The Source Roundup: May 2018 Edition

Happy May! In this edition of the Source Roundup, we cover four academic articles and reports from March and April. The topics this month include: 1) the unfilled promise of price transparency to encourage price shopping, 2) FDA's actions on prescription drug prices, 3) the phenomenon of overpayment for prescription drugs, and 4) results of Maryland's All-Payer global hospital budgeting program.

Unfulfilled Promise of Price Transparency to Encourage Price Shopping

In *Promise and Reality of Price Transparency*, a health policy report published by the New England Journal of Medicine, authors Ateev Mehrotra, Michael E. Chernew, and Anna D. Sinaiko examine the promise and reality of price transparency as a means of facilitating price shopping and decreasing healthcare spending. The authors assert that the promise of price transparency lies within its potential to encourage price shopping. Given the ability to price shop, patients would theoretically choose lower-priced, higher-quality providers, thereby decreasing healthcare spending. However, the reality is that although 28 states have passed price transparency legislation to date, price transparency efforts have failed to reduce healthcare spending. The reason is that only a small fraction of patients use the price transparency tools that are available to them. Therefore, according to the report, even though those who did use the tools saved money, when taken in aggregate, the savings were not significant enough to decrease overall spending because so few people participated.

Mehrotra et al. posit three reasons for the low rate of price shopping. First, patients face an information barrier, as many are still unaware that price data is available. Even if they are aware, the complexity of the medical billing system may render the information confusing and difficult to understand. Second, current benefit designs create an incentive barrier, as most health plans offer constant co-payments that result in a lack of incentive for patients to price shop. Finally, the relationship

patients have with their providers dictates that most patients are reluctant to switch physicians and disrupt that relationship.

Given these barriers and the unfulfilled promise of price transparency to encourage price shopping, the authors suggest that policymakers should look to other benefit designs to decrease healthcare spending. Reference pricing programs, where patients pay the difference between the reference price and the provider's price, act to encourage patients to switch to providers below the reference price. Provider tiering and narrow networks impose higher payments on patients who opt for higher-priced providers, while rewards programs reward patients who choose lower-priced options. According to the authors, these designs are more effective in encouraging patients to switch to lower-cost providers, thereby achieving the ultimate goal of reducing health care spending.

FDA's Actions on Prescription Drug Prices Require Additional Support

In an issue brief published by The Commonwealth Fund titled *What Commissioner Gottlieb's FDA Is Doing to Lower Prescription Drug Prices and Steps Congress Can Take to Help*, authors Henry Waxman, Bill Corr, Kristi Martin, and Sophia Duong assess the FDA's action plan to address the issue of high prescription drug prices by comparing it with their 2017 report, *Getting to the Root of High Prescription Drug Prices: Drivers and Potential Solutions*.

The authors first acknowledge that FDA Commissioner Scott Gottlieb has proposed several meaningful policy changes to encourage competition and transparency in the prescription drug market. The Drug Competition Action Plan of 2017 includes plans to expedite new drug applications (ANDAs), facilitate approval and adoption of biosimilars, and restrict compounding of drugs that are copies of FDA-approved drugs. The authors found that most of the proposed changes are still in the early stages of implementation with results yet to be realized, and while promising, the agency can do more to lower prices. Waxman et al. argue that the FDA can leverage its broad authority to further address anticompetitive behavior and indirectly impact high drug pricing. Suggested actions to encourage additional competition include finalizing the interchangeability guidance for the biosimilar pathway to spur

competition in the biologics market, limiting REMS abuse by requiring brand-name manufacturers to make samples available to generic manufacturers, and addressing the problems of "product hopping" and "evergreening" (See The Source Glossary).

While the FDA has taken promising steps to increase prescription drug competition, the authors assert that it is important to realize that FDA's authority has limits. The brief urges Congress to take action to support the FDA by reaffirming its authority for specific policy actions and establishing new authority for the FDA to expand current actions. Specific steps include closing loopholes in the Orphan Drug Act that allow manufacturers to obtain new exclusivities and giving the FDA authority to allow limited importation of drugs when only one manufacturer is on the market. In addition to congressional action, the brief calls upon the involvement of other agencies, such as the Department of Health and Human Services, the U.S. Patent and Trademark Office, the Federal Trade Commission, and the Department of Justice, to help address drug pricing problems that extend beyond the FDA's jurisdiction.

