

## The Flawed Third-Party Payer System Drives the Drug Affordability Problem

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### Executive Summary

- ✦ The problem of drug affordability is caused by the perverse incentives created by the third-party payer system that have disempowered patients in favor of insurers and other supply-chain intermediaries.
- ✦ The insurance flaws have created pricing systems that inequitably transfer a disproportionate share of drug costs on to patients. This arrangement inappropriately imposes a drug affordability problem on patients who require expensive medicines.
- ✦ The insurance flaws also incent benefit design policies that create additional affordability burdens and unnecessarily increase overall system costs.

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## Introduction

As delineated in Part 2 of the Coverage Denied series, the third-party payer system is rife with structural flaws. These flaws reduce the quality of our healthcare system and worsen health outcomes. They also inflate the pricing pressures that are unnecessarily raising patient costs. Before analyzing how the flaws inherent in the current third-party payer system drive these adverse outcomes, it is useful to extend Part 2's analysis to the pharmaceutical market given the political attention devoted to U.S. drug prices.

The flaws of the current insurance system undermine the quality of the U.S. drug market and fail to provide patients with the essential service of mitigating the financial risks associated with requiring high-cost medicines. The result is the high-profile drug affordability problem. Improving drug affordability and promoting drug innovation, which is a core measure of improving quality in the drug market, requires improvements to how the insurance industry provides drug insurance coverage.

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## Faux Health Insurance Drives the Problem

Insurance is a tool for managing risk. In exchange for periodic payments from a customer, an insurance company provides protection against a large but uncertain potential cost. Take disability insurance. A potential risk for many families is the possibility that the primary earner (or one of the dual-income earners) might meet with an accident that prevents him or her from working for a prolonged period. In such a case, a family could face potential financial ruin. To protect against this risk, many primary income earners will purchase disability insurance policies. In return for regularly scheduled payments, the insurance company pays a predetermined amount of money to the income earner should an unfortunate accident or disabling illness occur.

Health insurance does not work this way. Health insurance provides coverage for expenditures that are not healthcare risks and substitutes payer control for patient control, which creates a wedge between

patients and caregivers. As defined in Part 2, “the healthcare wedge occurs when the government or a third party spends money on healthcare separating the patient from the transaction.”<sup>1</sup> When either private or public health insurers currently spend money covering patient healthcare costs, they are not providing health insurance as the term is traditionally understood. The consequences are distortions in the delivery of care and lack of insurance services when patients need them most. Like the broader healthcare system, this wedge created by our third-party payer health insurance system afflicts drug coverage as well.

One way to visualize how large the healthcare wedge in the drug industry has become is to document the share of pharmaceutical spending that is appropriated by intermediaries rather than the manufacturer. When intermediaries receive a high and growing share of revenues, and particularly when there are large numbers of these intermediaries, then many entities separate the ultimate consumer (e.g., patients) from the ultimate supplier (e.g., drug manufacturers). This separation is the very definition of a healthcare wedge. A recent Berkeley Research Group (BRG) study performed this analysis by allocating the total gross expenditures on drugs to all the entities in the drug supply chain noting that,

since 2013, the share of total gross expenditures for brand medicines retained by pharmaceutical manufacturers has steadily declined as others in the pharmaceutical supply chain – including PBMs [pharmacy benefit managers], hospitals, the government, pharmacies, insurers, and other payers – have received an increasing share of total spending. In 2020, pharmaceutical manufacturers retained 49.5 percent of total spending on brand medicines, a decrease of 17 percentage points from 2013, the first year the analysis was conducted.<sup>2</sup>

The BRG study confirms that the share of revenues for the numerous intermediary entities has been growing quickly and they now retain more than 50 percent of total spending. The growing share of expenditures these organizations receive reflect their expanding influence

over crucial market decisions and confirms that these entities have replaced the patients as the effective demand-side of the drug market.

