FOLLOW THE DOLLAR: UNDERSTANDING HOW THE PHARMACEUTICAL DISTRIBUTION AND PAYMENT SYSTEM SHAPES THE PRICES OF MEDICINES

A medicine's path from the biopharmaceutical company to the patient is complex and involves many entities across the biopharmaceutical supply chain. Examining how money flows through this system – which includes wholesalers, pharmacy benefit managers (PBMs), pharmacies and insurers – and how that impacts what patients pay at the pharmacy can help consumers and policymakers find answers to their questions about affordability and access to medicines.

The prices wholesalers, pharmacies, PBMs, insurers and patients pay for a medicine all vary and are shaped by negotiations in the supply chain. In recent years, negotiated rebates have increased significantly. For example, in 2015, more than one-third of a brand medicine's list price was rebated back to health plans or the government or kept by other stakeholders.[i] Continued growth in rebates, discounts and other reductions in price provided by biopharmaceutical companies—which now exceed $150 billion per year—have kept payers' prices for brand medicines climbing at modest rates, despite more rapid growth in publicly reported list prices.[ii,iii] In fact, after accounting for all discounts and rebates, prices for brand medicines grew just 1.9 percent in 2017—slower than the rate of inflation.[iv]

But even though discounts and rebates are growing each year, insurers are dramatically increasing the share patients are required to pay out of pocket. At the pharmacy, commercially insured patients with a deductible have seen their out-of-pocket costs for brand medicines increase 50 percent since 2014. One reason these costs are increasing is because discounts and rebates provided by brand manufacturers do not flow directly to the patients taking the medicine. Large deductibles and coinsurance can create affordability challenges for patients, as these types of cost-sharing are typically based on a medicine's full, undiscounted price. In 2017, 55 percent of patients' out-of-pocket spending on brand medicines was for prescriptions filled in the deductible or with coinsurance rather than with a fixed copay—a 20 percent increase since 2013.[v]

The hypothetical patient profile below illustrates how patients often do not benefit from negotiated discounts and rebates and how they may end up paying more than their insurer for their medicine. This needs to change. Patients should benefit more from negotiated rates in the form of lower out-of-pocket costs at the pharmacy, like they do for other types of health care services. Sharing rebates with patients at the pharmacy could save certain commercially insured patients with high deductibles and coinsurance $145 to more than $800 annually.[vi]

