

Implementing Reference Pricing Led to Changes in Drug Selection, Lower Spending



A reference pricing initiative was linked to more prescription fills of lowest-priced drugs and a decreased average price per prescription, but higher rates of copayments by patients, a new study finds.

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Reference pricing is a price control mechanism where an insurer or employer specifies the highest amount it will contribute towards paying for a drug or service, leaving patients to pay the additional cost if they choose an option priced higher than that benchmark. A recent study published in the *New England Journal of Medicine* examined the results of a reference pricing program implemented by the healthcare purchasing organization RETA Trust in 2013.

The program set the trust's maximum drug payment for 1302 drugs in 78 classes at the price of the least expensive drug in each category. Unless an exemption was granted for clinical reasons, patients choosing a drug that was not the least costly would have to pay the difference in price.

Using pharmacy claims from 2010 to 2014, researchers analyzed changes in drug selection and expenditures after the implementation of reference pricing for the 17,500 employees covered by the RETA Trust. Members of a labor union which did not use reference pricing served as a comparison group to control for market trends.

Analyses indicated that more prescriptions were written for the lowest-priced drug in each therapeutic class for members of the RETA Trust after reference pricing was instituted. Specifically, the share of such prescriptions increased from 59.5% in July 2010 to 69.7% during the first quarter after reference pricing was implemented in July 2013. Over this time, the share of prescriptions written for the least costly drug among the labor union members did not change.

Researchers also determined that reference pricing had an effect on the RETA Trust's expenditures. Before reference pricing, the trust paid around 10.6% more per prescription than the union, but after the change it paid prices that were 13.9% lower than those paid by the union, equivalent to a \$9.24 lower average price per monthly prescription. Extrapolated to the total number of prescriptions filled in the 18 months after implementation, the RETA Trust saved \$1.34 million in this time.

While the trust itself saved money after implementing reference pricing, there was a 5.2% increase in out-of-pocket spending observed among RETA Trust employees compared with the union employees. The researchers estimate that the trust's employees paid a total of \$120,000 in higher copayments in the 18 months after reference pricing began, based on an average increase per copayment of \$0.84.

These findings of lowered payer expenditures are consistent with European experiences with reference drug pricing and with US-based studies of reference pricing for surgical procedures or diagnostic tests. However, the study authors noted that these results observed in a private trust may not be generalizable if applied within public insurance programs or by other employers. The study also did not assess the effects of reference pricing on drug utilization, adherence, or health outcomes, which are important metrics that would need to be monitored if reference pricing is used for specialty drugs.

Still, the study authors wrote that these findings provide support for the idea that "reference pricing may be 1 instrument for influencing drug choices by patients and drug prices paid by employers and insurers," especially as drug price increases are widely publicized in the media and criticized by politicians.

"In the future, pharmaceutical manufacturers who wish to charge premium prices may need to supply evidence of commensurately premium performance," the researchers concluded.

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