Prescription drug cost crisis

The fight for lower-cost prescription drugs

By Ruth Susswein

There are few issues that Americans agree upon more than this: The cost of prescription drugs is out of control. Drug prices are ballooning inexplicably and consumers are fed up. Some consumers are taking matters into their own hands and are caravanning to Canada for cheaper drug prices.

Outrage over skyrocketing prescription drug prices has drawn such consensus that Congress has been pumping out potential solutions to mounting prices in a multitude of new bills.

The problem

The average annual cost of brand-name drugs has more than tripled in the last 10 years, according to the AARP Public Policy Institute. While drug manufacturers argue that prices rise to cover the cost of research and development for new treatments and drugs, it does not account for the large percentage of taxpayer-funded research and development dollars provided by the National Institutes of Health. Nor does it explain dramatic price hikes in older medicines that have not changed in many years.

The list price for the life-saving drug insulin has risen 600% since 2002. These price hikes on a nearly century-old drug are forcing some diabetics to dangerously ration their insulin. A 2019 survey confirms previous studies’ findings that one in four U.S. diabetics has felt forced to ration their insulin.

Limiting insulin doses can be life threatening. In May, Colorado capped the price of insulin copayments (at $100 a month) for those with insurance. The law does not cover all diabetics, or even all insured diabetics, but it is the first state action to curb insulin price gouging.

Humira, a drug used to treat arthritis, colitis, psoriasis and Crohn’s disease, cost $19,000 per year in 2012. The same drug in 2018 cost $38,000 annually—with no plausible explanation from parent company AbbVie Inc.

Price spikes have hit senior citizens particularly hard—even those with Medicare drug coverage—because older Americans take four to five prescription medicines per month, on average. AARP says that its not unusual to find seniors facing costs of $30,000 a year for brand-name drugs.

There are a few factors that have led to this broken market. Federal law currently prohibits the Secretary of Health and Human Services from negotiating prescription drug prices for the tens of millions of consumers who participate in Medicare’s drug programs, despite the fact that Medicare Part B and Part D plans account for 30% of drug spending in the U.S.

Patent abuse keeps drug prices artificially high and generic drugs off the market. Drugmakers are entitled to hold patents on the new drugs they create to compensate them for the cost of developing new treatments for chronic conditions and deadly diseases. This gives drug manufacturers exclusive rights to sell a medication, often for 20 years. However, drug companies have a history of tweaking their patents to extend their monopoly control over the market and keep the competition out.

Drug companies also participate in “pay-for-delay” deals, in which they pay generic drugmakers to delay bringing much lower-cost versions of the drug to market. For more on these issues, see “Attacking barriers to lower drug prices,” at upper right.

Pharmacy benefit managers (PBMs)—the middlemen in this complex system—have also come under criticism. They are supposed to help reduce drug costs by controlling which prescription drugs are approved for insurance.

See “Fight” on page 3

Monopoly pricing. Once the FDA approves a drug for market, the company that owns it can begin selling it at virtually any price it chooses. Public Citizen explains (http://bit.ly/2aCt3Oh) that patent law and regulatory protections allow pharmaceutical pricing practices to go virtually unchecked. As a result, Americans pay the highest drug prices.

See “Barriers” on page 4

Attacking barriers to lower drug prices

By Monica Steinisch

Considering the outcry by consumers, advocacy groups and lawmakers for lower drug prices, it’s difficult to understand why there hasn’t been greater progress on controlling soaring prescription costs. Here are some of the major impediments to affordable prescriptions.

A bitter pill

Cost of medicine leaves little for basic necessities

By Lauren Hall

The public is angry and desperate over ballooning drug prices. Pharmaceutical company executives are enjoying record profits after raising the prices of more than 3,400 drugs in 2019 alone. Meanwhile, individuals and families have been forced to choose between tending to their health and paying for basic necessities.

