



The Prescription Escalator:

The Real Reason Why Americans Pay More for Drugs Each Year, Why They Are So Upset and What Can Be Done About It

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INTRODUCTION

In this paper we will introduce a new concept, the “prescription escalator.” The prescription escalator is a simple way of summarizing why Americans are so upset about their drug bills. Moreover, we propose solutions for getting Americans off the prescription escalator. Americans know, without a doubt, that their family’s prescription drug costs are rising—and they are angry. A survey commissioned in fall 2018 by the Progressive Policy Institute found that 83% of Americans worry that drug companies are “charging too much.”

The poll also found that 73% of Americans have negative feelings about drug companies.¹ Other polls corroborate these feelings, leading to multiple Congressional hearings and legislative proposals.²

Yet there’s a paradox: Government statistical agencies and private researchers collect and publish reams of data each year showing that average out-of-pocket expenses on prescription drugs are stable or even falling. For example, a May 2019 research report from the Agency for Healthcare Research and Quality reported that average out-of-pocket spending for prescribed medications, among persons who obtained at least one prescribed medication, declined from \$327 in 2009 to \$238 by 2016, a decrease of 27 percent.³ Data from the Bureau of Labor Statistics Consumer Expenditure Survey shows that average household spending on prescription drugs fell by 11% between 2013 and 2018.⁴

Moreover, OECD data shows that average out-of-pocket spending on prescribed medicines in the United States (\$143 per capita in 2017) is actually lower than countries such as Canada

(\$144), Korea (\$156), Norway (\$178), and Switzerland (\$215).⁵

How, then, can we reconcile the conflict between how people feel and the data? A visual image will help. Consider an escalator in an airport. The moving steps flow without stop upwards, lifting passengers and their luggage up to the ticket counters, the security lines and the waiting planes. If you ask individual passengers, they will tell you, beyond shadow of a doubt, that they are rising higher. And in fact, they are.

Yet the escalator itself goes stays in the same place. That's true for every escalator, including the daunting 5-story escalator in Denver Airport's main terminal. No matter how many passengers ride it up, the escalator itself stays in the same place.

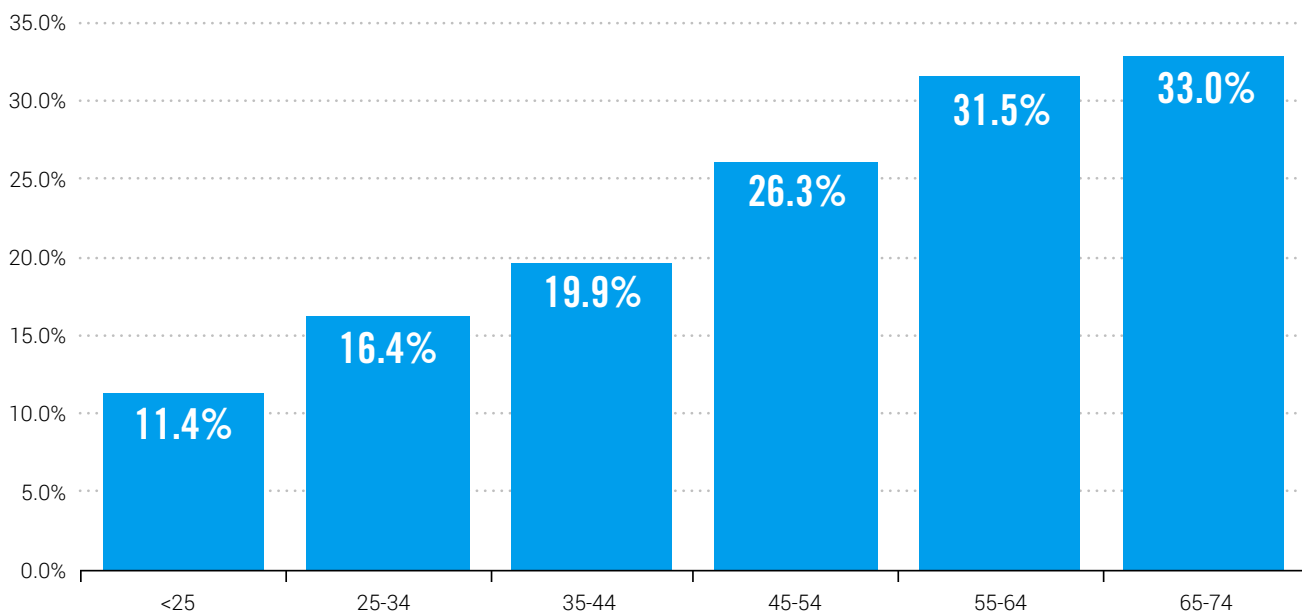
It turns out that an escalator is the appropriate model for prescription drug costs for individuals. As people get older, they unwillingly ride the prescription escalator, with their average

spending on prescription drugs rising by about 5-6% per year. This figure assumes no change in the underlying price of drugs. Rather, people fill more prescriptions as they age.

And here's the kicker: The age-based escalator rises much faster for prescription drugs than for other types of health spending. Overall, as people get older, their total average spending on healthcare only rises by about 2% per year, assuming no change in the underlying price of hospitalization, doctors, and other healthcare costs.

As a result, the relative out-of-pocket cost of drugs increases as people age, even assuming no increase in drug prices. Figure 1 shows the prescription drug share of out-of-pocket health spending, by age group. When Americans are in their mid 20s or 30s, prescription drugs make up 16% of their out-of-pocket spending. By the time they are in their late 50s and early 60s, prescription drugs account for 32%—one-third—of their out of pocket spending.

