

DRUG PRICING FACT SHEET



Prescription drug spending is rising and expected to grow faster than most other major health care goods and services by the end of the next decade.¹

- Prescription drug spending represents a significant share—about 14%—of all health care spending.²
- Drug spending grew by 32% over the 2012-2018 period, which was more than 3 times inflation during that same period.³
- The problem is not getting better. Drug spending growth is projected to accelerate to 62% between 2019 and 2028.⁴
- Monthly premiums and deductibles for Medicare Part B rose by approximately 7% from 2019 to 2020.⁵ This increase is attributed to greater spending on physician-administered drugs. From 2020 to 2021, monthly premiums and deductibles for Medicare Part B continued to rise by approximately 2.6%.⁶

\$33,460 **AVERAGE SPENDING**
per Medicare Part D beneficiary using brand-name specialty drugs (after rebates)

Faster growth in spending is driven by higher drug prices and an anticipated increase in spending on costly new specialty drugs.⁷

- Brand-name specialty drugs accounted for just 1% of prescriptions and about 30% of net drug spending in both Medicare Part D and Medicaid in 2015.⁸
 - The average net price per prescription of a brand-name specialty drug grew at an average annual rate of 22% in Medicare Part D and 12% in Medicaid between 2010 and 2015.⁹
- In Medicare Part D:
 - Between 2010 and 2015, spending per beneficiary who used a brand-name specialty drug tripled, reaching \$33,460 after rebates.¹⁰
 - Overall spending on specialty drugs has risen from \$3.4 billion in 2007 to \$37.1 billion in 2017.¹¹
 - Overall growth in spending is driven increasingly by the relatively few, but growing number of, enrollees who reach the catastrophic phase. In 2017, 3.6 million Part D enrollees (about 8 percent) had spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees). High-cost enrollees accounted for nearly 60% of all Part D spending in 2017, up from about 40% before 2011.¹²
 - The price for one of the most frequently used hepatitis C treatments (an antiviral) averaged about \$31,000 per claim, and many cancer therapies had prices that ranged from about \$10,000 to over \$14,000 per claim. Because of their high prices, even a single claim for antiviral drugs or drugs used to treat cancer would be sufficient to meet the true out-of-pocket (TrOOP) threshold, at which point enrollees enter the catastrophic phase of the benefit.¹³
 - In 2017, more than 370,000 enrollees filled a prescription for which a single claim would have been sufficient to meet the TrOOP threshold, up from just 33,000 in 2010.¹⁴
- In 2019, high cost specialty drugs accounted for 36% of the pharmacy industry’s prescription dispensing revenues—a new high for the industry.¹⁵ This is projected to reach 47% in 2022.¹⁶

Higher drug prices are a major driver of drug spending growth.

- Total per-person drug spending before rebates grew by 26% between 2014 and 2018 for people with employer-sponsored insurance. Average point-of-sale drug prices increased by 21% over the period while utilization only increased by about 4%.¹⁷
- Brand-name drug list prices grew 110% between 2012 and 2016 for employer-sponsored insurance while brand-name utilization declined.¹⁸
- The average annual retail price of 61 widely used specialty drugs for treating chronic conditions reached \$78,871 in 2017, which is nearly triple the average annual retail price for specialty drugs in 2006, the year Medicare implemented Part D.¹⁹
 - This means that many people with employer-sponsored health insurance have to pay 24% of this amount for these specialty drugs, on average, or nearly \$19,000.^{20, 21}
- Although brand-name drugs comprise only 10% of all dispensed prescriptions in the US, they account for 80% of drug spending.²²
- Pharmaceutical prices abroad are significantly lower than prices in the US.
 - The U.S. pays 3 times more than the UK for the top 20 highest-revenue-grossing brand-name drugs.²³
 - Single source drugs are, on average, 3.2 to 4.1 times higher in international markets (UK, Japan, and Canada) than in the US.²⁴
 - Prices for a selection of Part D drugs were nearly 4 times higher in the US than in other countries. Drug prices are significantly higher even when accounting for rebates.²⁵
 - Prices for certain top selling Part B drugs were 1.8 times higher in the U.S. than a basket of those same drugs in European countries.²⁶
- Pharmaceutical manufacturers slow price increases strategically in the face of political pressures, only to resume larger price increases later on.²⁷
 - Pharmaceutical net price increases moderated starting in 1993, around Clinton's proposed drug price regulations and in 2000 and 2004, just before the presidential elections. This suggests that these price moderations reflect manufacturers' efforts to limit political support for campaign platforms that include pharmaceutical price regulations.²⁸

