The Source Roundup: April 2018 Edition

By: Briana Moller, Student Fellow

Happy April! In this edition of the Source Roundup, we cover five academic articles from February and March. The topics this month include: 1) a comparative look at US health care spending and 2) solutions to the rising cost of prescription drugs.

Comparative Look at US Health Care Spending

In the JAMA article, "Health Care Spending in the United States and Other High-Income Countries," authors Irene Papanicolas, Liana R. Woskie, and Ashish K. Jha compare health care spending in the United States with other high income countries like the United Kingdom, Canada, Germany, and Japan. The study found that although the United States spent more per capita on health care than any other country, it consistently had the poorest health outcomes and coverage rates. From 2013 to 2016, the US spent approximately 17.8% of GDP on health care spending, whereas health care spending as a percentage of GDP in other countries ranged from 9.6% in Australia to 12.4% in Switzerland. Despite this, the US had the lowest percentage of people covered, lowest life expectancy, and highest infant mortality rate. Interestingly, Papanicolas et al. suggest that the most influential drivers of health care costs were not utilization nor the use of specialists, but rather, disproportionate pricing on pharmaceuticals and high administrative costs.

In fact, the study found that the US' utilization of health care services was very similar to other countries, with the exception

of imaging services. (The US performed the second most MRIs after Japan and the most CT scans per 1,000 people of all the countries studied.) Furthermore, despite spending more on physician and specialist salaries than other countries, the study found the US had a fairly comparable physicians-to-specialists ratio. The US also had a lower physician workforce than the mean of the countries studied. On the other hand, it had the highest levels of administrative burden– spending 8% of its GDP on administration and governance compared to the mean of 3% of all other countries. Moreover, the US had the highest pharmaceutical spending per capita at $1443, compared to the second highest spending country, Switzerland, at $939 per capita, and a mean of $749 per capita for all other countries. The study also compared the price of four major pharmaceuticals: Crestor, Lantus, Advair, and Humira, and found that the US paid the most for all four drugs out of all the countries studied. Even more surprisingly, the study found that for three out of the four drugs, the US paid more than twice that of the second highest paying country.

In the JAMA editorial "The Real Cost of the US Health Care System," Ezekiel J. Emanuel agrees with Papanicolas et al. that high pharmaceuticals prices, imaging, and administrative costs are some of the most influential drivers of health care spending. However, unlike Papanicolas et al., Emanuel suggests that overutilization is, in fact, a major driver of health care spending. He notes that although the US spends significantly more on physician and specialist salaries, this does not substantially contribute to high spending, because the volume of physicians and specialists is limited. In fact, he argues that it is the combination of high prices *and high volume* that drives up health care costs. To illustrate, he points out that the US not only spent $42.50 more than the Netherlands for knee

replacements, but it also performed nearly twice as many. This is just one example of many "high-volume, high margin procedures" that work to drive up costs.

To address these issues, Emanuel offers a variety of solutions. He suggests that both citizens and politicians become serious about regulating drug prices and streamlining administrative health care costs. In addition, he suggests that shared decision-making between doctors and patients, combined with reference pricing, will lead to lower costs. In fact, he cites a Health Affairs article written by The Source's Executive Editor, Professor Jaime King, and Benjamin Moulton, that found that shared decision making could reduce the volume of preference-sensitive procedures by approximately 33%. In addition, prices for CT scans, MRIs, and C-sections could be reduced by nearly 33% if reference prices are implemented for those procedures. If the US lowered the prices and volumes to match those of the Netherlands, it would save about $425 per capita, or $137 billion in total. Thus, addressing disproportionate volume, in addition to disproportionate pricing, could be an extremely effective way to contain increasing health care costs.

However, in "Challenges Between Understanding the Differences in Health Care Spending Between the United States and Other High-Income Countries," another JAMA editorial written in response to the Papanicolas study, Katherine Baicker and Amitabh Chandra contend that when designing policy that addresses health care spending, it is necessary to have comprehensive data that reflects the supply-side and demand-side drivers of prices, quantities, and quality. For example, they note that "individuals in the US may consume what *appear* to be similar health care services but some of these may actually be more intensive versions of the services consumed in other countries,"

(italics added), such as seeing board certified oncologists rather than general oncologists. Baicker et al. write while the Papanicolas study provides an important comparative look at health care spending, the true reason for higher pricing is more difficult to gauge. For instance, higher prices can arise from demand-side factors, such as more generous insurance that covers every service or proton therapy for prostate cancer, or they can arise from supply-side factors such as the number of competitors in the health care market. Ultimately, Baicker et al. emphasize that policy should be determined by the values of the voters, which will be entirely different in each country.

