

A Discussion of Recent Research on Health Care Prices: Prescription Drugs, Hospitals' Services, and Physicians' Services

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Prescription Drugs: Spending, Use, and Prices

How Prices for Prescription Drugs Are Determined

Retail prices are the prices paid at the point of sale; they are determined through negotiations between payers and pharmacies.

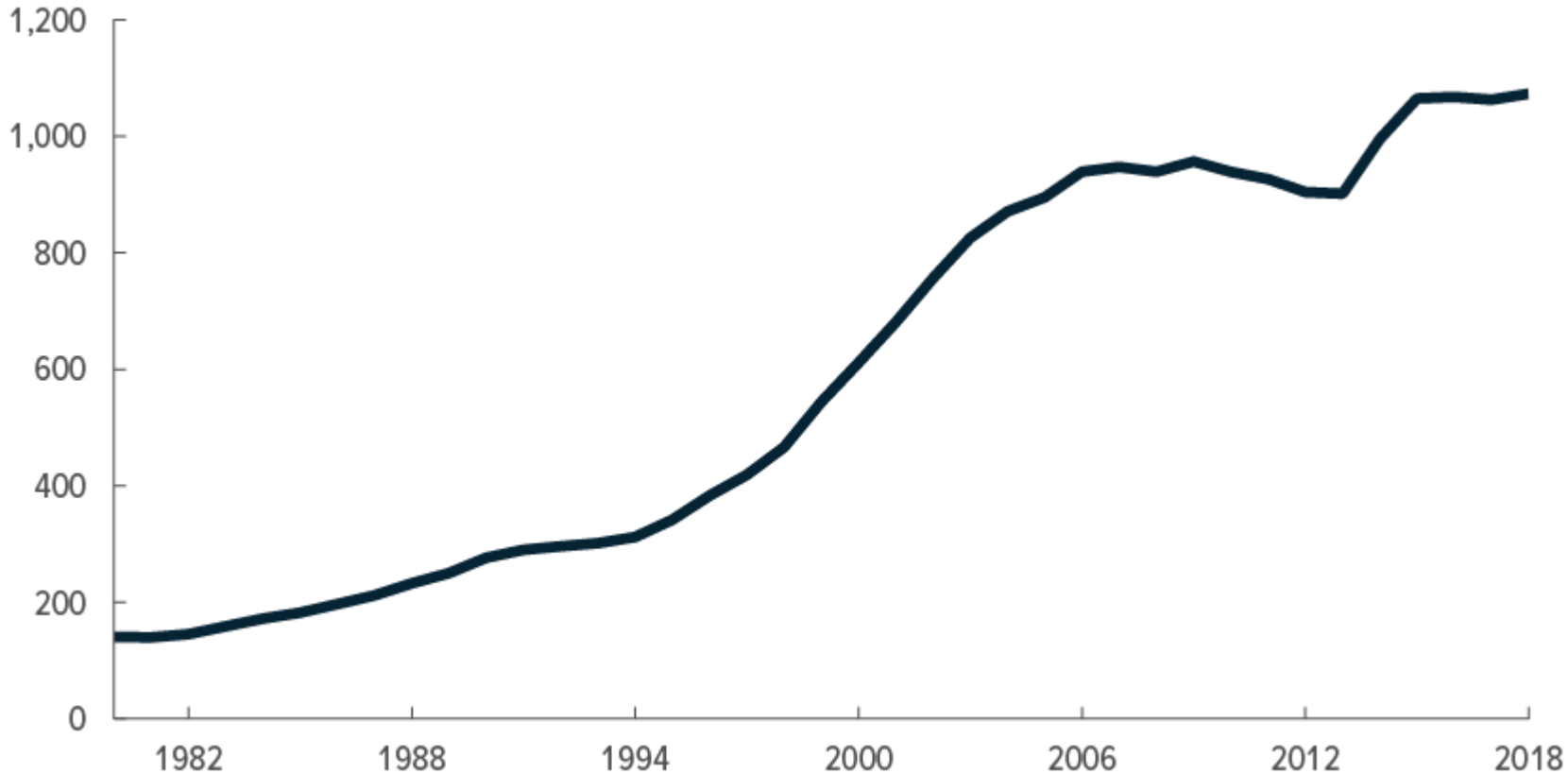
Net prices are retail prices minus any post-sale rebates or discounts (which are collected mainly from manufacturers).

Rebates and discounts are determined differently among various payers.

- Commercial Plans: Rebates are determined through negotiations between plans or their pharmacy benefit managers (PBMs) and manufacturers.
- Medicare Part D Plans: Rebates are negotiated between plans or their PBMs and manufacturers, and mandatory discounts are applied for some prescription drug sales in the coverage gap phase of the Part D benefit.
- Medicaid: Rebates are determined through a formula set in federal law and negotiations between state Medicaid programs and manufacturers.

Total Nationwide Spending per Person on Prescription Drugs Purchased From Pharmacies

2018 Dollars



Growth in per-person spending on prescription drugs began to slow in the mid-2000s, coinciding with the increasing availability and use of lower-priced generic drugs. However, the introduction of a particularly expensive class of drugs that are used to treat hepatitis C led to a sharp increase in per-person spending from 2013 to 2015.

