The Powers Report Podcast

Episode 17

Price Transparency, Part II: What to Do About Drugs

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

Americans have become increasingly frustrated with the health care system, and pricing is a big part of the problem. Drug pricing in particular is a bee in almost everyone's bonnet. And the reason is simple: about half of all Americans take a prescribed medication every day (1). Drug pricing is crazy and it matters a lot because it affects the daily lives of so many Americans.

As you know, I like to use this show to describe issues in health care but more importantly, to outline some ideas about how to fix them. I will provide an overview of the pharmaceutical supply chain. However, there are a lot of great resources out there that can explain in detail how things function. In particular, I suggest an excellent video "How Drug Prices Work" which was created by *The Wall Street Journal* (2). If you want to learn what's offered to Medicare beneficiaries, I invite you to check out the Medicare.gov site about prescription drugs (3).

OK. Let's talk about drugs.

It's important to note that there's a difference between the price that pharmaceutical companies charge for their drugs – which is called the List Price – and the price that we actually pay. If you listened to my last podcast about pricing for hospitals, I talked about the Charge Master. That's a hospital's List Price for their services. Insurers negotiate down from these prices, so hospitals are incented to make them very high. Same kind of situation with a drug company's List Price.

Except there aren't just insurers in between the drug manufacturers and the consumers. There's yet another intermediary complicating things, and that's the pharmacy benefit manager, or PBM.

PBMs exist, some argue, because some organization has to buy drugs from the manufacturers and ensure that a pharmacist properly dispenses the medications. Think about it. Your doctor

prescribes medication. But your doctor doesn't have the meds in her office to give to you. They're not certified to compound medications or talk to you about drug interactions. And it's crazy to think that we'd have inventory of all kinds of different drugs in doctors' offices. That's inefficient and it's dangerous.

That's what the pharmacy does. They are the community-based distribution center for drugs. If you're a national pharmacy chain, like CVS, you have enough muscle to negotiate directly with drug companies. In fact, Caremark, which is the nation's largest PBM, is owned by CVS and Aetna, an insurance company. Caremark has the top spot in prescription claims, with 30% (4).

PBM Express Scripts was in the second spot and OptumRx was in third. OptumRx is owned by UnitedHealthcare, which is the nation's largest insurer. These three companies comprise 76% of all prescription claims.

So we've got the pharmaceutical company that sets a List Price. That gets negotiated by the different PBMs. They take a slice and then they negotiate with insurers. Insurers make money by contracting with employers and the government and individuals for coverage. In other words, insurers are baking the cost of covering drugs into their prices for coverage of hospital care, doctor visits and everything else.

Add to the mix that some drug companies will provide their drugs for free to certain qualifying patients. Oftentimes there are rebates that either the pharmacy gets or the patient gets and those can be administered through the PBM. Hard to tell.

In the end, let's say you have coverage with Insurer A. Your friend is covered by Insurer B. You both need the same medication. Odds are, you won't be paying the same price, especially if it's not a generic drug. The medication may not be covered by your insurer, which means you may have to pay the insane List Price offered by the pharmaceutical company. If your friend's plan covers the medication, he may have to satisfy his deductible before he can access it. He might have to pay the List Price too, or some negotiated amount set by his insurer. Let's say both your insurers cover the drug, but you have to pay 20% of the cost and he has to pay 40%. So you're not paying the same. And here's a real zinger. Let's say you both have to pay 20% of the cost but you get your meds from Walgreens and your friend goes to CVS. You might pay different amounts because you're going to different pharmacies!

There are some great tools out there to help people find the best prices for generic drugs (and other drugs too). Good Rx is a terrific source of information and could be an even more useful tool if individuals had more of a need to shop around for generic medications. Which I will talk about more in a minute.

Despite such consumer tools, drug companies and the PBMs and the insurers love this wackadoodle structure because it's opaque. External parties don't know who's making what, so no one is directly culpable for price gauging. However, it's the pharmaceutical companies that get slammed the most for high drug prices because of their high List Prices. And there is some

legitimacy there. Zolgesma is the most expensive drug ever (5). It is a gene therapy drug with a List Price of $2.1 million. Maybe that can be rationalized because it's for a rare disease and it's cutting edge technology. Maybe.

But drug companies are not just setting high prices on new drugs to treat rare diseases, they're raising List Prices on established drugs (6). Price hikes are often larger than increases to inflation, which makes the drugs even more expensive on a comparative basis (7). A great example of this relates to the price of insulin used by type 1 diabetics. Between 2012 and 2016, the cost doubled (8). That's for an established drug, too!

I can't talk about drugs without talking about Medicare. 85% of Americans aged 60 and over are on at least one prescription medication. So by the time these folks hit 65, they have to deal with Medicare in some way shape or form to get drug coverage.

I have to say, I'm not Medicare eligible, but if I were, I'd be really overwhelmed about how to navigate getting my meds covered. Wow. There are different tiers of drugs. There are different ways to get drugs covered – and seniors have to pay for these options, be they through employers, union contracts, Medicare Advantage plans or Medicare Part D.

