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Rising pharmacy costs – drivers and containment strategies

After a decade of single-digit increases, annual prescription drug spending jumped by 13% in 2014. This sudden, surprising shift was due to a number of variables that will continue to affect spending in the coming years. We examine the leading causes: consolidations[1] and mergers, specialty pharmaceuticals[2], and companies who are hiking prices to maximize value to their shareholders[3].

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At Munich Health North America (part of Munich Re), we have seen a significant increase in specialty pharmaceuticals as a driver of reinsurance recoveries. These high-price drugs include Recombinant Factor VIII, prescribed for Hemophilia; H.P. Acthar, for Multiple Sclerosis; Soliris, for PNH Disorder; and Vimizim for Progressive Metabolic Disorder. New claims from Hepatitis C treatments currently average about $150,000 per claimant. With a rising number of claimants now being treated for Hep C, the "Cost x Incidence" figures have been astounding".

However these numbers are part of a much larger story, as illustrated by the recent spike in annual prescription drug spending. The following provides an overview of the trends behind these rising costs.

Defining "Specialty Pharmaceuticals"

Although there is no official definition for the term, "specialty pharmaceuticals," it generally applies to drugs administered by injection or infusion. The term can also apply to any drug costing over $600 per dose.

These drugs treat conditions, such as hemophilia, cancer, rheumatoid arthritis, HIV, multiple sclerosis, and Hepatitis C. And they represent a large percentage of prescription drug spending. After a decade of single-digit increases, annual prescription drug spending jumped by 13% in 2014[4]. The increase was largely fueled by a 30.9% increase in spending on specialty pharmaceuticals. Without compound medications and Hep C therapies, drug spending would have increased by just 6.4%[4].

The Price of Wonder Drugs: Wall Street, Cairo, and California

The investment community has hailed the manufacturers of the latest "miracle cures" for Hepatitis C – Sovaldi, Olysio, and Harvoni, but payors are devastated by the costs of these treatments[5]. In the U.S., for example, Sovaldi costs up to $150,000 per treatment. In Egypt, where more than 12 million patients are infected with Hep C, the same treatment costs only $300. Hep C drugs devastated health plan budgets in 2014. Health plans, particularly those connected with Medicaid, are pushing back. In a recent San Francisco Chronicle article, one healthcare CEO voiced his frustration:

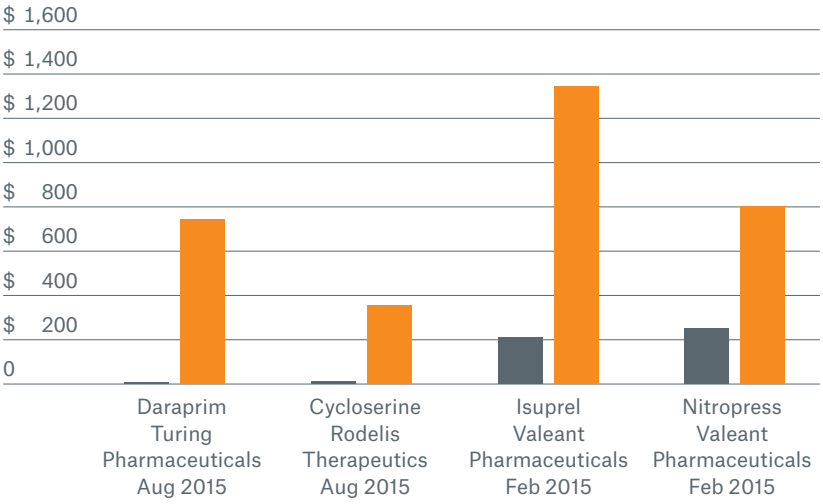
"You can cover, in California, probably 25 people with health insurance on Medicaid for one year for what it costs to treat one patient with Sovaldi," said Dr. J. Mario Molina, CEO of Molina Healthcare in Long Beach, which has 2 million Medicaid members nationwide.

Medicare data released in 2015 shows that other costly drugs account for more than a quarter of prescription drug spending for the elderly and disabled, even though they help only a small percentage of patients. Claims paid in 2013 reveal that, out of nearly 3,500 drugs prescribed, roughly 400, with a cost of $3,000 or more per beneficiary, added up to $26.5 billion. Revlimid, a blood cancer drug, and Copaxone, for MS, accounted for 26% of total spending, but just 1% of claims, according to the Wall Street Journal.