Three Measures of Spending on Prescription Drugs Purchased From Pharmacies

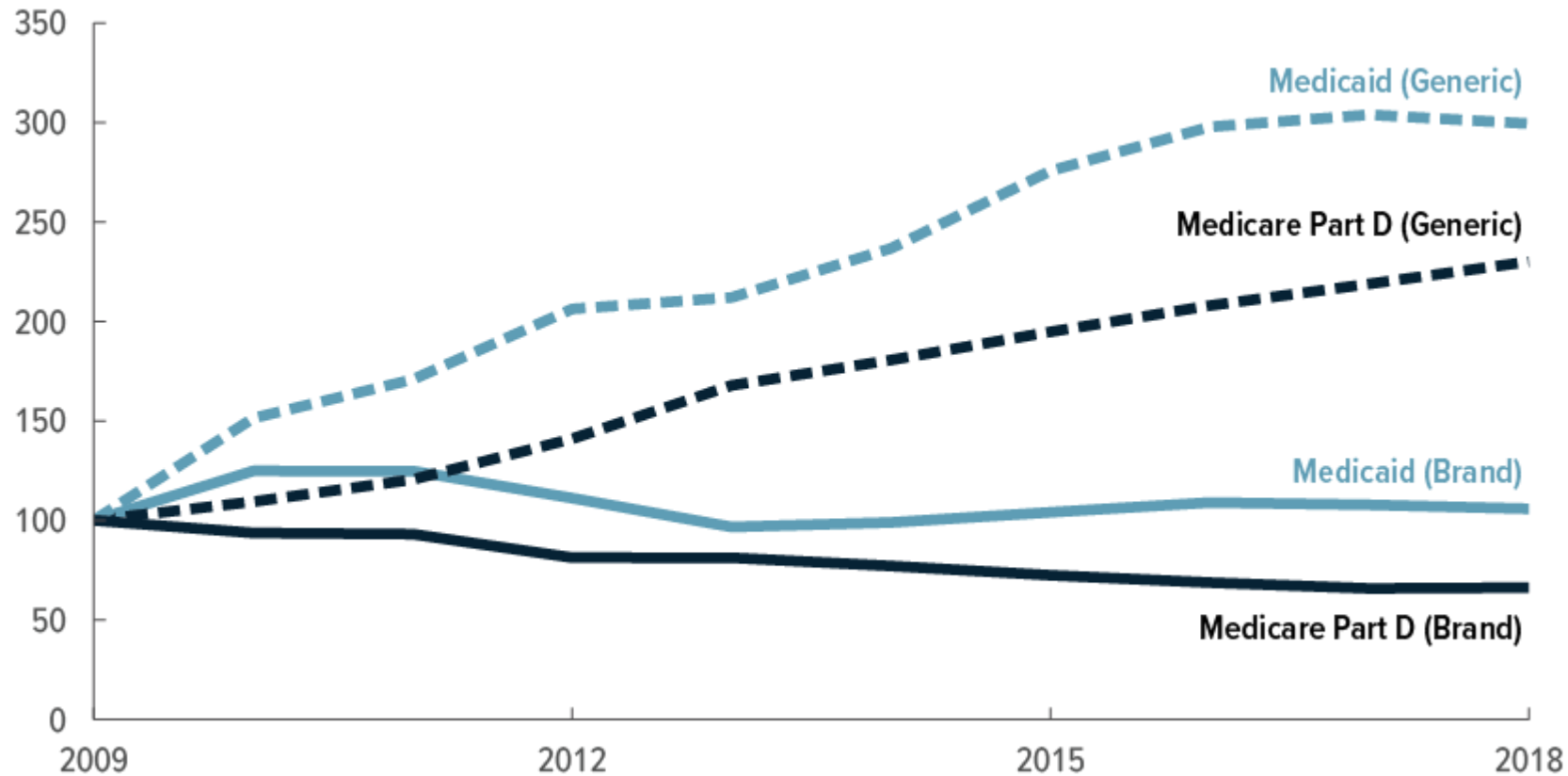
From 1980 to 2018, nationwide spending on prescription drugs purchased from pharmacies rose from \$30 billion to \$335 billion.

Over the 10-year period from 2009 to 2018:

- Nationwide per-person spending on prescription drugs purchased from pharmacies rose from \$957 to \$1,073 per year;
- Per-enrollee spending on prescription drugs purchased from pharmacies in the Medicare Part D program was relatively stable, averaging about \$2,700 per year; and
- Per-enrollee spending on prescription drugs purchased from pharmacies in the Medicaid program increased from \$445 to \$530 each year.

Changes in the Number of Brand-Name and Generic Prescription Drugs Dispensed Through Medicare Part D or Medicaid

Index, 2009 = 100



The use of generic drugs grew over the 2009–2018 period, but the use of brand-name drugs did not. Two factors account for that difference: Generic equivalents became widely available for a growing number of brand-name drugs, and insurers increasingly steered patients toward generic drugs by offering lower cost-sharing requirements for them.

Increases in the Share of Prescriptions Dispensed for Generic Drugs

From 2009 to 2018, the share of prescriptions dispensed for generic drugs rose:

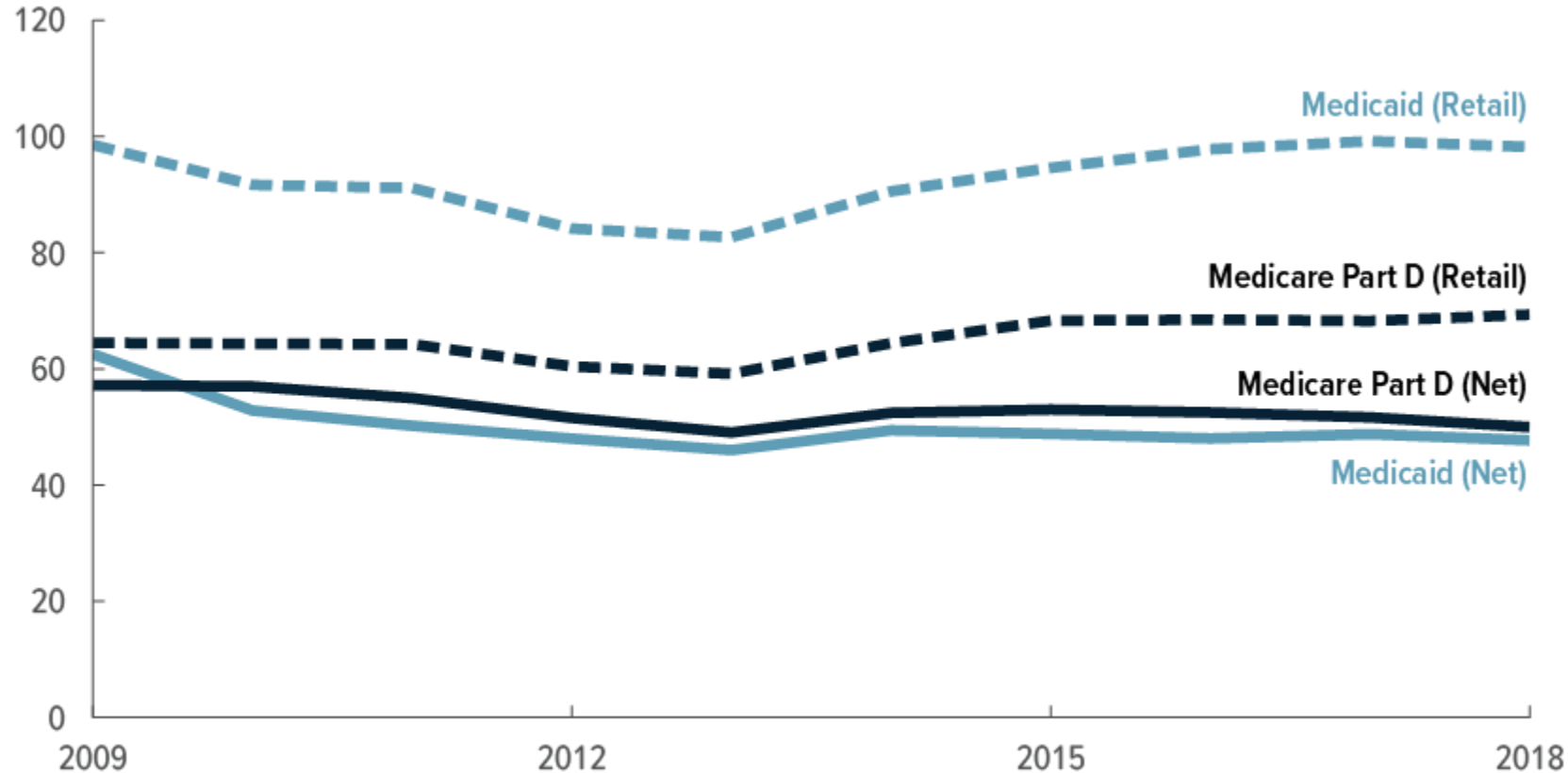
- Nationwide—from 75 percent to 90 percent;
- In Medicare Part D—from 72 percent to 90 percent;
- In Medicaid—from 70 percent to 87 percent.

