The Source Roundup: February 2018 Edition

Happy February! In this edition of the Source Roundup, we cover five academic articles from December and January. The topics this month include: (1) oncologists' bias against biosimilars, (2) effects of recent mergers and acquisitions on the health system, (3) initial results from Maryland's global budget mandate, and (4, 5) recent changes to the 340B program.

How Oncologists May Be Biased Against Biosimilars

In *Behavioral Economics and the Future of Biosimilars*, a commentary in the Journal of the National Comprehensive Cancer Network, authors Chad Nabhan and Bruce Feinberg examine biases that would prevent oncologists from prescribing biosimilars when given a choice between biologics and biosimilars, which are medicines "highly similar" to an already approved biologic.[1] Biologics currently take up 62% of the $18.5 billion Medicare Part B drug spending. If biosimilars could compete with biologics, it could lower the costs of biologics. The authors discuss seven types of biases oncologists may have: 1) loss aversion: fear of losing money with a lower priced biosimilar (resulting in lower profit margin)|2) defaults: "entrenched prescribing behavior" that prevent them from prescribing biosimilars|3) familiarity: tendency to prescribe biologics over biosimilars due to past experience and comfort with a biologic|4) outcome bias: fear that biosimilars, because they are not exactly the same, would "jeopardize" a known outcome|5) availability: judgment of biosimilars by equating them to generics which often times did not provide the proper response, 6) framing: aversion to biosimilars based on the way information comparing biosimilars and biologics is presented, and 7) anchoring: a negative, preconceived understanding of biosimilars. The authors suggest that understanding and addressing these biases is critical to lowering drugs costs, as it would result in wider acceptance of biosimilars, promote more competition, and reduce the cost

pressures that biologics are current exerting.

Whether Recent Mergers and Acquisitions Could Benefit the Health Care System

In the Harvard Business Review article, *Is M&A the Cure for a Failing Health Care System?*, David Blumenthal examines whether the formula of integrating insurers and health care delivery systems will spell success for the recent CVS-Aetna merger and UnitedHealth-DaVita Medical Group merger. Under this formula, the care delivery system, which consists of hospitals and health care providers, would also become the insurer and take on financial responsibility for its health care. Examples include Kaiser Health Plans and Intermountain Healthcare. Blumenthal notes that theoretically, the providers would focus on providing the most cost-effective approach to care, rather than trying to achieve a certain volume of services under the mainstream fee-for-service regime. In the case of CVS-Aetna, he explains that because the merger combines a pharmaceutical retailer and a pharmacy benefit manager with an insurer, it will result in only a limited set of services. Nonetheless, this merger could result in convenient preventative services through CVS's Minute Clinics for high cost, chronically ill patients who may have difficulty getting to their primary care physician. Aetna could incentivize the use of CVS's Minute Clinics over expensive emergency and hospital services by removing copays and deductibles for CVS services. But, Blumenthal cautions that because this merger would require expensive and challenging coordination with traditional providers like hospitals and providers, it would not help defragment the healthcare system. On the other hand, the UnitedHealth-DaVita merger would be a provider-insurer merger more similar to Kaiser and Intermountain. DaVita Medical Group has nearly 300 medical clinics, 35 urgent care clinics, 6 outpatient surgery centers, and 2,000 primary care and specialist physicians. But, Blumenthal cautions that health care is a "very local affair" and that a national system would be disruptive and challenging to implement. Blumenthal concludes that while these mergers are attempts to lower costs and increase value in a fragmented health care system, they face many challenges and uncertainty.

