

Prescription Drug Trends

June 2006

Overview

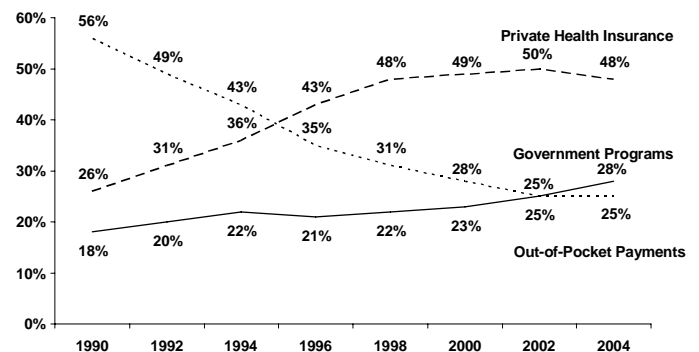
Prescription drugs are vital to preventing and treating illness and helping to avoid more costly medical problems. Rising costs and implementation of the new Medicare drug benefit have highlighted the need for a better understanding of the pharmaceutical market and for new approaches to address rising costs.

Rising Expenditures for Prescription Drugs

Spending in the US for prescription drugs was \$188.5 billion in 2004, over 4½ times more than the \$40.3 billion spent in 1990.¹ Although prescription drug spending has been a relatively small proportion of national health care spending compared to spending for hospital and physician services (10% in 2004, compared to 30% and 21%, respectively), it has been one of the fastest growing components, increasing over the past decade at double-digit rates compared to single-digit rates for hospital and physician services. However, the annual rate of increase in prescription spending has declined from a high of 20% in 1999 to 8% in 2004, which is comparable to the 9% increases for hospital care and physician services² (Figure 1).

The share of prescription drug expenses paid by private health insurance increased substantially over the past decade (from 26% in 1990 to 48% in 2004), contributing to a decline in the share that people pay themselves out-of-pocket (from 56% in 1990 to 25% in 2004) (Figure 2).

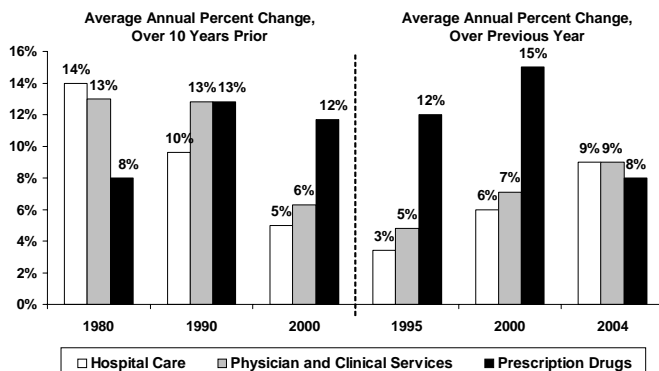
Figure 2: Percent of Total National Prescription Drug Expenditures by Type of Payer, 1990-2004



Notes: Out-of-Pocket Payments includes direct spending by consumers for health care goods and services not covered by a health plan and cost-sharing amounts (coinsurance, copayments, deductibles) required by public and private health plans. It does not include consumer premium payments and cost sharing paid by supplementary Medicare policies, which are included in the Private Health Insurance category. With the 2004 estimates, CMS incorporated new concepts, methods, and data sources and revised the entire time series back to 1960.

Source: Kaiser Family Foundation calculations using National Health Expenditures data from Centers for Medicare & Medicaid Services, at <http://www.cms.hhs.gov/NationalHealthExpendData/>.

Figure 1: Annual Percentage Change in Selected National Health Expenditures, 1980-2004



Notes: With the 2004 estimates, CMS incorporated new concepts, methods, and data sources and revised the entire time series back to 1960.

Source: Kaiser Family Foundation calculations using National Health Expenditures data from Centers for Medicare & Medicaid Services, at <http://www.cms.hhs.gov/NationalHealthExpendData/>.

Factors Driving Changes in Prescription Spending

Three main factors drive changes in prescription drug spending: changes in the number of prescriptions dispensed (utilization), price changes, and changes in the types of drugs used.

