

The Source Roundup: August 2019 Edition

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Happy August! Even as the summer winds down, there is no waning of health policy literature. In this month's Source Roundup, we take a look at academic articles and studies that analyze 1) potential prescription drug savings from generics and biosimilars, 2) the need for price transparency, and 4) a multitude of efforts in health system reform.

Potential Prescription Drug Savings from Generics and Biosimilars

As prescription drug pricing continue to capture the nation's attention, Stacie B. Dusetzina et al. take a dive into cost discrepancies between brand name drugs and generics for Medicare Part D beneficiaries in their *Health Affairs* article [Sending The Wrong Price Signal: Why Do Some Brand-Name Drugs Cost Medicare Beneficiaries Less Than Generics](#). The authors discuss the current benefit design of Medicare Part D and how its structure contributes to seniors paying more out of pocket costs for generic drugs. Specifically, Medicare Part D allows users of brand name drugs to receive manufacturer discounts that would reduce their out-of-pocket spending. The Bipartisan Budget Act of 2018 established that brand name biosimilars couldn't be more expensive than the original biologic it resembles. However, generics do not receive this same requirement. Taken together, Dusetzina et al. argue that this structure led to lower prescription level of generics, which discourages generic competition. To address this problem, the authors suggest

removing manufacturer discounts for brand name and biosimilar drugs from out-of-pocket spending calculations or simply extending the discounts to generics.

In another issue brief regarding biosimilars published by the Center for Medical Economics and Innovation, Wayne Winegarden discusses how biosimilars saved \$253.8 million dollars a year in total healthcare spending and their potential for greater savings. The study, titled [Incenting Competition to Reduce Drug Spending: The Biosimilar Opportunity](#), highlights the potential savings that could happen if biosimilars are able to gain more of a presence in the pharmaceutical market. To reach the potential, Winegarden urges addressing the various barriers that prevent biosimilar growth, including vague guidelines in prescribing biosimilars. Winegarden argues that by creating transparency guidelines, prescribers will gain the knowledge of when they can actually prescribe biosimilars to patients. This would also create additional options for patients. In addition, Winegarden encourages further research and development to expand the breadth of drug classes biosimilars cover, which he believes would could cause the potential savings to skyrocket.

More Push for Price Transparency in Healthcare

In 2018, California Lawmakers sought to increase transparency by looking to create an all-payer claims database (APCD) which would allow access to the cost of healthcare within the state. [The Secret of Health Care Prices: Why Transparency Is in the Public Interest](#), published by the California Healthcare Foundation and written by The Source's Katie Gudiksen, Sammy Chang, and Jaime King, analyzes the legal and economic implications of creating such a database and allowing access to the public. The article first goes into detail about trade

secret statutes involving negotiated healthcare prices. In California, if the trade secrets are determined to be in the public's interest, they can be disclosed as long as the disclosure of information follows general privacy laws. The article then explores when disclosing negotiated rates is in the public's interest. Lastly, the article concludes with several recommendations that California should employ to ensure a successful implementation of an APCD. Some of these recommendations include establishing a clear set of guidelines regarding when this data would be released and whether the release of such data would conflict with any confidentially agreements. In addition, Gudiksen et al. suggest the release of the pricing data should be based on a tiered system of the entity receiving the information. For instance, the base tier would be the public, then progressing to academic entities, and finally to private entities. The purpose of a tiered system would be to create oversight on the data released and preserve security of such confidential information.

In other price transparency literature, *Harvard Business Review* published an article regarding whether price transparency would really make an impact on the healthcare landscape. In [Price Transparency in Health Care is Coming to the U.S. – But Will it Matter?](#), authors David Blumenthal, Lovisa Gustfsson, and Shanoor Seervai analyze trends in legislation regarding transparency to see if such transparency would lower health care costs. Blumenthal et al. discuss how price transparency theoretically lowers the cost of health services, although there is little evidence to credibly back this up. The article looks at New Hampshire as the only state that posts prices for hospital care for public consumption. However, since only a handful of the population utilizes the information, it is inconclusive to say whether the state's overall costs have decreased specifically due to transparency. In addition, the

article looks at other factors that could affect the effectiveness of price transparency, including the fact that many patients correlate higher costs of services to higher quality, and the urgency of certain medical procedures preventing patients from shopping around. The authors conclude that although its actual effects are unknown, price transparency needs to be implemented to understand its true potential for cost savings.

Delivery and Value-based Reform at the Forefront of Health System Reform

Value-based payment is one of the major reform efforts in healthcare. Blue Cross Blue Shield of Massachusetts initiated a population-based payment model eight years ago that changed the way physicians are reimbursed. Zirui Song, Yunan Ji, Dana Safran, and Michael E. Chernew analyze the results of this alternative payment model in their study, [Health Care Spending, Utilization, and Quality 8 years into Global Payment](#). Published in the *New England Journal of Medicine*, the study illustrates a model of payment where doctors were paid a fixed amount of money to treat patients. This approach also allowed doctors to earn monetary bonuses if they stayed within the global budget. This is a contrast between the traditional payment model where providers are reimbursed for every single service rendered regardless of whether it contributes to the overall health of the patient. The study shows that by giving physicians a set amount of funds for services and encouraging them to not to exceed that set amount, patients required less services while at the same time received the same or slightly better quality of care. Song et al. found that this in turn decreased the amount of total healthcare spending. The study concludes that instead of delivering substandard care in order to bill for more

services, this model creates incentives for providers to deliver better quality care with lesser visits, thereby improving the quality of care and reducing healthcare spending.

In delivery reform, Fair Health published an analysis on telehealth and its effects on the healthcare landscape. Titled [A Multi-layered Analysis of Telehealth](#), the study uses data from over 29 billion private claim records to analyze trends regarding this rapidly growing medium of care. Some of the noteworthy findings from the study point to telehealth's rapid growth. For instance, from 2014 to 2018, there was a 624 percent claims increase in all telehealth related services. Other statistics highlight the most frequently used types of telehealth services. In 2018, 84% of all telehealth claims involved non hospital based provider to patient interactions. Additionally, the report finds the highest usage of telehealth are for upper respiratory infections and mental health related disorders.

Finally, turning to the recent debate on Medicare for All, the Center for American Progress released [Medicare Extra](#), a proposal for universal health coverage with the aim to insure 35 million uninsured while at the same time preserving the option to keep employer coverage. The proposal breaks down how this daunting task could be accomplished by using a comprehensive Medicare plan covering dental, vision, hearing, and reproductive care. The proposal presented different premium and cost-sharing schedules based on a family's income level. The plan would also save money by having Medicare Extra establish hospital prices at 110% of what Medicare pays now and expand these prices to employer-based insurance plans, creating an all-payer rate setting system. In short, the plan seeks to establish universal coverage without creating a single payer system with promises to cover everyone, cut costs by \$300 billion, and keep some private insurance.

That's it 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. Happy reading!