Consumer Action conducted a survey of more than 100 organizations this year to determine the impact of high drug costs on our network of community-based organizations and their clients. A whopping 85% of respondents stated that they or their clients were burdened by high drug prices. Perhaps most startling, more than three-quarters (77%) reported that their clients were forgoing needed goods and services to pay for their medications, with the vast majority (over 60%) cutting back on food.

Survey respondents said that, due to high drug costs, they or their clients had purchased drugs from a foreign country (over half from Mexico, approximately 65% from Canada, and another 37% from other countries). The survey revealed that 88% of respondents did not know how to tell whether they were buying drugs from an official pharmacy when they bought drugs online. Furthermore, about 37% said that, due to high prices, their
An unseen hand in prescription drug pricing

By Alegra Howard

T here are powerful middlemen at work who have the power to decide which drugs you get—if any—and at what price.

Prior to the late 1960s, health insurers would negotiate the price of prescription drugs directly with pharmaceutical companies. That changed when, in an effort to save money, insurance companies began outsourcing the management of prescription drugs to pharmacy benefit managers, or PBMs.

Today, just three companies control more than 85% of the PBM marketplace: Express Scripts, CVS Health Corporation (formerly CVS Caremark) and OptumRx (a part of United-Health Group).

These middlemen negotiate pricing with pharmaceutical companies and have the power to decide which drugs will be approved for insurance coverage (and when to cover them). This affects not only the affordability of prescription drugs for consumers but how and how much they pay for them. PBMs also contract with pharmacies to distribute medicines to patients, handle drug payments and oversee an opaque rebate system for drug discounts.

PBMs negotiate the price of drugs for health insurers, Medicare Part D plans, the Federal Employees Health Benefits Program and state government employee health plans. PBMs influence both the choice of medications used and the price. Drug choice is affected by whether a drug makes the list of drugs reimbursable by insurance plans (the plan’s ‘formulary’). PBMs receive price discounts and rebates from drug manufacturers when they include certain medications on the list of approved drugs. These discounts and rebates are passed on, in part, to health plans. An unknown amount remains with the PBM.

While the PBM’s role was supposed to result in more bargaining power and a reduction in drug costs for insurers and consumers, there is a growing question as to how much money PBMs actually save patients versus how much these middlemen profit. As a drug’s list price grows, so does the amount of revenue PBMs receive from drugmakers in the form of rebates. However, pricing and rebate information is usually secret.

(Read more about rebates in “Attacking barriers to lower drug prices,” online.)

In the interest of saving insurance companies money, PBMs can also require that patients jump through multiple hoops (http://bit.ly/2nf9cG4) before they are allowed to receive a medication prescribed by their doctor. Sometimes patients are required to receive special authorization to ensure that their coverage is free for particular drugs, or they must try a less expensive medication before receiving the one their doctor actually prescribed, a practice known as “fail first.” Often, patients just don’t get the drug their doctor prescribed because the authorization process for “off-formulary” drugs is so daunting.

Critics cite controversial practices like “clawbacks” (http://bit.ly/2lGOluR), overpayments that occur when insured patients’ copays exceed the total cost of the prescription, and “price spreading,” when PBMs pocket the negotiated cost savings instead of sharing it with patients, as proof that these powerful middlemen are simply in it for the large profits, and aren’t interested in cutting prescription drug costs for consumers.

Critics blame weak government oversight as the primary reason PBMs wield such power over drug pricing.

In the 1990s, pharmaceutical companies began buying PBMs, fostering a blatant conflict of interest. The Federal Trade Commission eventually cracked down on the drug companies by forcing drugmakers to sell their affiliated PBMs.

In the last decade, pharmaceutical companies have purchased PBMs for high fees and poor performance. PBMs are also attracting new players. CVS Health Corporation—a major PBM—purchased the health insurer Aetna in a recently approved deal opposed by Consumer Action and other public and patient interest groups.

Merging these types of companies presents a conflict of interest that can greatly disadvantage consumers who may be forced to pay higher drug prices, or who could be steered into affiliated pharmacies, which are usually huge chains rather than small pharmacies that may be more convenient for patients.