Utilization. From 1994 to 2005, the number of prescriptions purchased increased 71% (from 2.1 billion to 3.6 billion), compared to a US population growth of 9%. The average number of retail prescriptions per capita increased from 7.9 in 1994 to 12.3 in 2005.³ The percent of the population with a prescription drug expense in 2003 was 61% (for those under age 65) and 91% (for those 65 and older); the proportions of these populations with a drug expense has changed little since 1996, when they were 62% and 88%, respectively.⁴

Price. Retail prescription prices⁵ (which reflect both manufacturer price changes for existing drugs and changes in use to newer, higher-priced drugs) increased an average of 8.3% a year from 1994 to 2005 (from an average of \$28.67 to \$64.86),⁶ more than triple the average annual inflation rate of 2.5%.⁷

Changes in Types of Drugs Used. Prescription drug spending is affected when new drugs enter the market and when existing medications lose patent protection. New drugs can increase overall drug spending if they are used in place of older, less expensive medications, if they supplement rather than replace existing drugs treatments, or if they treat a condition not previously treated with drug therapy. New drugs can reduce spending if they come into the market at a lower price than existing drug therapies; this can occur when a new drug enters a therapeutic category with one or two dominant brand competitors. New drug use is affected by the number of new drugs (new molecular entities) approved by the US Food and Drug Administration; approvals fluctuated over the past decade, with 21 approvals in 1994, 36 in 2004, and 20 in 2005.⁸ Drug spending typically is reduced when brand drugs lose patent protection and face competition from new, lower cost generic substitutes.

Advertising. Both prescription use and shifts to higher-priced drugs can be influenced by advertising. After a decade of increases, the total amount manufacturers spent on advertising declined 3.5% from 2004 to 2005 (from \$11.9 billion to \$11.4 billion). The share directed toward consumers increased 5% in 2005 (from \$4.0 to \$4.2 billion), while the share directed toward physicians declined by 8% (from \$7.8 to \$7.2 billion). Spending for consumer advertising in 2005 was over 5 times the amount spent in 1996 (\$.8 billion), while 2005 physician advertising was 2 times the 1996 amount (\$3.5 billion).⁹

Profitability. From 1995-2002, pharmaceutical manufacturers were the nation's most profitable industry. In 2003 and 2004 they ranked 3rd. In 2005 they ranked 5th, with profits (return on revenues) of 16% compared to 6% for all Fortune 500 firms.¹⁰

Insurance Coverage for Prescription Drugs

Lack of drug insurance can have adverse effects. A 2003 survey found that uninsured adults (51%) are twice as likely as insured adults (25%) to say that they or a family member cut pills, did not fill a prescription, or skipped medical treatment in the past year

because of the cost. Prescription drug coverage comes from a variety of private and public sources.

Employer Coverage. Employers are the principal source of health insurance in the United States, providing coverage for 174 million (nearly 60%) of Americans in 2004.¹¹ About 60% of employers offered health insurance to their employees in 2005, and 66% of those employees took their employers' coverage. Others may have obtained coverage through a spouse. Nearly all (98%) of covered workers in employer-sponsored plans had a prescription drug benefit in 2005.¹²

Medicare. Prior to January 1, 2006, the traditional Medicare program (the federal health program for the elderly and disabled) did not provide coverage for outpatient prescription drugs. As a result, about one-quarter (27%) of seniors age 65 and older, and one-third of poor (34%) and near-poor (33%) seniors, had no drug coverage in 2003.¹³ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a voluntary Medicare outpatient prescription drug benefit (known as Part D) under which the 43 million Medicare beneficiaries can enroll in private drug plans, starting January 1, 2006. These plans vary in benefit design, covered drugs, and utilization management strategies.

Department of Health and Human Services (HHS) data show that as of June 11, 2006, 22.5 million Medicare beneficiaries had Medicare Part D drug coverage (including about 6 million low-income seniors and people with disabilities, known as dual eligibles, who were transferred from Medicaid drug coverage to Medicare Part D drug coverage), 10.4 million had coverage from creditable employer/union plans including FEHB and TRICARE retiree coverage, and an estimated 5.4 million had creditable drug coverage from the VA and other sources. About 5 million beneficiaries did not have coverage (were not enrolled in a Part D drug plan or a source of creditable coverage).¹⁴