In recent years, that growth has slowed.

- Since 2016, the share of prescriptions with a generic option has equaled 92 percent.
- Since 2013, 97 percent of prescriptions with a generic option have been dispensed as generic drugs.

Average Prices for Prescription Drugs Obtained Through Medicare Part D or Medicaid

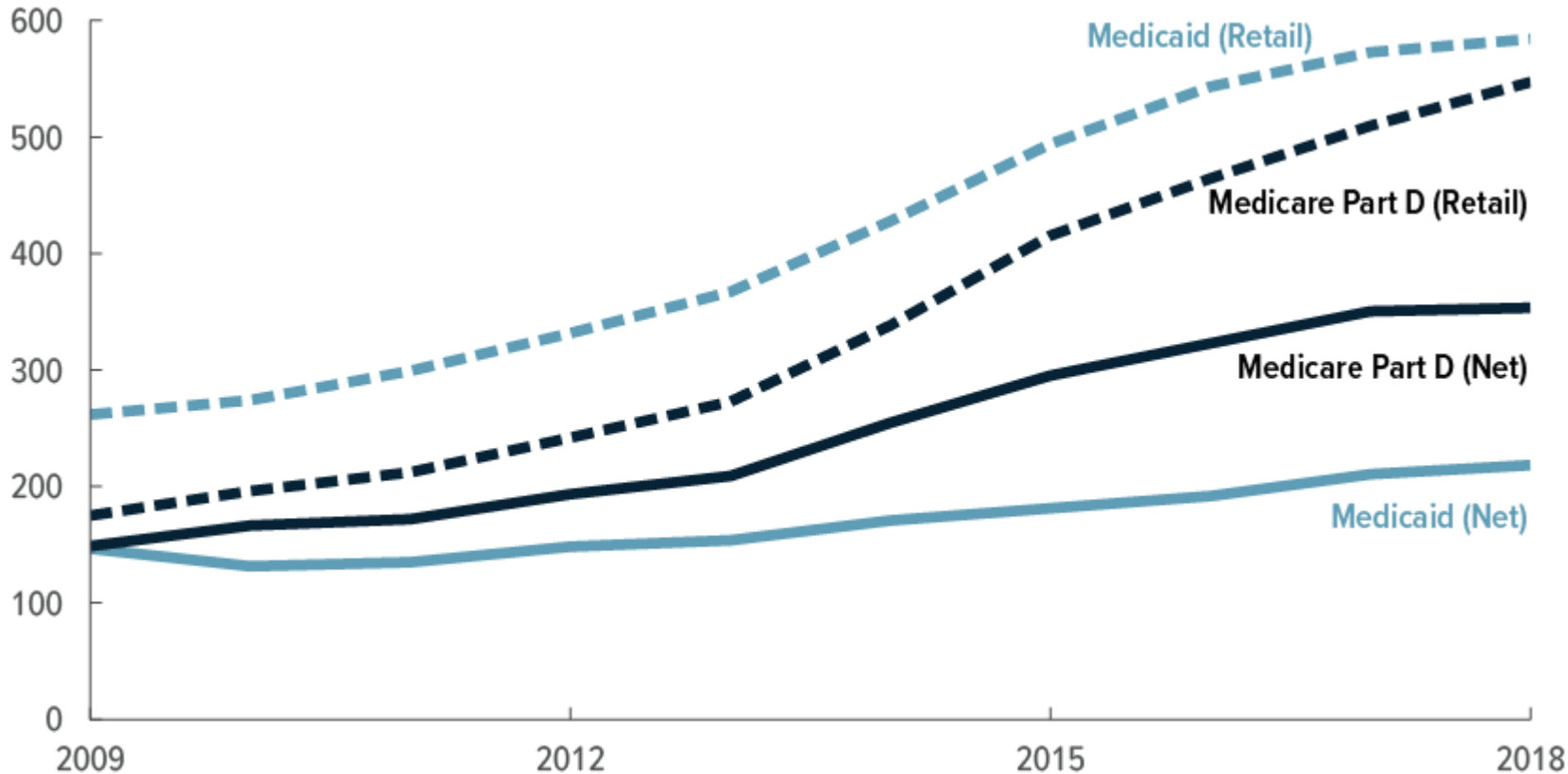
2018 Dollars



Average prices for prescription drugs did not fall significantly over the 2009–2018 period (despite greater use of lower-cost generic drugs) because prices for brand-name drugs increased. Variations in prices between Medicare Part D and Medicaid reflect differences in the types of drugs that physicians prescribed for enrollees and differences in the two programs’ post-sale rebates and discounts.

Average Prices for Brand-Name Prescription Drugs Obtained Through Medicare Part D or Medicaid

2018 Dollars



Growth in prices for brand-name drugs from 2009 to 2018 stemmed from various factors, including higher average prices for drugs entering the market than for drugs already on the market and year-over-year price increases for drugs after they entered the market.

