The most recent Centers for Medicare & Medicaid Services (CMS) projection of national health expenditures (NHE) was released in March 2020, covering 2019 through 2028. CMS projects that retail prescription drug spending will represent about 9% of NHE over this period. (In December, CMS released the 2019 NHE. At $369.7 billion, retail prescription drug spending increased 5.7%. Separately, analysts estimated that “[s]pending on prescription drugs dispensed in retail pharmacies peaked in March 2020 at 6.1 percent above the February level, followed by a one-month decline and a subsequent gradual recovery.”)

Yet not all drugs are dispensed in a retail pharmacy. Some are administered in a physician visit (eg, infused chemotherapy) or during a hospital or nursing home stay. “Nonretail” drugs are paid with the associated health care service. CMS counts these as spending on physician, hospital, and nursing home services. We have estimated that including nonretail drug spending increases the total US drug spending by about 50%, and it will grow faster than retail spending for at least the next few years. We discuss the projected growth of retail and nonretail drug spending as factors driving NHE growth, trends in drug launches, and the implications of drug spending component estimates for bipartisan policies.

**Drug Spending Projections**

CMS estimates retail spending on prescription drugs at 9.2% of NHE in 2018 and projects that this share will fall to 9.0% by 2028. We estimate that nonretail drug spending accounted for an additional 4.5% of NHE in 2018, growing to 4.9% by 2028. Total drug spending will grow from 13.7% to 13.9% of NHE, from about $500 billion in 2018 to $863 billion in 2028. The retail component is projected to grow from $335 billion to $560 billion and the nonretail component from $165 billion to $302 billion. These projections do not reflect coronavirus disease 2019 (COVID-19) effects. Estimates through October 2020 indicate sustained retail drug spending growth with spending on health care services falling sharply and recovering slowly. Accordingly, our projection of nonretail drug spending in 2020 is likely overstated, as much of the nonretail drug growth occurs in clinic settings inhibited by the pandemic. It is too soon to know whether permanent COVID-19–related changes will affect the 10-year projections.

**Factors Driving Drug Spending Growth**

Two factors contribute substantively to drug spending growth: new drugs and expanded use of existing, high-price drugs. Both occur in retail and nonretail settings. While many specialty drugs embody novel treatment with meaningful clinical benefits, launch prices are high. In 2018, the top 3 drugs by spending (adalimumab, insulin glargine, and etanercept) were biological agents; spending continues to grow among these owing to absent incentives for physicians to substitute cheaper products as well as limited competition. Among nonretail drugs, physicians and hospitals face limited incentives to mitigate spending, and there is weak provider negotiating power for price concessions from manufacturers. These factors will continue without policy change.
Policy Implications

Increasing drug price affordability is a priority for bipartisan policy making. Retail drug prices receive considerable attention because they are highly visible to consumers and represent a significant out-of-pocket burden even to those with insurance. Although it is less visible, nonretail spending offers a target for reducing health care spending, affecting premiums and fiscal budgets. Because coverage provisions differ between retail and nonretail drug expenditures (e.g., Medicare Part D vs Medicare Part B), different policies are required to address them. While Congress did not enact drug reforms in 2018-2020, the Trump administration finalized 3 rules intended to improve access and affordability—2 apply to retail drugs, and 2 apply to nonretail drugs.

The first rule would increase transparency in the charges for retail and nonretail drugs administered by clinics and hospitals to privately insured patients. The second rule aims to reduce prices of nonretail drugs covered under Medicare Part B based on the lower prices paid by peer countries. The third rule would pass through the rebates given to intermediaries in the retail drug supply chain, lowering the out-of-pocket costs for Medicare Part D beneficiaries.

The first rule enjoys bipartisan support and is based on Affordable Care Act provisions. The fate of the last 2 rules is uncertain given legal and procedural challenges. Nevertheless, efforts to increase transparency and reduce spending on prescription drugs will continue. Two additional reforms may achieve bipartisan compromise: (1) promotion of competition among drug manufacturers through reductions in pay-for-delay deals, refinements to patent and market exclusivities, and promotion of biosimilar use and competition and (2) reductions in revenues that may be earned by clinics, hospitals, and other intermediaries from the use of high-priced prescription drugs. These policies would reduce drug spending for patients and payers, particularly among the nonretail component.

ARTICLE INFORMATION

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REFERENCES