FIGURE 1. THE AGE-BASED PRESCRIPTION ESCALATOR: PRESCRIPTION DRUG SHARE OF OUT-OF-POCKET HEALTH SPENDING BY AGE (2015)

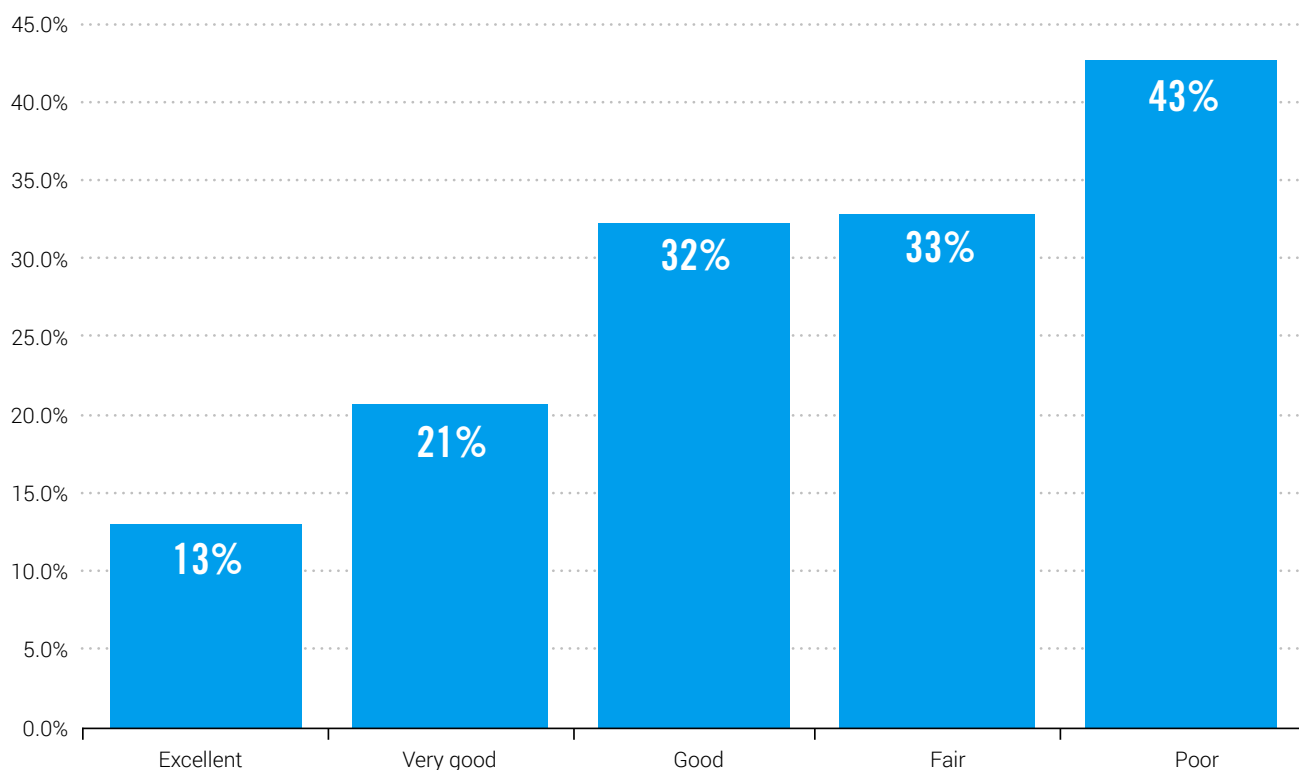


Source: MEPS, Agency for Healthcare Research and Quality, PPI analysis

How can it be that drug costs rise sharply for everyone, while barely rising in the aggregate? In the case of the airport escalator, the answer is that the moving steps fold down and return back to the bottom. For the age-based prescription escalator, the somewhat morbid equivalent is that when people age and die, their drug spending suddenly drops to zero. This decline balances out the age-based rising costs for everyone else.

Similarly, the number of prescriptions and out-of-pocket spending on drugs both shoot up sharply as perceived health deteriorates. As Figure 2 shows, for Americans who say that they are in excellent health, prescription drugs account for only 12% of their out-of-pocket spending. But for people in poor health, the sharp rise in the number of prescriptions means that prescription drugs account for 43% of their out-of-pocket spending.

FIGURE 2. THE HEALTH-BASED PRESCRIPTION ESCALATOR: PRESCRIPTION DRUG SHARE OF OUT-OF-POCKET HEALTH SPENDING BY PERCEIVED HEALTH (2015)



Source: MEPS, PPI analysis

Both the age-based and health-based prescription escalators are completely driven by rising utilization, not by rising price. For example, the average out-of-pocket cost per prescription is \$15 for someone in excellent

health, compared to \$13 for someone in poor health. The big difference is that the person in poor health has 46 prescriptions, on average, compared to 3 prescriptions for the person in excellent health.

POLICY IMPLICATIONS

The prescription escalator means that Americans face skyrocketing out-of-pocket drug costs as they get older and sicker. But the spending increases are being driven by higher utilization, rather than rising prices.

Any proposal to significantly help Americans deal with drug costs must address the prescription escalator. The most important step is to put a cap on the OOP expenses from drug spending. For example, in July 2018, Senator Elizabeth Warren and Senator Ron Wyden introduced the *Capping Prescription Costs Act of 2018*, which set caps for prescription drug copays at \$250 per month for individuals and \$500 per month for families.

Equally important is legislation that would control cost sharing for prescription drugs for Medicare beneficiaries.⁶ According to one 2018 study: “Part D enrollees with out-of-pocket costs above the catastrophic threshold comprised just 2 percent of all enrollees but 20 percent (\$3 billion) of enrollees’ total out-of-pocket drug spending (\$15 billion) in 2015.” The study estimated that a cap for all Part D enrollees in 2015 would have raised monthly premiums by only \$0.40–\$1.31 per member.⁷

By contrast, the current crop of proposals designed to moderate list prices for drugs and allow Medicare to bargain over drug prices won’t address what’s really driving the pain that Americans are feeling. Without changes to cost-sharing arrangements, such legislation will lower the Medicare budget without directly helping Americans.

Similarly, price transparency and price-gouging legislation will restrain some of the more egregious price increases, but won’t directly address the prescription escalator that is hitting many Americans.

THIS PAPER

We will first describe the basic data about drug spending in the United States. While most studies show a significant increase in list prices for pharmaceuticals, net prices, including discounts and rebates, have been rising much slower. Moreover, we show that average out-of-pocket spending on prescription drugs has been falling, not rising. This implies that the benefits from rebates and discounts are in the aggregate being passed onto consumers.

We then explore the survey data on prescription drugs, which shows that Americans are very upset and angry by their drug bills. This evidence is consistent across surveys, suggesting that it reflects a real truth about how Americans experience their drug expenditures.

The next section reconciles the spending and price data with the survey data. We describe the age-based and the health-based prescription escalator, showing that as Americans get older, their average drug costs increase more rapidly than overall health costs. Similarly, if we compare Americans in good health with those in poor health, the increase in out-of-pocket drug spending is much larger, on a percentage basis, than the increase in overall out-of-pocket health spending.

