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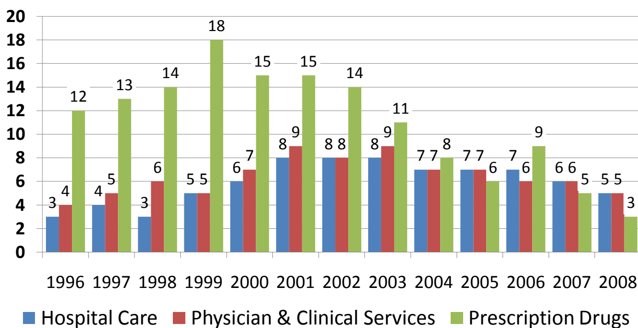
Prescription Drug Trends

Prescription drugs are a vital part of health care plans, and it is important for employers to understand the trends beyond prescription drug costs and what they can do to manage those costs.

Spending in the United States for prescription drugs was $234.1 billion in 2008, more than 6 times the $40.3 billion spent in 1990.[1] Although prescription drug spending has been a relatively small proportion of national health care spending, it has been one of the fastest growing components compared to hospital and physician services. However, due to various trends, the rate of increase in drug spending has declined in recent years. By 2008, the annual rate of increase in prescription spending was 3 percent, compared to 5 percent for hospital care and 5 percent for physician services (Figure 1).

Figure 1: Average Annual Percentage Change in Selected National Health Expenditures, 1996-2008

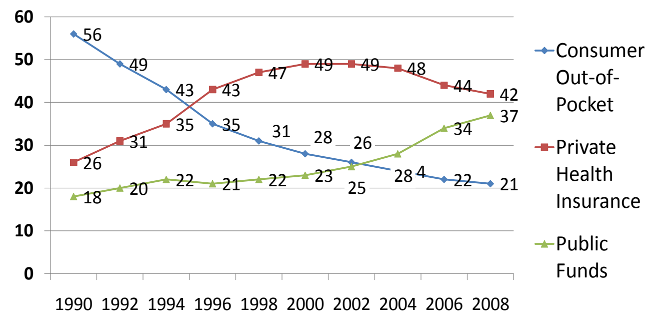


Source: Kaiser Family Foundation calculations using National Health Expenditure historical data from Centers for Medicare & Medicaid Services.

Annual prescription spending growth slowed from 1999 (18 percent) to 2005 (6 percent) because of the increased use of generic drugs, the increase in tiered copayment benefit plans, changes in the types of drugs used and a decrease in the number of new drugs introduced.[2] The annual change in drug spending in 2006 (9 spending) increased as a result of a number of factors, including the implementation of Medicare Part D. The 2007 change in drug spending (5 percent) decelerated because of an increase in the generic dispensing rate, slower growth in prescription drug prices and growing consumer safety concerns about certain drugs.[3] The 2008 drug spending change (3 percent) declined because of a slight decline in per capita use of prescription drugs due to the impact of the recession, a low number of new drug products and safety and efficacy concerns.[4]

As seen below in Figure 2, the share of prescription drug spending paid by private health insurance increased substantially between 1990 and 2005 (from 26 to 48 percent), contributing to a decline in the share that people paid out-of-pocket (from 56 to 24 percent); the public funds (government) share of expenditures increased from 18 to 28 percent in that period. However, the implementation of the Medicare Part D drug benefit in 2006 substantially changed the mix of funding sources, as the government's share rose from 28 to 37 percent between 2005 and 2008, while the private insurance portion fell from 48 to 42 percent, and the consumer out-of-pocket share declined from 24 to 21 percent.

Figure 2: Percent of Total National Prescription Drug Expenditures by Type of Payer, 1990-2008



Source: Kaiser Family Foundation calculations using National Health Expenditure historical data from Centers for Medicare & Medicaid Services.