Increases in the Rebates and Discounts Paid for Brand-Name Drugs

From 2009 to 2018, the sum of rebates and discounts paid for brand-name drugs as a share of spending for those drugs (at retail prices) rose:

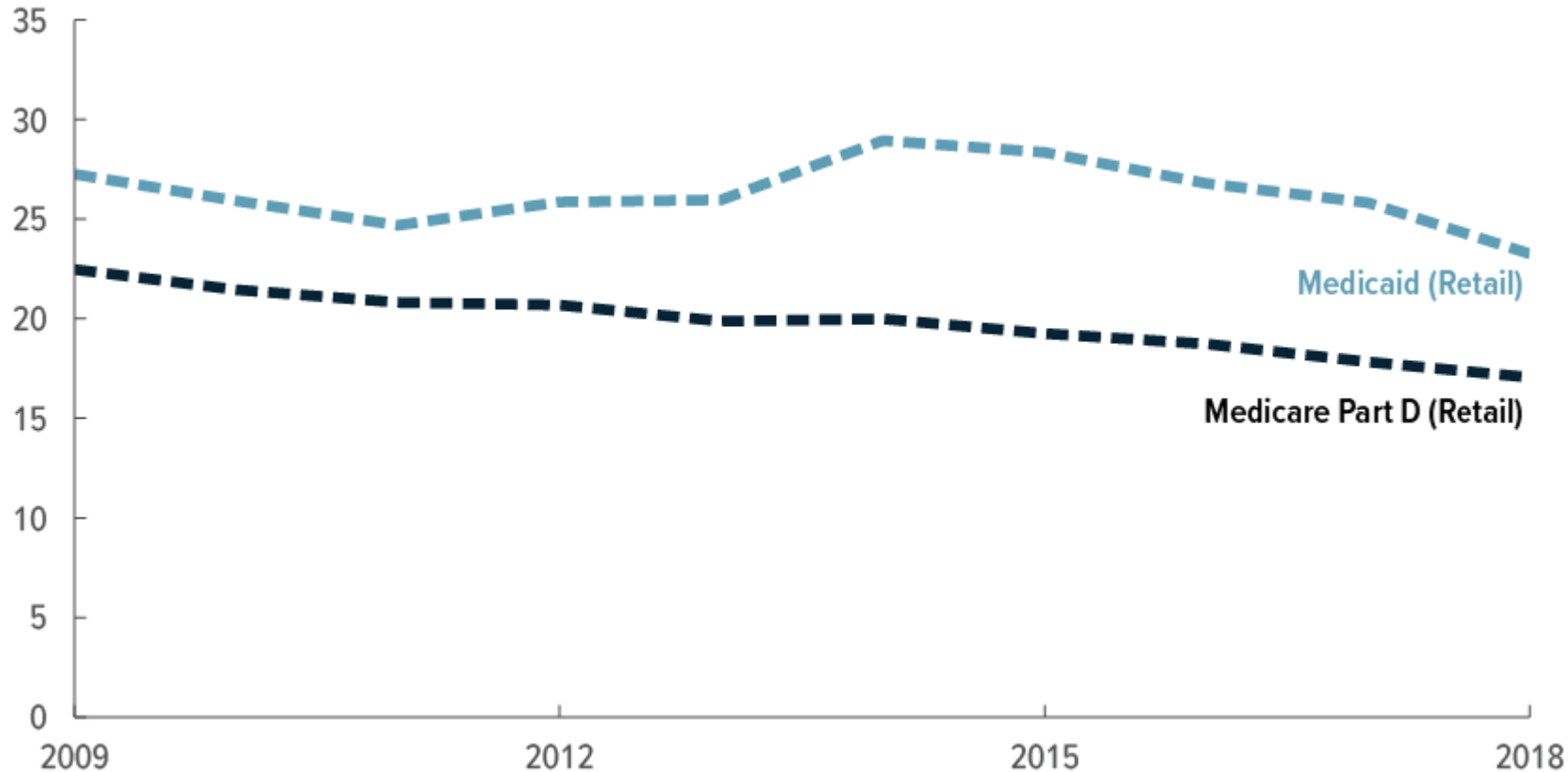
- In Medicare Part D—from 15 percent to 35 percent; and
- In Medicaid—from 44 percent to 63 percent.

Those increases in rebates and discounts resulted from two underlying factors.

- Statutory requirements:
 - In Medicare Part D, a manufacturer discount program was added in 2011.
 - In Medicaid, the minimum rebate percentage increased in 2010, and the inflation-based component tends to increase rebates over time.
- Increased competition among therapeutic substitutes also could have played a role.

Average Prices for Generic Prescription Drugs Obtained Through Medicare Part D or Medicaid

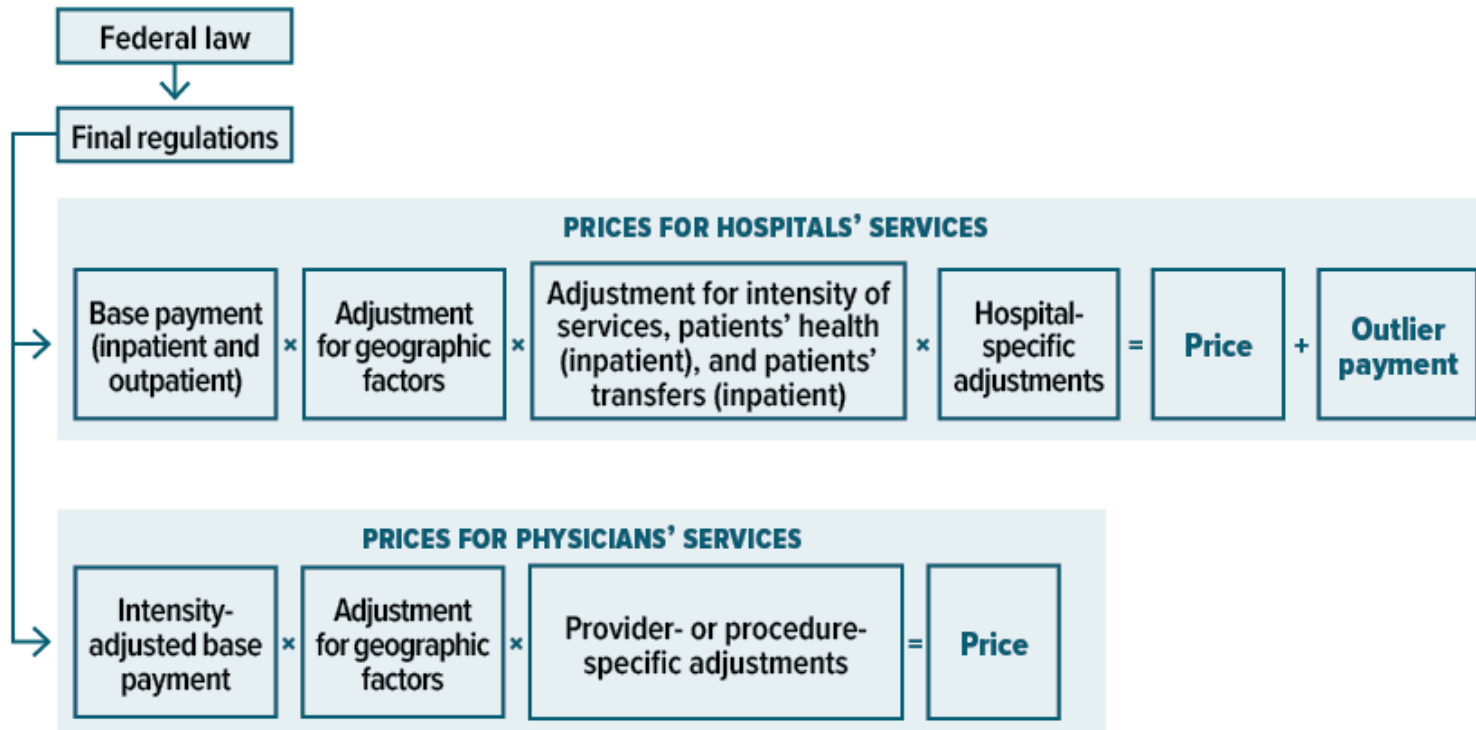
2018 Dollars



Unlike average prices for brand-name drugs (which tend to rise over time), average prices for generic drugs tend to fall over time as competitors enter the market.