As a result, the prescription drug share of household health spending rises sharply as people get older and sicker, even though average out of pocket spending on prescription drugs has been falling. In effect, the very efficacy of drugs for dealing with aging and poor health has become a source of dissatisfaction. This paradox, we believe, lies at the heart of American’s dissatisfaction with the drug industry.

We then turn to the implications for policy. How can the prescription escalator be stopped in its tracks? Legislation that focuses on restraining list prices misses the point, since the prescription escalator is being driven by changes in utilization and not by changes in prices.

Instead, policymakers should concentrate on capping co-pays and deductibles for drugs. The current system of insurance does not take into account the prescription escalator.

THIS BASICS OF DRUG PRICE STATISTICS

Before explaining the prescription escalator paradox, we have to provide some background on prescription drug prices in general. One would think that it would be easy to measure such an important question, but there turns out to be multiple measures which all tell very different stories.

Let's start with the distinction between list prices and net prices. List prices are the published prices that manufacturers charge to wholesalers. Net prices reflect the revenues that drug manufacturers receive, net of rebates and discounts to prescription benefit managers, insurance companies, and hospitals.

Studies of list prices invariably show very strong growth. For example the IQVIA Institute for Human Data Science found that the list price of the average brand rose from \$364.92 to \$657.08 since 2014, an 80% increase.⁸ Similarly, a widely cited recent study based on list prices found that from 2008–16, the costs of oral and injectable brand-name drugs increased annually by 9.2 percent and 15.1 percent, respectively.⁹

By contrast, net prices and net pharma revenue have been growing much more slowly, once rebates and discounts are accounted for. From 2009 to 2018, IQVIA estimates that net revenue of pharmaceutical makers increased by 37%.¹⁰ That's slower than the 42% increase in gross domestic product over the same stretch, and much slower than the estimated 46% increase in personal healthcare expenditures.¹¹ By contrast, IQVIA also calculates invoice-level pricing for pharma companies, which is similar to list prices but not identical. The research institute found a 57% increase in invoice-level spending from 2009 to 2018.

PPI totaled up the U.S. pharma revenue of the top 20 drug manufacturers, as reported on their annual report. This figure, which is net of discounts and rebates, rose by only 8.5% from 2016 to 2018. By comparison, gross domestic product rose by 9.6% over the same period. That's hardly the sign of an industry raking in big bucks.

Note that this slow growth of net pharma revenues is quite consistent with rising list prices, combined with rising discounts and rebates. For example, in its 2018 10K, Pfizer reports global net revenues rose by only 1.6% from 2016 to 2018.¹² However, Pfizer also reports that its revenue deductions – including rebates to Medicare and Medicaid rebates and discounts to private sector customers, and similar reductions to revenue both domestic and foreign—rose by 22% from \$16.9 billion in 2016 to \$20.6 billion in 2018. While Pfizer does not say so outright, these figures imply that global gross revenues rose by 6.5% over this two-year period, quadruple the growth rate of net revenues.

OUT OF POCKET SPENDING ON DRUGS

By itself the slow growth of net revenues and net prices tells us nothing about the actual price of drugs to consumers. It's possible that rebates and discounts are not being passed onto buyers at the retail level. Indeed, insurers and PBMs have turned drug reimbursement into a maze. Patients must wrestle with rising deductibles, co-pays, and co-insurance bills for essential medicines, all of which can add up over time.

Moreover, as a Washington Post article notes, consumers often pay a percent of list price.¹³ Particularly vulnerable: Medicare Part D enrollees without low-income subsidies, who do not have a cap on their co-pays and are not allowed to purchase supplemental insurance, potentially exposing them to large bills.¹⁴

Surprisingly, average household out-of-pocket spending on prescribed medications in the U.S. is lower than some countries that are usually held up as exemplars. In 2017, according to OECD data, Americans spent \$143 per capita out-of-pocket on prescribed medications, compared to \$144 in Canada, which is highlighted by critics of the drug industry as a model to emulate (these figures include people who take no prescribed medications at all).

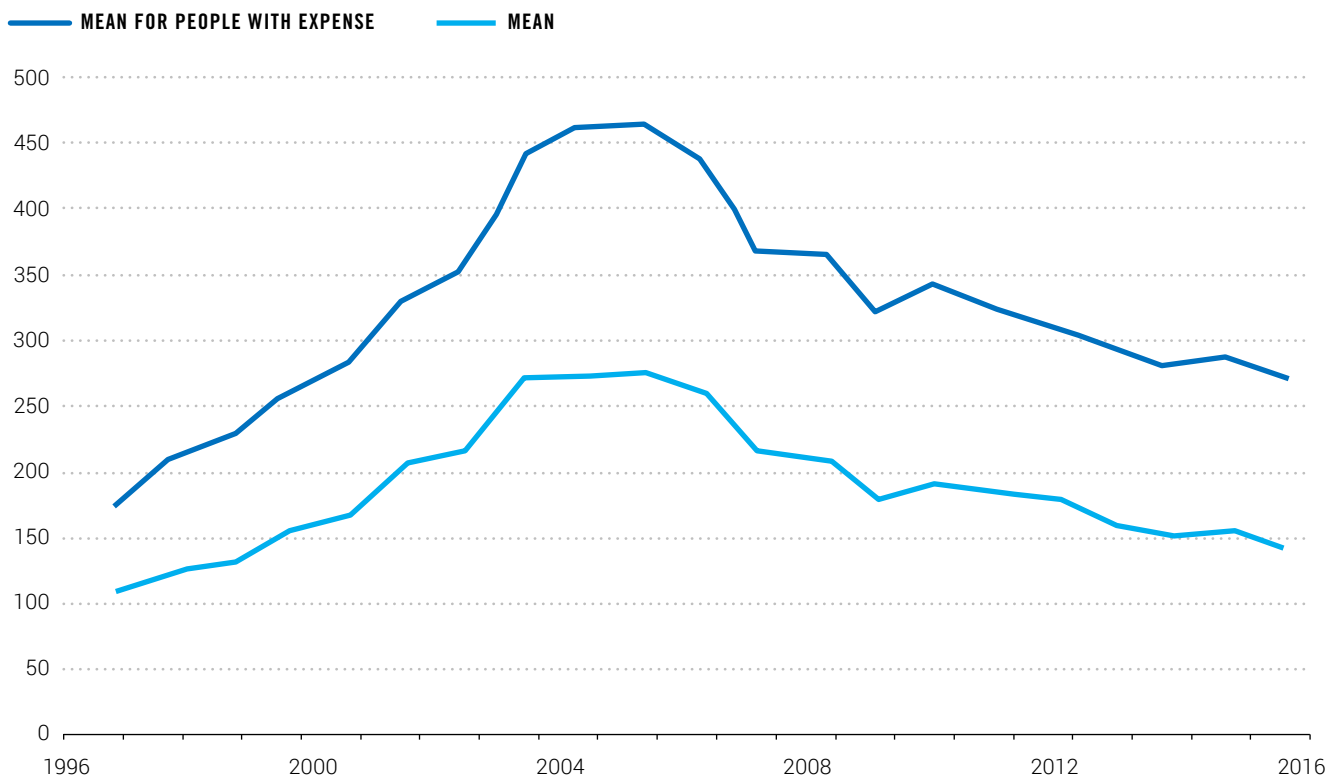
Moreover, all the available quantitative evidence suggests strongly that average out-of-pocket costs for drugs has remained basically flat in recent years. For example, IQVIA calculates that while “[t]he list price of the average brand rose from \$364.92 to \$657.08 since 2014, while final out-of-pocket costs for patients on those brands were nearly unchanged at \$30.59.”¹⁵