This was the case after the 2007 CVS pharmacy merger with the PBM Caremark. Before the merger, only 12% of CVS’s retail prescription revenue came from Caremark. By 2014, that figure had tripled to 35% (http://bit.ly/2qPgCo).

As Big Pharma, PBMs and insurers are seeing their annual profits rise into the billions, Americans continue to pay more for prescription drugs than any other country, and drug costs continue to rise relatively unchallenged. The pharmacy benefit manager business model is more transparent and closely aligned with the interests of patients, consumers will be at the mercy of this hidden hand.

Despite opposition, CVS-Aetna merger is approved

Late last year, the national drugstore chain CVS purchased health insurer Aetna for $69 billion. In early September, a judge signed off on the merger, allowing CVS to retain its tens of thousands of retail pharmacy outlets, its status as a powerful pharmacy benefit manager (PBM) making drug coverage decisions and negotiating drug prices for health insurers, and making it one of the country’s largest health insurers.

Consumer Action joined the American Medical Association, the Alzheimer’s Association, the American Heart Association, and U.S. PRIG as friends of the court (amicus) to oppose the merger on behalf of the millions of consumers who now stand to see higher drug prices and restricted pharmacy access.

In his initial review of the merger, Judge Richard Leon of the U.S. District Court in Washington, D.C., raised concerns by delaying his decision in order to hold a hearing with testimony from both sides of the deal.

As one massive healthcare company, CVS-Aetna could crush the competition and leave consumers with little choice on price and market options. Given the lack of data on drug supply transparency in PBM contracts (see above), further concentration of power in industries that already lack competition could mean higher drug prices for consumers and a lack of pharmacy choice for those in Aetna health plans. It’s also feared that CVS could give Aetna what has so far been proprietary information that could disadvan-
tage patient health privacy and harm competitors’ businesses.

Prior to Judge Leon’s recent approval, the U.S. Department of Justice (DOJ) had signed off on the CVS-Aetna merger. The DOJ’s consent is required for large acquisitions, in order to prevent monopolies and anticompetitive deals. The DOJ ordered Aetna into a consent decree to sell off its Medicare prescription drug (Part D) business to WellCare Health Plans, a specialty pharmacy benefit manager—a significant conflict of interest.

However, while Judge Leon allowed testimony on behalf of amici, and criticized the DOJ for its very narrow consent decree, he ultimately sided with the deal. Enrollees in Aetna’s Medicare drug plans recently were notified that they will be covered by WellCare.
Programs help families with drug coverage

By Lauren Hall

Despite criticism from opponents, and congres
sional administration efforts to ax it, the Patient Protec
tion and Affordable Care Act (or ACA) has successfully expanded health insurance and, by exten
tion, prescription drug coverage. The ACA, still called Obamacare by many, mandates that qualified health plans provide prescription drug coverage as one of 10 “es
tential health benefits.”

The ACA (enacted in 2010, un
der the Obama Administration) has been particularly beneficial to low-income individuals and families, those with pre-existing conditions, and young adults. Continuers have been fueled by expanded state Medicaid pro
grams and the extended period during which dependents can be covered by their parents’ insurance (up to age 26). The ACA has given states the option to extend Medicaid eligibility to nearly all individuals with incomes at or below 138% of the federal poverty level. (As of March, 14 GOP-led states have continued to refuse to expand Medicaid.)

Due in no small part to the ACA, the nation’s uninsured rate hit a historic low of 8.8% in 2016, and again in 2017. Another federally funded initiative, the Children’s Health Insurance Program (CHIP), offers low-cost health coverage to children in households with incomes too high to qualify for Medicaid. State rules vary on who qualifies for CHIP and what is covered, but certain fund
damental elements remain the same: Doctor visits, vaccines and prescriptions are covered.

Premium dollars returned

Another ACA requirement that helps consumers financially and encourages insurance plans to use premi
um dollars wisely is the 85/15 medical loss ratio. This provision states that if a health insurer spends less than 85% of local premiums on benefits, it must return the excess premiums to policyholders.