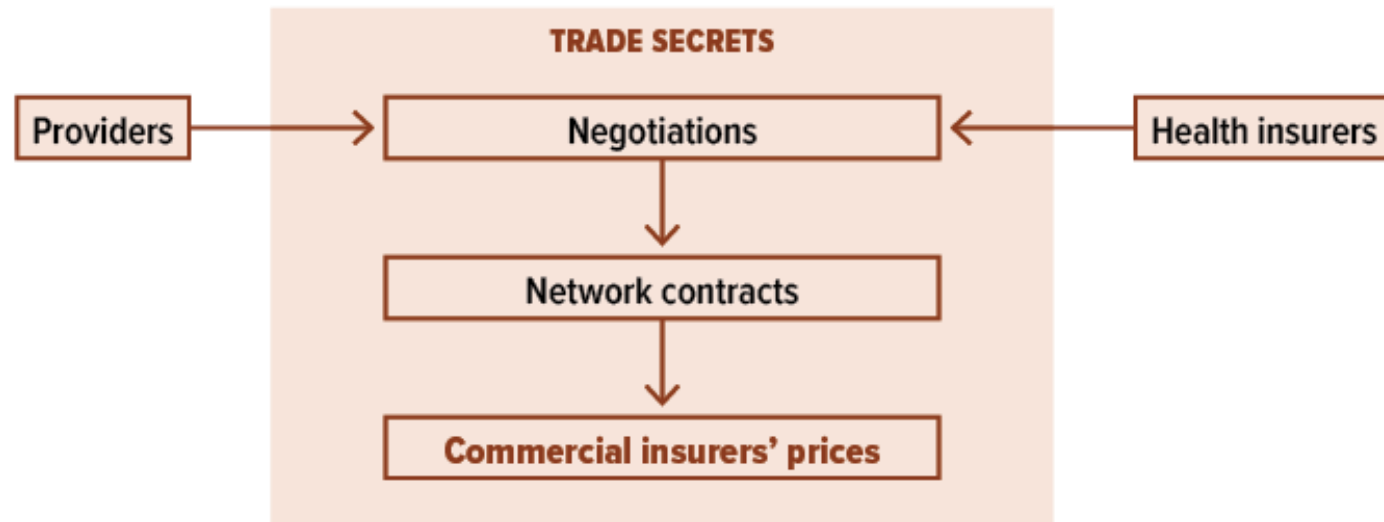
The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services

How the Medicare Fee-for-Service Program Determines Prices for Hospitals' and Physicians' Services



Prices for inpatient, outpatient, and physicians' services in the Medicare fee-for-service (FFS) program are set administratively by the federal government. Base-payment rates are adjusted to account for specifics of the provider, patient, or service.

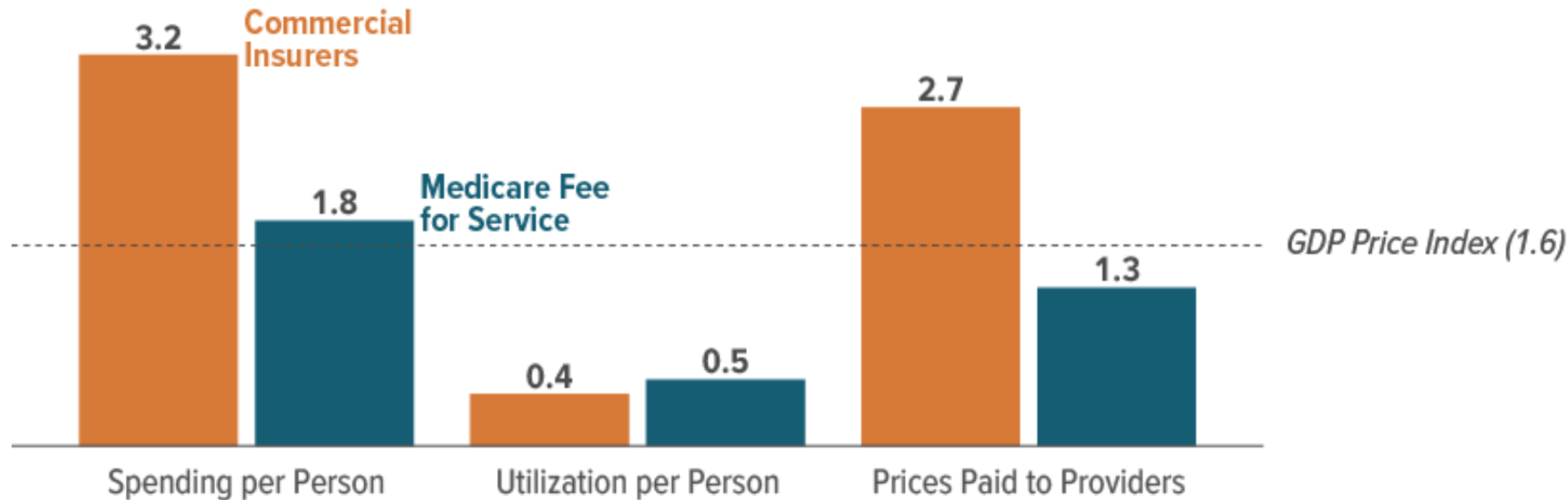
How Commercial Insurers' Prices Are Determined



The prices paid by commercial insurers are determined through confidential negotiations between individual insurers and individual providers or groups of providers.