Solutions to the Rising Costs of Prescription Drugs

In the Health Affairs article "Promoting Competition to Address Pharmaceutical Drug Pricing," Jonathan J. Darrow and Aaron S. Kesselheim discuss how to promote competition within two different markets: the inter-brand market and the brand/generic market. Inter-brand competition is competition that occurs among chemically distinct drugs that treat the same disease|inter-brand competition may also occur in drugs in different therapeutic classes. The authors explain that inter-brand competition does not lower drug prices because laws that prohibit payers from leveraging formulary exclusions during negotiations work to keep low-value drugs in and drug prices high. To some, high price is perceived as an indicator of better quality|however, this is likely due to a severe lack of information regarding the comparative effectiveness of inter-brand drugs. As solutions to these issues, Darrow et al. suggest that the US enhance federal agencies or other organizations' authority to evaluate and disseminate information about drug value. Additionally, they suggest broader substitution laws to allow pharmacies to dispense different chemical entities within

the same therapeutic category without explicit physician authorization. Finally, they suggest evidence-based formularies to allow payers, like Medicaid, to exclude low value drugs.

Unlike inter-brand competition, the entry of generic drugs to the market actually lowers drug prices. In fact, the authors note that the introduction of a generic drug results in approximately 50% price reduction of the branded product within six months, and to approximately 10% of the branded product's original price within 2.5 years. In spite of this, certain exclusivity laws have stifled competition and the amount of manufacturers in the market. Darrow et al. suggest reducing approval times for generics and allowing temporary drug importation from other countries in times of shortage to facilitate competition. Additionally, they suggest prohibiting brand names drugs from blocking generic entry by obtaining overlapping patents or leveraging available exclusivities improperly. Although more than 90% of brand name drugs with annual sales exceeding $250 million experience patent challenges, the average period of time between FDA approval and generic entry remains at 13.5 years. Thus, there is still much to be done to curb exclusivity abuses and address exorbitant drug costs.

The National Academy for State Health Policy (NASHP) provides insight on how the government may be able to do so in its report, "How the Federal Government Can Help States Address Rising Prescription Drug Costs." In this report, NASHP details how Medicaid's "best price" rule and laws that prevent states from operating closed formularies keep the government from negotiating the lowest possible prices for prescription drugs. Currently, in exchange for a manufacturer's best price (the lower price on the commercial market), state Medicaid programs

must cover all the manufacturer's drugs, with very few exceptions. Thus, drugs that have relatively little cost effectiveness are nonetheless covered. States are also entitled to negotiate additional rebates if the manufacturer's drug price increases|however, states are prohibited from disclosing their negotiated rates with other states, thus significantly stifling their bargaining power. Additionally, manufacturers are reluctant to engage in meaningful negotiation to lower prices with neither Medicaid state programs nor non-Medicaid agencies, in fear of creating a new "best price."

To address some of these issues, NASHP makes several recommendations to improve price transparency and state formulary management tools. First, NASHP suggests conducting audits to verify that a drug's best price and average market price on which Medicaid discounts are based are truly accurate, in order to ensure the lowest price possible. Second, NASHP recommends enlisting the Centers for Medicare and Medicaid Services (CMS) to share states' negotiated supplemental rebate with each other, to give states more effective bargaining power. NASHP also suggests that CMS approve demonstrative waivers that would permit states to be exempted from Medicaid's "best price" requirements. Similar to the Darrow article above, NASHP also contends that allowing states to operate closed formularies will have a profound impact on states' negotiating power. NASHP recommends the creation of a joint federal-state Medicaid Technical Advisory Group that would address complex Medicaid drug coverage and rebate issues to improve communication between states and CMS.

Even though the world of health care spending has an array of complex issues, organizations like NASHP and scholars like Emanuel and Darrow et al. demonstrate there is no shortage of

potential solutions.

That’s all for this month’s Roundup. As always, if you find articles or reports that you think should be included in the monthly Roundup, please send them our way. Enjoy your reading!