That result suggests that rebates and discounts are being passed onto consumers, on average. Similarly, the Kaiser Family Foundation studied prescription claims at large employer plans. They found that from 2009 to 2014, “average out-of-pocket spending for retail prescription drugs has decreased for people with large employer coverage.” The report concluded “on average, insurance covers a larger share of retail prescription drug spending than a decade ago.”¹⁶

Meanwhile, several different surveys done by the different government agencies using different methodologies show that average household burden of drug costs has actually been easing in recent years, not getting heavier. These include the Medical Expenditure Panel Survey (MEPS), sponsored by the Agency for Healthcare Research and Quality (AHRQ); the Consumer Expenditure Survey, done by the Bureau of Labor Statistics; and the National Health Expenditures Accounts from the Centers for Medicare and Medicaid (CMS). In addition, the Consumer Price Index (CPI) for prescription drugs adds some useful but limited information.

The most reliable source for out-of-pocket drug spending is MEPS, which in many cases can get permission from participants to tap directly into their pharmacy records.¹⁷ A May 2019 research report from the Agency for Healthcare Research and Quality using MEPS data found that average out-of-pocket spending for prescribed medications, among persons who obtained at least one prescribed medication, declined from \$327 in 2009 to \$238 by 2016, a decrease of 27 percent.¹⁸

FIGURE 3. AVERAGE OUT-OF-POCKET SPENDING PER CAPITA ON PRESCRIPTION DRUGS--MEPS (DOLLARS)



Source: MEPS

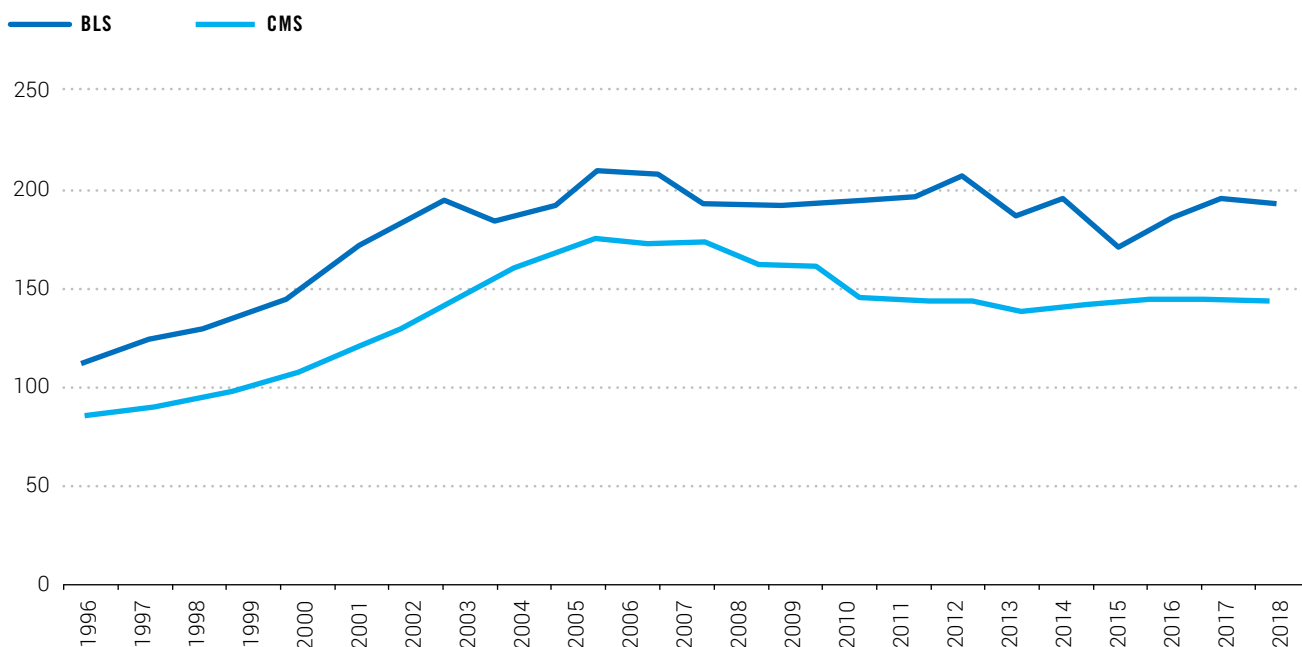
Figure 3 shows average or mean out-of-pocket spending on prescription drugs, both for everyone and also for people who have at least one prescription. We see that average out-of-pocket spending per capita peaked in 2005 at \$279, falling down to \$144 in 2016 (these figures are in current dollars, not inflation-adjusted dollars).

The BLS CES data on household drug spending, which uses a combination of interviews and diaries, comes to a similar conclusion from a completely separate data collection. We adjust the data by dividing by average household size to approximate per capita spending. Our analysis shows that out-of-pocket prescription and nonprescription drug spending peaked at

\$208 per capita in 2005, compared to \$193 in 2018 (in current dollars).¹⁹ This decline is not as large as the one shown by MEPS, but still in the same direction.