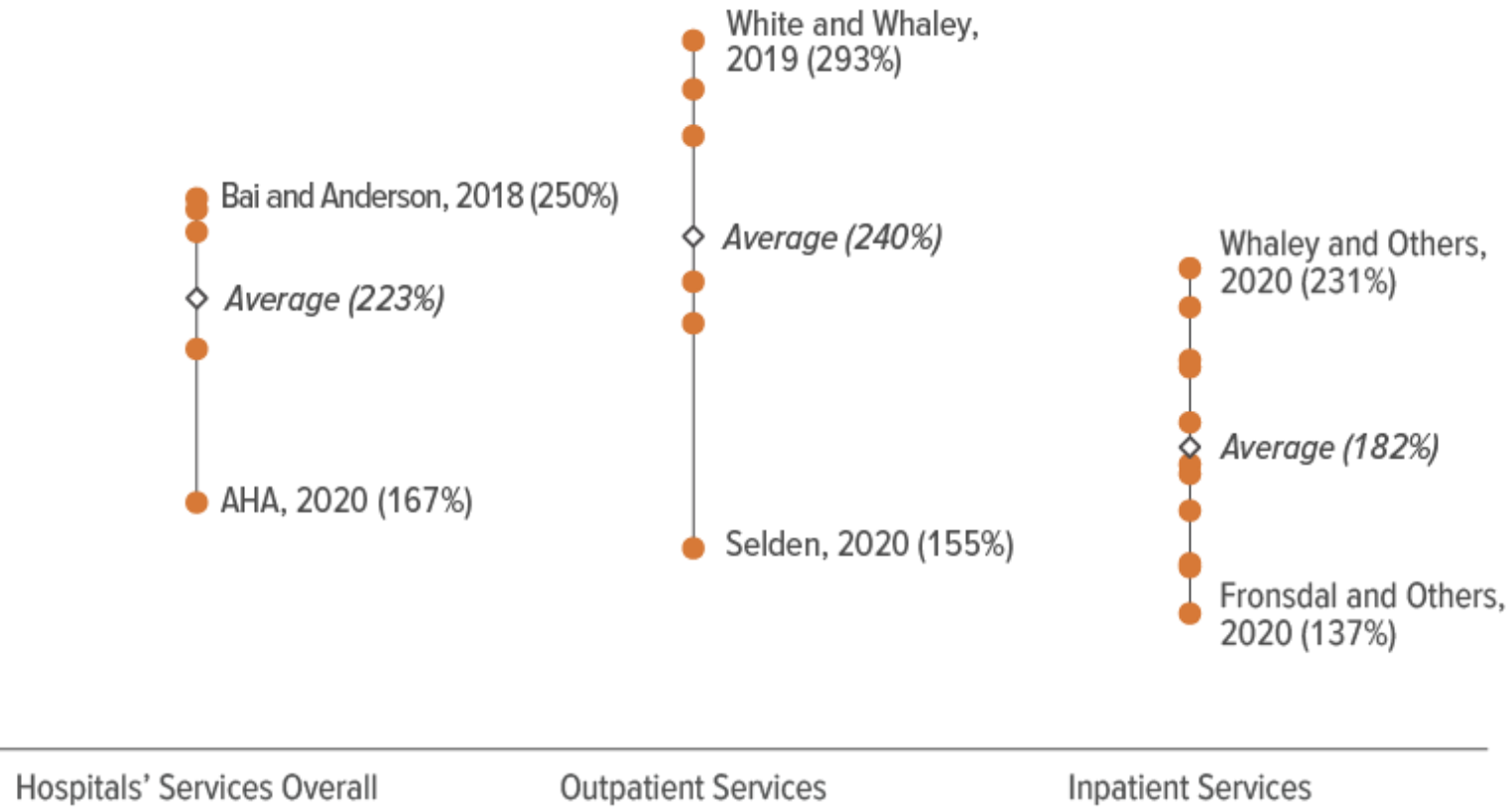
Average Annual Growth Rates of Spending, Utilization, and Prices for Hospitals' and Physicians' Services, 2013 to 2018

Percent



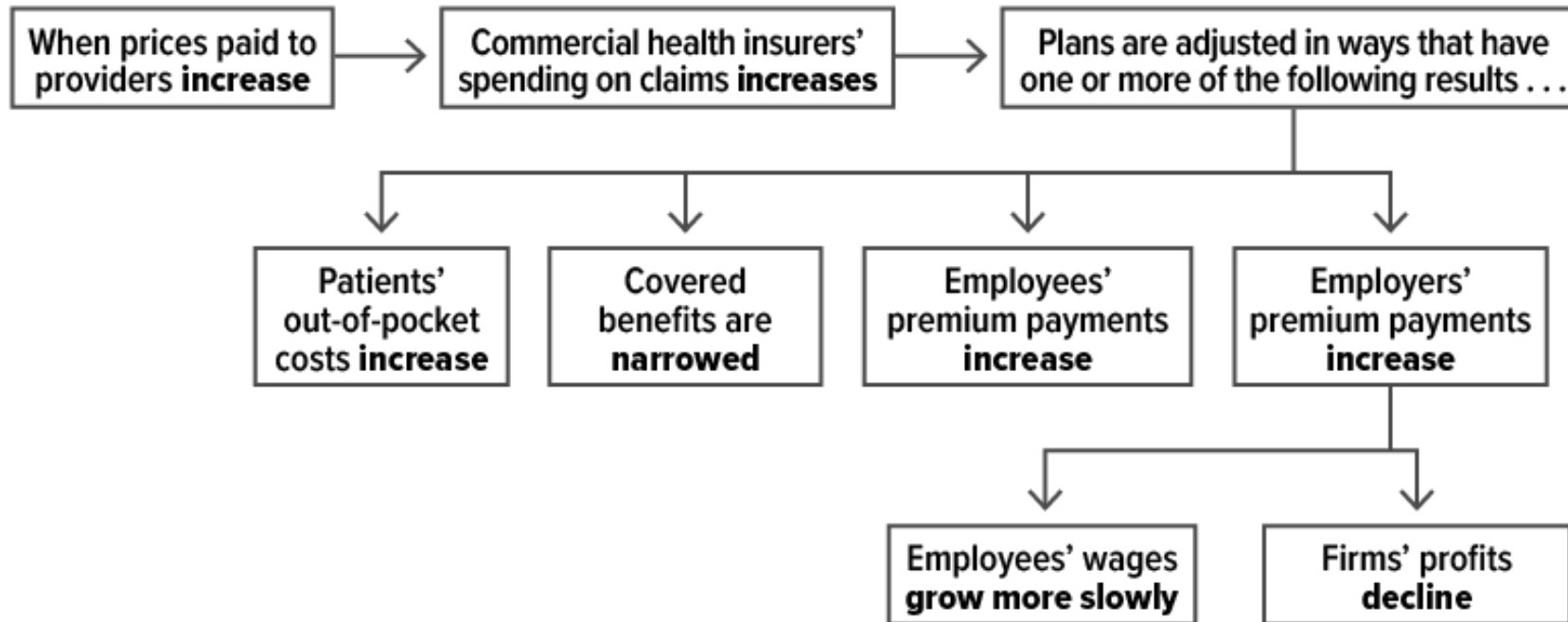
Increases in the prices paid by commercial insurers and Medicare FFS were the major reason for growth in their per-person spending on hospitals' and physicians' services. Price increases were larger for commercial insurers, exceeding the rate of inflation.