The Effects of Acquisitions

Several pharmaceutical company acquisitions have been in the news this past year. In one instance, Valeant Pharmaceuticals bought the rights to Nitropress and Isuprel, a pair of lifesaving heart drugs on February 10, 2015. On the same day, according to the Wall Street Journal, the list prices of these drugs rose by 525% and 212%, respectively. There was no change to the formulas, no new high-tech manufacturing facility, and no additional investment in research or laboratory testing. The only change was the ownership. According to a Valeant spokesperson, "Our duty is to our shareholders and to maximize the value." In another instance, Rodelis Therapeutics acquired the rights for Cycloserine, a drug used to treat Tuberculosis, and increased the price by 2160%. After the topic was picked up by major newspapers and politics the company announced only one month later that they return the rights of Cycloserine to the previous owner, The Chao Center[6].

Increase in average retail price after acquisition



Sources: Truven Health Analytics, Wall Street Journal, New York Times, Catamaran Rx

Pharmacy Benefit Managers: Acquisitions, Loyalties, and Spread Pricing

Pharmacy benefit managers (PBMs) are third-party administrators that contract with health plans and employers to process pharmacy claims. The 2015 acquisition of Catamaran, a PBM acquired by UnitedHealth Group for $10.5B may indicate that health plans view PBM acquisition as a way to control costs and manage profits.

The nation's three largest PBMs – Express Scripts, CVS Caremark, and OptumRx – control about 80% of the market.

Although PBMs have succeeded in delivering value to their shareholders, their value to clients is often compromised by the widespread practice of spread pricing, where PBMs buy drugs wholesale from pharmacies and manufacturers, mark up the prices for clients, and keep the difference. The amount of spread is not apparent to a PBM's customers[7].

Usage Trends

Within the reinsurance industry MHNA has seen a 90–10 rule: 10% of the population drives 90% of the cost. At Munich Re, we plan according to a 30–3 rule for specialty pharmacy: only 3% of the total pharmacy prescriptions are considered specialty, but cost 30% of a plan's overall pharmacy expense. These costs are expected to increase; according to most industry estimates, specialty drugs will represent over 50% of total pharmacy costs by 2017.

A number of factors are driving the rising use of specialty pharmaceuticals. One cause is our aging population – people over age 65 consume three to four times more drugs than those under 65. New medical guidelines, which call for more aggressive and earlier treatments, also contribute to the uptick in spending. Another reason is that manufacturers are making compliance easier for patients, by switching from injectable formulas to pill formats, for example. Direct-to-consumer advertising is increasing patient awareness.

And an increase in testing, even for asymptomatic patients, means that more disorders can be diagnosed.

One of the biggest reasons for the increased use of specialty drugs is the growing number of patients who need them. According to recent statistics, each American has a 50% chance of developing at least one chronic illness in his or her lifetime. One-third of Americans are obese, which is a leading contributing factor to most chronic conditions. One in three American adults will develop cancer in his or her lifetime[8]. And millions more are already diagnosed with a number of chronic conditions:

- 37 million Americans are contending with high cholesterol[9].
- 400,000 suffer from MS[10].
- 20,000 are hemophiliacs[11].
- 50 million adults (one in five) have been diagnosed with arthritis[12].

Medical Versus Pharmacy Benefit

It can be difficult for many health plans and employers to see a clear picture of the specialty pharmacy costs that are embedded in their medical benefit costs. Overall, 50% of specialty drug spending is administered under the pharmacy benefit; the remainder falls under the medical benefit.

However, this varies significantly by clinical condition. For example, in 2014 UnitedHealth Group reported a 65% share covered under the medical benefit for oncology and only 10% covered under medical benefit for Multiple Sclerosis[13].

The site of care also highly influences specialty drug spending within the medical benefit. While *physician* administration of injectable cancer drugs remained flat from 2008–2013, UnitedHealth Group[13] observed a marked increase in cost per-member, per-month for the same drugs that were *facility* dispensed.

Conclusion

With so many factors influencing drug spending, it can be a daunting prospect for health plans and employers to find ways to manage their costs while providing benefits to their members/employees. Outside of negotiating best pricing, MHNA has identified a number of clinical and cost-containment measures emerging to meet this need:

- Automated prior authorization
- Prospective clinical care management/adherence
- Days supply limits
- Restricted/exclusive distribution network
- Separate SPD/ policies from base PBM benefit
- Preferred products or restricted formulary
- Step therapy programs
- Specialty Rx co-pay/coinsurance tier

More advanced strategies may include genetic testing, parity pricing for pharmacy and medical benefits, and "site of care channeling" to ensure that prescriptions are provided at the lowest possible cost. Reviewing high-priced drug spending by site of care, and deploying strategies that reduce the markup of drugs within particular settings, can significantly lower a health plan's costs.

Drug costs are trending at an all-time high, and as the most encountered benefit within any plan, it affects both first-dollar and reinsurance exposures. Pharmacy trend is a complex problem with multiple causes, but ultimately, greater transparency and stronger management are the best solutions to address it.

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