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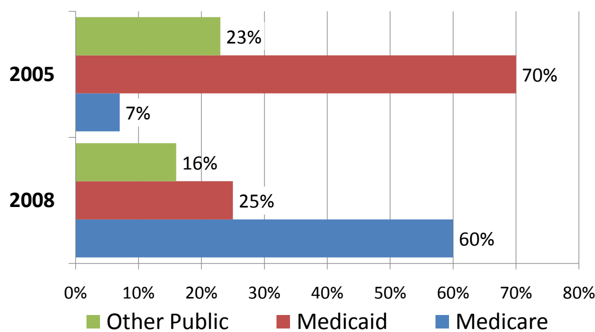
Notes on Figure 2: "Consumer Out-of-Pocket" includes spending by consumers for health care services not covered by a health plan and cost-sharing amounts (coinsurance, copayments, deductibles) from public and private health plans. It does not include consumer premium payments and cost sharing paid by supplementary Medicare policies, which are included in the Private Health Insurance category.

Medicare's and Medicaid's shares of public funding changed when the Medicare drug benefit took effect in 2006. Between 2005 and 2008, Medicare's share grew from 7 to 60 percent, and Medicaid's share fell from 70 to 24 percent (Figure 3), because Medicare replaced Medicaid as the primary source of drug coverage for beneficiaries with coverage under both programs.

Figure 3: Distribution of Total Public Prescription Drug Expenditures by Type of Payer, 2005 & 2008



Source: Kaiser Family Foundation calculations using National Health Expenditures historical data from Centers for Medicare & Medicaid Services.

Factors Driving Changes

A number of factors contribute to changes in prescription drug costs.

Increased Utilization. The number of prescriptions dispensed in the United States in 2009 increased 2.1 percent, a larger growth rate than the 1.0 percent increase in 2008 over 2007. From 1999 to 2009, the number of prescriptions increased 39 percent, compared to a U.S. population growth of 9 percent.[5]

Lack of Adherence. A recent study found that the rate of unfilled prescriptions has increased. Together, health plan denials and patient abandonment resulted in 14.4 percent of all new, commercial plan prescriptions going unfilled in 2009, up 5.5 percent from 2008.[6] A 2009 study found that drug-related morbidity, including poor adherence (not taking medication as prescribed by doctors) and suboptimal prescribing, drug administration and diagnosis, costs as much as $289 billion annually, about 13 percent of total health care expenditures.[7]

Price. Prescription drug prices increased 3.4 percent in 2009, 2.5 percent in 2008, 1.4 percent in 2007 and 4.3 percent in 2006. The average annual growth in prescription drug prices from 2000 to 2009 was 3.6 percent, compared to 4.1 percent for all medical care and 2.5 percent for all items.[8]

Changes in Types of Drugs Used. Prescription drug spending is affected when new drugs enter the market and when existing medications lose patent protection. New drugs can either increase or decrease overall drug spending, depending on price and how the new drug relates to existing drugs on the market (replaces something, is a new treatment, adds competition, etc.). Drug spending is also typically reduced when brand name drugs lose patent protection and face competition from new, cheaper generic substitutes. FDA analysis of 1999-2004 data shows that for products with a large number of generics, the average generic price falls to 20 percent and lower of the branded price.[9] Several high-sales brand name drugs are expected to go off-patent in the next five years. New competition from generic drugs may bring down costs for patients.[10]

Sales and Profitability. Prescription drug sales were $300.3 billion in 2009, an increase of 5.1 percent over 2008. This increase was over double the 1.9 percent increase from 2007 to 2008. IMS Health attributes the 2009 growth to various factors including stronger demand, manufacturing pricing practices, greater use of specialty drugs and fewer product safety issues.[11] IMS Health forecasts a 3 to 6 percent annual growth in the U.S. pharmaceutical market in the next five years.[12]

PPACA Changes Affecting the Pharmaceutical Industry. The Patient Protection and Affordable Care Act, enacted March 23, 2010, includes several provisions that affect the pharmaceutical industry:

- Imposes an annual fee on certain manufacturers and importers of brand name drugs whose branded sales exceed $5 million.
- Establishes a process for FDA licensure of biosimilar (i.e., interchangeable) versions of brand name drug; drugs are granted 12 years of exclusivity before biosimilar versions of a drug can be approved.
- Changes certain drug labeling requirements and requires the HHS Secretary to determine whether adding certain information to a prescription drug's labeling and advertising would improve health care decision-making.

Insurance Coverage

Lack of insurance coverage for prescription drugs can have adverse effects, including not filling prescriptions or skipping doses because of cost. Prescription drug coverage comes from a variety of private and public sources, including employer coverage, individually purchased policies, Medicare and Medicaid.