While the intermediaries act on behalf of the demand-side of the market, their interests will often diverge from the interests of patients. This divergence of interests drives many of the observed adverse drug market outcomes. To understand how this divergence causes adverse market outcomes, it is necessary to understand the complex drug pricing landscape.

## Too Many Prices Spoil the Market

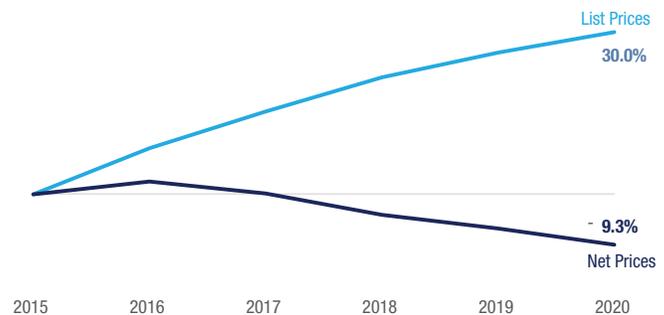
When people complain about the price of drugs rarely is the appropriate question asked: which price? Drug pricing is a convoluted and opaque process that begins when manufacturers announce their list prices for drugs. List prices are the most transparent price and, perhaps without realizing it, policymakers complaining about large growth in drug prices are typically referring to list prices. List prices are not the cost of the drug to the healthcare system, however.

Once manufacturers announce these list prices, pharmacy benefit managers (PBMs), on behalf of insurers, negotiate discounts and rebates. These discounts and rebates are large and growing. Prices net of discounts and rebates are referred to as net prices. The net prices are the prices actually paid on behalf of patients by insurers and other payers. The growth in discounts and rebates has been so large that while the headline list prices have been quickly rising the actual prices insurers pay (the net prices) have been declining, as depicted in Figure 1.

Figure 1 compounds the average annual percent change in list and net prices for branded drugs since 2015 as measured by Drug Channels.<sup>3</sup> Figure 1 demonstrates that list prices grew 30 percent between 2015 and 2020 but net prices declined 9.3 percent. The trends in Figure 1 confirm the results from the BRG study cited earlier as the difference between the growth in list prices and the decline in net prices are the discounts and rebates that are “earned” by the industry intermediaries. For the healthcare system writ large, since it is the net prices

that correctly measure the costs of drugs to the entire healthcare system, the decline in net prices indicates that drug costs have been going down on average over the past five years, not up.

**FIGURE 1**  
**GROWTH IN BRANDED DRUGS LIST PRICES COMPARED TO DECLINE IN BRANDED DRUGS NET PRICES 2015–2020**



Source: Author calculations based on Drug Channels data

Such an outcome appears to contradict the experiences of many vulnerable patients who face growing problems of drug affordability. These unaffordability problems exist because rising list prices affect patients’ pocketbooks with respect to the “price” that patients care most about: out-of-pocket costs. In fact, based on the current incentives, it is rational for most patients to only care about their out-of-pocket expenditures not the actual prices of their medicines. Patients’ out-of-pocket expenditures depend on their specific deductibles (the amount a patient pays before insurance kicks-in), co-pays (a fixed dollar cost), and co-insurance rates (the patients’ percentage share of the costs). These costs are determined by the insurance relationship.

The affordability problem arises because patients’ co-insurance rates are typically set as a percentage of the list price not the systemically relevant net price. This means as list prices have been rising quickly (particularly the list prices for expensive medicines), patient costs have likewise been increasing quickly. Therefore, the patients who take these medicines will often experience growing affordability problems even though the net costs of the drugs are not increasing.

The fact that rising list prices create an affordability problem for patients even though net prices for payers are declining indicates that an inequitable cost shifting is occurring. To see how this cost shift works, consider a simple arithmetic example.

