Too Good to Be True?

David B. Nash, MD, MBA

As any employee benefit manager sadly knows, drug costs are an increasing component of overall health care costs for most employers. Ask managers with commercial insurance, and they will be ready to regale you with stories about their annual increase in premiums. That is why I was surprised by a recent authoritative report from Milliman, Inc., a well-respected actuarial firm in New York City.1

The report caught my eye, because it covered one of the many topics relating to P&T committees that would be of great interest to our Department of Health Policy at Jefferson Medical College. I was a bit skeptical, because the Biotechnology Industry Organization (BIO), the main lobby with headquarters in Washington, DC, commissioned the report. Nevertheless, because of the report’s excellent pedigree, I wanted to have an open mind while reviewing the findings.

The main finding of this “counterintuitive” account was simple:

New and improved medical treatments have a cost. This cost is often absorbed by the patient’s health insurance program, creating employer and payer concerns regarding potential rising costs.1

The study’s conclusion was straightforward: the costs of innovative therapies, in general, will not create a large cost burden relative to other costs for private health care payers by the year 2011. In fact, the study says that by 2011, the total cost for all existing and innovative therapies will probably be about 6% of total private–commercial payer costs, compared with a figure of about 5% for the calendar year 2006. The report further notes that given the current high annual rates of medical cost inflation, it will be difficult for many payers to discern the cost increases directly related to these new therapies.1

Is it simply wishful thinking to assert that by the year 2011 innovative therapies will consume only 6% of total private–commercial spending for health care?

Let’s examine these findings in more detail and speculate about the future. First, some needed definitions.

The authors explain that innovative treatments in this study include:

- Therapies administered as oral medicine, ointment, injections, infusions, or inhalations. These therapies may be proteins or enzymes or other complex chemicals that may be manufactured through genetic alteration of yeast, bacteria, or other organisms, or through other complex synthesis. Our analysis does not consider generic drugs, herbal therapies, devices, or durable medical equipment.1

According to the study’s methodology, which we will review in a moment, the authors conclude that new therapies will add approximately $5.00 per member per month in extra costs and that continued growth of existing products will add approximately $4.80, totaling $9.80 per member per month by 2011. They believe that this cost of $9.80 per member per month to the payer will assume relatively low cost-sharing by the member. From a national perspective, the authors estimate that total spending for innovative therapy (i.e., by all payers, including Medicare and Medicaid) will exceed $100 billion by 2011, up from about $55 billion in 2005.”1

Exactly how did the authors arrive at these estimates of both future innovative therapy costs and future medical costs?

It appears that projections of innovative therapy sales were used as one source for the estimates. The authors then reviewed the cost of individual innovative therapies from these projections and the diseases targeted by the therapy. They explained:

Using medical opinion, we estimated the portion of each that would be used for the commercial population; dividing the projected 2011 commercial sales by the projected 2011 aggregate commercially insured population produces a per capita cost for innovative therapy.

The authors then used Milliman’s proprietary health cost guidelines to estimate current medical costs for a particular employer population. These guidelines are an extensive claims cost database containing detailed average charges and utilization experience and fee schedules for roughly 60 benefit categories. The estimates include current innovative therapies in the market.

Well, there you have it. Their conclusions may be “too good to be true,” but it is certainly is worth taking a look at the Milliman study. I am sure that the conclusions are pleasing to those in the biotechnology industry and to many of our readers! At this point, however, I am cautiously optimistic. I believe that more comparative research is needed and that additional corroborative studies from other organizations are required. As with any good science, other investigators need to review the assumptions made by Milliman and the estimates inherent in its guidelines.

Whatever your viewpoint about the future cost of innovative FDA-approved therapies, it certainly is an important area for investigation and discussion. Has your P&T committee estimated the impact of future FDA-approved therapies on your organization? Have you had an opportunity to review the Milliman guidelines? This is a serious matter and deserves an extensive review by all of us.

If you are interested in obtaining a copy of the report, you can send an e-mail to the principal author, Bruce Pyenson, at bruce.pyenson@milliman.com.

As usual, I am interested in your views. You can reach me at my e-mail address, david.nash@jefferson.edu.

REFERENCE