Rx Cost Growth: Controlling the Cost

Speakers

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Three Broad Topics

- Medicare
- Other Payors
- Other Concerns

Medicare Background

- Part D drug coverage is provided by prescription drug plans (PDPs)
- Medicare is prohibited from directly negotiating with the drug companies
- The CBO has said that unless Medicare establishes a formulary, there are no savings associated with negotiating with drug companies
- Part D benefits are in four steps – deductible, initial coverage, “doughnut hole” and catastrophic coverage

Medicare Policy Concerns

- Value-based purchasing and bundled payments do not include drugs
- Part D catastrophic spending is increasing rapidly
- Most rapidly growing category of spending is reinsurance payments to Part D plans

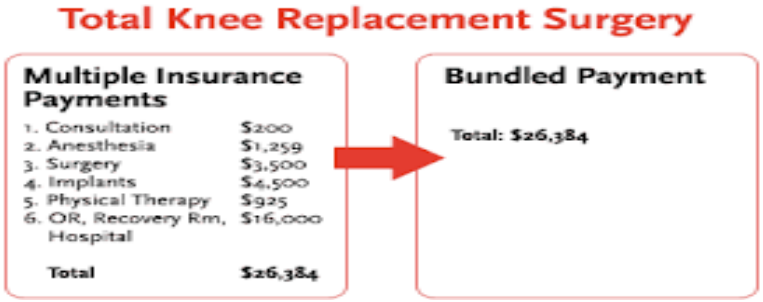
One Type Of Value-Based Purchasing: Bundled Payments

- Bundled payments combine payments for an episode of care into a single payment
  - Diagnosis-Related Group's (DRGs) were the first bundled payments
  - Public and private insurers are combining hospital, physician and post-acute services into one bundled payment
- Drugs are an important part of a treatment plan

And yet drugs are still paid fee-for-service

Knee and Hip Replacements

- Current demonstrations excludes Part D drugs
- This is an example of a bundled payment



- There is clinical evidence demonstrating a tradeoff between spending on drugs and medical services for knee and hip replacements

Starting with Baby Steps

- Lets start with conditions where drugs are a small portion of spending like hips and knees and learn from the experience

- Once we can include Part D drugs in procedures with small amounts of drug spending we can expand to other areas with more spending, such as chronic conditions

Why Include Part D Drugs in the Bundle?

- It allows the clinician to consider all the factors that influence the best treatment options for that specific patient

- Physicians can do this easier than PDPs or PBMs because the physician knows the patient better

- Leads to more cost-effective allocations

ESRD Bundled Payment

- Congress mandated that drugs be included in end stage renal disease (ESRD) payments beginning in 2011

- OIG report - “By implementing the bundled rate, CMS sought to eliminate incentives to overuse separately billable drugs and to promote equitable payment and access to services in ESRD facilities that treat more costly patients”

- Much has been learned from this experience

Rx Bundled Payments

- There are technical challenges to overcome before drugs can be included in bundled payments
- But
  - Using the principles of bundled payments for hospital, physician and post-acute care
  - Incorporating what we have learned from ESRD bundled payments that include drugs

We can incorporate drugs in bundled payments

Catastrophic Spending in Part D

- Increasing 3 times faster than overall drug spending in Part D
  - When legislation passed, the concern was for beneficiaries with multiple chronic conditions who were taking many drugs and PDPs would not want to enroll them
  - Most of the recent increase involves specialty drugs
- Current cost sharing in catastrophic Part D
  - 5% - Beneficiary
  - 15% - Pharmaceutical drug plan
  - 80% - Medicare program
- Does the PDP have enough "skin in the game" to negotiate for the expensive drugs?

Catastrophic Spending in Part D

- The Medicare program has no ability to negotiate prices in spite of paying 80% of the price

- For very expensive drugs, the Medicare beneficiary is spending almost half of their Social Security payment on the specialty drug

MedPAC recommendation

- Shift the mix of cost sharing to:
  - 20% - Medicare
  - 80% - Pharmaceutical Drug Plan
- Increase subsidies to make the drug plan no worse off
- Eliminate cost sharing for beneficiaries
- Concern – there will be incentives to discriminate against people with multiple chronic conditions or who have conditions like hepatitis C where an expensive drug is available if the health plan pays 80% of the cost

