INTRODUCTION
The United States healthcare system needs to confront one of its biggest issues head on—the escalating cost of healthcare. According to the Centers for Medicare and Medicaid Services, total healthcare costs in the U.S. more than doubled between 2000 and 2011, from $1.37 trillion to more than $2.7 trillion. Per capita healthcare spending rose during that time from $4,878 to $8,680.

The use of prescription drugs, notably brand-name prescriptions, has been a significant cost driver for several decades. The many new drugs available have significantly improved people’s health, but they have also increased healthcare costs, and prices continue to rise.
Why Are Prescription Drug Costs So High?

Prescription drugs account for an estimated 10 percent of all healthcare spending in the United States, an estimated $307 billion in 2010, projected to rise to $457.8 billion by 2019 according to the United States Department of Health and Human Services (HHS). Some 90 percent of seniors and 57 percent of non-elderly adults had some kind of prescription drug expense in 2010, according to HHS’s Agency for Healthcare Research and Quality. U.S. prescription drug spending is high compared to other developed nations—even though the U.S. has only 4.5 percent of the world’s population, it accounts for 42 percent of the world’s annual prescription drug expenditures.

Prescription costs continue to rise even though there are more generic drugs available at lower costs than at any time in history. Currently, the average price of a generic drug is approximately 80 percent to 85 percent lower than the average price for a brand-name drug, according to the FDA’s “Facts about Generic Drugs.” In 2012, generic drug costs decreased by 24 percent while overall, prescription drug prices rose 3 percent to 6 percent, which is twice the rate of inflation, according to the Bureau of Economic Analysis.

Even though brand-name drugs account for only 22 percent of all prescriptions dispensed, they account for 78 percent of all drug spending. That’s because

This white paper examines why prescription drug costs are so high, and details an increasingly popular solution for driving down costs—consumer-driven healthcare, in which consumers are given information and incentives to participate more fully in managing their own healthcare, and in doing so, help drive down costs and improve outcomes.

The paper outlines why prescription drug costs are high, reviews why consumer-driven healthcare is becoming popular, details how consumers can be engaged to take more responsibility for their healthcare choices, and shows the very real-world savings that consumers and payers can see as a result.
brand-name drug prices are rising far more quickly than generic drug prices go down, especially when there are no generic alternatives for the brand-name drugs. Health plans and Pharmacy Benefit Managers (PBMs) have done a great deal of work switching members away from brand names to generics. But to drive costs down, something has to be done about the 22 percent of drugs dispensed—the brand-name prescriptions—the cost of which cancels out any savings achieved through generics switching.

Adding to high costs is the increasing number of prescriptions. The Kaiser Foundation reports that between 1999 and 2009, the number of drugs prescribed grew 39 percent, from 2.8 billion to 3.9 billion, even though the U.S. population grew during that time by only 9 percent. The average number of prescriptions per capita grew from 10.1 in 1999 to 12.6 in 2009.

The cost of individual prescriptions continues to rise, with the average price of a generic drug at $72, and the average price of a brand-name drug at $198 in 2010.

The release of new drugs contributes to an increase in spending on prescription medications if they replace older, less-costly drugs, if they supplement rather than replace existing drugs, or if they are used to treat a condition that previously had not been treated with drug therapy.
The Growing Trend Towards Patient-Centered, Consumer-Driven Care

All healthcare costs, not just those related to prescription drugs, have been rising precipitously, and employers, health plans, and PBMs have looked for ways to reduce costs without sacrificing quality. One of the most promising is patient-centered, consumer-driven programs, which have become increasingly common and can play a large role in both reducing costs and improving healthcare outcomes.

The increasing popularity of patient-centered, consumer-driven healthcare is driven not only by rising prices, but also by a number of other factors, some mirroring overall societal changes in the way that people seek out and use information, and others driven by government action and regulation. It promises to change the way healthcare is delivered and consumed for decades to come.

