INFERENTIAL FOCUS

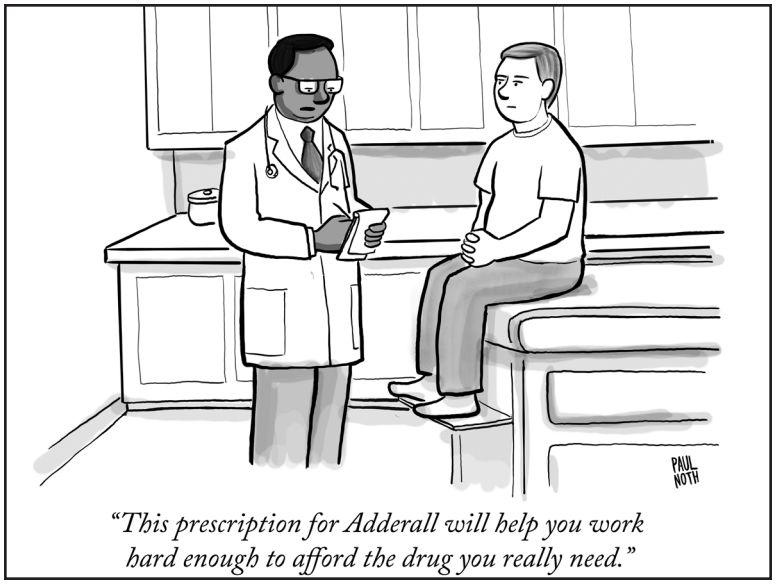
*in*FOCUS

*in*F 1313 September 27, 2018

Healthcare

RISING PRESSURES ON THE HEALTHCARE INDUSTRY AND BIG PHARMA

In the last issue of our *inFocus,* we explored how various payers, patients and healthcare providers are embracing aspects of telemedicine, in part because such technology can help reduce the costs of providing quality care. That desire to control costs is showing up in a series of actions that go beyond the adoption of telemedicine. Recent events suggest that various healthcare payers, particularly American employers and U.S. states, are reaching their limits in terms of willingness to shoulder rising healthcare expenses and are looking for ways to put pressure on various providers to limit costs, in particular with respect to drug prices (see **inF 1312**, "Telemedicine Hits Its Stride," 8/9/18).



"This prescription for Adderall will help you work hard enough to afford the drug you really need."

TAKEAWAYS

- U.S. healthcare spending has risen for many years to a record high as a percent of GDP.
- Recent actions by payers, particularly U.S. corporations and government institutions, suggest an increasing scrutiny of the cost burden of providing healthcare to American workers and citizens.
- An acute focus of pushback against rising costs appears to be centered currently on the prescription drug industry, following several years of drug price increases that vastly outstripped inflation.

IMPLICATIONS

- More companies band together to purchase insurance and pharmacy benefits, as well as to negotiate prices in the healthcare industry.
- States, particularly blue-leaning states, become more interventionist in setting prices for drugs or demanding discounts.
- The pharmaceutical industry will face a challenging period for public relations, with negative feedback coming from the media, patients, payers and even the President with respect to the cost of drugs.
- Increased regulation of the pharmaceutical industry in the U.S. is a real possibility.

Drugmakers' Bad PR Moment

There is a "moral requirement to sell the product at the highest price." That was the explanation offered by Nostrum Laboratories CEO Nirmal Mulye after his company raised the price of a 66-year-old generic antibiotic last month from $474.75 a bottle to $2,392 a bottle. The drugmaker was able to enact such a hefty price increase on an old-line drug in part because of acute shortages of the drug following changes in FDA regulations about how such drugs are manufactured. Mulye noted that other drug companies and their CEOs, citing Martin Shkreli by name as an example, have made similar price jumps to reward their shareholders, and stated that it is their prerogative and obligation to do so without regard to any other considerations. (*Financial Times,* 9/11/18)

On the one hand, with his comments, Mulye appears to wade into a growing debate within capitalist societies: What are the obligations of corporations to their shareholders versus other possible stakeholders, and what ought those obligations be from a moral point of view? Such a debate is in an early stage and may proceed for decades. On the other hand, Mulye's comments come at an acutely awkward moment for the pharmaceutical industry and, indeed, the entire healthcare sector in the United States. Our observations suggest that this sector is facing an onslaught of rising scrutiny as payers balk at ever-increasing costs – with that scrutiny particularly focused on rising drug prices.

