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Controlling Prescription Drug Costs in Manitoba

MANITOBA CENTRE FOR HEALTH POLICY

Summary by
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based on the report:
Pharmaceuticals: Therapeutic Interchange and Pricing Policies,
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From time to time, most of us buy generic products instead of brand name versions. Why? Usually because they're just as good and it saves us some money. Curiously, most Manitobans don't seem to apply the same consumer savvy when they buy prescription drugs. But there are some who would like to change that. Why? Because it could cut spending on pharmaceuticals in Manitoba by millions each year.

At the request of Manitoba Health, this MCHP project looks at policies designed to improve the cost-effectiveness of prescription drugs. Put simply, it asks how much would Manitobans and the government save if generic drugs were prescribed or substituted instead of name brands. It also asks what would be saved if *tried-and-true* drugs were used before newer, often more expensive ones. Our report first looks at several forms these cost-effectiveness strategies could take, and then at the projected public and private savings that would result.

For our study we chose two related classes of drugs commonly used to treat high blood pressure: angiotension converting enzyme inhibitors—ACEIs—and angiotension II receptor antagonists—A2RAs (also called ARBs). These products accounted for 5.5% of total prescriptions and 8.2% of total prescription spending in Manitoba in 1999/2000.

Before we go any further, it is important to know some things about these two drugs. ACEIs are the older of the two, and have been around a relatively long time. They are a proven, effective treatment for high blood pressure. Most of the possible side effects, including those from long-term use, are fairly well known.

A2RAs, on the other hand, are comparatively new. So, for one thing, their side effects are less well known, especially the effects of long-term use. For another, newer isn't necessarily better. In short, they are not as tried-and-true as ACEIs.

Therefore, it has been generally recommended that physicians have patients try an ACEI before an A2RA. This protocol is not without controversy; some groups now feel that A2RAs should also be considered a first-line therapy. However, during the period of this study (1998/99 to 2000/01) trying an ACEI prior to an A2RA—known as *step-up* prescribing—was the recommendation (Figure 1).

It is also important to point out that for each of these drugs, there are name brands and there are generic forms. So just as you can buy a store brand ASA instead of Aspirin, there are several name brand ACEIs or A2RAs, and then several generic versions. And unlike generic, non-pharmaceutical products—such as peanut butter or coffee—these generic drugs must measure up to high standards to ensure they are "just as good" as the name brands; their active ingredients must be chemically the same.

Now there are a couple of assumptions you might make from all this. For example, you might assume, given all the

generic substitutes, that there would be intense price competition; the generics would sell at a much lower price. Right? You might also assume that since A2RAs are the new kids on the block compared to ACEIs, they would be priced competitively with ACEIs—at least at first. Right?

Wrong.

While generic drugs are generally lower in price, they are not as a whole priced that much lower than name brands. And despite A2RAs being a newer drug, they are not, as one would assume, "priced to sell." In fact, they are more expensive than their ACEI cousins. So it appears that what we normally see in the marketplace we don't see with these two classes of drugs.

We should also make clear that our study isn't questioning the doctor's decision to prescribe either an ACEI or an A2RA. We assume that the patient needed something to treat high blood pressure.

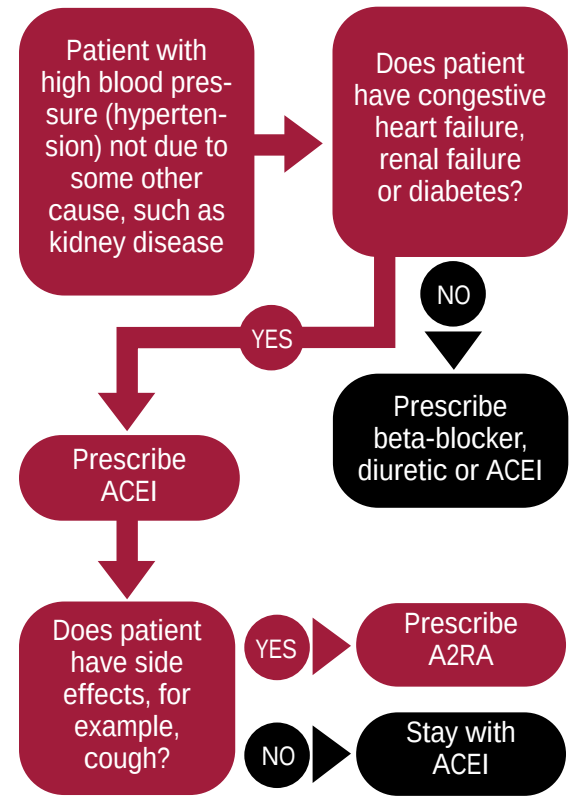
What if?

