

# To Curb Medical Costs, Let Market Forces Do Their Job

*Competition and a focus on effectiveness rather than price will lower America's healthcare bill.*

By Ron Cohen

*Health insurers have entered* a new phase in the battle over drug pricing. It's a world of hyperbole, wild counterfactual scenarios and policy recommendations that sound more like veiled threats. The concerns are understandable. However, this escalation in rhetoric could push to the side more common-sense proposals to bring down high medical costs.

In a recent opinion piece published by *Forbes*, **Express Scripts Inc.** Chief Medical Officer Steve Miller, MD, used the phrase "Robin Hood in reverse." He was referring to **Gilead Sciences Inc.**'s pricing of its hepatitis C drug, *Sovaldi*, which costs Americans \$1,000 a pill. In Egypt, Miller wrote, Gilead charges patients just \$900 for a course of 84 pills identical to the U.S. product. The implication? Gilead's profits are subsidized by "the charitable efforts of poor and sick Americans," Miller wrote, adding that if all three million American hepatitis-C patients took *Sovaldi*, it would cost the nation \$300 billion a year. Reuters and a columnist for *The New York Times* have put forth similar estimates.

But the \$300 billion per year number is an illusion—like two mirrors that reflect each other into an infinite series of mirrors. *Sovaldi* essentially cures around 90% of patients in one course of treatment. Indeed, if three million patients did take *Sovaldi* in 2015 – something nobody expects to happen – there would be little need or demand for the drug in any subsequent year, and therefore little future expenditures.

Then there's the fact, acknowledged even by critics, that *Sovaldi* will save enormous financial and human costs of the disease. These would otherwise accrue over subsequent years, and even decades, as the illness leads to repeated hospitalizations and liver transplants. In fact, the U.K.'s watchdog agency, the National Institute for Health and Care Excellence (NICE), which is notorious for rejecting many drugs on cost-effectiveness grounds, recently advised in favor of reimbursing *Sovaldi*.

In addition, there is no likely scenario in which Gilead will attain 100% market share. **Johnson & Johnson's** new hepatitis-C drug, *Olysio*, is already realizing more than \$1 billion in sales and other drugs are in the pipeline at **Merck & Co. Inc.** and **AbbVie Inc.** *Sovaldi's* price shows that Gilead is a first-mover, not a price monopolist.

## Dismaying stance

At a May health care conference covered by *The Pink Sheet*, **Memorial Sloan-Kettering Cancer Center's** Director of Health Policy and Outcomes Centers' Peter Bach suggested the U.S. either needs "a new regulatory entity to set prices," or should allow the Centers for Disease Control and Prevention to declare a public health emergency in hepatitis C and break Gilead's patent.

This is a dismaying stance. Price controls have been dismal failures historically, and allowing the government to break patent protections at its whim would risk undermining the

entire patent system, which has allowed U.S. innovation to thrive and our economy to prosper.

Innovator companies that produce cutting edge medicines receive a limited number of years of patent protection in which to recoup their investments and make a profit – and many of these medicines nevertheless face competition from newer therapies during their exclusivity period. After that, generic competitors are allowed to market the drug and lower its costs substantially. Generic drugs now account for fully 80% of all prescriptions filled, and at a small fraction of the cost of the original innovative medicine.

This unique regulatory and market structure inherently provides cost-containment for medications. Thus, while overall health care costs represent at least 17% of GDP and continue to rise, the costs of pharmaceuticals comprise only about 10% of these health care costs – a percentage that has remained virtually flat over the years. This belies claims that overall drug costs have become unsustainable.

In addition, many medications save money in the long run, as they prevent disease progression, costly repeat hospitalizations and the need for expensive surgical procedures. For example, in a series of controlled pricing experiments carried out between 2009 and 2012, **UnitedHealthCare** and five medical oncology groups tried to realign incentives by reimbursing doctors upfront for the entire course of treatment – an approach known as “payment bundling.” The details of this pilot program were published in the July 8 issue of the *Journal of Oncology Practice*.

In a nutshell, physicians in the pilot reached a consensus on the best treatments for patients’ medical “episodes,” and prescribed drugs as they deemed necessary. Doctors preserved the flexibility to change regimens based on individual patient responses. Over three years, *total spending on drugs was 179 percent higher* than program managers predicted, yet *total costs were 34 percent lower*, possibly because the number or duration of hospital visits decreased. UnitedHealthcare plans to expand its “episode payment” project, and many other experiments in value-based payment are underway, including several with pharmaceutical industry support and involvement.

## Dialogue and Communication, Not Price Controls

In moving towards value-based payment systems, it is critical that we keep several important principles in mind.

First, a narrow focus on cost-benefit analysis could put payors or even physicians in the inappropriate role of making

### A Prescription For Addressing Health Care Costs

- Require every medical student to take a class on health care economics and comparative effectiveness, so that each doctor possesses tools to make comparisons within and among medical interventions, not just drugs.
- Ask specialized medical societies (oncologic, neurologic, endocrine, cardiovascular, etc.) to maintain open, up-to-date databases on the relative efficacy of all medical interventions, including segmented genomic and subpopulation data relevant to their specialties.
- Furnish all physicians with tablet-based systems that can instantly access information in the databases, paired with natural-language tools so doctors can better inform their conversations with patients.
- Overhaul the logic behind formulary placement, so that insurers, PBMs and other intermediaries structure their tiers based on patient needs and effectiveness, rather than discriminating against patients based on the costs of their treatment needs.
- Encourage adoption of payment systems that promote the most effective medical approaches.

clinical decisions *on behalf of* patients rather than in consultation with patients – and based on what they believe is good for the overall system or is good enough for the proverbial “average” patient, rather than what is best for the individual patient sitting in front of them.

That said, a telling example of how the system can work effectively occurred in October 2012, when Peter Bach himself, together with two colleagues, published an OpEd in *The New York Times* titled “In Cancer, Cost Matters.” The authors announced that they would not prescribe a particular cancer drug because, based on their review of published data, they believed there was a less expensive alternative with a similar mechanism of action that worked just as well against colorectal cancer. A few weeks later, the company that marketed this newer drug significantly reduced its price to address the asserted value-based concerns of these members of the oncology community.

This situation serves as an example of how dialogue and communication among the relevant parties ultimately can lead to solutions, without the unintended negative consequences of government intervention or other forms of price regulation.

Indeed, it is incumbent on the pharmaceutical industry to demonstrate the value of its medicines to physicians and other health care professionals, based on scientific data. Conversely, doctors should never be put in the position of basing their therapeutic decisions for their patients solely, or even largely, on cost considerations.

Second, when assessing the value or comparative effectiveness of medicines, it is essential that we look at the whole treatment picture over a patient's course of disease – not just the medicines themselves, and not just the short-term costs.

As the *Solvadi* and UnitedHealthcare study examples discussed above demonstrate, the value of medicines when compared to

other healthcare interventions can be stunningly high when assessed over time, even if the short-term cost of those medicines could present an immediate financial burden to payors.

We need to begin a conversation about how we can help the system pay for the upfront costs of such medicines, recognizing the long-term value they provide. A myopic focus on short-term costs only will undermine the incentives to develop the innovative medicines we need and that can save overall costs in the long-term.

**RPM**

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