Medicaid. Medicaid is the joint federal-state program that pays for medical assistance to over 55 million low-income individuals. Medicaid has historically been the largest public payer for prescription drugs (contributing 19% of total US drug spending in 2004)¹⁵ and the major source of outpatient pharmacy services to the low-income population. All state Medicaid programs provide coverage for prescription drugs, although there are important differences in state

policies with regard to copayments, types of drugs that are covered, and the number of prescriptions that can be filled. About 6 million dual eligibles (those eligible for both Medicaid and Medicare) have been transferred from Medicaid drug coverage to Medicare Part D drug coverage. These dual eligibles represented an estimated 14% of Medicaid beneficiaries but accounted for 48% of Medicaid prescription drug spending in FFY2003.¹⁶ States are required to provide payments to the federal government to help finance this coverage.

Private and Public Responses to Increasing Prescription Costs

Public and private health plans have implemented a variety of strategies to attempt to contain their rising costs for prescription drugs, as described below.

Utilization Management Strategies. Health plans have responded to increasing prescription drug costs by excluding certain drugs from coverage, using quantity dispensing limits, and increasing enrollee cost-sharing amounts. In 2005, about three-quarters (74%) of workers with employer-sponsored coverage had a cost-sharing arrangement with 3 or 4 tiers, over 2½ times the proportion in 2000 (27%).¹⁷ Copayments for nonpreferred drugs (those not included on a formulary or preferred drug list) have doubled from an average of \$17 in 2000 to \$35 in 2005. Copayments for preferred drugs (those included on a formulary or preferred drug list, such as a brand name drug without a generic substitute) increased by 69%, from \$13 in 2000 to \$22 in 2005 (Figure 3).

Discounts and Rebates. Private and public drug programs negotiate with pharmaceutical manufacturers (often using contracted organizations known as pharmacy benefit managers) to receive discounts and rebates which are applied based on volume, prompt payment, and market share. Manufacturers who want their drugs covered by Medicaid must provide rebates to state Medicaid programs for the drugs they purchase; many states have also negotiated additional rebates, known as supplemental rebates. The shift of about 6 million dually eligible beneficiaries from Medicaid to Medicare drug coverage will affect the ability of state Medicaid programs to negotiate prices and secure supplemental rebates.

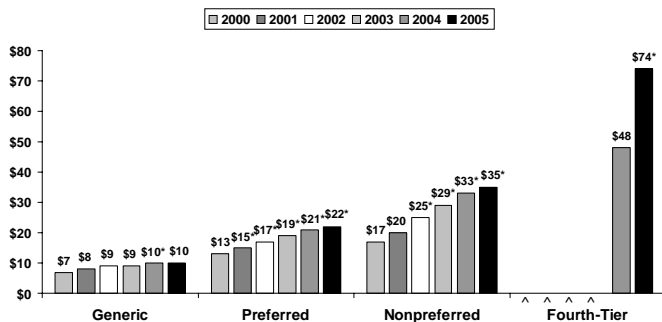
Several government agencies, including the Department of Veterans Affairs, the Defense Department, the Public Health Service, and the Coast Guard, participate in a program known as the Federal Supply Schedule through which they purchase drugs from manufacturers at prices equal to or lower than those charged to their “most-favored” nonfederal purchasers. Under the Section 304B Program, in order to participate in Medicaid manufacturers are required to provide drugs to certain nonfederal entities (such as community health centers and disproportionate share hospitals) at reduced prices.

Medicaid. Historically, drugs have been one of the fastest-growing Medicaid services. Drug spending as a share of Medicaid spending on services rose from 5.6% in FFY1992 to 13.4% in FFY2003.¹⁸ To control drug costs, a 2005 survey of 36 states+DC found that all (100%) states attempted to control Medicaid drug costs by requiring prior authorization, 95% imposed limits on quantities dispensed per prescription, 92% required the use of generics, 81% charged limited copayments for prescription drugs, and 68% used preferred drug lists.¹⁹

Under the Deficit Reduction Act of 2005 (enacted 2/8/06), states have been given more authority to control Medicaid drug spending through increased cost sharing for non-preferred drugs, changes in the way Medicaid pays pharmacists, allowing pharmacists to refuse prescriptions for beneficiaries who don’t pay their cost sharing, and inclusion of authorized generic drugs in the calculation of “best price” for drugs.