CMS publishes annual data on out-of-pocket spending for different categories of healthcare costs, including prescription drugs, using a variety of data sources.²⁰ We divide by the total US population to derive per capita out of pocket drug costs. Out-of-pocket prescription drug spending per capita peaks at \$173 in 2005 and 2007, before falling to \$144 per person in 2018.²¹ Once again, these figures are current dollars, without adjusting for inflation. Inflation-adjusted spending would show a much bigger drop.

FIGURE 4. AVERAGE OUT-OF-POCKET SPENDING ON PRESCRIPTION DRUGS PER PERSON (DOLLARS)*



* BLS = prescription and nonprescription drugs. CMS = prescription drugs only.
 Source: BLS (Consumer Expenditure Survey), CMS (National Health Expenditures)

The IQVIA Institute, based on its analysis of prescription records, arrives at a somewhat higher but still restrained estimate of the growth in out-of-pocket drug spending. According to IQVIA, total out of pocket spending rose from \$56 billion in 2014 to \$61 billion in 2018. Taking into account population growth, that's equivalent a 6 percent increase in per-capita out-of-pocket spending over four years from \$176 to \$186 per person, roughly equal to the overall rate of consumer inflation.

IQVIA's analysis also shows that less than 10% of all patients pay more than \$500 per year in out-of-pocket drug costs. However, 20% of patients in Medicare Part D pay more than \$500 per month. As we will show, this result is completely consistent with the age-based prescription escalator.

What about the cost per prescription? As part of the same analysis, IQVIA reports out of pocket spending per prescription have fallen from \$10.28 in 2014 to \$9.05 in 2018. This includes both brands and generics.

Next we examine the consumer price index (CPI) for prescription drugs, as based on a monthly BLS survey. Price data from the BLS is usually assessed as being reasonably dependable, but there are worries that with fewer and fewer people paying retail prices for drugs, the prescription drug CPI may be misleading.²²

Nevertheless, we note that in the first half of 2019, the consumer price index for prescription drugs fell by 0.8% compared to the first half of 2018. That's the first year-over-year decline in prescription drug prices since the mid-1970s, according to BLS data.²³

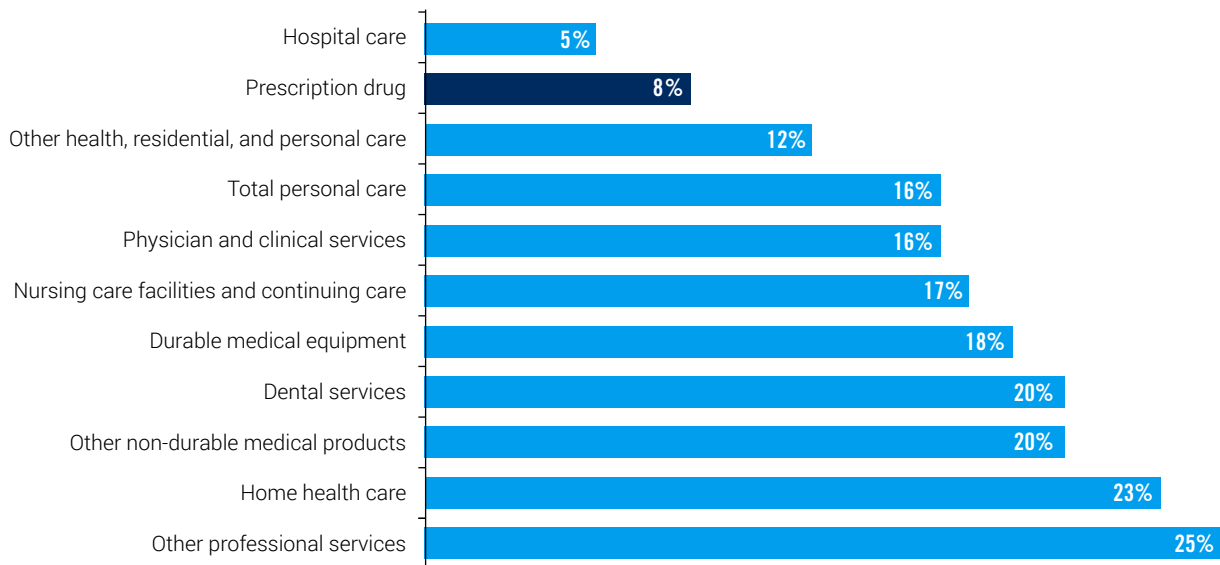
Looking at five-year inflation rates, the consumer price index for prescription drugs rose at a 2.7% rate from 2014 to 2019, based on the first six months of this year (see chart below). This represents the slowest rate of prescription drug inflation in forty years, according to BLS data.

Finally, Figure 4 shows that from 2013-2018, OOP spending on drugs was one of the slowest growing categories of OOP spending, up by only 8%. By comparison, OOP spending for all health care rose by double that, or 16%. These calculations are based on the CMS National Health Expenditure data. Especially

notable is the 20% increase in dental out-of-pocket expenses.

With several different data sources showing roughly the same pattern, we can be relatively confident that average out-of-pocket expenses have been stable in recent years. We note, however, that these results potentially reflect the impact of patients abandoning drugs with high out-of-pocket expenses, or not even starting treatments if they have to pay too much. We will discuss the impact of abandonment on the prescription escalator later in the paper.

FIGURE 5. OUT-OF POCKET SPENDING BY CATEGORY, PERCENT CHANGE 2013-2018



Includes projections for 2018
 Source: CMS (National Health Expenditures)

THE PRESCRIPTION ESCALATOR

Here we come to the paradox identified in the introduction. Just based on the weight of quantitative evidence about out-of-pocket spending on drugs, Americans seem to be spending less on prescription drugs out of their own pocket. Indeed, if you just had access to government data, you'd assume that policy was a success.