The healthcare reform law passed in 2010, the Patient Protection and Affordable Care Act (often referred to by its acronym ACA), makes clear that patient-centered care has a significant future in the healthcare system. Its provisions frequently refer to patient satisfaction, the patient’s experience of care, patient engagement, patient-centeredness, and shared decision-making—concepts that are at the core of patient-centered care. The law goes beyond paying lip service to the concepts. It requires that measures be used to judge the quality of care, and that the information be publicly reported. These measures include patient-centered assessments, such as those related to medication management services in treatment of chronic disease.

Michael L. Millenson and Juliana Macri note in a paper funded by the Robert Wood Johnson Foundation and Urban Institute that, “A serious and sustained effort to build a patient-centered healthcare system is starting to gain momentum, in part because of the ACA and in part because of a growing evidence base showing the importance and usefulness of engaging patients as a way to improve clinical and financial outcomes.”

Patient finances are also a driving factor. Patients are paying more of their healthcare costs and are looking at ways to reduce them. A study by Aon Hewitt found that employees are being asked to pay significantly more in premiums each year, and that their out-of-pocket costs are increasing significantly as well. It found that the average employee contribution for premiums rose from $1,952 in 2010 to an estimated $2,306 in 2012, and out-of-pocket expenses in their households rose from $1,691 in 2010 to an estimated $2,275 in 2012. That translates into a 26 percent increase in only two years.

The Internet’s self-service culture and people’s expectations for increased information and control over every aspect of their lives are also driving consumer-driven care. In a world in which people book and track their travel online, buy everything from books to furniture online, and can access the accumulated knowledge of the world with a single click, they expect that they should be able to get healthcare information and manage their own health via Internet, smartphone, and tablet technologies. Services, such as Microsoft HealthVault, which stores people’s health and fitness information, were developed to meet this need. Some pharmacy chains give customers online access to their prescription information, and some doctors have been giving their patients access to their medical records via Internet portals.

Access to personal medical information can help drive down medical costs and improve outcomes by allowing people to manage their own healthcare—for example, tracking changes in their weight, blood pressure, and cholesterol level while participating in a wellness program.

Employers are asking that employees become more involved in managing their own care, largely because they have found that member involvement drives down health costs and leads to a healthier workforce. As a result, Consumer-Driven Health Plans (CDHPs) have become common. These plans typically feature high deductible levels, a health fund to which the consumer contributes and can draw upon, and information tools to help consumers make more-informed and better healthcare choices. Payers are also turning more frequently to care managers to look for the greatest cost-drivers and to design consumer-oriented programs to drive down those costs.
Consumer-Driven Care Works

A 2013 Consumer Health Mindset study conducted by the National Business Group on Health, Aon Hewitt, and the Futures Company found that after enrolling in a CDHP, 60 percent of people say they changed their behavior for the better concerning health. 28 percent say they more frequently receive routine preventive care, 23 percent look for lower-cost options more frequently, and 19 percent more frequently research healthcare costs.

In Utah, Regence BlueCross BlueShield surveyed 13,000 users of its internet healthcare portal. 30 percent of users found information that helped lower their healthcare costs, and 25 percent had changed their provider based on information there.

Greater insurance cost transparency and increased competition among health plans also spur consumer involvement. This is one area where ACA will have a dramatic impact because it establishes state-regulated insurance exchanges across the country. All insurers will have to list insurance premiums, out-of-pocket copayments, and other coverage information side-by-side to make it easier for consumers to choose among them.

As noted earlier, prescription drug costs are a substantial driver of overall healthcare costs. Prescription drug spending is one area where consumer-driven healthcare can have a significant impact because consumers, health insurance companies, and PBMs can work together to drive down the cost of prescription drugs.

Out-of-pocket healthcare expenses rose 26 percent in only two years.

### RISING EMPLOYEE HEALTHCARE COSTS

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In order to drive down prescription drug costs and improve patient care, employers, insurance companies, and PBMs must find ways to engage members in participating in their own care. One of the simplest and increasingly common ways to engage members is with pharmacy outreach—changing the role of pharmacies from the traditional passive role of primarily filling prescriptions, to one of providing direct consumer information and advice.