Studies' Estimates of the Prices Paid by Commercial Insurers for Hospitals' Services as a Percentage of Medicare FFS's Prices



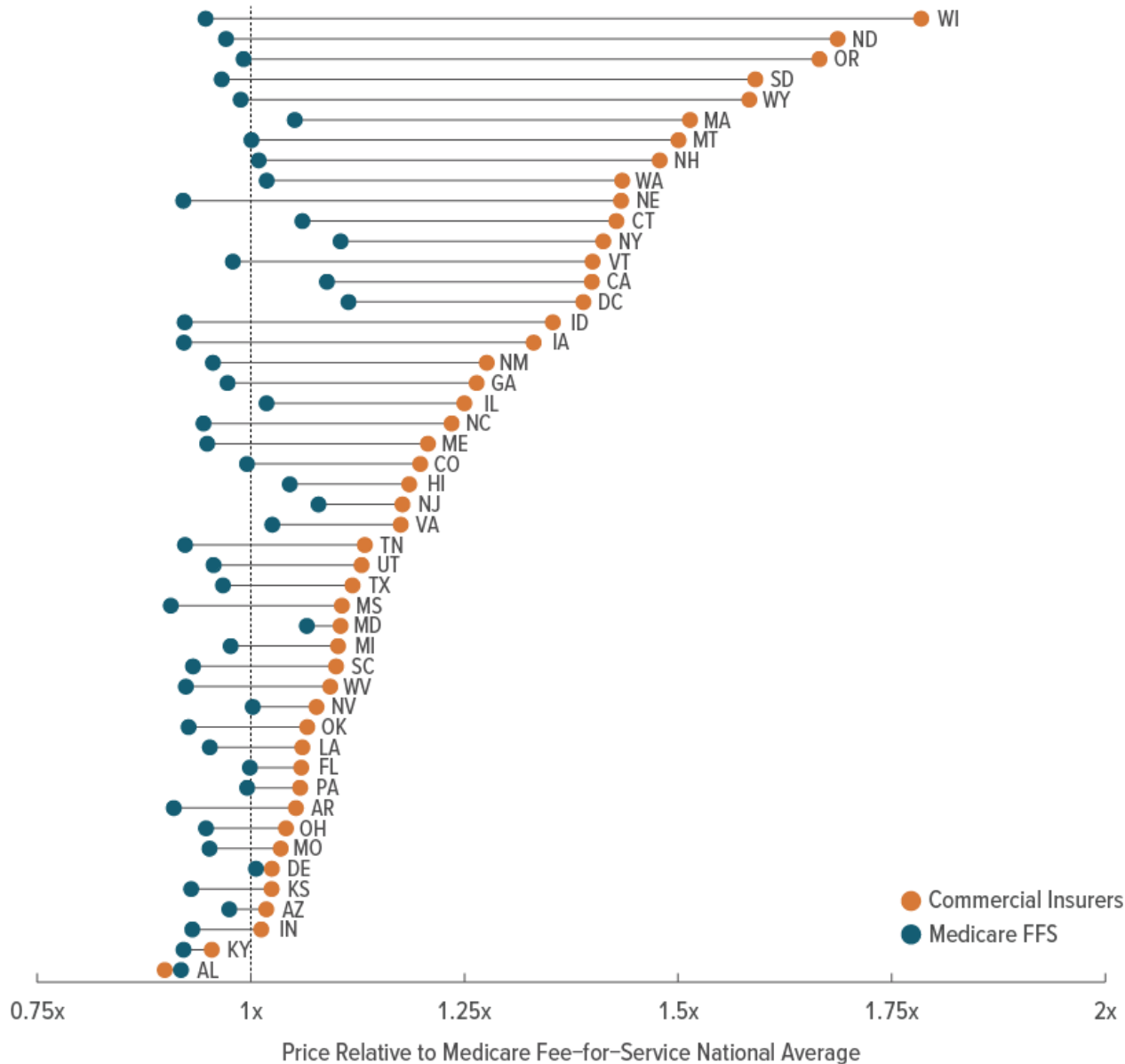
For hospitals' services as a whole, the prices paid by commercial insurers were more than double the prices paid by Medicare FFS, on average, in recent years.

Effects of Higher Prices Paid by Commercial Insurers on Health Insurance Premiums, Benefits, Out-of-Pocket Costs, and Wages



All else being equal, increases in the prices that commercial insurers pay providers are associated with higher premiums for employers and employees, greater out-of-pocket costs for enrollees, narrower covered benefits, slower wage growth for employees, or smaller profits for firms.

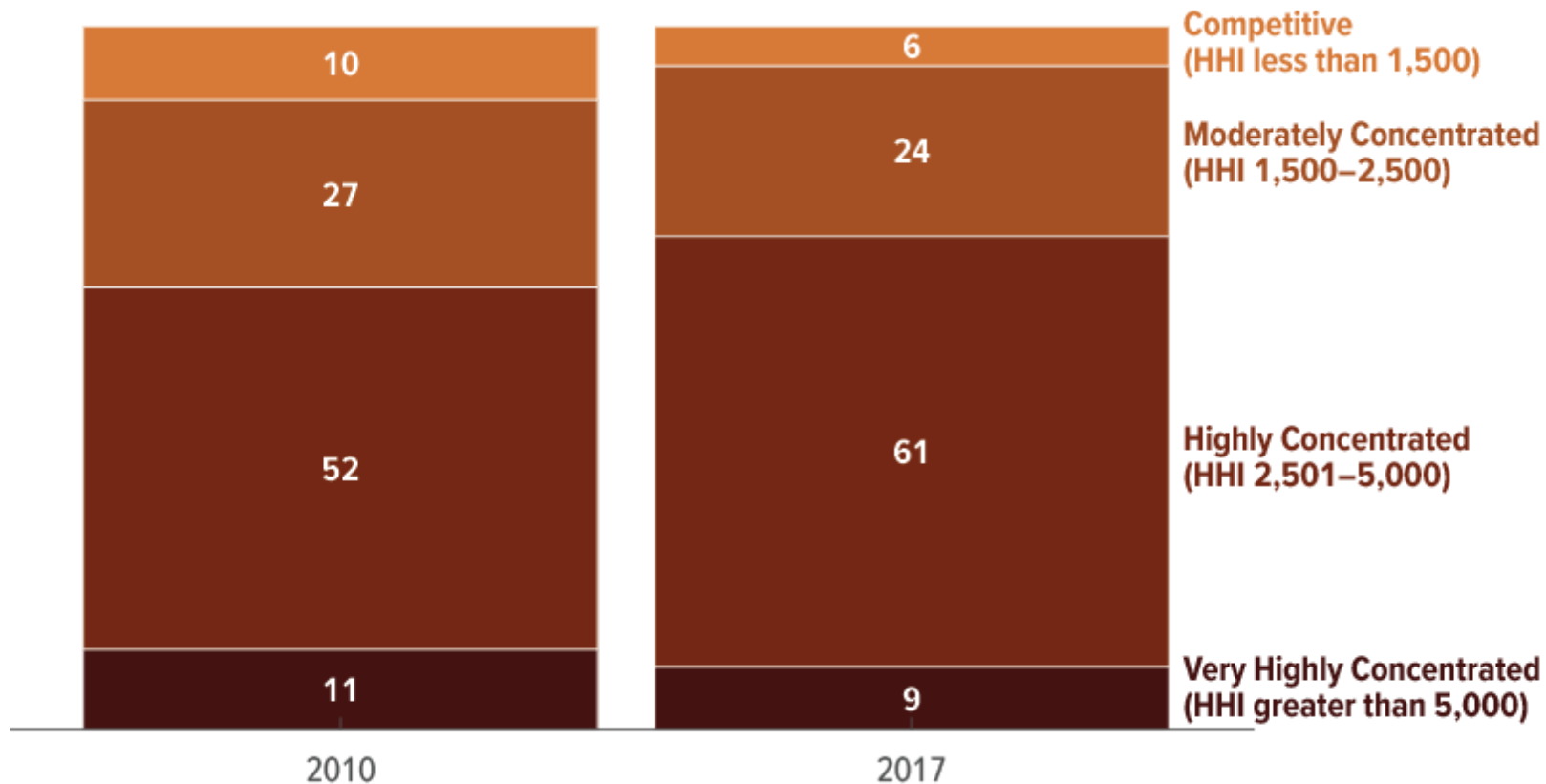
Average Prices for Physicians' Services, by State, 2017