But in the real world, of course, Americans are almost unanimous in detesting the drug companies. A survey commissioned in fall 2018 by the Progressive Policy Institute found that 83% of Americans worry that drug companies are "charging too much." The poll also found that 73% of Americans have negative feelings about drug companies.²⁴

It's all too easy to find similar results. A March 2019 nonpartisan poll sponsored by Arnold Ventures found that over 8 in 10 of voters (84%) think prices charged for prescription drugs are unreasonable, including 45% who thought they are very unreasonable.²⁵

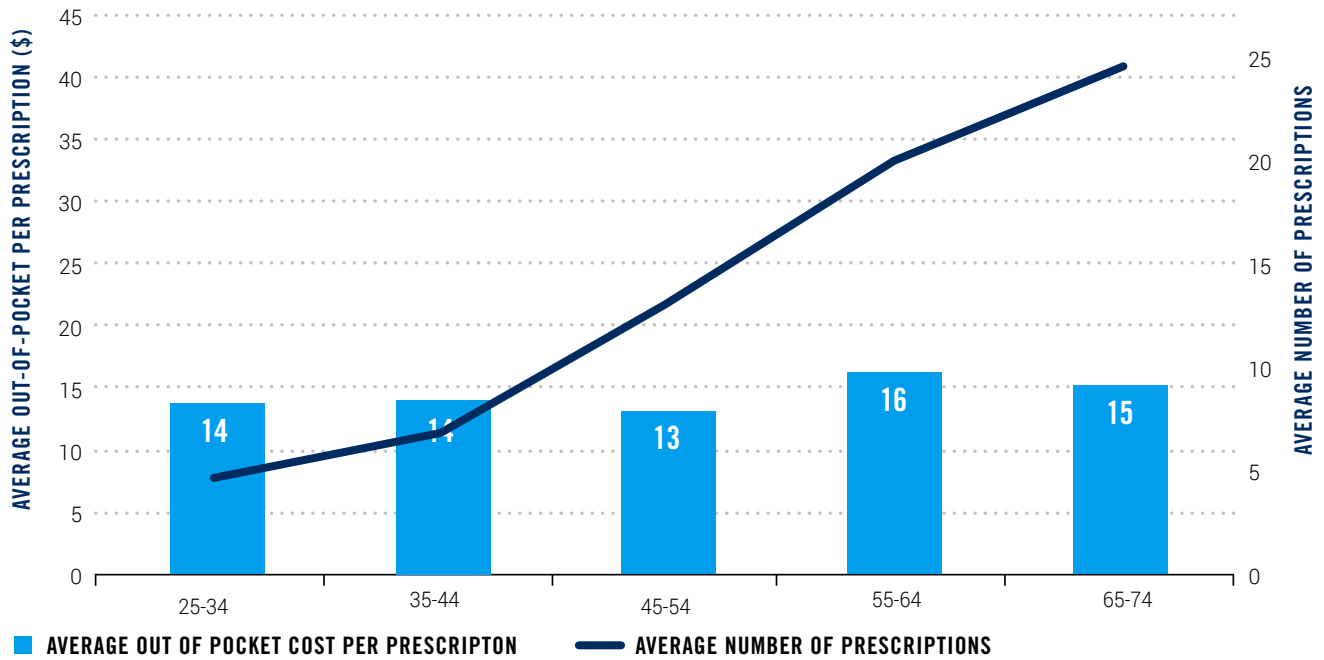
One possible explanation is that average figures for out-of-pocket spending conceals pockets of patients who are being hit hard by high drug costs. And these pockets certainly exist.

But the polls suggest that the dissatisfaction with drug prices and the drug companies is far broader and pervasive than can be attributed to a few bad anecdotes. What's going on here?

When Americans look at changes in their drug bill over time, they are seeing a combination of price changes and utilization changes. In particular, as people get older and/or transition into worse health states over time, their utilization soars. By contrast, there is little evidence for a rise in out-of-pocket spending per prescription.

Let's consider age first. The data shows that drug spending has a remarkably steep age profile. As people get older, their physicians write a soaring number of prescriptions—each of which requires its own co-pay and often co-insurance. Figure 6 shows the average number of prescriptions per person by age-category in 2015, as drawn from the Medical Expenditure Panel Survey. We see that the average number of prescriptions, including refills, at ages 54-65 is more than four times the number at ages 25-34.

FIGURE 6. THE AGE-BASED PRESCRIPTION ESCALATOR IS DRIVEN MAINLY BY RISING UTILIZATION, NOT HIGHER PRICES



Source: MEPS

The average out-of-pocket cost per prescription does rise, but by much less than the number of prescriptions.

This rapid increase in the number of prescriptions—and the number of co-pays—means that out-of-pocket drug costs increase faster with age than other healthcare costs. When Americans are in their mid 20s or 30s, prescription drugs make up 16% of their out-of-pocket spending. By the time they are in their late 50s and early 60s, prescription drugs account for 32%—one-third—of their out of pocket spending.

So if we could focus on individuals and track Sam or Sally’s expenses over time, we would see their average out-of-pocket drug expenses rise simply because their drug use rises as they get older. This age-based prescription escalator is completely independent of any secular trend

in drug prices or out-of-pocket drug outlays. Paradoxically, the age-based prescription escalator means that it is possible for almost every individual’s out-of-pocket drug outlays to rise on a year by year basis, while average out-of-pocket expenses for the whole country are flat or falling.²⁶

The average out-of-pocket cost per person for prescription drugs for people in the 55-64 age bracket is \$319, more than 5 times the \$62 per person cost in the 25-34 year age bracket.