American Healthcare Has a Cost Problem

The refrain is often repeated, particularly in an election year: The U.S. spends more overall, and per person, and as a percent of GDP, on healthcare than any other country, but gets middle-of-the-road health outcomes among developed nations. To be somewhat more specific, the U.S. spends 18.2 percent of GDP on healthcare, about 50 percent more as a proportion of its GDP than Switzerland, which is the next highest-spending country as a proportion of its GDP at 12.4 percent of GDP spent on healthcare. The U.S. percentage has increased from five percent in 1960, to 13.3 percent in 2000, and to 17.4 percent in 2010, before reaching its 18.2 percent level in 2016. (*ProPublica*, 5/25/18; *Health System Tracker,* 2/13/18)

These costs are borne by many different payers, from private individuals, to governments, to U.S. employers, and have created fiscal challenges for American households.

• For the roughly half of Americans who got their healthcare benefits through their employers from 2002 to 2016, premiums increased nominally more than 240 percent. Overall, inflation was up about 40 percent during that time. (*Los Angeles Times*, 4/9/18; *ProPublica,* 5/25/18)

• About one in five people is currently being pursued by a collection agency over medical debt. (*ProPublica*, 5/25/18)

• According to Bureau of Labor Statistics data, every time healthcare costs rose by one dollar, employers cut an employee's overall compensation by 52 cents. (*ProPublica*, 5/25/18)

Continuously rising real healthcare costs are problematic for U.S. households because overall wage growth has been quite slow in real terms. While nominal wages have risen by 12.9 percent since 2006, real wages have fallen by 9.3 percent. Real wages fell by 1.8 percent from the first to second quarter of 2018. (*Vox*, 7/23/18)

Part of the healthcare cost increases that routinely outpace inflation can be attributed to changes in prescription-drug prices. Consider a variety of price increases that have outpaced general inflation:

• Pharmaceutical companies have imposed price increases of several times more than inflation on more than a thousand drugs in the U.S. Rx Savings Solutions, a provider of software analytics for healthcare spending, said it recorded price increases on more than 1,300 products on the first day of the year. (*Financial Times,* 1/4/18)

• According to IQVIA, a healthcare consultancy, the wholesale prices of major blockbuster prescription drugs increased by more than 120 percent between 2012 and 2017. Other data show that cancer-drug prices rose from about $10,000 a year to more than $100,000 per year in just over a decade, from 2002 to 2012. (*Economist*, 5/12/18)

• In 2017, Pfizer raised the average wholesale price of 148 drugs by between 6.0 and 13.5 percent, and for some of its medications, the company increased list prices three separate times that year. (*Financial Times,* 1/4/18)

• Hikma raised the price of several strengths of morphine between 75 and 90 percent. (*Financial Time*s, 1/4/18)

The Pushback on Drug Prices

The rising price of drugs appears to be an area of rising scrutiny as various payers, such as companies, health insurers and states, and even President Donald Trump, seek to pressure the pharmaceutical industry into offering lower pricing.

• In 2016, a number of U.S. companies formed the Health Transformation Alliance (HTA) to curb rising healthcare costs, particularly drug prices. The HTA now includes more than 40 large employers that spend a collective $27 billion on healthcare. The alliance is using its size to get better contracts from Pharmacy Benefit Managers (PBMs) and to demand more say on which drugs are covered. The HTA says that in 2018 it reduced members' drug costs by a median of 15 percent. (*Economist*, 5/12/18)

• United Healthcare is encouraging HIV-positive patients to choose a cheaper drug regime by offering to cover all co-pays and co-insurance on the cheaper option, as well as giving each patient a $500 gift card to cover other health expenses. A typical HIV drug regime can cost $39,000 a year in the U.S. (*New York Times*, 9/18/18)

