JCB Boardroom

Rejuvenating American Healthcare

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INTRODUCTION: IT'S TIME FOR AN OPEN, HONEST, AND ROBUST DEBATE

During his March 2022 State of the Union Address[1], President Biden suggested a policy of price controls through direct Medicare negotiation to lower the costs of prescription drugs. This approach has long been discussed in the abstract. Let's examine the details and potential consequences of such a proposition more closely.

THE ROLE OF DRUGS IN AMERICAN HEALTHCARE SPENDING

Prescription drug costs are not the largest driver of American healthcare costs. In the United States hospital care ranks first at 31.4%, next are physician services at 14.9%, "other" personal healthcare at 15.5% and then prescription drugs at 9.7% — under a dime on the American healthcare dollar[2] and they are the slowest growing slice of the healthcare pie[3].

Spending on pharmaceuticals is growing at a slower rate (less than four percent) than either hospital (just less than five percent) or physician costs (just more than five percent). This doesn't mean addressing cost and access to prescription medicines isn't a crucial public health issue. What it does mean is that we must keep the policy debate in the proper perspective.

THE COSTS OF DRUGS: UNITED STATES VS. EUROPE AND CANADA

Are drugs less expensive in Europe and Canada than they are in the United States? It depends on which drugs we're talking about and how we choose to define and measure cost. By volume, it's certainly not an accurate statement. Over 90% of all prescription drugs dispensed in the United States are generic drugs and (with some exceptions) generic drugs are less expensive in the United States than either Europe or Canada[4]. Even with that large market share, generic drugs represent only 20% of our national drug costs[5].

What about newer, on-patent brand name products? The list prices for these medicines are significantly higher in the United States than north of the border or across the Atlantic and represent about 80% of the dollars spent in the United States on prescription medicines[6].

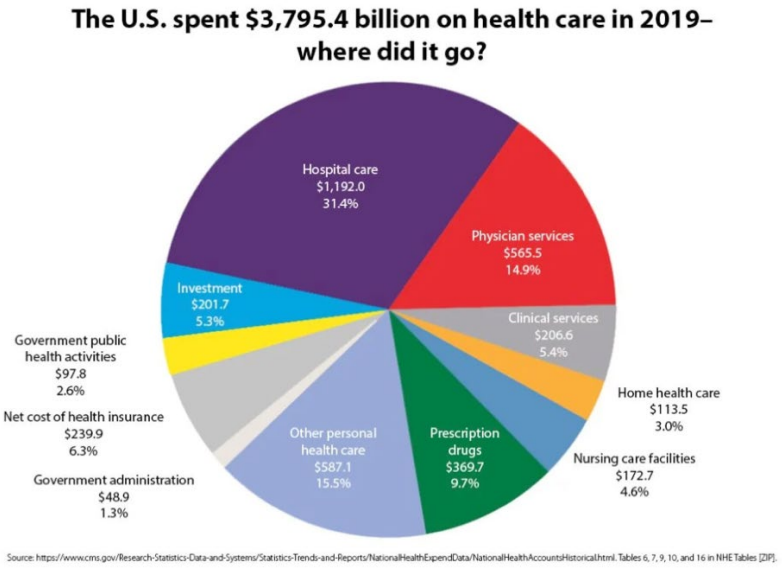
But is this the most appropriate measure of the cost differential between the United States and other Western industrialized nations? An important point that is generally overlooked is that almost no patient (either in the US or abroad) pays the list price for these branded, on-patent innovative, life-saving medicines.

In the United States, the nearly 300 million patients with health insurance (90+% of the population)[7], don't pay the "higher" list price but rather an out-of-pocket expense in the form of a co-payment. Europeans and Canadians don't pay the "lower" list price either but carry a higher healthcare-related burden in taxes. For example, in the United Kingdom, healthcare funding is approximately 20% of income tax, and the model tax rate is 32% (including national health insurance)[8].

What do Americans mean when they say, "my drugs are too expensive?" For the 90% of insured Americans, it means that, in addition to their ever-increasing monthly insurance premiums[9], their co-payments are too expensive[10]. Co-payment rates are not set by drug manufacturers, but rather by insurance companies and pharmacy benefit managers (PBMs). Even in the complicated ecosystem of drug pricing, one fact stands out: $166 billion in discounts from pharmaceutical companies go directly into the coffers of pharmacy benefit managers annually. That's 37% of our nation's entire expense on drugs[11].

Not a single dollar of those rebates is used to reduce patients' out-of-pocket costs when they need medicines. When the White House developed a rule to change the dynamic by banning many rebates drug companies pay to pharmacy benefit managers under Medicare, many policy experts applauded[12].

When a group of pharmaceutical CEOs testified before the Senate Finance in February 2019, Pfizer CEO



Albert Bourla said he supported "reforms that would create a system in which transparent, upfront discounts benefit patients at the pharmacy counter, rather than a system driven by rebates that are swallowed up by companies in the supply chain"[13]. When asked if they would lower prices if the pharmacy benefit managers played fair, every hand on the panel went up. This is a policy initiative that recognizes that cost and access are ecosystem issues that warrant careful consideration.

WHAT ABOUT A SINGLE PAYER SYSTEM?