For example, CVS Caremark launched a program several years ago in which it sent out personalized communications to consumers in order to encourage them to take medications as directed by their doctors. The program was a clear success: Not only did consumers sign up for automatic prescription refills more frequently, but they also were more willing to substitute generic medications for brand medicines, which lowered costs. Bari Harlam, senior vice president of member engagement for CVS Caremark, said of the program’s impact, “By providing personalized prescription guides that outline options in easy-to-understand language—whether the communications be on the telephone, face-to-face with pharmacists or by letter—we are seeing an increase in the numbers of patients willing to consider generics.” He added that, “These programs are exciting because they offer the opportunity to improve the quality of pharmacy care while helping to reduce overall medical costs.”

The point about engaging patients to improve quality while reducing costs is important. Because the burden of expensive brand-name drugs is so high, one way plans have attempted to reduce prescription costs is denying high-priced brand prescriptions when they are submitted by pharmacies. More than 14 percent of new commercial prescriptions in 2009 went unfulfilled because they were denied. More than 10 percent of prescriptions for new brand-name drugs were denied. But this can be a self-defeating strategy, because denials lead to abandoned prescriptions (up 68 percent) as well as poor adherence. In the end, this most likely increases overall healthcare costs.

A better solution is to find alternatives to high-cost brand-name prescriptions rather than denying access to them. Patent-protected brands may not have generic counterparts, but there are often therapeutic alternatives to them. Frequently a different brand drug, or else a combination of other brand-name drugs, can provide the same medical efficacy but can be significantly less expensive than the original brand-name drugs prescribed—in some cases by as much as 75 percent. Because of recent advances in drug database technology, these alternatives can be easily found and suggested to prescribers, pharmacists, and patients, notably by using the MEDalternatives database. MEDalternatives is a clinical engine solution that identifies appropriate medication alternatives and prescription cost savings. It can empower members and providers to improve medication choices by providing relevant information, including dosing information and monthly and annual cost savings. Its benefits go beyond prescription drug costs. By reducing costs and removing barriers to adherence with drug regimens, it can reduce overall healthcare costs as well.

Members can be shown this information in a number of different ways. Postcards can be sent to them, telling them how much they can save monthly, with a link to their own personalized portal. QR codes can also be printed on the postcards, allowing members to scan them with their smartphones or tablets, which would then send them to the link. Similarly, emails can be sent with embedded links that, when clicked, sends members to a lookup page with pre-populated money-saving prescription options. Text messages can also be used. The information can also be provided to consumers via self-service, Web-based portals and mobile applications.

Physicians can offer patients this information at the point of prescribing, via follow-up letters, or using medication therapy management services that look at a patient’s complete list of prescriptions and treats them holistically.
Finding alternatives for high-cost brand-name prescriptions can offer significant savings to consumers, insurance companies, and PBMs. To help gauge how much can be saved, Elsevier has created a calculator (www.goldstandard.com/MEDalternatives) that looks at the savings that can be realized by substituting less costly alternatives for brand-name drugs. The three examples above, generated by the calculator, give a sense of what savings can be gained.

**CONCLUSION**

Consumer-driven healthcare holds great promise for improving healthcare and lowering costs, particularly prescription drug spending. As consumer-driven care becomes standard, consumers will want more information about their medications, especially concerning cost and efficacy.

Insurers and PBMs can help with tools like MEDalternatives, a clinical engine solution that empowers members and providers to improve medication choices. By reducing costs and removing barriers to medication adherence, it can reduce overall healthcare costs as well as improve outcomes.
MEDalternatives offers therapeutic alternatives and prices, comprehensively derived from the drug database available, able to integrate across diverse HIT systems. Our experienced pharmacy professionals construct and updated MEDalternatives’ drug data and clinical content following peer review of drug classes and medications.

To ensure effectiveness of our drug selection process, we use established formulary methodologies including critical evaluation of medical literature, such as clinical studies, practice guidelines, meta-analyses, FDA-approved package labeling, and consensus approval of therapeutic applications.

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