FIERCE Healthcare

Industry Voices — Cracking the code on drug cost savings through transparency

This is the first in a series of Industry Voices articles that look at the current state of drug cost transparency for prescribers, pharmacists and patients.

By Mackenzie Clark, PharmD, Edward Fotsch, M.D.

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Imagine shopping in an expensive store that has no price tags, and you were unaware of the prices until you reached the checkout line. The inefficiency and absurdity of such a system would be obvious.

Now imagine that the store was selling essential life-saving products, still with no price tags. You needn't imagine such a system—just try picking up a prescription at the pharmacy. For decades, physicians have prescribed medications, while being blind to their costs. Extensive electronic health record (EHR) adoption within the past few decades has done little to improve drug cost transparency. The Centers for Medicare and Medicaid Services has attempted to require cost transparency at prescribing through real-time pharmacy benefit check regulations.

However, the savings and benefits provided by drug cost transparency efforts remain elusive. Why?

First, the good news, physicians are now regularly seeing patients' out-of-pocket costs for prescription drugs at the point of electronic prescribing driven by cost transparency regulations from CMS and thanks to the work of Surescripts and other intermediaries who are integrated into EHRs at the point of prescribing.

The regulations do not require costs for every prescription, just some. They do not require the identification of lower-cost alternative medications. They do not require the identification of total drug costs net of manufacturer rebates to health plan or pharmacy benefit managers, which is the actual cost of the medication.

In short, cost transparency mandates have created a low bar for drug cost transparency which, in practice, leaves providers unable to consistently prescribe in a cost-aware and cost-effective manner. Most PBMs have simply met the minimum standards for cost transparency and have focused on functionality that best fits their business models, including alternative fulfillment messaging that directs patients to the PBM-owned pharmacies, including mail-order pharmacies. Documented savings from cost transparency services have been minimal and therefore, most major employers have not prioritized cost transparency services.

Despite cost transparency regulations, prescribers may not see a drug price in their EHRs when prescribing. Even if they see a price, it is unlikely that they will see a lower-cost alternative. A price tag on a particular good or service is valuable and actionable when the buyer is given a choice between similar alternatives.

Choice breeds competition and places a governor on costs. This is the case for nearly every consumer product or service from smartphones to mortgage rates. Current regulations for cost transparency do not, however, require the inclusion of lower-cost therapeutically equivalent alternatives, which would make cost transparency actionable and arguably reduce costs through enhanced competition.

The lack of lower-cost alternatives, along with all the relevant cost information, also makes savings calculations and return-on-investment analysis very difficult. If this essential information is provided to the prescriber, subsequent analysis of pharmacy claims can identify specific alternatives selected as well as quantify total patient and payer saving and ROI. Without these essential data elements, key stakeholder savings and ROI calculations are impossible. Most cost transparency services provide transaction counts but lack clearly documented savings and ROI resulting from more cost-effective prescribing.

Lastly, a key data element missing in the transparency equation is manufacturer rebates. For a variety of reasons, drug-specific rebate information is not shared between the PBM, payer, patient, or provider. Therefore, the true net cost of a particular drug is rarely known. This is important for several reasons.

First, many patients have a pharmacy benefit with a deductible, including high deductible health plans. In 2020, the average deductible in the United States was $1,945 for a single person and $3,722 for a family. When the deductible resets, the patient may well pay the full cost of the drug until the deductible is met. This also comes into play with the Medicare Part D benefit structure where beneficiaries may pay 25% of the drug cost during the coverage gap phase (aka donut hole) or 5% during the catastrophic phase. For many specialty drugs, this can be hundreds of dollars a month. Therefore, showing copays for patients who are currently out of their deductible phase tells only a part of the cost story.

Second, prescribers who are trying to be cost-effective in prescribing and/or are working with provider groups in accountable care organizations or related at-risk contracts need to know the full cost of the drugs they prescribe net of rebates, not just patient copayments. Rebates are associated with brand-name drugs—the most expensive drugs covered by the pharmacy benefit and those contributing to the majority of the total cost. Rebates can have a substantial impact on lowering the total cost of drugs. Incorporating this information into the final cost calculation and disseminating it through an easy-to-use application should equip prescribers to make more informed prescribing decisions, thus benefiting the key at-risk stakeholders: patients, payers, and providers.

Research underway at the University of California, San Francisco is documenting the impact of missing drug costs, missing or incorrect alternative medications, and lack of complete drug costs. It is important to note that busy prescribers rely on electronic systems to practice medicine.

Prescribers rightfully expect accuracy, completeness, and consistency in these systems. However, if prescribing workflows have patient copays missing, lower-cost alternatives rarely provided or inaccurate, and lack total cost of the drugs, it is not surprising that clinicians question or ignore cost transparency information presented. Not only does cost transparency rely on health plans and PBMs to provide accurate and complete information, but it also relies on the EHR to process and display the information. Accurate cost transparency information is complex and requires multiple parties to collaborate. A first step is improved standardization by agencies such as the National Council for Prescription Drug Programs to ensure a drug billing unit is the same in the manufacturer, health system/PBM, wholesaler and EHR databases. This will allow for an apples-to-apples comparison of a drug's cost, the intent of price transparency.

RTPB as currently mandated and typically provided by PBMs:

1. Provides patient costs for some drugs selected by the prescriber
2. Rarely presents useful lower-cost alternative medications
3. Does not present total costs of drugs net of rebates
4. Lacks significant and measurable ROI

Some payers, however, have taken a more comprehensive approach to drug cost transparency, led by Blue Shield of California. In collaboration with Gemini Health, BSC has reported tens of millions in drug cost savings documented in their pharmacy claims in the past year alone.

Central to their success has been providing complete drug costs information consistently and including lower cost therapeutic equivalent alternatives that are covered by the patient's pharmacy benefit when available. Equally important are the system and algorithms to identify and quantify in pharmacy claims, the impact of this more robust approach to cost transparency. Blue Shield has shown the way to leverage cost transparency to deliver documented drug cost savings for their members.

In the next article in this series, we will look at the application of drug cost transparency beyond at-prescribing for new prescriptions, to include existing maintenance and specialty medications.

Mackenzie Clark is the pharmacy supervisor at UCSF Specialty Pharmacy.
Edward Fotsch, M.D., is CEO of Gemini Health.