Drug Costs Driven By Rebates

OVER $100 BILLION IN PRICE CUTS GO DIRECTLY TO INSURERS, NOT PATIENTS

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Most of the Increase in Drug Spending Were Rebates Pocketed by PBMs

By Robert Goldberg, PhD

Media coverage of the The IMS Institute for Health Informatics study: “Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020” focused mainly at the change in top-line drug spending from 2014-2015. That approach, as I have suggested in the past, is uniquely unrevealing.

Spending on drugs in the outpatient, hospital and nursing homes was $425 billion. However, the drug and biotech companies made $310 billion of that total. Where did the other $125 billion go?¹ The vast majority of articles don’t tell.

In fact, that spread – which has gotten larger in both total dollars and as a percentage of the increase in drug spending flows directly to insurers, pharmacy benefit managers, hospitals and employers, not the patient. Anthem is suing Express Scripts, the largest PBM, because it alleges the PBM did not give it about $12 billion in drug rebates over the past 4 years. That’s on top on the billions they were already receiving.²

Follow the Money and the Prices

The Anthem lawsuit and complaint provides a rare glimpse of how rebates have become a major source of revenue for every organization paying for or delivering health care.

To find out why such rebates aren’t going directly to the consumer, you have to follow the money and the difference in prices net of rebates and the invoice or retail price. The amount of prescription drug revenue pouring into such ‘stakeholders’ has increased since Obamacare began taking effect. Net price increases have actually dropped by half since 2011. As the IMS study observes: “The average net price for brands already in the market is estimated to have increased by 2.8% in 2015, down from 5.1% in 2014 and significantly lower than seen in prior years.”³

¹ Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020, page 1
² http://usat.ly/1Wd0Vuu
³ Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020 page 2
Meanwhile, the increase in rebates as a share of price growth surged. As the charts above and below reveal, rebates as percent of total price growth increased ten fold since 2011.

Data source: Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020
Further analysis shows that rebates were $10.8 billion (40 %) of the total increase in specialty drug spending between 2014-15. As a percent of all brand medicine spending, \textit{rebates were 71 percent of the total increase from 2014-2015. This means much of the price increase imposed on patients reflects the cost of rebates that PBMs and other claim make medicines ‘affordable’}.

\textbf{Patient Cost Sharing Increases as Rebate Revenue Soars}

Even as the share of drug spending as a percent of rebates has soared and the contribution of net price increases to spending has declined, PBMs and insurers have increased cost sharing by more than 25% since 2010.\textsuperscript{4}

Patient cost sharing is a percent of the ‘invoice’ or retail price, not the net or rebated price. This suggests that rebate dollars are not passed through directly to patients.

As IMS points out...”in response to this rising level of patient cost exposure, brand manufacturers are steadily increasing their use of “buy-downs” through patient savings programs such as coupons or vouchers, to help patients offset these costs.

\textsuperscript{4} Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020, page 27
Even after coupons are applied, patients with pharmacy deductible plans are still facing high cost exposure.”

Even worse, the percent of patients facing cost sharing of up to 40 percent of a retail price has soared even as rebate revenue increased. And the number of drugs with the highest cost sharing amount also generate the most rebates.

A recent study found that many insurers – with help from the PBMs that design drug formularies and cost sharing “....placed all drugs in a class on the specialty tier. Specifically, in the Protease Inhibitor and Multiple Sclerosis Agents classes, 29 and 51 percent of plans respectively place all drugs, including available generics, on the highest tier. There are no generics in the other three classes of drugs listed below.”

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5 Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020, page 27

Specifically, in 8 of the 10 classes, 2015 exchange plans were more likely than 2014 plans to assign all single-source branded drugs to the highest cost sharing tier. A single-source branded medication is a brand name drug without a generic equivalent. The practice was most common for some cancer drugs and drugs used to treat multiple sclerosis. Roughly 30 percent of plans also place all single-source drugs for HIV/AIDS on the specialty tier.7

**Conclusion: The Real Source of High Drug Costs**

The real story about drug pricing is how PBMs like Express Scripts and health plans are pocketing about a bigger and bigger share of drug revenues while increasing what patients – especially those with the greatest need for the newest drugs generating the biggest rebates – are seeing their share of the invoice price of a medicine surge.

The outrage about high drug prices is directed at biopharmaceutical firms. But the IMS study suggests that the $100 billion in rebates and discounts that could reduce the out of pocket cost of consumers is taken by $100 PBMs, insurers and hospitals. And to add insult to injury, these organizations turn around and charge consumers retail price and require them to pay an increasingly greater share of that cost.

The fact that such practices not only increase PBM, insurer, etc. revenues but deny people access to new medicines – that in turn increase the risk of staying sicker or getting sicker --

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7 ibid.
should be a big story. Why aren't media outlets and policymakers focusing on the real source of high drug costs?