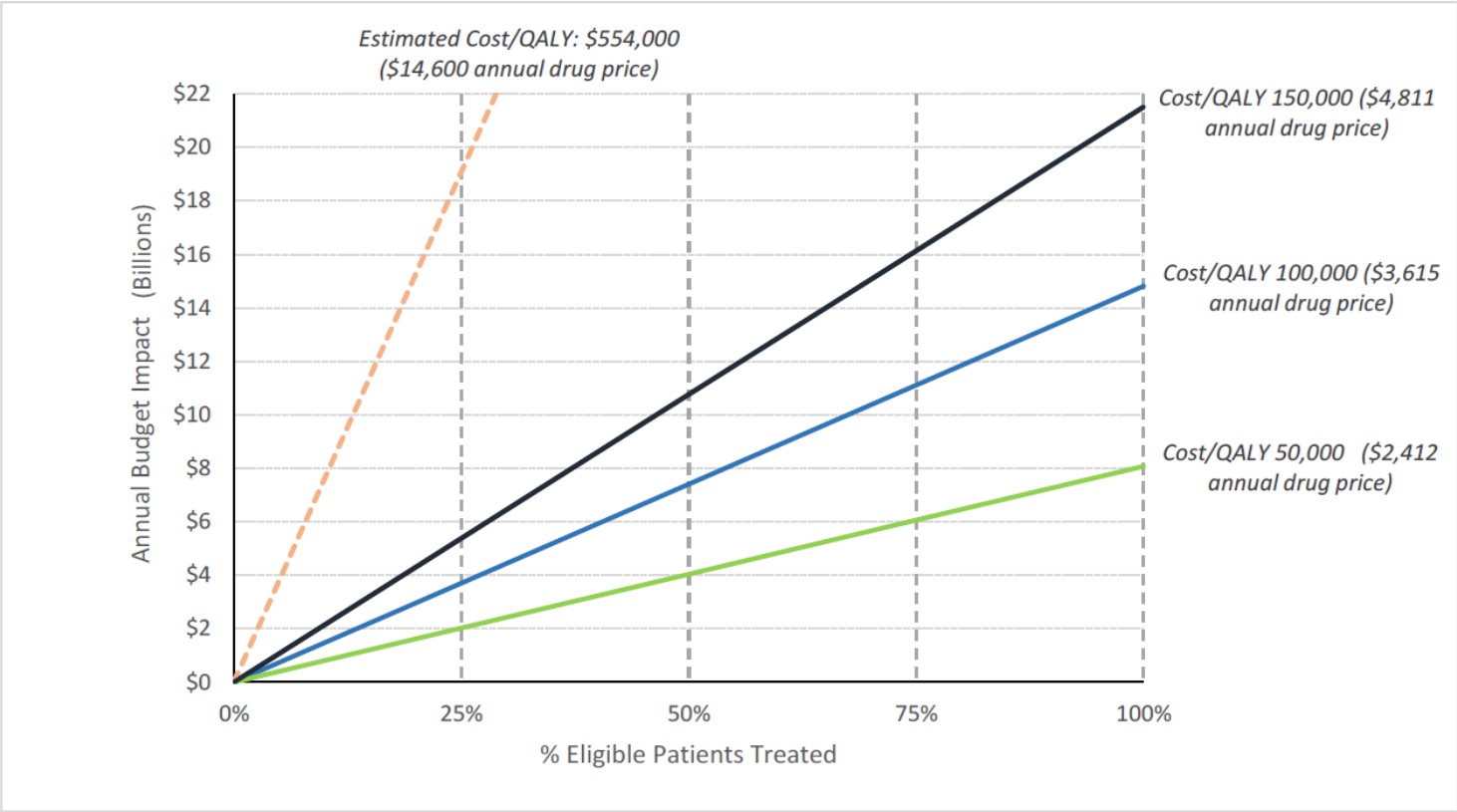
Alternative Proposals

- Allow Medicare to set prices when the drug price is more than $7,500 since this immediately puts the beneficiary into the catastrophic spending category and requires Medicare to pay 80% of the cost
- Medicare can use the value of the drug to set the price
- Means test the catastrophic benefit (Part D premiums are already means tested) to protect the low income Medicare beneficiary
- Drug companies will want their expensive drug to be covered by Medicare since Medicare coverage will help set the standard for the private insurers and the rest of the world.

Other Medicare Alternatives

- Arbitration for Part B Drugs
- Reference Pricing to set limits
  - Use framework like Institute for Clinical and Economic Review
    - https://icer-review.org/

Figure ES1. ICER combined cost-effectiveness and potential budget impact graph. Colored lines represent the impact on annualized budget impact of different uptake patterns (eligible patients treated) at the actual list price of the drug (dashed line), and at drug prices needed to achieve common incremental cost-effectiveness ratios.