Under legislation sponsored by Senator Bernie Sanders[14], an American single-payer health care system that would eliminate all private insurance and place medical care in the hands of the federal government would cost an additional $32 trillion and require a 20% tax increase to implement[15]. Politicians and pundits in the United States who refer to such policy schemes as "free healthcare" should rethink their nomenclature to more precisely represent the financial realities of the Sanders plan and similar proposals. Americans remember only all too well where political hyperbole in healthcare leads. President Obama's statement, that "If you like your health care plan, you'll be able to keep your health care plan," was widely recognized as an unnecessary and unfortunate misrepresentation of the Affordable Care Act[16].

Words matter. We don't need more rhetoric — we need broader access to prescription drug pricing transparency and a recognition of a medicine's value to patients.

ARE AMERICANS WILLING TO PAY HIGHER TAXES FOR A SINGLE-PAYER SYSTEM?

According to one poll, 54% of Americans said they support tax increases for a single payer universal healthcare system[17]. However, according to another, more than two-thirds of Americans do not support the plan once they are told a government-run, single payer system would require an increase in their personal income taxes[18]. As the old saw goes, where you stand depends on where you sit. Perhaps it's time for a fact-based national plebiscite to accurately gauge the will of the people.

BEYOND HIGHER TAXES: THE COST OF PRICE CONTROLS IN TERMS OF ADVANCING MEDICAL INNOVATION AND IMPROVING THE HUMAN CONDITION

Lower overseas list prices are a result of government price controls and have an impact not only on cost but access. What can't be overlooked is that price controls equal choice controls. One consequence of price controls is a negative impact on pharmaceutical innovation and a patient's access to it.

Of the new drugs licensed between 2011 and 2017, 67% were immediately available in the United Kingdom, 49% in Japan, and 48% in Canada and France. Americans, meanwhile, had access to 87% of these drugs[19].

Government-imposed price controls would discourage the medical innovation that benefits so many Americans[20]. Incorporating the fully loaded costs of

research and development, it costs north of $2.5 billion to bring a single drug to market[21]. That tab is staggeringly high because most experimental drugs fail in the lab. And the ones that make it out of the lab generally prove either ineffective or unsafe in human testing. Only about 12% of drugs entering clinical trials are ultimately approved by the FDA[22].

Artificially capping prices would have the unintended (but highly predictable) result of preventing companies from recouping their investments. President Biden, during his State of the Union, claimed that under a price control regime, "Drug companies will still do very well." In fact, such a policy could reduce the revenue of the innovative biopharmaceutical industry by $1.5 trillion over the next decade[23].

These biopharmaceutical companies, on average, dedicate nearly one-fifth of revenue to research and development. Simple math suggests that price control legislation would cut funding for R&D spending by hundreds of billions of dollars. Economic modeling estimates that price control legislation would snuff out 56 new drugs — including 16 cancer treatments — that would have otherwise reached patients[24].

DIRECT MEDICARE NEGOTIATIONS

During his State of the Union, President Biden said, "Let's let Medicare negotiate the price of prescription drugs." Would this increase a Medicare beneficiary's access to prescription drugs? According to the Congressional Budget Office (CBO), Part D plans "have secured rebates somewhat larger than the average rebates observed in commercial health plans"[25]. And the Medicare Trustees report that many brand-name prescription drugs carry substantial rebates, often as much as 20-30 percent and that on average, across all program spending, rebate levels have increased in each year of the program[26].

Is the argument that Uncle Sam could do better? According to the CBO, revoking the Kennedy/Daschle Non-Interference Clause, "would have a negligible effect on federal spending because CBO estimates that substantial savings will be obtained by the private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree. Because they will be at substantial financial risk, private plans will have strong incentives to negotiate price discounts, both to control their own costs in providing the drug benefit and to attract enrollees with low premiums and cost-sharing requirements"[27].

In 2007 after two years of experience with bids in the Part D program, the CBO found that striking noninterference "would have a negligible effect on federal spending because … the Secretary would be unable to negotiate prices across the broad range of covered Part D drugs that are more favorable than those obtained by PDPs under current law"[28].

In 2009 after even further program experience, the CBO reiterated its previous views, stating that they, "still believe that granting the Secretary of HHS additional authority to negotiate for lower drug prices would have little, if any, effect on prices for the same reason that my predecessors have explained, which is that…private drug plans are already negotiating drug prices." Importantly, the CBO says that no further savings are possible *unless the government restricts beneficiary access to medicines or establishes market-distorting price interventions*[29].

In the words of USA Today (America's *vox populi*) "Government price negotiation could leave people without drugs that manufacturers decide aren't sufficiently profitable under the plan. With that kind of clout, government might try to dictate prices, not just negotiate them. This could leave people without drugs that manufacturers decide aren't sufficiently profitable under the plan. The U.S. Department of Veterans Affairs plan illustrates the point. It offers 1,300 drugs, compared with 4,300 available under Part D, prompting more than one-third of retired veterans to enroll in Medicare drug plans"[30].

WHAT'S NEXT?

The debate over overhauling the American healthcare system is stuck on hold and plagued by soundbites. It's time to insert substance and science into the conversation. It's time for President Biden to form a Blue-Ribbon commission to study serious proposals for systemic change. If we learn nothing else from the COVID-19 experience, it's that when the entire healthcare ecosystem works together to solve a seemingly unsolvable problem (in this case broader access to innovative prescription drugs) … we can. Nothing less than the future of American healthcare is at stake.

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