Imagine a patient with a 20 percent co-insurance benefit design. Patients would reasonably assume they should be paying \$20 in out-of-pocket costs when the list price of a drug is \$100. They also reasonably assume that the payer is spending \$80. But we know that the list price of the drug is not the actual price to the payer. The net price is. If after all the discounts and rebates the net price is \$60, then the patient would still pay \$20 for this drug (remember the co-insurance costs are based on the list price), but the payer is only spending \$40 (the difference between the net price and what the patient has paid). Patients are now covering one-third of the drug's costs rather than 20 percent. That difference is the cost-shift from payers to patients. For innovative drugs that cost thousands of dollars, this inappropriate cost shift adds up to a lot of money.

The drug affordability problem persists because the excessive rise in list prices does not directly benefit, nor harm, the supply-side of the market and because it does benefit the effective demand-side of the market (e.g., PBMs' profits tend to increase because their compensation is often a function of the size of the list-to-net price gap). This reality demonstrates that the needs of patients now often directly conflict with the incentives of the health insurance system that is supposed to be representing their interests.

One response to this situation is that patients still benefit from the discounts because even though their drug costs are higher, the lower payer expenses are passed back to patients through lower premiums. As described by Lieberman, Ginsburg, and Patel (2020), "in Medicare Part D and many commercial health plans, rebates lower overall costs for the insurer and thus premiums, but not what a patient pays out of pocket when purchasing a brand drug."<sup>4</sup>

However, an inequitable cost shifting occurs regardless of what payers do with the discounts unless the full value of these discounts is passed directly on to patients at the retail counter or at the point of service through lower costs for their medicines.

Assume for a moment that 100 percent of the discounts and rebates are dedicated toward lowering patient premiums. Even under this extreme assumption there is still an inequitable cost shifting occurring because the financial arrangement imposes additional costs on patients who are prescribed expensive medicines to lower the costs for all patients, including those who do not require expensive medicines.

Covering patients' financial costs should they require expensive medicines is the exact type of risk that health insurers are supposed to mitigate. Forcing these patients to pay higher costs to subsidize everyone else is the opposite of how insurance is supposed to work. If health insurance worked as intended, then resources would be transferred from those patients who did not experience the risky outcome to those who did. Therefore, whether the insurance system uses the higher costs to reduce premiums or not, there is an inequitable cost shifting that is occurring.

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## Ineffective Insurance Harms Patients

Unfortunately, the inequitable cost shifting caused by the diverging trends between list prices and net prices is only one of several conflicts of interests that ultimately harm patients' welfare. Take the problem of rebate walls.

Rebate wall tactics leverage the large discounts and rebates to create competitive barriers for new, lower-cost, medicines. Rebate walls happen when blockbuster drugs use their exceptionally large sales volumes to offer payers very large concessions that are predicated on meeting volume targets. If these targets are not met, the payers lose all the concessions. The threat of losing all the concessions generated by blockbuster drugs imposes large potential costs on payers that dwarf the per-unit savings created by the significantly smaller competitor products regardless of the price discount.

The potential loss of these concessions encourages payers and PBMs to either depress the use of competitive medicines or block these competitive medicines from the drug formulary (the list of approved drugs that patients are allowed to access) entirely. The rebate wall strategy creates unnecessary obstacles that deny patients access

to lower-cost medicines, raises systemic healthcare costs, and increases patients' out-of-pocket costs (patient costs are based on the inflated list prices and are not reduced by the concessions that insurers and PBMs receive).

“Fail-first” policies implemented by many payers are a common method for enforcing rebate walls. When used as a cost saving mechanism, fail-first policies require the use of lower-cost generic medicines first and then, only if the less expensive medicine fails the patient, will an insurer approve the more expensive branded medicine. Fail first policies work in reverse when applied to many high-cost medicines, typically biologic medicines that are some of the highest valued but highest cost medicines currently available. In this case, the fail-first policies prevent doctors from prescribing a cheaper medicine (typically a competitor product to the originator biologic known as a biosimilar) unless the patient first fails on the more expensive originator drug. This criterion makes no sense. Worse, it creates a large disincentive against biosimilar use, which could generate significant systemic savings. The result are excessive systemic costs and higher out-of-pocket expenditures for patients.