At the time of this study, there were 16 types of products that could be prescribed from the ACEI and A2RA categories—10 ACEIs and 6 A2RAs. Yet despite the presence of generic equivalents, name brands still achieved a majority of market share. At a glance this is surprising. It becomes less so when you realize that generics were not that much cheaper; few fell below 80% of brand name prices. Generic versions of the ACEIs Captopril and Lisinopril offered virtually no discount. Furthermore, in price comparisons, Manitoba paid 7% to 9% more for generics than eight other provinces.

So clearly any cost-saving initiatives will have to address high generic pricing. But also affecting Manitoba's bottom line is product selection. Despite guidelines at the time of our study, the newer—and more expensive—A2RAs were not being reserved only for those patients who had tried and failed on ACEIs. The use of A2RAs rose from 13% to 22% vis-à-vis ACEIs. And growth in spending on A2RAs far exceeded that of ACEIs. Much of that growth was due to increased purchases by new users who had not tried an ACEI.

So our study asks: What would happen if there were policies in place that managed both prices and product choices within these therapeutic classes? Specifically, we look at the impact on both public and private spending of: 1) pricing policies for generic drugs as they relate to brand name equivalents; 2) policies for substituting therapeutically equivalent generics for name brand ACEIs; 3) a step-up protocol for prescribing A2RAs.

1. Step-up Approach for Prescribing Drugs to Treat High Blood Pressure



The Model

We created a five-step model that shows what savings could potentially be had through: a) stimulating competitive pricing between generics and name brands; b) encouraging patients and/or physicians to keep price in mind when choosing drugs. Simply put, as one

step—or option—follows another, the potential cost savings, both public and private, grow larger.

Figure 2 shows what the total public and private savings on ACEIs would have been in 2000/01 if each of the five cost-saving strategies were fully realized. The following is a general description of each step, which could be applied to any drug.

1) *Mandated generic discount only:* Generics must be priced 30% lower than name brands.
OR
2) *Generic substitution at actual cost:* Government will pay no more than an equivalent generic cost. If patients want a name brand (using a non-prescription example, Advil) they must pay the difference privately. Otherwise, a generic (in this example, ibuprofen) would be substituted.

3) *Mandated generic discount with generic substitution (1+2):* Government will pay no more than a generic cost—which must be priced 30% lower than name brands. If patients want a name brand, they must pay the difference privately.

4) *Therapeutic interchange—approximate reference pricing at actual cost:* Government will pay no more than the lowest priced generic cost of a drug in the same class. (Using a non-prescription example, Bayer (ASA) or Advil (ibuprofen) would be substituted with, say, a generic brand of ASA.)

5) *Approximate reference pricing with mandated generic discount (4+3):* Government will pay no more than a generic cost of a drug in the same class—all of which must be priced at least 30% lower than name brands.

For all policies, there would be exemptions for people who can't tolerate the lower priced drugs.

