UNDERSTANDING THE PHARMACEUTICAL DISTRIBUTION AND PAYMENT SYSTEM AND HOW IT COULD WORK BETTER FOR PATIENTS

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.

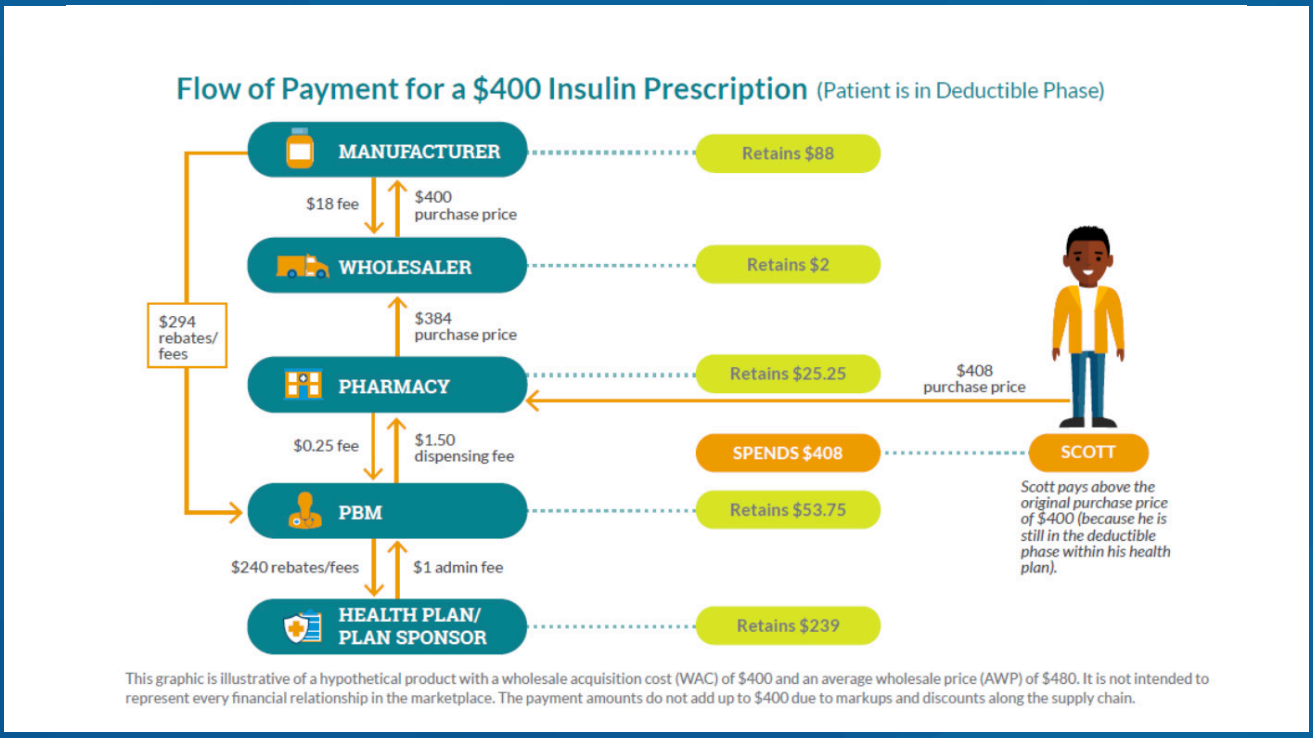
The prices wholesalers, pharmacies, PBMs, insurers and patients pay for a medicine all vary and are shaped by negotiations among supply chain entities. In recent years, rebates negotiated between payers and biopharmaceutical companies have increased significantly. On average, over 40% of a brand medicine's list price is 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 $160 billion per year—have kept payers' prices for brand medicines climbing at modest rates, despite more rapid growth in publicly reported list prices.[II]

After accounting for all discounts and rebates, prices for brand medicines grew just 0.3% in 2018 – the slowest rate in years and slower than the rate of inflation.[III] But even though discounts and rebates for brand medicines are growing each year, insurers increasingly require patients to pay for a larger share of their medicines out-of-pocket. At the pharmacy, commercially insured patients with a deductible have seen their out-of-pocket costs for brand medicines increase 50% since 2014. One reason that it seems as if the costs of medicines are going up is because discounts and rebates provided by biopharmaceutical companies do not flow directly to the patients taking the medicine. Large deductibles and prescriptions that require coinsurance pose particular challenges, as these types of cost sharing are typically based on a medicine's full, undiscounted price. More than 50% of patients' out-of-pocket spending on brand medicines in 2017 was for prescriptions filled in the deductible or with coinsurance rather than with a fixed copay—a 20% increase since 2013.[IV]

The hypothetical patient profile below illustrates how patients often do not benefit from discounts and rebates negotiated between biopharmaceutical companies and payers, and how patients may end up paying more than their insurer for their medicine as a result.

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. 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.



A medicine's rebate—rather than its list price—generally determines if it is covered or where it sits on a formulary. This creates an unfair system in which patients are often paying based on higher list prices, regardless of the discount their insurer receives. The system can incentivize PBMs and others in the supply chain to favor medicines with high list prices and rebates.[V, VI] Cost sharing based on the list price can hurt patients and increase costs. This must change. Alleviating distortions in the current supply chain could help the system work better for patients.

- In Medicare Part D, ensuring discounts are reflected in patient cost sharing at the pharmacy counter would lower patient out-of-pocket costs for many beneficiaries. For example, a typical diabetes patient taking five medicines could save about $1,000 a year in out-of-pocket costs.[VII]
- Sharing rebates with patients at the pharmacy could save certain commercially insured patients with high deductibles and coinsurance $145 to more than $800 annually, while increasing premiums by just about 1% or less.[VIII]
- Lower cost sharing would lead to improved adherence and lower costs for Medicare. A recent study by IHS Markit found that passing through a share of rebates just for diabetes medicines alone could reduce overall health care spending (including Parts A and B) for Medicare beneficiaries with diabetes by $20B over the next 10 years.[IX]

Rebates and other price concessions that payers negotiate with biopharmaceutical companies should be used to lower cost sharing for medicines at the pharmacy. Additionally, reforms to prevent PBMs and others in the supply chain from being compensated based on the list price of a medicine—and to instead receive a fee based on the value their services provide—could address misaligned incentives in the supply chain and help the system work better for patients.

I Health. U.S. brand Rx net price tool- 1Q19. Accessed May 2019.

II Fein, Adam J., The 2019 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute, 2019. .

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IV 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

V Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees. 84 Fed. Reg. 2340, 2341 (Feb. 6, 2019)

VI Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. Chapter 14: The Medicare Prescription Drug Program (Part D): Status Report. March 2018; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program. 82 Fed Reg, 56336 (Nov. 28, 2017).

VII Holcomb K, Klein M. Medicare Part D Diabetic Member Cost-Sharing: Impact on Non-Low Income Members. Milliman. February 2019. Available at: http://www.milliman.com/uploadedFiles/insight/2019/medicare-part-d-diabetic-cost-sharing.pdf

VIII 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

IX IHS Markit. Passing a Portion of Negotiated Rebates Through to Seniors with Diabetes Can Improve Adherence and Generate Savings in Medicare. May 14, 2018.