Initial Results from Maryland's Mandatory Global Budget Program

In 2014, Maryland mandated all hospitals to set a budget that encompasses all payers including Medicare, Medicaid, and commercial insurers. This move aimed to control hospital spending and incentivize hospitals to reduce hospital utilization and enhance primary care. In JAMA Internal Medicine's *Changes in Health Care Use Associated With the Introduction of Hospital Global Budgets in Maryland*, Eric Roberts, et. al. report that Maryland's global budget program did not achieve its goals for three reasons. First, because the global budget program did not include payments to physicians, it had little effect on physicians' behavior to reduce cost like they would in an Accountable Care Organization (ACO). While physicians would bear all or some of the risk in an ACO, incentivizing them to lower patient spending and improve care outcomes, only hospitals bear the risk in the global budget program, Second, because the budget program set a limited revenue for hospitals and healthcare cost increases were minimal, hospitals were not incentivized to reduce volume to reach the designated revenue target. Third, because hospitals had difficulty initially implementing new programs and adjusting existing programs, the global budget program was not finalized until several months after the program had started. This means these results may not reflect a fully implemented, fully functional global budget program. The overall study, however, was limited, by its reliance on Medicaid beneficiaries only and an imperfect control group, since all of Maryland was under the global budget program. While this may be a first step in understanding the effects of the global budget program, the authors note that further monitoring of the program is needed for a fuller picture.

Focus on the 340B Drug Pricing Program

This month saw multiple articles and reports relating to the 340B Drug Pricing Program, which is a program that requires drug manufacturers to provide outpatient drugs at discount prices to covered entities. On January 10, 2018, the U.S. Congress House Committee on Energy and Commerce released its report, *Reviewing of the 340B Drug Pricing Program*, calling for audits to ensure greater program

compliance, transparency, and regulatory authority. A few days later, the New England Journal of Medicine (NEJM) released two articles: *Consequences of the 340B Drug Pricing Program* and *Discounted Drugs for Needy Patients and Hospitals — Understanding the 340B Debate*. The former examines whether the 340B Drug Pricing Program actually expanded care to low income patients as intended, while the latter focuses on the controversy surrounding the Centers for Medicare and Medicaid Services (CMS) new rule to reduce Medicare Part B payments to hospital outpatient departments. Taken together, these articles provide a fascinating narrative to the 340B Drug Pricing Program.

In *Discounted Drugs for Needy Patients and Hospitals — Understanding the 340B Debate*, authors Walid F. Gellad and A. Everette James examine the controversy surrounding the 340B program and CMS's recent reduced reimbursement rule that seeks to limit the abuses of the 340B program. Because the 340B program reimburses hospitals the same amount even when the hospitals buy drugs at a discounted price, the program provides 340B hospitals with a significant amount of revenue. These revenues in turn help hospitals provide care to medically underserved communities. However, limited transparency and accountability, as highlighted in the House Committee on Energy and Committee's report, have also raised concerns of possible, yet unknown abuse. While hospitals argue that a loss of revenue is a loss of care to medically underserved communities, the pharmaceutical industry called for a limitation in the 340B program's scope so that the revenue from the program could be used directly to help the medically underserved rather than allowing hospital free rein. The authors agree and conclude that the 340B program, "though well-intentioned," became so "large and convoluted that it requires scaling back."

As an example of the abuse raised in the article above, in *Consequences of 340B Drug Pricing Program*, authors Sunita Desai and J. Michael McWilliams examine how the 340B program influenced hospital-physician consolidation in three specialties: hematology-oncology, ophthalmology, and rheumatology. 340B eligible hospitals had significantly more physicians in those specialties practicing in hospital-owned facilities than hospitals that were not eligible for the 340B programs. This implies that 340B eligible hospitals were incentivized to acquire physician practices or employ physicians that tend to prescribe drugs covered by the 340B program.

Consequently, hospitals that were eligible for the program had (a) more patients receiving drugs and (b) more drug claims than average, but (c) "significantly less" percentage of patients dually eligible for Medicare and Medicaid (i.e. low-income patients) for the hospital's hematology-oncology and ophthalmology practices, which suggests that these hospitals treat more Medicare patients who can afford to pay the 20% of drug costs not covered by Medicare Part B. Thus, instead of expanding care for the medically underserved population, the 340B eligible hospitals have increased "affiliations with hematology-oncology practices serving affluent communities." Consequently, the authors argue that hospitals eligible for the 340B program were gaming the system to increase their revenue flow instead of using that revenue to increase care to medically underserved populations.

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!

---

[1] An imperfect analogy could be that biologics are very much like brand name drugs and biosimilars are very much like generic drugs for the purposes of cost reduction. *See also Biologics &amp|Biosimilars*, PhRMA (last visited January 26, 2018), https://www.phrma.org/advocacy/research-development/biologics-biosimilars.