Medicare. The new Medicare Part D drug benefit will shift spending from the private sector and Medicaid to Medicare, making Medicare the nation’s largest

Figure 3: Average Drug Copayments, Among Covered Workers Facing Prescription Drug Copayment Amounts, 2000-2005



* Estimate is statistically different from the previous year shown at p<.05.

^ Fourth-tier copayment information was not obtained prior to 2004.

Notes: Average copayments for generic, preferred, and nonpreferred drugs are calculated by combining the weighted average copayments for those types of drugs among firms with a single copayment amount or a multi-tier cost-sharing structure. The average copayment for fourth-tier drugs is calculated using information from only those plans that have a fourth-tier copayment amount.

Source: Kaiser Family Foundation and Health Research and Educational Trust, Annual Surveys of Employer-Sponsored Health Benefits, 2000-2005, at <http://www.kff.org/insurance/7315/index.cfm>.

prescription drug purchaser. Medicare spending for prescription drugs is projected to rise from 2% of total US prescription spending in 2005 to 27% in 2006.²⁰ Under the Medicare Part D legislation, Medicare is prohibited from directly negotiating drug prices or rebates with manufacturers, but will rely on the private Part D drug plans to negotiate these discounts/rebates, which are assumed by HHS to be higher than earlier estimated (27%, instead of 15%, in 2006 and later years).²¹

Purchasing Pools. Some private and public organizations have banded together to form prescription drug purchasing pools to increase their purchasing power through higher volume and shared expertise. Examples include the Department of Defense and VA joint purchasing from manufacturers; individual state purchasing pools for their Medicaid, state employees, senior/low-income/uninsured pharmacy assistance programs, or other public programs; and multi-state pools.

Consumers. Consumers are turning to a variety of methods to reduce their prescription costs, including requesting cheaper drugs or generic drugs from their physicians, using the Internet and other sources to make price comparisons, using over-the-counter instead of prescribed drugs, buying drugs in bulk and pill-splitting, using mail-order pharmacies, and using pharmaceutical company or state drug assistance programs.²²

Importation. The high cost of prescriptions has led some to suggest that individuals be permitted to purchase prescription products from distributors in Canada or other countries (called “importation,” or “reimportation” if the drugs were originally manufactured in the US). Although it is generally not lawful for individuals or commercial entities such as pharmacies or wholesalers to purchase prescription drugs from other countries, the government does not always act to stop individuals from purchasing drug products. Importation of pharmaceutical products from Canada through Internet sales and travel to Canada totaled about \$700 million in sales in 2003, or 0.3% of total US prescription sales. An equivalent amount of prescription drugs was estimated to have entered the US from the rest of the world, mostly through the mail and courier services.²³ Actual savings amounts, drug safety, and marketplace competition and pricing are issues being debated.

Outlook for the Future

US prescription drug spending is projected to increase from \$188.5 billion in 2004 to \$446.2 billion in 2015, a 138% increase in 11 years. The annual increases in drug spending are projected to fall from 8.2% in 2004 to 7.7% in 2006, and then increase to 8.4% each year from 2013-2015. Drug spending as a percent of overall health spending is projected to increase from 10% in 2004 to 11% in 2015. Over the next decade, HHS projects that drug spending increases due to greater prescription use by Medicare beneficiaries under the new Medicare Part D coverage will be offset by increased availability and use of lower-cost generic drugs, more people covered under tiered copayment drug plans, fewer blockbuster drugs, and more drugs shifting to over-the-counter status.²⁴

¹ All spending amounts in this report are in current dollars (i.e., not adjusted for inflation).

² Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, Historical, at <http://www.cms.hhs.gov/NationalHealthExpendData/>.

³ Kaiser Family Foundation calculations using data from IMS Health at <http://www.imshealth.com> (US Top-Line Industry Data) and Census Bureau at <http://www.census.gov>.

⁴ Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, *2003 Compendium of Tables – Medical Expenditures*, Table 2, at http://www.meps.ahrq.gov/MEPSNet/TC/TC15.asp?File=HCFY2003&Table=HCFY2003_PLEXP, and *1996 Compendium of Tables—Medical Expenditures*, Table 2, at http://www.meps.ahrq.gov/MEPSNet/TC/TC15.asp?File=HCFY1996&Table=HCFY1996_PLEXP.

