How Much Does the U.S. Spend on Prescription Drugs?

Prescription drugs currently account for 15 percent of overall health spending, or about $480 billion in 2016.1 This includes drugs purchased from the pharmacy—sometimes called the “retail” setting—as well as drugs administered in doctors’ offices and hospitals.

Are Prescription Drug Prices Too High?

New innovative drugs have helped patients live longer, healthier lives. However, many new drugs come with shocking price tags, and many drugs that have been around for years have had steep price increases that defy explanation. In 2015, Americans spent more than double, per person, on retail pharmaceuticals than comparable countries.2

What Causes High Drug Prices?

Most drug manufacturers are for-profit companies that often face little competition for their products. Barriers to competition in the pharmaceutical market include patent protection, market exclusivity and natural monopolies for drugs treating diseases with patient populations that are too small to attract multiple manufacturers.3 As a result, drug companies can set high prices—to fund future research and development but also to maximize their profits. Drug manufacturers were able to maintain average profit margins of between 15 and 20 percent for the period 2006 through 2015.4 For the sake of comparison, average profits among non-pharmaceutical Fortune 500 companies fluctuated between 4 and 9 percent during the same time period.5

How are Consumers Harmed from High Drug Prices?

High drug prices lead patients to make the difficult choice between their health and other basic needs. According to recent poll results, 19 percent of adult Pennsylvanians did not fill a prescription due to cost and 17 percent cut pills in half or skipped doses of medicine. Additionally, 67 percent of Pennsylvania residents over 18 reported that they were “worried” or “very worried” about prescription drug costs.

Not taking medication as prescribed can lead to poor health outcomes—leading to more expensive complications down the road.6 These added costs, in addition to the excessive cost of the drugs themselves, are built into the premiums we all pay for health coverage.

Do We Need to Pay These High Prices to Fund Future Drugs?

Drug companies often justify high prices as needed to fund the research and development (R&D) of future drugs. It is true that drugs have a lengthy development cycle and many early investments never result in a drug that is successfully brought to market. However, studies have demonstrated that taxpayers fund about a quarter of all pharmaceutical R&D.7 A recent National Academy of Sciences report showed that taxpayers contributed to all innovative drugs approved by the FDA between 2010 and 2016.8 Due to this public contribution, taxpayers are essentially paying for drugs twice—by funding research and at the pharmacy. Moreover, analyses of annual reports show that big drug manufacturers spend as much, or sometimes more, on marketing and sales as they do on R&D.9

See the companion glossary for help with this complex policy topic.
ADDRESSING HIGH DRUG PRICES

Many of the rules that allow drug manufacturers to keep prices high are federal rules that would have to be addressed by Congress. For example, patents are issued by the U.S. Patent and Trademark Office and “market exclusivity” is granted by the Food and Drug Administration (FDA). However, states are tackling this issue the best they can. Here are some state options:

STATE SOLUTION 1: CREATE A PRESCRIPTION DRUG TASK FORCE TO STUDY PRESCRIPTION DRUG PRICING

In 2019, Pennsylvania considered legislation to create a Prescription Drug Task Force to study prescription drug pricing and issue a report. The report will focus on factors contributing to high out-of-pocket costs, medication adherence, access to drugs, manufacturer research and development costs, profit margins and financial assistance offered by drug companies. Similarly, in 2019 Maryland established a prescription drug affordability board to evaluate the cost of expensive medications, or ones whose prices increase significantly. The board would then set an upper payment limit for individuals covered by state or local health care plans (other than Medicaid).

STATE SOLUTION 2: REQUIRE PRICE TRANSPARENCY FROM DRUG MAKERS

State drug price transparency laws require drug makers to justify price increases higher than a certain threshold. For example, proposed 2019 legislation in Pennsylvania (HB 568) would require manufacturers of drugs with wholesale prices of more than $5,000 per year or whose wholesale price has increased by 50 percent or more in the past five years to file an annual report with the state insurance department. Notably, these approaches rarely include regulator authority to roll back unjustified price increases. The hope is that public pressure will roll back high prices. In the first year after a similar law passed in California, at least four manufacturers canceled or reduced price hikes.¹⁰

STATE SOLUTION 3: ALLOW IMPORTATION FROM CANADA

Under federal law, wholesale importation from Canada is allowed if quality standards are met. States are looking at drug importation programs whereby the state functions as a licensed wholesaler, allowing for the purchase of lower-cost drugs from Canada and making them available to residents through state-licensed, in-state pharmacies and administering providers.¹¹ Though critics have expressed concerns that drugs from Canada may not be safe, more than 30 Canadian manufacturers are already registered with the FDA to produce drugs for U.S. markets.¹² Moreover, approximately 40 percent of drugs available in the U.S. market are already manufactured in other countries. Vermont was the first state to create such a program.

STATE SOLUTION 4: REGULATE PHARMACY BENEFIT MANAGERS

Pharmacy benefit managers (PBMs) contract with health insurers to administer pharmacy benefits. PBMs often design the formulary—the list of drugs covered by the health plan and which cost-sharing tier the drug falls into. PBMs negotiate rebates with drug makers, but these negotiations are confidential. Additionally, this industry is becoming more consolidated, indicating a lack of competition.

State legislation regulating PBMs attempts to shed light on their opaque business practices, for example: banning gag clauses that prevent pharmacists from sharing lower-cost options; requiring PBMs to be licensed by the state; mandating PBMs disclose whether a generic is available; limiting cost-sharing; preventing PBMs from charging plans more than what a pharmacy paid, and requiring reports on pricing and rebate information to promote transparency.¹³ In 2019, Pennsylvania considered six bills that target PBMs.

See the companion glossary for help with this complex policy topic.
SOLUTION 5: CAP PATIENT COST-SHARING

Under some health plan designs, patients have to pay their entire deductible before insurance begins to help pay for prescription drugs. Several states, including New York, Vermont, Maine, Delaware, Maryland, Louisiana and Montana, have implemented monthly copay limitations to help spread the burden of cost-sharing throughout the plan year. In 2019, Pennsylvania considered legislation that would cap how much residents pay for a 30-day supply of one specialty prescription drug to $100. Additionally, the bill would cap cost sharing for two or more specialty tier drugs at $200 per month. These caps would not apply to drugs that are not classified as specialty drugs. Specialty drugs treat complex conditions and are often manufactured through biologic processes and/or targeting a specific gene. Typically, these drugs are costly and accompanied by high patient cost-sharing.

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NOTES
5. Ibid.