Brand-name manufacturers often engage in anti-competitive practices that help extend their monopoly power long after FDA exclusivities or original patent protections run out.

- Brand-name manufacturers often obtain additional patents on features of drugs that do not change clinical effectiveness as a tactic to delay more affordable generic drugs from entering the market.^{29, 30}
- Between 2005 and 2015, about 75% of new patents for drugs were for existing drugs on the market. Of the roughly 100 best-selling drugs, nearly 80% obtained an additional patent to extend their monopoly period at least once; nearly 50% extended it more than once.³¹
- Humira, a biologic with nearly \$20 billion in annual sales (\$12 billion of which comes from U.S. payers), was originally approved by the FDA in 2002, but its manufacturer, AbbVie, has over 100 patents on Humira that are successfully blocking launch of its biosimilar until 2023.³²
 - The net price of Humira rose from \$19,000 a year in 2012 to \$38,000 a year in 2018, 5 times the price of other developed countries.³³
- Unlike in the U.S., biosimilars to Humira were able to launch successfully in Europe. Europe has over 50 approved biosimilars.³⁴ These products have launched with discounts sometimes exceeding 70%.³⁵ As of December 2020, 29 biosimilars are approved in the U.S. with only 20 confirmed launches to-date.^{36, 37} The remaining face significant legal challenges that delay their market entry.
 - Humira revenues fell 13.6% internationally in 2020 when compared to 2019 due to biosimilar competition, according to AbbVie, while revenues increased 8.4% in the United States, where there is currently no biosimilar competition until 2023.³⁸
- Brand-name manufacturers can delay generic competition by paying a generic competitor to withhold the generic version of the product from the market. These “pay-for-delay” deals cost American consumers \$3.5 billion a year in the form of higher drug prices.³⁹
- Abuse of the citizen's petition process by brand-name manufacturers prevented generic introduction and resulted in an estimated financial cost to society of \$1.9 billion, or \$3.6 million per day. The total financial cost to government insurance programs was roughly \$782 million.⁴⁰

Profits generated from high launch prices well exceed the amount necessary for research and development.

- In 2018, the pharmaceutical industry spent \$6.46 billion on direct to consumer advertising—nearly double the amount spent in 2012.⁴¹
- Pharmaceutical manufacturers based in the U.S. generated 176% of the revenues needed to fund their global R&D budgets by charging high prices to the US.⁴²
- Some industry reports assert that it costs \$2.9 billion to bring a new drug to market. However, a report found that the direct R&D costs to develop a new cancer drug were less than a quarter of that amount (\$648 million) suggesting industry estimates are exaggerated.^{43, 44}
- NIH funding contributed to the development of all new molecular entities approved by FDA between 2010 and 2016. Collectively, this research involved more than 200,000 years of grant funding totaling more than \$100 billion.⁴⁵
- Publicly supported research had a major role in the late stage development of at least one in four new drugs approved over the last decade, either through direct funding of late stage research or through spin-off companies created from public sector research institutions.⁴⁶

High drug prices create access problems for many Americans.

