



Invited Commentary | Health Policy

Private Sector Strategies to Address High Drug Prices and the Promise of Reference Pricing Programs

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The study by Robinson et al¹ evaluated a prescription drug reference pricing program offered to employees of Catholic organizations who purchased health insurance through the Reta Trust. The reference pricing program charged employees more out of pocket if they chose more expensive drugs in a therapeutic class. Robinson et al¹ reported that the program was associated with increased use of lower-priced drugs among beneficiaries. During the first 2 years after program implementation, drug prices decreased, but patients paid more out of pocket. Yet by the end of the period, after many patients had switched to lower-priced drugs, drug prices and patient cost sharing were generally lower. These findings suggest that the private sector can take meaningful actions to address the issue of high prescription drug costs without government intervention.

This topic is of exceptional importance. The high price of prescription drugs has become a focal point in the health policy debate. The policy discussion spans, and often conflates, several distinct problems. The first problem is that drug prices are high. This is to be expected given the patent system, but when health insurance is involved, prices can increase even more. While this combination of patents and insurance has incentivized the development of extremely valuable medications, the fiscal burden is increasingly crushing for patients and payers alike. The second problem, and the likely proximate cause of much of the policy attention, is the high out-of-pocket prices that patients are required to pay. These prices are often based on the list price of the drug rather than the actual amount being paid to manufacturers. Many potential policy solutions involve government action, and undoubtedly some policy intervention is needed. A few such interventions have already been proposed to address the high price of drugs² and problems in the way the rebate system functions.³

The results found by Robinson et al¹ demonstrate the potential of private action, but there are a few important issues to consider. First, in the period immediately after implementation, employee cost sharing increased considerably. Although it then decreased over time, mean out-of-pocket spending increased by almost 10% in the first 2 years. It can take time for employees to respond to market forces, and employers must recognize that the transition could be difficult for some. Moreover, the reference pricing program emphasizes that while drug manufacturers have patent protection, there can still be competition between drugs within a class. Yet, the substitution is not perfect because drugs are not equivalent. Some patients may not be able to switch to the lower-price medications based on clinical grounds and may face a significant financial burden in a reference pricing situation. Lower out-of-pocket prices on average are not the same as a lower out-of-pocket cost for all.⁴ Employers may be willing to accept this outcome, given the savings opportunities, but it could be mitigated by so-called good soldier provisions that allow beneficiaries who try the lower-price drug without success to access the higher-price medication without facing the reference pricing charge.⁵ Fundamentally, these provisions could lower the cost-sharing burden for patients who attempt to follow policies encouraging first-line use of lower-cost therapies but are ultimately unable to do so and must seek a second- or third-line treatment alternative.

A second concern is that, depending on the program design, patients may still face high out-of-pocket cost for the lower-price drug. Value-based insurance design programs can mitigate some of this concern by ensuring that there is at least 1 low out-of-pocket cost option available in high-value clinical areas, such as insulin for diabetes treatment, and a reference pricing program could be

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implemented in addition to that.^{6,7} Also, while the results of this evaluation by Robinson et al¹ suggest that the private sector can be part of any solution, one should not forget that the effect would be bigger if many employers chose to act. Only widespread pressure will be able to change launch prices and subsequent price increases of new medications. Such widespread efforts could induce industry responses to undo the effects of cost sharing, such as copay assistance, suggesting that market forces may need some policy support.

Nevertheless, it has become clear that some action to address concerns about prescription drug prices is warranted. While it is unlikely that market forces can solve the problems alone, private stakeholders are not powerless if they are willing to design benefit packages that incentivize wiser, cost-conscious use of drugs. The study by Robinson et al¹ provides a clinically relevant evaluation of one such initiative.

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