A critical thing to understand is that the federal government is prohibited from negotiating directly with drug companies for drugs covered by enrollees in the Medicare Part D program. So that affects some Medicare enrollees, but not all. For example, when drug coverage is provided as part of a Medicare Advantage plan, the drug prices are negotiated by the insurance company that operates the Medicare Advantage plan. Like Humana or UnitedHealth.

Of course the federal government could try to negotiate prices for every Medicare enrollee, regardless of how they got their drugs covered – although they'd have to shift around some regulations and that would involve Congressional approval. So that's a problem. But it seems like a pretty good idea. Why shouldn't the U.S. government negotiate some drug prices for Medicare enrollees? Most people think they should.

The push-back against this idea is that the government will be de facto setting prices for drugs. They have that much leverage. Certainly the pharmaceutical companies don't want that. And free market purists don't like it either. The problem with the free market concept is that there is no free market when the government is involved. Right now, the government sets prices that are paid to hospitals and to doctors via Medicare and Medicaid. So if we extend the logic, the feds should do the same thing with pharmaceutical companies.

There are other ideas being considered that give the government more control to negotiate prices. The Trump administration has floated pegging American drug prices to those paid by foreign countries. There are even thoughts of importing some drugs from Canada.

Well, I think there are some other things to consider.

First of all, one of the challenges we have with negotiating pricing for drugs is that there are so many drugs. 5.8 billion 30-day equivalent prescriptions were filled in 2017 (9). And that was an increase from the prior year. The number may be a bit misleading because many prescriptions, especially for chronic conditions, are for 90 days. So three 30-day equivalent prescriptions maps to one 90-day prescription. Nonetheless, it's a lot of drugs.

We take drugs to regulate our mood, to change our metabolism, to block pain, to slow the spread of cancer, to make our eyelashes thicker. If there's a way to use a chemical to change who we are, then someone's invented it or someone's trying to create it.

In fact, scientists and companies are using big data, or AI, or whatever you want to call it, to identify diseases that have no cure so they can make a drug for it and sell it (10). The more esoteric the disease, the higher the price tag. Hence, the $2.1 million price for Zolgesma, which addresses a rare genetic disorder.

Then again, why use Big Data when you can just go to the National Institutes of Health and scroll around the Genetic and Rare Diseases Information Center (11)? This is an excellent resource for individuals who may be affected with rare diseases. It's an attempt to centralize all kinds of data, including orphan drugs, related to rare diseases. As noted on the site, they are adding diseases every month as new things are discovered.

With these orphan and designer drugs, pharmaceutical companies are creating demand that didn't previously exist. They've expanded the entire drug market. That means that drug costs are going up not only because more people take more of the same types of drugs, not only because prices for drugs have gone up but also because there are more drugs to take.

So step 1 should be to disambiguate the drug market. Separate out the different types of drugs and use different payment mechanisms to fund them. Or at least, to price them. We need to do this for government negotiating and for commercial negotiating.

This is sort of thing is sort of done today because Medicare and PBMs and insurers have different tiers for drugs. They typically put the generic stuff in one tier and then go from there. Pricing is different by tier, depending on the tier that your drug falls in. But the negotiations for all the tiers can happen together, which masks the costs of each tier and makes the contracting really complicated.

Let's talk generics. Drug companies have a period of exclusivity when they release a new medication which theoretically allows them to cover the costs of their R&D by owning the market. Then generic drugs can enter the market. When generics are introduced, pricing comes down. There is competition and the market generates some pricing stability.

So how big is the generic drug market? In 2018, about 90% of prescriptions filled were for generic medications. Yup. Nine out of ten. Here we are, panicking about drug prices when the vast majority of our prescriptions are filled with generic medications.

I think we need to shift as many generic drugs out of drug coverage programs and offer them at direct-to-consumer prices. The scale of these medications – 90% of 5.8 billion prescriptions – creates a veil of pricing opacity for all the other drugs covered in any formulary or plan. If we remove the veil – and price these generic drugs at direct-to-consumer prices – we can better focus on everything else. Further, we've eliminated a huge layer of contracting complexity by removing the administrative costs associated with negotiating prices for all these drugs. Put as many of them as we can on the open market!

Of course when consumers have to pay out of pocket for health care many simply won't do it. They'll avoid preventive care and many won't not fill prescriptions. We're going to have to get creative about how these medications are covered. For example, employers could offer a debit card for prescription generic drugs with an annual maximum. Or they could put the money in their employees' Health Savings Accounts or HSAs. Those who don't hit the maximum can save the money and those who need to use it will use it. Given that the pricing would be better identified, employers should be better able to predict how much their employees' costs for these types of drugs might be.

Assuming we can take the tried and true drugs out of the mix, we then get to the branded (non-generic) drugs and specialty drugs. The newer they are, the more expensive they seem to be. Consider that from 2014 to 2018 prices for common generic drugs dropped 37% (12). But branded drug prices jumped 60% over the same period. In the last ten years, spending on specialty drugs almost doubled. Increased list pricing is a major driver of these high drug costs.

According to the Centers for Disease Control and Prevention (the CDC), antidepressants were the most commonly prescribed medication for people aged 20 to 59. I went to GoodRx and plugged in "Zoloft," an antidepressant. 30 100mg tablets cost about $12 at Costco, and under $7 if I accessed a coupon. Great.