The prices paid by commercial insurers for physicians' services varied substantially among states in 2017. Relative to Medicare's FFS prices, the prices that commercial insurers paid were highest in Wisconsin, North Dakota, and Oregon.

Hospital Market Concentration, 2010 and 2017

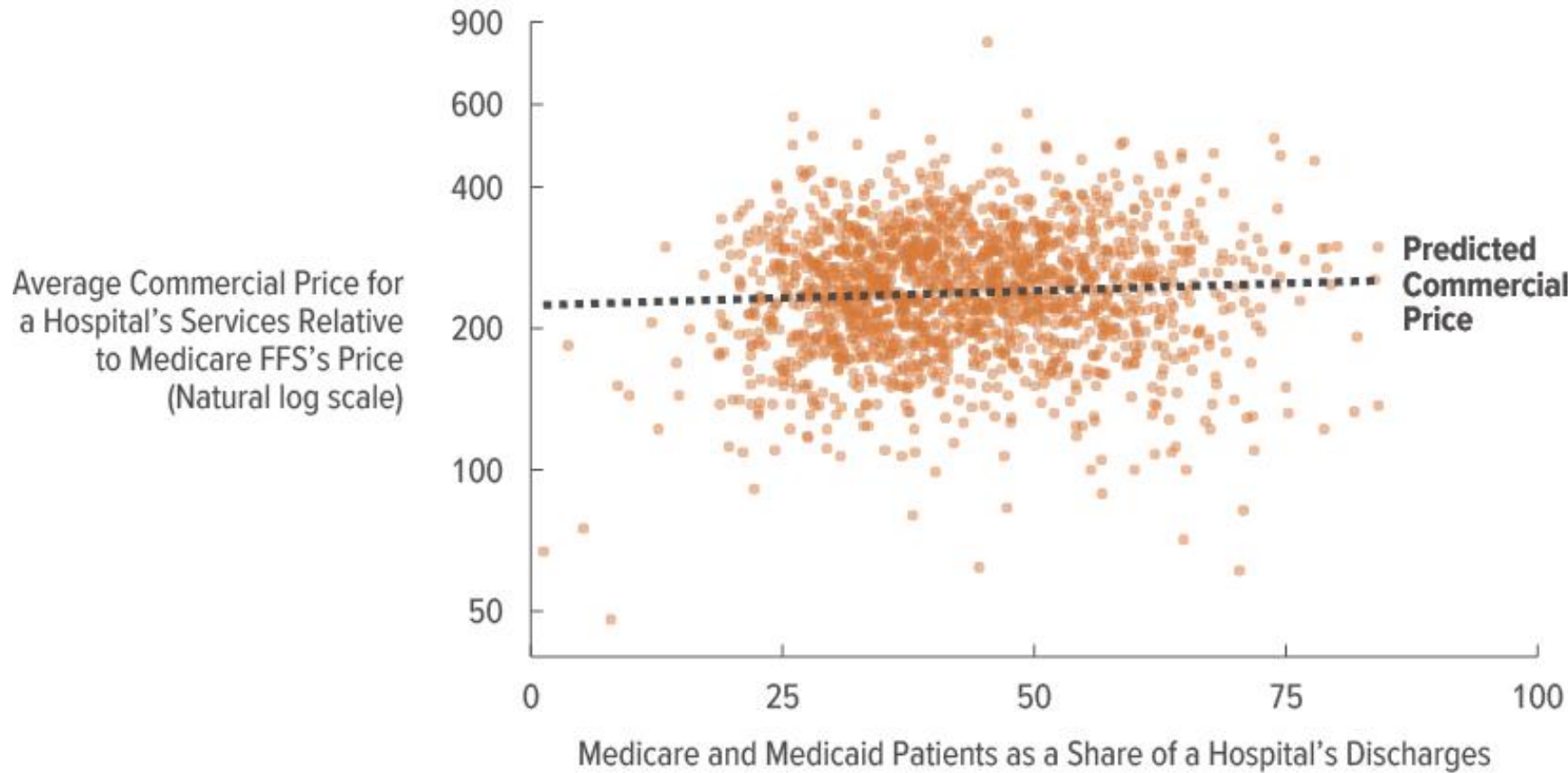
Percentage of MSAs



The percentage of metropolitan statistical areas (MSAs) with hospital markets that were highly or very highly concentrated (as measured by a Herfindahl-Hirschman Index of more than 2,500) increased from 63 in 2010 to 70 in 2017.

Relationship Between a Hospital's Share of Medicare and Medicaid Patients and Commercial Insurers' Average Price for Its Services

Percent



Over the 2016–2018 period, the average price paid by commercial insurers for a hospital's inpatient and outpatient services combined was weakly associated with the hospital's share of discharged patients covered by Medicare or Medicaid.