PPACA Changes Affecting Prescription Drug Coverage. PPACA provisions affecting prescription drug coverage include:

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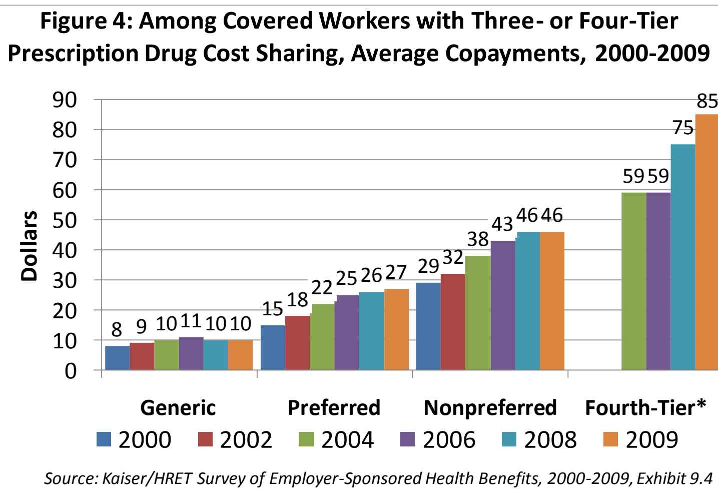
- Significant expansion of coverage to the uninsured. PPACA provides that prescription drugs are one of the "essential health benefits" that must be included in health plans in the new Health Benefit Exchanges and in the benchmark benefit package or benchmark-equivalent for newly eligible adults under Medicaid.
- Rebates, discounts and other benefits for certain Medicare Part D beneficiaries over the next several years

Response

A variety of public and private strategies have been implemented to try to contain rising prescription drug costs.[13]

Utilization Management Strategies. Health plans have responded to rising prescription drug costs by increasing enrollee cost-sharing amounts, using formularies to exclude certain drugs from coverage, applying quantity dispensing limits, requiring prior authorization and using step therapy (starting with the most cost-effective drug and progressing to more costly therapy only if necessary). In 2009, over three-quarters of workers with employer-sponsored coverage were in plans with three or more tiers of cost sharing for prescription drugs, almost 3 times the proportion in 2000 (27 percent).[14] Figure 4 shows worker copayment amounts for three- and four-tier structures.



*Fourth-tier drug copay information was not obtained prior to 2004.

A 2009 survey of individually purchased health policies found that the vast majority had drug benefits, with copayments being the predominant form of cost sharing. All HMOs and the majority of PPO/POS policies charged copayments which averaged, respectively, $10/$13 for generic drugs, $26/$28 for preferred brand name drugs, and $44/$48 for nonformulary drugs. Fewer than half of the PPO/POS policies had a prescription drug deductible, while over half of the HMOs had a drug deductible.[15]

Discounts and Rebates. Private and public drug programs negotiate with pharmaceutical manufacturers (often using contracted organizations known as pharmacy benefit managers) to receive discounts and rebates which are applied based on volume, prompt payment and market share.

Medicaid. Historically, prescription drugs have been one of the fastest-growing Medicaid services. Medicaid spent $19.4 billion for prescription drugs in 2008, an increase of 3.5 percent over 2007.[16]

Medicaid requires drug manufacturers who want to sell their products to Medicaid patients to agree to pay rebates to states for outpatient drugs purchased on behalf of Medicaid beneficiaries. PPACA increases the Medicaid drug rebate percentages for several types of outpatient drugs and requires that the resulting savings be remitted to the federal government.

Medicare. The Medicare Part D drug benefit shifted spending from the private sector and Medicaid to Medicare, making Medicare the nation's largest public payer of prescription drugs (from 7 percent in 2005 to 60 percent in 2008). Medicare prescription drug spending as a share of total U.S. prescription spending rose from 2 percent in 2005 to 22 percent in 2008. Medicare prescription drug spending totaled $52.1 billion in 2008, an increase of 13 percent over 2007.[17]

Purchasing Pools. Some public and private organizations have banded together to form prescription drug purchasing pools which increase their purchasing power through higher volume and shared expertise.[18]

Consumers. Consumers are turning to a variety of methods to reduce their prescription costs,[19] including requesting cheaper drugs or generic drugs, using the Internet and other sources to make price comparisons, using the Internet to purchase drugs, buying at discount stores, buying over-the-counter instead of prescribed drugs, buying drugs in bulk and pill-splitting, using mail-order pharmacies[20] and using pharmaceutical company or state drug assistance programs.