Private Payors - Background

- Often drug benefits are carved out from other benefits
- Pharmaceutical benefit managers often negotiate drug prices and determine formularies
- Drug spending has been increasing very rapidly in the last few years
- Cost sharing “tiering” is making it difficult for people to afford certain drugs

Coupons

- Public programs do not allow coupons
- PBMs have developed cost sharing mechanisms to steer privately insured people to the most cost-effective drugs
  - Part of value-based purchasing initiative
  - Aside – There is some concern that PBMs steer people to drugs that earn them the highest profits through rebates
- Drug companies dispense coupons that eliminate all cost sharing
  - People perceive the drugs as a free good to them

Coupons – Add to the cost

- Dafny, Ody and Schmitt In NEJM on October 12, 2016
  - "In our sample, consisting of 85 drugs facing generic competition for the first time between 2007 and 2010, we estimate that spending on the 23 drugs with coupons was $700 million to $2.7 billion higher than it would have been if the coupons had not been issued or had been banned."
- This cost estimate only covers drugs facing generic competition for first time between 2007 and 2010. There are many other drugs receiving coupons

Coupons – Two Specific Examples

- Two or more branded drugs and one of the branded drugs has a coupon
  - Is it the less clinically valuable drug?
  - Is it the more costly drug?
  - Is it the least cost-effective drug?
- A branded and generic drug
  - The branded drug has a coupon and so the patient wants the more expensive branded drug

Coupons – Policy options

- Assume people will not be willing to give up coupons
- Industry may not be willing to tell their employees that coupons are a bad idea
- Ban coupons in private sector like public sector
- Ban coupons for people in exchanges
- Prohibit coupons when there is a generic alternative
- Force companies issuing coupons to lower the price to reflect the cost of the coupon

Price Gouging and Public Reporting

- Recently there have been rapid increases in the prices of certain drugs - Martin Skhreli or EpiPens
- Often these are generic drugs without any competitors
- Input price increases cannot justify the cost increases
- Significant public concern about access to these drugs because there are shortages

Price Gouging and Public Reporting - Policy Options

- Price gouging legislation
- Public reporting of price increases above a certain level
- Challenges
  - What level of increase triggers price gouging or public reporting?
  - What are appropriate justifications that drug companies could make?

Price Gouging and Public Reporting - Economics

- While there is not any literature on fairness in drug pricing, there is a considerable literature on fair pricing coming out of the behavioral economics literature
- Three main criterion to measure fairness:
  - reference transactions (what do other drugs cost)
  - outcomes to the participants (value to person)
  - circumstances of changing transaction terms (reason for price increase).

Survey

- We are undertaking as survey of economists asking them when a price increase is unfair
- What do you think is an unfair price increase and what could justify a price increase?

Other General Drug Pricing Policy Options

- Reduce Exclusivity length or tie exclusivity to pricing "reasonableness" for biologics
- End Pay for Delay
- Speed up FDA backlog for generics
- Fast access and diagnostics for better matches

Public Health Purchasing

- The Public Health Service can purchase vaccines at bulk prices and distribute them widely
- Having everyone vaccinated benefits the public
- Some drugs are used to treat infectious diseases
- Policy question – can the vaccine program be used to purchase drugs that treat infectious diseases?
  - There is a similar rationale – public benefit

Other Topics

- Cost of R&D
- Proposition 61 in California

Cost of R&D

- Considerable efforts to require the drug companies to report the cost of R&D for specific drugs
  - State initiatives - Obama budget proposal
- We do not know the cost of overall R&D because of a lack of price transparency
  - Most common cited estimate is $2.6 billion
  - However, we do not know what companies or what drugs were used to calculate the number so it cannot be verified
  - Also they assumed an 11% cost of capital when the companies can borrow at <3%

Cost of R&D - Proposals

- Require drug companies to report the cost of R&D by drug
  - Very complicated - many drugs fail in development and it is difficult to assign the cost of a failed drug to a specific successful drug
  - Drug companies do not actually price on the R&D cost of that specific drug
- Alternative approach
  - Allow drug companies to get a return or investment in R&D

Proposition 61 in California

- Allow California's public programs to purchase drugs at VA price
- Raises more fundamental question - Why should different government entities pay different prices for the same drug?
- In federal government, the VA, DOD, Prisons, Medicare, Medicaid, 340B, PHS, all have different systems for purchasing drugs and pay very different prices
- Statutory discounts may have unintended effects

Price Transparency

- Have the government disclose the prices that it pays for drugs
- The government discloses what it pays for nearly all goods and services – why not drugs?
- Then the different federal and state governments could compare prices and determine which agency gets the better deal
- PBMs may be earning the largest margins in health care

Additional Options

- Medicaid program group purchasing
- Medicaid PLUS Medicare group purchasing
- Encourage performance based-payment contracts

Questions?