This example is for ACEIs only, but conceivably these policies would be applied to other drugs too. In the case of hypertensive drugs, even more savings (around $250,000 a year)

2. Costs for ACEIs With Projected Costs/Savings Under Proposed Pricing Policies: Manitoba 2000/01

Actual Cost	Payer	$ Spent	Combined $ Spent	Combined $ Saved
	Public Private	7,631,000 11,261,000	18,892,000	
Option 1: Mandated Generic Discount Only	Public Private	7,553,000 11,150,000	18,703,000	189,000
Option 2: Generic Substitution at Actual Cost	Public Private	7,519,000 10,806,000	18,325,000	567,000
Option 3: Mandated Generic Discount with Generic Substitution	Public Private	7,136,000 10,194,000	17,330,000	1,562,000
Option 4: Approximate Reference Pricing at Actual Cost	Public Private	5,470,000 8,287,000	13,757,000	5,134,000
Option 5: Approximate Reference Pricing with Mandated Generic Discount	Public Private	4,877,000 7,199,000	12,076,000	6,816,000

might result if this model was used in concert with the step-up approach to prescribing.

The bottom line

Our model showed Manitoba could have saved almost $7 million in 2000/01 in combined public and private spending. That's for ACEIs alone. Now consider that the ACEI/A2RA class of drugs represents roughly 8% of the total spent on prescription drugs in Manitoba each year. One can easily foresee the financial benefit that would result if these strategies were applied across all prescribed drugs.

A necessary first step toward realizing these savings is generic pricing and substitution policies. Generic price cuts alone (option 1) on ACEIs could save almost $200,000 a year; generic substitution (option 2) almost half a million. But in a prime example of the whole being greater than the sum of its parts, combining these two (option 3) could lead to major savings of between $1.5 and $2 million. That's more than 10% of total spending on blood pressure drugs in Manitoba.

Ideally, generic price cuts would come about through a tendering process. This in turn would make manufacturers a cooperating partner, so to speak, in the savings initiative.

Once those policies are in place, policy-makers might consider incorporating therapeutic interchange policies (options 4 and 5). In 2000/01 this would have cut spending on ACEIs in our province from a total of almost $19 million down to just over $12 million—or a saving of almost $7 million.

Now probably some of you reading this are pointing the finger at physicians. After all, aren't they the ones prescribing these higher priced drugs? But consider the following. Many doctors don't prescribe a brand name at all, just a drug; it may be the pharmacist choosing a name brand, perhaps because it's the one they have in stock. And, as mentioned, generic equivalents haven't been all that much cheaper. Therefore, doctors (like everybody else) may simply stay with what they know.

For that matter, so do some patients. As a recent *Winnipeg Free Press* article pointed out (September 2, 2003), many patients will ask for a specific high-priced brand. Why? Because they see it advertised on American television. In short, it would be wrong to pin this all on physicians.

Which brings us to what has been one of the underlying problems with controlling drug costs: Manitobans are largely unaware that generic equivalents are out there. These pricing policies will likely change that. It's foreseeable, for example, that patients not getting full reimbursements because of wanting a name brand are going to start asking for a lower priced generic equivalent. Consumers' pharmaceutical awareness should go up.

Now it must be mentioned that the potential savings generated by these policies must be weighed against a possible backlash from manufacturers and doctors. Therapeutic interchange, in the form of reference-based pricing, was initiated in British Columbia. By 1997 it applied to five drug categories. The industry then threatened to reduce investment in B.C. The province has since put on hold plans for expanding their program to other drugs.

That being said, various pricing policies are being used in other provinces. In Ontario, pharmaceutical prices have been frozen since 1994. The price for any new drug is negotiated. The first generic to follow must sell at 30% less than the brand name. Subsequent generics must sell at 10% less than the first generic.

In Saskatchewan, pharmacists must substitute name brands with the least expensive generic. This means higher sales volume for that particular generic, which then allows the government to negotiate a better price.

What these last two examples tell us is that pricing policies for prescriptions in Manitoba can work. What this study tells us is that millions of dollars might be saved. The financial impact of pharmaceuticals on our health care system—and pockets—can be reduced, with patients, physicians, manufacturers and government all having a part to play. As we said in a previous look at pharmaceuticals, we all need to take a closer look at what drugs we're taking.

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