Importation. The high cost of prescriptions has led some to suggest that individuals be permitted to purchase prescription products from distributors in Canada or other countries (it is currently illegal, though it does still happen). Importation issues such as actual savings amounts, drug safety, and marketplace competition and pricing continue to be debated.

Outlook

HHS projects U.S. prescription drug spending to increase from $234.1 billion in 2008 to $457.8 billion in 2019, almost doubling over the 11-year period. The average annual increase in drug spending from the previous year is projected to increase from 3.2 percent in 2008 to 5.2 percent in 2009, and then rise to 7.3 percent in 2019 (reflecting increases in drugs prices, the number of new drug approvals and the share of expensive specialty

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drugs). Drug spending as a percent of overall national health spending is projected to increase somewhat from 10.0 percent in 2008 to 10.2 percent in 2019.[21]

In the coming years, implementation of various provisions of PPACA will affect prescription drug coverage, utilization, prices and regulation.

- Coverage and utilization of prescription drugs will be expanded by PPACA's:
  - Health insurance mandate and premium and cost-sharing subsidies
  - Designation of prescription drugs as an essential health benefit to be covered by private health plans through the new Health Benefit Exchanges and by Medicaid for newly eligible adults
  - Medicare prescription drug rebate, cost-sharing and catastrophic threshold changes.
- Prices charged to government programs will be affected by changes to Medicaid rebate requirements and expansions to the Section 340B program.
- Prescription drug regulation will be affected by the new process for licensure of biosimilar versions of brand name biological products and by drug labeling requirements.

These and other PPACA changes will ultimately impact national spending for prescription drugs in ways yet to be seen.

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1 All spending amounts in this report are in current dollars (i.e., not adjusted for inflation.)

2 Aaron Catlin et al., "National Health Spending In 2005: The Slowdown Continues, "Health Affairs 26, no. 1 (January/February 2007)142-153.

3 Micah Hartman et al., "National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998," Health Affairs 28, no. 1 (January/February 2009) 246-261.

4 Micah Hartman et al., "Health Spending Growth At A Historic Low In 2008," Health Affairs 29, no. 1 (January 2010)147-155.

5 Kaiser Family Foundation calculations using data from IMS Health, www.imshealth.com (Press Room, US Top-Line Industry Data 2008), and Census Bureau, www.census.gov. The per capita number may differ from the number reported at KFF's website www.statehealthfacts.org because of differing data sources which use different retail pharmacy definitions (e.g., IMS Health includes mail order, Verispan does not).

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12 IMS Health Press Release, ibid., April 20, 2010.

13 See also Kaiser Family Foundation, Cost Containment Strategies For Prescription Drugs: Assessing The Evidence In the Literature (March 2005), www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51885.

14 Kaiser Family Foundation and Health Research and Educational Trust, op. cit., Ex. 9.1, http://ehbs.kff.org/?page=charts&id=2&sn=24&ch=1136.

15 America's Health Insurance Plans, Center for Policy and Research, Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits (October 2009), www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.

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17 Ibid.

18 National Conference of State Legislatures, "Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2008 edition" (Updated May 8, 2008), www.ncsl.org/programs/health/bulkrx.htm.

19 Devon Herrick, National Center for Policy Analysis, Shopping for Drugs: 2004, National Center for Policy Analysis, Policy Report No. 270 (October 2004), www.ncpa.org/pub/st/st270.

20 US mail services sales have increased 54 percent since 2003, though their share of total US prescription sales has increased only slightly -- 2007: $44.6 billion in sales, 16 percent of total prescription sales; 2003: $28.9 billion in sales, 13 percent of total prescription sales. IMS Health, www.imshealth.com (About Us, Press Room, US Top-Line Industry Data, 2007 U.S).

21 Christopher J. Truffer et al. "Health Spending Projections Through 2019: The Recession's Impact Continues," Health Affairs 29, no.3 (March 2010), 522-529.

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