Addressing Market Distortions

A well-functioning market can ensure patient access to innovative medicines without sacrificing investment in future treatments and cures. The market-based U.S. health care system has worked well over time, but more can be done to help it work even better. Addressing distortions would help improve affordable access to medicines for patients, protect the safety net and revive the U.S. health care market.

SOLUTION #1

Address Market Distorting Price Controls

Price controls and government-mandated discounts exist in the United States in several contexts. By holding prices for prescriptions artificially low, this approach can lead to cost shifting within the market and/or reductions in private sector research and medical discovery.

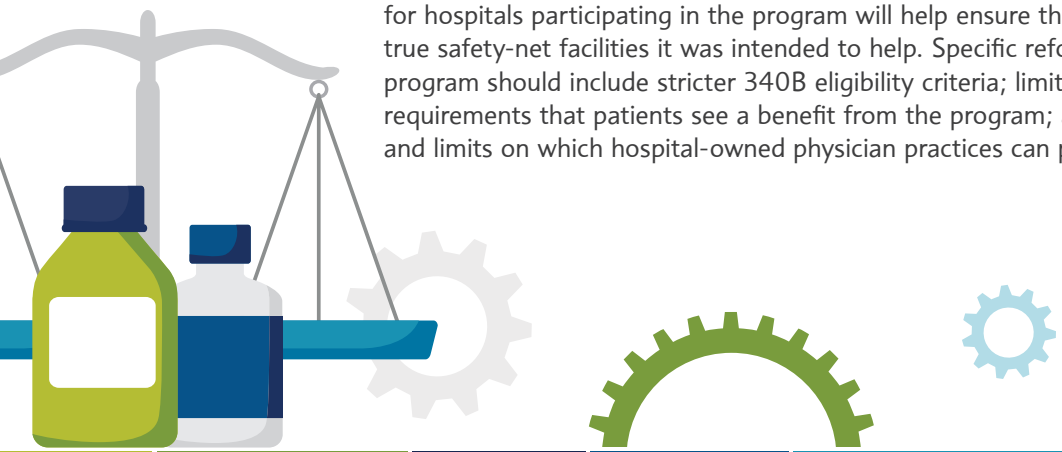
Example: The 340B program currently accounts for roughly 6 percent of U.S. branded drug sales (non-Medicaid) and is valued at roughly $18.5 billion. These figures are projected to increase to 8 percent and $25.1 billion by 2019. The overall numbers mask the concentration of 340B in certain therapeutic classes. In cancer classes, for example, 340B hospitals account for 62 percent of hospital reimbursement.

Congress created 340B in 1992 to help vulnerable or uninsured patients access medicines at safety-net facilities. Manufacturers provide steep, mandatory discounts on medicines to eligible facilities. Even as the number of Americans with insurance is on the rise, however, 340B is growing exponentially. This is in part due to eligibility criteria for hospitals that rely in part on the number of Medicaid patients a hospital treats. Accordingly, Medicaid expansion has increased eligibility for 340B even as hospitals' uncompensated care burden is declining. Today, roughly 45 percent of all Medicare acute care hospitals participate in 340B.

Many hospitals have further expanded their reach by buying community-based physician practices and/or through contractual profit-sharing arrangements with pharmacy chains. While clinics participating in the 340B program have requirements on demonstrating patient benefit, there is no similar requirement for hospitals and their affiliates, including retail pharmacy chains that profit from the program.

In too many cases, 340B discounts are becoming a windfall for hospitals, a trend that will continue to distort the market and apply upward pressure on pricing for other payers. According to a recent article in the *New England Journal of Medicine*, "lawmakers could lower the price of prescription drugs by reforming the federal 340B Drug Pricing Program. [...]The scope of the 340B program is currently so vast for drugs that are commonly infused or injected into patients by physicians that their prices are probably driven up for all consumers."

Solution: We need to protect the health care safety net by ensuring the underlying market works. The 340B program needs reform and better oversight so that it can benefit patients. Stronger rules for hospitals participating in the program will help ensure the program targets the patients and true safety-net facilities it was intended to help. Specific reforms for hospitals participating in the program should include stricter 340B eligibility criteria; limits on contract pharmacy arrangements; requirements that patients see a benefit from the program; a tighter "patient" definition for eligibility; and limits on which hospital-owned physician practices can participate in 340B.



SOLUTION
#2

Include Prescription Drug Costs In Commercial Insurance Risk Adjuster

Today, U.S. consumers have a wide range of health insurance options. Despite efforts to make sure everyone has health coverage, consumers still have the choice to forgo insurance. As a result, commercial insurers face the risk of adverse selection in which individuals delay getting covered until they know they need services. This risk can raise premiums for everyone.

To mitigate the risk of adverse selection the individual and small group markets employ a range of strategies to promote fairness and encourage enrollment. Insurers are incentivized to price plans at the lowest possible premium, which encourages enrollment but may raise other costs for patients. Other strategies include penalties for not enrolling and a financing mechanism (known as risk adjustment) designed to protect against adverse selection by spreading the costs of the sickest patients across insurers.

The risk-adjustment mechanism for exchange plans currently is hampered by limited data that do not consider prescription drug claims. If risk adjustment is inadequate, there is a danger that insurers have an incentive to discourage enrollment by the sickest individuals. This is in conflict with the government's interest in expanding coverage and with patient interests in gaining access to coverage and care. In other words, the interests of patients, insurers and government would not be well aligned.

Example: Adverse tiering. Adverse tiering is when a health plan subjects all medicines for treating certain conditions to very high cost sharing. The growing prevalence of this practice suggests issuers may face difficulty managing financial risk caused by enrolling too many patients with certain health conditions. The consequence is these patients – often with chronic but manageable conditions – are left with fewer choices or inferior coverage.

Solution: An improved risk adjuster that includes prescription drug data, combined with stronger oversight, could mitigate problems like adverse tiering. The current risk-adjustment model relies on clinical diagnoses and demographic data to predict the relative cost of covering individual or small group policyholders. It does not draw from pharmacy data even though research shows that including the data could make predictions more accurate. Pharmacy data could also help account for costs likely to be incurred by patients who are not enrolled for the whole year or other individuals with chronic conditions managed with medicines rather than frequent medical visits. With a more accurate risk adjuster, incentives would be better aligned across patients, insurers and government, which would help improve affordable access to care for patients.