⁵ Retail prescription prices reflect the prices paid by insured and uninsured patients, and do not reflect rebates, discounts, and other payments that in effect lower the cost of prescriptions.

⁶ Kaiser Family Foundation calculations using data from National Association of Chain Drug Stores, “Industry Facts-at-a-Glance,” at <http://www.nacds.org>, based on data from IMS Health.

⁷ Consumer Price Index, US City Average, All items, from the Bureau of Labor Statistics, at <http://www.bls.gov>.

⁸ US Food and Drug Administration at <http://www.fda.gov/cder/rdmt/NMEapps93-05.htm>; the 2004 and 2005 numbers include new BLAs (biologic license applications) for therapeutic biologic products transferred from FDA’s Center for Biologics Evaluation and Research to its Center for Drug Evaluation and Research.

⁹ IMS Health website at <http://www.imshealth.com> (US Top-Line Industry Data); Kaiser Family Foundation, *Prescription Drug Trends, a chartbook*, July 2000, Ex.3.13, at <http://www.kff.org/rxdrugs/3019-index.cfm>. The data on spending for advertising directed towards physicians excludes the retail value of drug samples left at sales visits to physicians' offices, which totaled about \$16 billion in 2004.

¹⁰ *Fortune*, April 17, 2006, and earlier April issues.

¹¹ US Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, August 2005, pp. 16 and 60, at <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

¹² Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*, September 2005, Section 9, at <http://www.kff.org/insurance/7315/index.cfm>.

¹³ DG Safran et al., "Prescription Drug Coverage And Seniors: Findings From A 2003 National Survey," *Health Affairs*, April 19, 2005, p. W5-160, at <http://www.kff.org/medicare/med041905pkg.cfm>.

¹⁴ US Department of Health & Human Services News Release, June 14, 2006, at <http://www.hhs.gov/news/press/2006pres/20060614.html>.

¹⁵ C Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs*, January/February 2006, pp.186-196, at http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

¹⁶ Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, July 2005, at <http://www.kff.org/medicaid/7346.cfm>.

¹⁷ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*, September 2005, Exhibit 9.1, at <http://www.kff.org/insurance/7315/exhibits/index.cfm>.

¹⁸ Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Budget Reconciliation: Options and Implications of Savings Proposals*, October 2005, at <http://www.kff.org/medicaid/7410.cfm>. Percentages are net of drug rebates.

¹⁹ Kaiser Commission on Medicaid and the Uninsured, *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update*, October 2005, Fig. 3, at <http://www.kff.org/medicaid/7381.cfm>.

²⁰ C Borger et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs*, Web Exclusive, February 22, 2006, p.W70, at http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage.

²¹ *Ibid.*

²² D Herrick, National Center for Policy Analysis, *Shopping for Drugs: 2004*, National Center for Policy Analysis, Policy Report No. 270, October 2004, at <http://www.ncpa.org/pub/st/st270>.

²³ US Department of Health and Human Services Task Force on Drug Importation, *Report on Prescription Drug Importation*, December 2004, p. ix, at <http://www.hhs.gov/importtaskforce/Report1220.pdf>, based on IMS Health data.

²⁴ C Borger et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs*, Web Exclusive, February 22, 2006, pp.W61 to W73, at http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage.

For More Information:

In addition to the Kaiser Family Foundation reports in the Endnotes above, this Fact Sheet (#3057-05) and the following reports are available on the Foundation's website at www.kff.org: *Trends and Indicators in the Changing Health Care Marketplace* (#7031), *Prescription Drug Trends—A Chartbook Update* (#3112), *Cost Containment Strategies for Prescription Drugs: Assessing the Evidence in the Literature* (#7295), *Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain* (#7296), *Medicare Prescription Drug Benefit Fact Sheet* (#7044-03), *Resources on the Medicare Prescription Drug Benefit, Medicaid and Outpatient Prescription Drugs* (#1609-03), *Federal Policies Affecting the Cost and Availability of New Pharmaceuticals* (#3254), and *Prospects for Retiree Health Benefits as Medicare Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits* (#7439). See also <http://www.statehealthfacts.org> for state-specific prescription drug utilization, sales, and average prices (under Health Costs & Budgets), and <http://www.kaiserEDU.org> (Prescription Drugs) for a Tutorial and Issue Modules on prescription drugs.