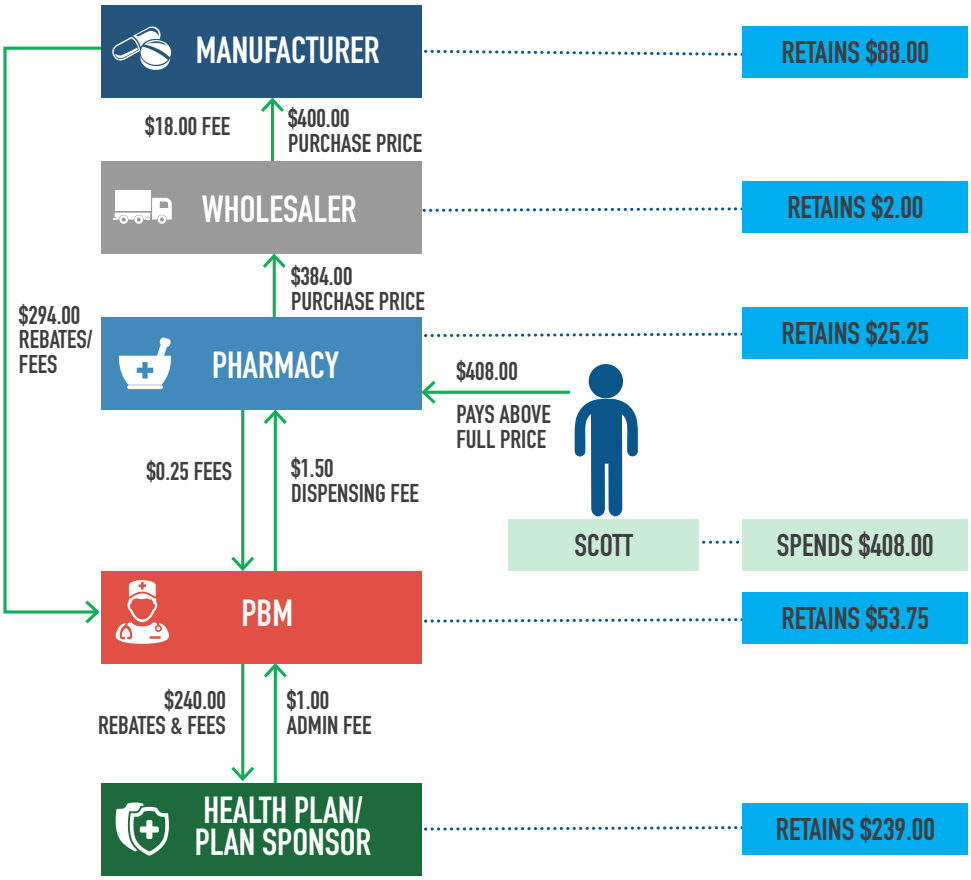
PATIENT PROFILE: SCOTT

Scott takes insulin for his type 2 diabetes and has a health plan with a high deductible. Prior to meeting his deductible each year, he pays $408.00—more than the full undiscounted cost of his medicine—even though his health plan receives a rebate from the biopharmaceutical company that reduces the list price by 65 percent. Scott is paying the amount that is contracted between the health plan and the PBM, which in this case is higher than the list price of the medicine. Although the health plan does not pay for Scott's insulin while he is in his deductible, it still receives the negotiated rebate and earns $239 per prescription. The PBM earns $53.75, including fees and a share of the rebate it negotiated, while the manufacturer retains $88.00.

FLOW OF PAYMENT FOR A $400 INSULIN

(PATIENT IS IN DEDUCTIBLE PHASE)

This graphic is illustrative of a hypothetical product with a WAC of $400 and a AWP of $480. It is not intended to represent every financial relationship in the marketplace.



Although PBMs and other intermediaries say they prefer lower list prices, in many cases the system creates incentives for them to prefer medicines with higher list prices and higher rebates. As a result, some industry observers and government agencies have questioned whether insurers and PBMs are more focused on the size of rebates than on achieving the lowest possible costs and best outcomes for patients.[vii]

As the market begins to move in the direction of a system that better aligns the price of prescription medicines with their value, biopharmaceutical companies are working with private health insurers to implement new payment arrangements for a variety of diseases. These innovative and flexible ways to pay for medicines could lower out-of-pocket costs and enable patients to access the right treatments the first time.

i Vandervelde A, Blalock E; Berkeley Research Group. The pharmaceutical supply chain: gross drug expenditures realized by stakeholders. 2017. http://www.thinkbrg.com/media/publication/863_Vandervelde_PhRMA-January-2017_WEB-FINAL.pdf

ii Ibid.

iii AJ Fein; Pembroke Consulting, Inc. Drug Channels Institute. "The Gross-to-Net Bubble Topped $150 Billion in 2017." April 2018. https://www.drugchannels.net/2018/04/the-gross-to-net-rebate-bubble-topped.html

iv IQVIA Institute for Human Data Science. Medicine use and spending in the U.S.: A review of 2017 and outlook to 2022. https://www.iqvia.com/institute/reports/medicine-use-and-spending-in-the-us-review-of-2017-outlook-to-2022. Published April 19, 2018. Accessed April 2018.

v IQVIA. Patient Affordability Part One: The Implications of Changing Benefit-Designs and High Cost Sharing. May 2018 https://www.iqvia.com/locations/united-states/patient-affordability-part-one

vi Milliman. Point of Sale Rebate Analysis in the Commercial Market: Sharing Rebates May Lower Patient Costs and Likely Has Minimal Impact on Patients. October 2017. https://www.phrma.org/reports/milliman-sharing-rebates

vii Ibid.