.[7] Lack of continuity of care becomes concerning especially when those who are commercially insured have a higher chance of not continuing with their prescribed medication if they are having to pay more than $250 of their own money.[8]

How a Drug is Priced

Looking more closely at how a price is set it is necessary to first look to the Average Wholesale Price or what is commonly referred to in the media as the list price. Once manufacturers set this price it is used as the starting point for all its negotiations, often times this is not the price that the drug is actually sold at to the other parties. PBMs and wholesalers are privy to certain markdowns when they negotiate with the manufacturers. These markdowns may be negotiated based on the willingness of the buyer to ensure usage of a specific drug, meet certain sales goals, or the speed at a manufacturer is re-compensated *(Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain, 2015).*[9] Most recently, there has been an increase in value based negotiations, where the PBM will increase its reimbursement to the manufacturer if the patients have the same outcomes as those documented in the clinical trials. For drugs dispensed at the pharmacy the insurer or PBM will reimburse the pharmacy based on a negotiated formula between the two parties. In the media there has been scrutiny specifically of PBMs in that the discounts they receive may not be passed onto the patient.

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[4] 2014 Drug Trend Report (March 2015). *IMS Institute for Healthcare Informatics.*
[5] Aitken, M., Kleinrock, M., Lyle, J., Nass, D. & Caskey, L. (2015). Medicines Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014. *IMS Institute for Healthcare Informatics.*
[6] Aitken, M., Kleinrock, M., M. Pennente, K., Lyle, J., Nass, D.& Caskey, L. (2016). Medicines Use and Spending in the U.S.: A Review of 2015 and Outlook to 2020. *IMS Institute for Healthcare Informatics.*
[7] Aitken, M., Kleinrock, M., Lyle, J., & Caskey, L. (2014). Medicines Use and Shifting Costs of Healthcare: A Review of the Use of Medicines in the U.S. in 2013. *IMS Institute for Healthcare Informatics.* Retrieved from http://www.imshealth.com/deployedfiles/imshealth/Global/Content/Corporate/IMS%20Health%20Institute/Reports/Secure/IIHI_US_Use_of_Meds_for_2013.pdf.
[8] Aitken, M., Kleinrock, M., Lyle, J., Nass, D. & Caskey, L. (2015). Medicines Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014. *IMS Institute for Healthcare Informatics.*
[9] Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain. (2005). The Health Strategies Consultancy LLC. Retrieved from http://avalere.com/research/docs/Follow_the_Pill.pdf

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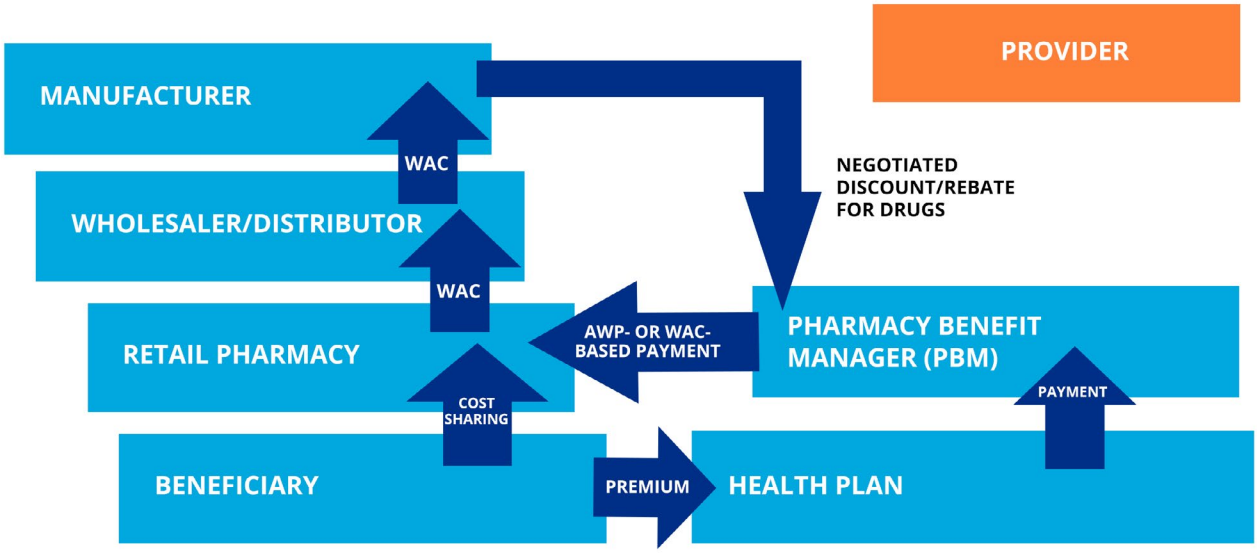
The chart below shows how payments flow between different stakeholders.



For more information, contact the Academy's Practice Management Center:
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