In addition to the problems of rebate walls and fail first policies, there is a broader systemic failure for too many older patients who tend to use more medicines. As Mandel (2019) notes,

As people get older, they unwillingly ride the prescription escalator, with their average spending on prescription drugs rising by about 5-6% per year. This figure assumes no change in the underlying price of drugs. Rather, people fill more prescriptions as they age.

And here's the kicker: The age-based escalator rises much faster for prescription drugs than for other types of health spending. Overall, as people get older, their total average spending on healthcare only rises by about 2% per year, assuming no change in the underlying price of hospitalization, doctors, and other healthcare costs.

As a result, the relative out-of-pocket cost of drugs increases as people age, even assuming no increase in drug prices.<sup>5</sup>

The combination of the prescription elevator and the problems created when costs are inappropriately shifted to patients threatens many older patients with exceptionally high out-of-pocket costs that are simply unaffordable. This risk is particularly large for patients under Medicare Part D who have already spent \$7,050 in out-of-pocket costs (so qualify for Medicare Part D's catastrophic coverage phase). In the catastrophic coverage phase patients face an unlimited exposure to 5 percent of a medicine's costs.<sup>6</sup> For many high valued drugs that older patients are more likely to need, this unlimited cost exposure creates exceptionally large affordability problems. This demonstrates another health insurance failure (as it is traditionally understood) precisely when patients need such services the most.

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## Conclusion

This analysis demonstrates that the drug affordability problem can be addressed most efficiently by fixing our ineffective third-party payer health insurance system. Just like the broader healthcare system, the disincentives from the third-party health insurance system drive up drug costs for patients and expose them to excessive financial risks. Given the political attention drug price affordability garners, when coupled with the many adverse consequences that would arise should proposals to impose drug price controls be implemented, it is critical to understand how the current third-party payer system creates the observed adverse outcomes. Performing this detailed analysis is the subject of Part 4 of the series.

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## Endnotes

- 1 Winegarden W and Bookin C “The Fundamental Flaws of the Third-Party Payer System” Center for Medical Economics, Pacific Research Institute, January 2022.
- 2 Brownlee A and Watson J “The Pharmaceutical Supply Chain, 2013 – 2020” Berkeley Research Group, January 2022.
- 3 “Gross-to-Net Bubble Update: Net Prices Drop (Again) at Six Top Drugmakers” Drug Channels, April 14, 2021, <https://www.drugchannels.net/2021/04/gross-to-net-bubble-update-net-prices.html> (accessed January 26, 2022).
- 4 Lieberman SM, Ginsburg PB, Patel KK “Balancing Lower U.S. Prescription Drug Prices And Innovation – Part 1,” *Health Affairs*, November 24, 2020, <https://www.healthaffairs.org/doi/10.1377/forefront.20201123.804451/full/>.
- 5 Mandel M “The Prescription Escalator: The Real Reason Why Americans Pay More for Drugs Each Year, Why They Are So Upset and What Can Be Done About It” Progressive Policy Institute, October 2019, [https://www.progressivepolicy.org/wp-content/uploads/2019/10/PPI\\_The-Prescription-Escalator-The-Real-Reason-Americans-Pay-more-for-Drugs\\_V3c.pdf](https://www.progressivepolicy.org/wp-content/uploads/2019/10/PPI_The-Prescription-Escalator-The-Real-Reason-Americans-Pay-more-for-Drugs_V3c.pdf).
- 6 See: “Phases of Part D coverage”, <https://www.medicareinteractive.org/get-answers/medicare-prescription-drug-coverage-part-d/medicare-part-d-costs/phases-of-part-d-coverage>.



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### Coverage Denied

#### Part Three

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