• Earlier this year, Massachusetts asked the federal government for permission to limit its coverage of drugs in an effort to secure larger discounts from drugmakers – in other words, the state would like to be able to threaten to stop covering the drug if the manufacturer doesn't provide a discount. (*New York Times*, 6/24/18)

• California and Vermont have passed laws requiring drug companies to turn over certain financial details whenever those companies raise drug prices significantly. This allows the states to analyze if the price increases can be justified by amortization of R&D costs, and other reasonable expenses, or if the increases reflect price gouging. (*New York Times*, 6/24/18)

• This year, New York officials identified 30 drugs that they deemed to be priced too high, and manufacturers of all but one of those drugs agreed to deeper discounts when confronted with the state's analysis. Vertex was the only pharmaceutical company that refused to lower the price of a drug, ORKAMBI, a cystic-fibrosis drug. (*New York Times*, 6/24/18)

• On April 26, New York's Medicaid board went to court demanding a 70 percent discount from Vertex on ORKAMBI. A report from the *Institute for Clinical and Economic Review* (ICER) says the treatment should cost approximately $83,000 a year based on Vertex's development costs, instead of the $272,000 that Vertex charges. This is the first test of a 2017 law aimed at reining in the cost of drugs in the New York Medicaid program. (*Economist*, 5/12/18, *New York Times,* 6/24/18)

• Alabama has proposed a significant reduction in the number of prescription drugs that health insurers must cover as "minimum essential health benefits" for individual and small-business health plans starting in 2020. The change will eliminate coverage on 32 percent of drugs. (*Modern Healthcare*, 7/30/18)

Some of the above actions by states demonstrate the tension that exists between payers and the philosophy voiced by Nirmal Mulye of his "moral obligation" to reward his shareholders with the highest possible price for drugs. Meanwhile, the states' legal (and perhaps moral) obligation is to provide healthcare to the state's impoverished and elderly with the most efficient use of taxpayers' money. In such a tension of obligations, the "state," of course,

holds a theoretical trump card in its ability – if there is a political will – to regulate, a willingness which above actions suggests is increasing.

Even the White House, which generally espouses a philosophical bent toward deregulation, has put drug prices on the agenda. In a Rose Garden speech two months ago, the President unveiled a blueprint to "lower drug prices," which included some plans for regulatory and legislative changes, with more details to follow by the end of the year. Some major drug makers took notice. (*New York Times,* 7/10/18)

• In July, Pfizer said it would defer some price increases after President Trump bashed the company in a Twitter post. The company said it would wait until the President's new "blueprint" goes into effect or the end of the year, whichever is sooner. (*New York Times*, 7/10/18)

• Following Pfizer's response to President Trump, Novartis also froze prices for its medicines in America. (*Economist*, 7/21/18)

These actions are early and tentative. But, in all, they represent an interest by companies, states, and the federal government, as payers, in containing drug prices.

It is therefore very interesting to see pushback against drug prices by a group that is not the ultimate payer: hospital networks. A group of health systems that collectively represents more than 500 U.S. hospitals has decided to launch its own not-for-profit generic drug company, Civica Rx, to establish transparent prices and stable supplies of generic drugs commonly used in hospitals – initially focusing on 14 such drugs. Civica Rx's mandate will be to focus on supplying drugs that experienced price increases of 50 percent or more between 2014 and 2016. In other words, hospitals, which ultimately bill patients, the government and insurers for medicines given to patients, see these price increases as so disruptive to care (and perhaps to the overall perception of the healthcare industry) that they are getting into the business of drug manufacturing themselves. Mulye and other drug company officials should take notice. (*Washington Post,* 9/6/18)

The coming years will see the U.S. face the demographic reality of the continued aging of the Baby Boomer demographic, whose oldest members are now aged 72 years. As this group ages and demands more healthcare, payers will likely find themselves under growing pressure to find ways to contain costs. A pushback on drug prices has already begun.