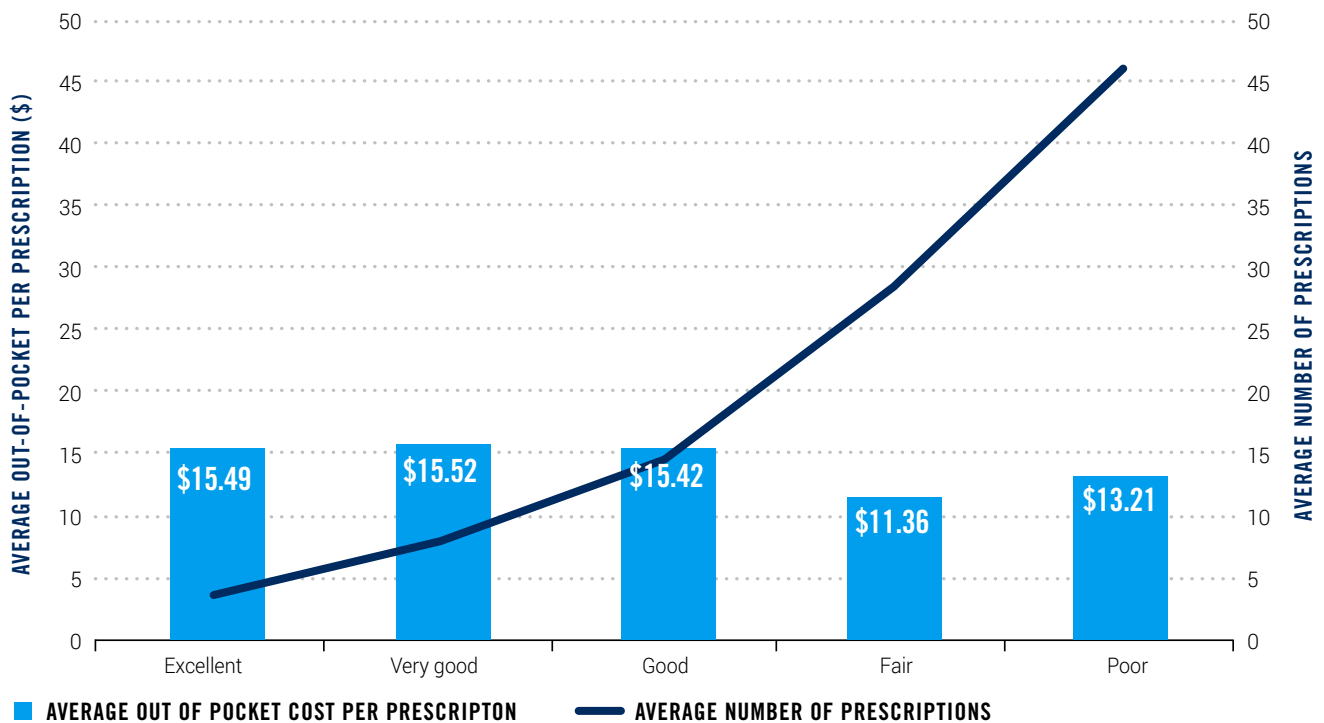
This sharp increase in drug spending by age is supported by other data sets as well. For the BLS Consumer Expenditure Survey tracks spending on drugs for households, broken down by the age of the ‘reference person.’²⁷ The average out-of-pocket drug outlays per person are \$265 for the 55-64-age category, compared to \$80 for the 25-34-age bracket. That’s more

than quadruple the spending. These numbers represent household spending outlays on drugs, divided by the number of people in the household, where the age of the household is tied to the “reference person”

HEALTH-BASED PRESCRIPTION ESCALATOR

Now let’s consider the relationship between drug spending and “perceived” health status, as defined in the MEPS survey. “Perceived” health status is how one thinks of one’s own health relative to the health of people in one’s age group.²⁸

FIGURE 7. THE HEALTH-BASED PRESCRIPTION ESCALATOR IS DRIVEN BY RISING UTILIZATION, NOT HIGHER PRICES



Source: MEPS

The MEPS survey shows a very sharp rise in the number of prescriptions as perceived health status worsens. For example, comparing excellent to poor perceived health, the number of prescriptions goes from 3 per year to 46 per year. This average is taken across all age groups.

On the one hand, we can think of this as a sign of success. Doctors prescribe drugs to deal with health problems because they are thought to work.

On the other hand, each of these prescriptions has its own co-pays and co-insurance. As a result, out-of-pocket spending on drugs skyrockets for Americans who say that they are in poor health. Someone in excellent health pays \$45 per year for prescription drugs, on average. By contrast, a person in poor health pays over \$600 per year, on average, more than ten times more.

Moreover, out-of-pocket drug spending goes up

faster than other types of healthcare spending when health deteriorates. For people in excellent health, prescription drugs account for only 12% of their out-of-pocket spending. But for people in poor health, the sharp rise in the number of prescriptions means that prescription drugs account for 43% of their out-of-pocket spending.

Finally, let us consider the effect of abandonment on the prescription escalator. Studies show that patient willingness to start and follow a drug treatment is heavily influenced by out-of-pocket expenses. Analysis by the IQVIA Institute shows that at \$50 out-of-pocket for a prescription, new patient abandonment rates for both commercial and Medicare are in excess of 25%. To put it another way, high out-of-pocket expenses are effective in deterring spending, which was their original policy purpose.

We can define “anticipated” out-of-pocket expenses to include those patients who were prescribed medicine but choose not to take them because they cost too much. Average “anticipated” out-of-pocket expenses are likely to be higher than the actually observed expenses.

It’s likely that the prescription escalator would be even steeper if we took abandonment and anticipated expenses into account. The biggest users of specialty drugs with high out-of-pocket expenses are older patients and patients in worse health—the people at the top of the escalator.

QUANTIFYING THE AGE-BASED PRESCRIPTION ESCALATOR

Quite logically, the data suggests that out-of-pocket spending on drugs rises with age. What’s surprising, though, is how big the impact is. If we consider the various available datasets, over a period of 10 years, individual Americans can

expect their out-of-pocket drug outlays to rise 50%-70% even if drug prices and co-pays are flat. As a result, as people age, they will see their drug outlays rise by 4-5.5% per year for adults under the age of 65. Of course, their outlays will rise even more if either drug prices or co-pays rise.

By comparison, our analysis suggests that other healthcare expenses have a much smaller age-based escalator effect, on the order of 2-3.5% per year. And surprisingly, Census Bureau suggests that age by itself adds very little to income, on the order of 1% per year.

Taken together, these facts create a situation where many Americans see their out-of-pocket drug outlays rise significantly each year, outpacing other medical expenses. Moreover, given the slow pace of average income growth, many Americans observe drug spending rising as a share of their household budgets, even if drug prices themselves are not flat or only moderately up.

Let’s repeat that—even if drug reform efforts were successful and there were no more increases in drug costs, every individual would still face a 5.6% increase each year in drug spending as they got older. That would total 30% after five years, and 70% after ten years, across the board. These are enormous increases.

Table 1 below reports on the age-based prescription escalator, plus the impact of aging on other types of spending, drawing from several data sources. Note that the age-based escalator is bigger for drugs than for medical office visits, hospital care, total healthcare expenditures, and total household spending.