Yet a look at a PBM for commercial contracts notes that by far, the highest per member per month costs in this age group were not for antidepressants. They were for drugs to treat inflammatory conditions. These drugs have higher List Prices than anti-depressants. Consider Humira, which can be used to treat a number of things, like rheumatoid arthritis. It costs twice as much in the US as it does in the United Kingdom. I plugged that into GoodRx. Two pens of 40 mg Humira at Costco…with a free coupon…$ 5,130.76. Costco was the cheapest provider, by the way.

What we're seeing is that we get these new drugs on the market and drug companies are taking advantage of the messed up US system to jack up prices. But we're also dealing with a couple of other weird, contradictory economic phenomena related to supply and demand.

Usually, when something new comes to market, it's expensive. Like the latest i-Phone. Or the Model-T. Not everyone can afford it. Which means that, basically, rich people get access to the new stuff. Over time, prices for these newfangled products comes down because more people buy them. More people can join the crowd and pricing continues to drop. Then the item

becomes commoditized. People copy it and make cheaper versions and the initial manufacturer has to get good at cutting costs to absorb the price reductions so they can make a profit.

What happens in the drug world is that everyone wants to access the newfangled drugs right away. There's no sort of "price down" period where people gradually can afford the drug as the manufacturers improve their ability to deliver them. Instead, the drug companies charge these early adapter prices to everyone. They get high volume purchases at top dollar prices. That means that they are generating revenue to cover their R&D expenses much faster than they might if fewer people could access the drugs. So…we should let generics onto the market faster, to start hacking away at these high drug prices.

But we need to go further. We need to deal with the skyrocketing cost of "orphan" drugs, or the medications produced for rare disorders and diseases. I have to say this. It is amazing that we're able to cure some of these conditions. At the same time, we have to find an appropriate funding mechanism to pay for them.

The problem is that small to medium sized employers don't want to offer coverage for these orphan drugs because, on the remote chance that one of their employees (or their family member) develops the condition, the cost to pay for it could literally bankrupt the company. Large employers aren't too keen on covering these drugs either because any multi-million dollar expense impacts their bottom line.

So insurers are looking to spread the cost of these drugs to *all* employers (13). Anthem, Cigna and CVS are looking at different options, one if which is to have employers kick in a dollar per member per month to fund these drugs so that no one employer gets stuck with the bill. The trouble is, when does it stop? Do we keep just spreading the cost for everything to everyone? How do we keep track of which drugs are being covered and who's benefitting?

The more important question that needs to be answered is this: just because we have these designer drugs, does that mean that everyone can access them using the current insurance system? Well, let me answer that right now. No.

We can't keep spreading the cost of things to everyone because once we do, we ice out dollars that could be spent on drugs that many people need just to fund drugs that only a handful of people benefit from. Similar to how I think we need to handle generics, which are on the opposite end of the drug pricing spectrum, I think we must remove orphan drug funding from the major insurance pool.

We need to tap other funding sources to pay for these drugs. Foundations created to educate and lobby for coverage for different rare diseases might funnel some (or more) of their money to help pay for the drugs themselves. And then there's crowdfunding. Believe it or not, a third of the dollars raised on the crowdfunding platform GoFundMe were for medical expenses in 2017. Such a platform allows people to contribute personally, if they know the individual

afflicted with the condition, as well as by category. That means that you may want to contribute to any infant that's developed a rare genetic disorder, even if you don't know who it is.

In closing, the best thing we can do to control the skyrocketing cost of drugs in America is to use less of them. Many of the drugs on the market that are used widely today are prescribed to treat preventable, chronic conditions. For people aged 60 years or older, the top three most commonly prescribed medications were lipid lowering drugs (high cholesterol), beta-blockers (high blood pressure and heart disease) and antidiabetic drugs. All of these conditions are, for many, preventable.

Then there's the concern over the long-term use of mind-altering medications. For kids 0 – 11 and 12 – 19, anti-depressants were in the top one or two spots for most commonly prescribed medications. We haven't really grasped the long-term impacts of these drugs. And now, there are studies demonstrating the potentially negative impacts of the long-term use of these drugs from their potential to disrupt growth, digestion and immune functions (14).

And of course we cannot overlook studies that indicate that long-term use of common drugs correlates to a higher possibility of developing dementia (15). I mean, it makes sense. Our bodies are miracles of chemistry. Once we introduce a drug – any drug – into our system, it throws off our individual chemical balances. When we have anything in the system for too long, it will, if logic holds, create some funky chemical byproducts which can result in the development of disease. It has to be even worse to give children and adolescents medication, because their bodies are still growing. We have to do whatever we can to reduce overall drug intake. Period.

The health care industry has a long way to go before it is able to build trust in the pharmaceutical industry. Demanding price transparency is just one step in getting there. When we're talking about billions of prescriptions every year, the data is simply too massive for a consumer to weed through. We also alternative funding models for the drugs we use. And most importantly, we need to do everything we can to reduce our dependence on drugs so we can lower drug costs and be as healthy as we can be.

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