AARP Public Policy Institute

Consumer Perspective on Rising Prescription Drug Costs

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AARP

Overview

- Why do prescription drug costs matter to AARP?
- What can be done?
- Outlook for the future

Older adults are particularly vulnerable to prescription drug costs

- Older adults use a lot of prescription drugs
  - 68% of Medicare beneficiaries are being treated for 2+ concurrent chronic illnesses
- Most Medicare beneficiaries live on modest incomes
  - Median income is roughly $23,500
  - 1/4 have incomes below $14,400
- Many Medicare beneficiaries have limited financial resources
  - More than 1 in 4 have less than $10,000 in savings

Medicare can lead to high cost-sharing

- Part B beneficiaries are responsible for 20% of their prescription drug costs
  - Part B does not cap out-of-pocket spending

- Part D plans are increasingly using coinsurance
  - Out-of-pocket spending is limited by catastrophic cap
    - Nevertheless, someone taking Sovaldi can face as much as $7,000 in cost sharing

Private insurance is following Part D's lead

- An increasing number of employer-sponsored plans have created a fourth or even higher tier of drug cost sharing
  - The average copayment for a fourth-tier drug is $83 and the average coinsurance is 29%
- Most exchange plans rely on coinsurance for drugs on Tier 3 and 4, which can result in extremely high cost-sharing

	Silver	Bronze
Deductible	$2,658	$5,249
% of plans charging coinsurance for specialty medications	80%	91%
% of plans charging coinsurance of 30% or more for specialty medications	41%	52%

High drug prices affect <u>everyone</u>

- All Americans are paying the costs associated with these products
- High cost-sharing—which is directly linked to high prices—is making it harder for consumers to access the medications they need
- Efforts to limit cost-sharing can tie insurers' hands
    - They will find other ways to limit access (e.g., growing concerns about formulary design)

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Current system faces a lot of challenges

- Very fragmented system makes it extremely difficult to negotiate adequate discounts and/or counteract the influence of the drug industry
    - Efforts to reduce prices in part of the system can lead to higher prices for everyone else (“squeezing the balloon”)
- FDA’s role is ensuring safety and efficacy—price is not a concern
    - Also does not compare new drugs to existing therapies
- No real incentive (or funding) to perform comparative effectiveness research

So what might work?

- AARP has been extremely supportive of various proposals that would reduce prescription drug costs
- Starting to consider ideas used by other countries that maintain consumer access but also introduce comparative effectiveness
    - Not price controls—simply asking companies to prove that their product is worth the cost
        - Fair question given consumers/taxpayers are footing the bill

Some preliminary ideas to consider

- Threshold (e.g., price, spending, utilization) triggers automatic comparative effectiveness evaluation
- Allow drugs to be sold immediately after FDA approval, but the government will not pay for the drug until it has adequate information to negotiate a price
  - Patients who want the drug immediately have to pay out-of-pocket
- Allow manufacturers to sell their product at their chosen price for a year but require them to provide research proving it's better than what's already on the market
  - Drug has no added benefit = reference pricing
  - Patients still have the option of buying the drug but would have to pay the difference

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Key word: unsustainable

- The costs associated with prescription drugs are not sustainable for patients or payers
- Efforts to reduce costs could save taxpayer-funded programs like Medicare and Medicaid billions of dollars
- Many patients will be unable to afford their prescription drugs if they do not receive some level of price relief

Medical advances are meaningless if no one can afford to use them

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