Health plans provide prescription drug

Continued from page 1

coverage and by negotiating

coverage, especially for Medicare Part

D drug plan enrollees.

Genetics. Prohibit pay-for

delay, and cap patient exposure of which could encourage generic versions of drugs to come to market quicker.

International reference price.

Boards require PBMs to

price drugs on what other developed countries are paying.

Imports. Allow drugs to be

imported from Canada in cases

where there would be significant

savings for U.S. residents.

Rebates. Require PBMs to

pass rebates on to group health

plans who self-fund

their supplies due to costs.

Cap consumer costs.

Cap consumers’ out-of-pocket spend

ing, especially for Medicare Part D plan enrollees.

Some solutions

While there’s tremendous con

sensus that a drug pricing crisis exists, there’s no one solution. Here are some proposals that would have a positive impact on the people directly affected. (For
details, see “Attacking barriers to lower drug prices,” on page 1.)

Government negotiation.

Give the government the ability to negotiate drug prices directly with drug manufacturers. Nearly all other foreign governments help contain drug costs through negotiation.

Patents. Grant patents for true

innovations, not for the ques

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sultgroup.org), due to the 85/15 policy, insurers returned approximately $707 million to almost 6 million enrollees, with an aver

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Pill

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the greater the kickback (rebate), which benefits the PBM's bottom line but not yours. As consulting firm Milliman explains (http://bit.ly/2zLmgwG), the secrecy around rebate contract terms means that nobody knows. But if a competitor rebate the PBM is pocketing as profit before passing the remainder on to the health plan (to lower premiums and/or copays for consumers).

PBMs also make money when they collect a copay from the consumer that's higher than the cost of the drug and keep most of the difference. There is no transparency on discounts, pricing or profits. A PBS story (http://bit.ly/2zLmgwG) covered a customer who paid a $285 copay to her health plan PBM for a drug that Costco sells for $40, throwing light on the hidden, convoluted system that enables such inequity.

Lobbying and financial influence. Big Pharma invests huge amounts of money in political contributions and lobbying to influence lawmakers to maintain the unregulated drug pricing status quo. On the consumer side, companies make charitable contributions and fund patient assistance programs to squelch criticisms. Research by a UCLA associate professor (http://bit.ly/2moK1X0) reveals that "pharmaceutical companies are spending something like double the amount that they spend on research and development [of new drugs] on marketing to doctors," with the goal of convincing doctors to write more prescriptions for their drugs.

Reduced competition. Mega-mergers such as last year's union between health insurer Aetna and CVS, the nationwide pharmacy chain that also is a top PBM deciding on drug pricing and drug coverage availability, is the latest example of cut in consumer healthcare choices and pricing options. A UCLA professor filed a friend of the court (amicus) brief opposing the merger on behalf of consumers (see "Merger," on page 2, in the fall 2018 issue).

Taming the massive, multi-layered pharmaceutical industry has proved to be a Herculean task because proposed measures require cooperation from diverse stakeholders with different objectives. For example, Forbes reports that, in 2018, pharmaceutical company Amgen lowered the price of its drug Repatha by 60%.

Why are drug prices lower in other countries?

The U.S. government does not regulate or negotiate the price of prescription drugs when they hit the marketplace. Once the Federal Drug Administration deems a drug "safe," drug companies can set their own prices. Other countries, including Australia, Canada and Great Britain, have government agencies that negotiate prices with drugmakers. These regulatory bodies also review the risks and benefits of new drugs, making sure they really are a better deal than drugs already on the market. As a result, not every new drug that is developed is available in these countries—something critics of this process say is harmful to patients.

However, patient advocates argue that just because a new drug is available in the U.S. does not mean it is an improvement on an older, less expensive option. Since no U.S. agency weighs the value of a new drug, Americans could be paying for an expensive new prescription that offers no greater benefit than a cheaper alternative, if one is available.

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