Overpayment for Prescription Drugs Is Real and Should Be Prohibited

The phenomenon of prescription drug overpayments (also known as "clawbacks") has received much attention from state policymakers in recent years. A clawback occurs when commercially insured patients pay more in copayment for prescription drugs than the actual amount their insurer or pharmacy benefits manager (PBM) has to pay the pharmacy (reimbursement amount), allowing the insurer or PBM to pocket the difference. In the white paper titled *Overpaying for Prescription Drugs: The Copay Clawback Phenomenon*, Karen Van Nuys, Geoffrey Joyce, Rocio Ribero, and Dana P. Goldman of the Leonard D. Schaeffer Center for Health Policy & Economics report their findings of an empirical analysis of the phenomenon conducted using actual claim data from 2013. To identify overpayments, the authors compared patient copayments with the national average reimbursement received by pharmacies for the same prescription. The copayment data came from a 25% random sample of pharmacy claims in the first half of 2013. The reimbursement data was collected from a survey conducted in January 2013 by the Centers for Medicare

& Medicaid Services (CMS), which established the National Average Retail Price (NARP).

The results of the analysis showed that in 2013, 23% of pharmacy prescriptions involved overpayment of more than $2.00 and the average amount of overpayment was $7.69. In addition, overpayments were more common on claims for generic drugs than brand name drugs (28% vs. 6%), although overpayment on generic drugs was less than brand drugs ($7.32 vs. $13.46). Furthermore, the top 20 drugs with the highest frequency of overpayment included medications for common conditions including insomnia, high cholesterol, pain, and cough, which in aggregate resulted in a significant total amount of $135 million.

Given that insurers and PBMs typically keep the overpayments as profit, the authors contend that overpayments directly increase out-of-pocket expenditure for patients and that the government should discourage and prohibit such practices. Many states, including Maryland, Arkansas, and Georgia, have already banned the practice of overpayment. In addition, many states specifically prohibit "gag clauses" in pharmacy contracts with insurers and PBMs that prevent pharmacists from informing patients when they are overpaying. The authors believe that while eliminating overpayments cannot completely solve the issue of the high prescription costs, it is nonetheless a step in the right direction.

Maryland On Track to Meet Goals of Its All-Payer Hospital Program

In 2014, Maryland and the Centers for Medicare & Medicaid Services (CMS) entered an agreement to require an all-payer global budget program for all hospitals in the state in an effort to improve quality and limit hospital costs. The Health Services Cost Review Commission of Maryland details the results from the first three years of implementation in the report titled *Maryland's All-Payer Hospital Model Results Performance Year Three*, published by the Maryland Department of Health. According to the report, the All-Payer Model established a series of requirements for a five-year period. The report indicates that in the first year of the program, Maryland shifted all hospitals from volume-based reimbursement to the global budget system and included value- and quality-based payment changes.

Stakeholders ranging from the state, hospitals, other providers, community organizations, and consumers participated in the care delivery transformation to improve the quality of care and increase cost savings.

The report shows that Maryland is on track to meet all seven requirements under the All-Payer Model. First, the state met the goal of limiting per capita hospital revenue growth to 3.58% per year, with growth rates between 0.8% and 2.31%, well below the established ceiling. Second, the state easily met the requirement of saving at least $330 million in Medicare hospital expenditures over the five-year period, with cumulative savings totaling $586 million for the first three years. Third, the growth rate for total Medicare spending per beneficiary stayed below the national average growth rate as required, by approximately 2%. Fourth, Maryland has steadily reduced Medicare readmissions more quickly than the rest of the nation and is on track to reach national average levels by the end of the five-year period as required. Fifth, the state has reduced potentially preventable conditions by 44%, well exceeding the target requirement of 30%. Sixth, Maryland moved 95% of hospital revenues to global budgets in the first year alone, and reached 100% by the end of 2016, easily surpassing the required target of 80%. Finally, as required, Governor Larry Hogan submitted a Total Cost of Care Model proposal known as the "Progression Plan" to expand the existing model beyond hospitals for Medicare beneficiaries, allowing the state to continue to reduce costs while improving quality of care.

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!