

## Old Tricks, New Drugs

*(Adapted from, "Who is Designing the New Cost Management Tools?" Reissman, Drug Benefit Trends 16(4):176, 178, 2004)*

Time was when getting drug costs down meant encouraging generic or lower-cost brand drugs that treated the same illness. Patients had choices for nearly all the common conditions - heart burn, high blood pressure, birth control, depression, high cholesterol, and others. **In fact, the top 10 drug classes have been the same since the mid 1990s.**

Prescription benefit managers (PBMs, e.g. XPress Scripts) did not worry about whether the drugs were used effectively, following evidence-based protocols, and for the right patient. They simply negotiated discounts on drugs and encouraged patients toward the lowest cost drug within the same class.

**This year two entirely new drug classes landed in the top 10, and they won't obey the discount command.** The new classes - anti-psychotics and anti-convulsants - are not interchangeable groups of drugs. A heartburn patient can take either Nexium or Omeprazole, but an epileptic patient does not have that flexibility. The (fewer) drug makers for these drugs have less competition, and need less market boost from the benefit managers. Therefore, no discounts apply. And, for an employer, having even a few people on these drugs can put them in the top 10 list.

**And there are more drugs coming that will ignore discount requests.** Biotechnology agents will grow in the market; treatment is based upon unique patient response, rather than the effect that a class of drugs has. Co-payments based upon the drug's brand status will be meaningless, as patients cannot be "persuaded" to switch to a lower cost alternative.

**In short, the old tricks will not work on these new drugs.** To put a leash on costs, employers will need to look at overall patient costs, not just drugs as a percentage of total costs or generic drugs as a percentage of total drugs.