- Nearly a third of adults reported not taking a medication as prescribed in 2018 because of cost.⁴⁷
- Specialty medications cost, on average, over \$78,000 a year at retail prices and many people with employer-sponsored health insurance have to pay, on average, 24% of this amount, or nearly \$19,000.^{48, 49}
- 42% of cancer patients deplete their entire net worth within the first 2 years of treatment.⁵⁰
- 30% of Americans cannot afford a \$400 emergency, making high drug copayments difficult to manage.⁵¹
- To help reduce prescription drug spending, the Utah public employee's health plan is offering to send some members to Mexico to purchase certain drugs that treat multiple sclerosis, cancer, or autoimmune diseases. The drug Avonex, for treatment of multiple sclerosis, costs about \$6,700 for a 28-day supply in the U.S., but costs only about \$2,200 in Mexico. The savings more than outweigh the travel costs.⁵²
- One out of every three GoFundMe donations go towards medical costs.⁵³
- By the end of 2019, 22.9% of adults (approximately 58 million adults in total) experienced an inability to pay for a prescribed medication in the past year, and this percentage has been on the rise. This so-called “medication insecurity” also disproportionately affects women.⁵⁴
- A study of 9.5 million newly-diagnosed persons with cancer 50 years of age or older found that 42.4% of individuals depleted their life assets 2 years following a cancer diagnosis, extending to 38.2% at 4 years following. Financial toxicity was independently associated with worsening cancer, demographic and socioeconomic factors, and clinical characteristics.⁵⁵

10% VS. 80%

BRAND-NAME DRUGS

comprise only one in 10 dispensed prescriptions but drive 80 percent of the drug spend

33%

PERCENTAGE OF ADULTS

who said they were unable to take medication as prescribed because of cost

\$78,871

AVERAGE RETAIL PRICE

for 61 most widely used specialty drugs for chronic conditions

Americans are demanding that lawmakers act.

- 53% of voters identify the cost of health care as a top issue Congress and the president should address, more than any other issue.⁵⁶
- 84% of voters surveyed said prices charged for prescription drugs are unreasonable.⁵⁷
- Nearly 90% of U.S. adults report that the costs of prescription drugs are “usually much higher” (69%) or “tend to be somewhat higher” (20%) than what consumers should be paying for them.⁵⁸
- Nearly 90% of voters support Medicare negotiation for single source, high cost drugs even when taking into account concerns over R&D investments and access concerns.⁵⁹
- More than 85% of voters nationwide, including 81% of Republicans, want the United States Senate to take more action to lower the cost of prescription drugs.⁶⁰
- An overwhelming majority of Americans, both Republicans and Democrats, support aggressive action to lower drug prices including making it easier for generic drugs to come to market and allowing the government to negotiate prices in Medicare.⁶¹
- 83% of voters support the Senate’s Prescription Drug Pricing Reduction Act: 87% of Democrats support the bill and Republicans support it by an 84%-to-7% margin.⁶²
- 83% of voters reject the pharmaceutical industry’s claim that the inflation penalties in this bill are too harsh.⁶³
- 80% of voters reject the pharmaceutical industry’s claim that penalizing drug corporations for hiking prices beyond the rate of inflation will affect patient care, and 82% of voters believe the bill will have no impact or result in better care.⁶⁴
- Nearly 75% of all voters said they would be more likely to support a candidate for Senate if they supported the bill.⁶⁵
- Voters across party lines and in a variety of Congressional districts have supported government intervention in drug patent monopolies and manufacturing to help speed affordable prescriptions to market.⁶⁶

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2 Calculated using Exhibit 1: <https://altarum.org/sites/default/files/uploaded-publication-files/Altarum%20Projections%20of%20the%20Non-Retail%20Drug.pdf>

3 Analysis of Centers for Medicare & Medicaid Services, Office of the Actuary prescription drug spending data from the National health Expenditure Accounts, Table 16 and BLS data on CPI-U 2011-2017.

4 Analysis of Centers for Medicare & Medicaid Services, Office of the Actuary prescription drug spending data, Table 11.

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