TABLE 1. THE AGE-BASED PRESCRIPTION ESCALATOR

DATA SOURCE	SPENDING/INCOME CATEGORY	IMPLIED CHANGE IN SPENDING FROM ONE EXTRA YEAR OF AGE FOR ADULTS UNDER 65 YEARS OLD
MEDICAL EXPENDITURE PANEL SURVEY (2015)	Prescribed medications paid by self or family	5.6%
	Medical office visits paid by self or family	2.1%
	Total healthcare expenditures, paid by self or family	3.2%
BLS CONSUMER EXPENDITURE SURVEY (2017)	Drug outlays per capita	4.1%
	Total healthcare outlays per capita	2.9%
	Total consumer expenditures per capita	1.3%
CMS ESTIMATES OF PERSONAL HEALTHCARE EXPENDITURES BY AGE (2012) EXPENDITURE SURVEY (2017)	Out-of-pocket spending on prescription drugs per capita	5.1%
	Out-of-pocket spending on hospital care per capita	1.2%
	Out-of-pocket spending on physical and clinician services per capita	1.9%
CENSUS (2017)	Household per capita income	1.2%

Source: MEPS, CMS, BLS, Census, PPI

We see that both total household expenditures per capita and income per capita actually rise very little with age, going up only 1.2%-1.3% per year.

The implication is that drug spending as a share of household spending rises quite sharply by age. That’s especially true if the real incomes are increasing very slowly over time. So the age-based prescription escalator is actually eating up a big share of the overall increase in individual household income, even if its share is not changing in the aggregate.

POLICY IMPLICATIONS

For many years healthcare economists talked about the need for patients to have “skin in the game” so they would have the incentive to shop around for better prices. Cost-sharing instruments such as co-pays and co-insurance were supposed to hold drug spending.

In fact, research shows that cost sharing does work to reduce drug spending.²⁹ The downside, though, is that American consumers are forced to ride the much-hated prescription escalator. Because co-pays and co-insurance

are tied to individual prescriptions, the typical American sees their drug bill going up year after year, faster than their other medical expenses or their income. As a result, the drug burden is systematically increasing from the individual's perspective.

Similarly, the health-based prescription escalator means that as people become less healthy, they see their out-of-pocket drug spending soar faster than other medical expenses or overall incomes. No wonder they are angry with drug companies!

However, the data show that this increased burden is mainly driven by increased utilization of pharmaceuticals when faced with ill health or aging, combined with per-prescription cost sharing. The system is working exactly as it was designed. Patients have some "skin in the game," and it's painful.

According to a report from the Commonwealth Fund, all countries do more than the U.S. does to limit patients' exposure to high out-of-pocket costs. In Germany, out of pocket spending limits are capped at 2% of patient's gross income (or 1% of gross income for chronically ill patients).³⁰

So what are the best policy measures to make Americans feel more comfortable with their drug bills? The most important step is to put a cap on the OOP expenses from drug spending. For example, in July 2018, Senator Elizabeth Warren and Senator Ron Wyden introduced the ***Capping Prescription Costs Act of 2018***, which set caps for prescription drug copays at \$250 per month for individuals and \$500 per month for families.

Related is legislation that would control cost sharing for prescription drugs for Medicare beneficiaries.³¹ According to one 2018 study: "Part D enrollees with out-of-pocket costs above the catastrophic threshold comprised just 2

percent of all enrollees but 20 percent (\$3 billion) of enrollees' total out-of-pocket drug spending (\$15 billion) in 2015." The study estimated that a cap for all Part D enrollees in 2015 would have raised monthly premiums by only \$0.40–\$1.31 per member.³²

These measures will flatten out the prescription escalator. Capping out-of-pocket expenses will actually address the real problem, and show tangible results for Americans who are hurting when their drug bills go up.

How much would this cost? Perhaps not as much as we would think, based on data from states such as Maryland and Delaware that have instituted partial caps on co-pays.

For example, Maryland caps out-of-pocket expenses for patients who have a complex or chronic medical condition, or a rare medical condition; require a specialty prescription drug costing \$600 or more for up to a 30-day supply; and have insurance that is regulated by the State of Maryland. The law does not apply to Medicaid, Medicare and self-insured health plans, which are not regulated by the state of Maryland.³³ But it does cover many patients who were being hit by high out of pocket payments.

A recent paper presented at the annual meeting of the American Society of Healthcare Economists examined partial caps instituted by Maryland, Delaware, and Nevada, and found that "they reduced out-of-pocket spending for high-priced specialty drugs for the highest spenders without increasing health plan spending, a proxy for future insurance premiums."³⁴

As PPI has written, it would also be worthwhile to make the payment system for drug reimbursement more transparent, focusing on pharmacy benefit managers.³⁵ Instead of today's

perverse incentives, policymakers could allow for a fee structure that would reimburse PBMs for the actual service they provide: setting and managing a drug formulary. If implemented, the fee could not be tied to the list price of drugs. This would get rid of the incentives to increase list prices – driving up co-pays – and using rebates to garner a preferred tier on the formulary.

By contrast, some of the most widely touted pieces of drug pricing legislation will have little or no impact on the prescription escalator. For example, a variety of measures target the list price of drugs. States have focused on anti-gouging and price transparency laws, requiring drug makers to justify their price increases. For example, in October 2017, Governor Jerry Brown of California signed a “drug price transparency bill,” requiring pharma and biotech companies to give advance notification of significant price increases and provide specific justifications. Nevada has tackled the cost of diabetes medicines such as insulin, requiring drug makers that have raised list prices by a significant amount to release data about the costs of making and marketing the drugs. Vermont and Oregon have also passed transparency laws.

On the federal level, lawmakers have proposed a wide variety of approaches, including increased imports of drugs; allowing Medicare to bargain over drug prices; and accelerating generic competition to branded products. A recent letter from a coalition of liberal groups called for House Democrats to pass legislation to “lower stratospheric launch prices for new drugs and prevent price gouging on existing drugs for all payers.”

In theory, holding down list prices won't affect fixed co-pays, but could reduce co-insurance payments—assuming that health insurance companies keep their co-insurance rates the same. That's important, because coinsurance has become an increasingly important part of patient payments.³⁶

But ask yourself this question—what is to stop the health insurance companies and PBMs from raising the coinsurance rates even more to compensate for lower list prices? Because the plans control the coinsurance rates, there is literally no direct connection between list prices and what the patients pay. At best, measures to address list prices will have only a small and uncertain effect on the prescription escalator.

If policymakers want to make a difference to how much Americans pay for drugs, they should focus on flattening out the prescription escalator. Capping out-of-pocket expenses is the way to go.

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