Why Does 1 Pill Cost More than 2?

By Chuck Dinerstein, MD, MBA — March 4, 2020

For patients taking multiple medications, one extended-release pill increases their compliance in taking the medication, as compared with two immediate-release pills. So if we want to encourage compliance, why are extended-release pills more expensive than what they replace?

Patients ask for physician's advice and, once satisfied with the response, go and do what they want. And while we may quibble about warnings like, "lose some weight" or "exercise more," it is tough to argue about taking your medications. Studies have shown that compliance with medical "orders" is at about 50% for those with chronic diseases, even if severe; and that compliance gets worse over time.
In a study of about 22,000 patients diagnosed with new-onset hypertension, at the end of the first year, 56% of patients were still taking their one pill a day, while only 29% of patients were taking a medication that requires twice a day dosing. [1] This is an even bigger problem for individuals taking several medications, typically five or more, a situation known as polypharmacy that affects almost 40% of elderly patients. And when you don't take your medicine, your health suffers. For this reason, manufacturers have developed several extended-release forms of common medications that reduce dosing to once a day. But, a new study reports that in the world of "unintended" consequences, extended-release medications may improve compliance, lowering the "pill burden," but they cost more, sometimes a lot more.

Researchers made use of 2017 Medicare Prescription Drug Event data on prescriptions and drug prices looking at drugs that had both an extended-release (ER) and immediate-release (IR) forms. They limited the medications to those ER formulations not known to be therapeutically better than IR formulations and consider only drugs that reduce the "pill burden" from twice to once a day. So the data is limited, but they did identify 67 medications, about 1% of the total formulary, with both formulations.

- Medicare spent $1.9 billion on these ER formulations. About one-third were generic, at the cost of $1.47 per pill of brand name ER formulations and $0.59 per pill for generic ER formulations.
- The cost of generic IR formulations was $0.16 per pill
- If all brand name ER formulations were changed to generics, the savings would be $183 million, and if all ER formulations were changed to IR formulations the savings would be $1.6 billion
- Medicaid spent $952 million on ER formulations. About one-third were generic, at a cost of $3.24 per pill for brand name ER formulations and $1.47 per pill for generic ER formulations.
- The cost to Medicaid for generic IR formulations was $0.18 per pill
- If all brand name ER formulations were changed to generics, the saving would be $299 million, and if all ER formulations were changed to IR formulations, the savings would be $836 million.

None of these savings are chump change. If we ignore the brand name drugs and consider only the generics, you still have to ask why two pills cost $0.27 more for Medicare patients and $1.11 more for Medicaid patients. That is a pretty expensive packaging, I guess.

Of course, those figures I reported are the aggregates, and there are many variations among the medications considered. But as the researchers write, "Although fewer pill may be more convenient, the added cost burden of ER vs. generic IR formulations may be associated with a negative utility for patients and perhaps in cost-related nonadherence."

The study only considers part of the cost-benefit equation; and, in truth, only part of the cost. Patients out-of-pocket costs cannot be calculated with any precision; there are too many before, during, and after the donut-hole payments to take into account. More importantly, we do not have any data on medical compliance; were those patients using ER formulations more and or less compliant, and did it impact their health? The study created more questions than it answered.
The political and regulatory landscape suggests that this cost variation will not be addressed as a population health issue. In essence, there are too many special interests other than the public and its health. But it can be addressed by physicians and pharmacists who prescribe and fill these prescriptions. It would be appropriate and an easy win for "personalized" medicine to determine just how compliant the patient sitting or standing across from you might be and how their financial circumstances can impact their frequency of dosages. No fancy algorithms, no wearables, just a knowledgeable conversation. Perhaps the pharmacies that have decided to get into medical care could start by ball rolling, they have the necessary information and expertise. It would go a long way in convincing the skeptical that they are indeed healthcare "providers" rather than companies looking for a greater market share.

[1] Continuation of Initial Antihypertensive Medication After 1 Year of Therapy Clinical Therapeutics DOI: 10.1016/s0149-2918(98)80130-6


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