



Institute For Policy Innovation

# ISSUE BRIEF

## SELECTIVE TRANSPARENCY TRANSPARENCY EFFORTS OBSCURE REAL HEALTH CARE PRICING ISSUES

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*“Price transparency” has become the new health care mantra, especially with regards to prescription drugs. However, price transparency is a challenge for the entire health care system. Much of the problem stems from the way we pay for health care, through health insurers and pharmacy benefit managers. Some state lawmakers and members of Congress want to address the price transparency challenge, but there are right and wrong ways to do it.*

### Synopsis

Rising health care costs, coupled with high-profile stories of price gouging by certain pharmaceutical companies, have energized some lawmakers to push for so-called “transparency” in prescription drug pricing.

But the fact is that price transparency is a problem for all sectors of the U.S. health care system, especially hospitals. At least with prescription drugs you know how much they will cost before you agree to buy. Try finding out how much your surgery and subsequent hospital stay will cost beforehand.

Prescription drugs account for about 10 percent of all health care spending, and have for decades. Hospitals, by contrast, account for about 32 percent and rising; physicians’ services make up about 20 percent.<sup>1</sup> But which of the three gets all of the political and media attention? Prescription drugs.

And yet there is pressure on lawmakers at both the federal and state levels to try and hold down costs. The problem is that most political efforts to do so have had just the opposite impact. Consider that the Affordable Care Act—i.e., Obamacare—was supposed to make health insurance more accessible and affordable. And yet premiums are exploding and health insurers are abandoning the Obamacare exchanges. Now some lawmakers want to bring that record of failure to bear on prescription drug prices through so-called price transparency.

### Introduction

1. “Moderate 2016 Health Spending Growth Continues a Slow Downward Trend,” Altarum Institute, September 9, 2016. [https://structurecms-staging-psyclone.netdna-ssl.com/client\\_assets/dwonk/media/attachments/581b/7a0a/6970/2d79/17c0/0a00/581b7a0a69702d7917c00a00.pdf?1478195722](https://structurecms-staging-psyclone.netdna-ssl.com/client_assets/dwonk/media/attachments/581b/7a0a/6970/2d79/17c0/0a00/581b7a0a69702d7917c00a00.pdf?1478195722)

Before lawmakers act, they need to understand why it is so difficult for patients—and others—to identify and compare prices for health care products and services. And if politicians are determined to do *something*, they should ensure that they don't add to the complexity and costs.

## Health Care and Price Transparency

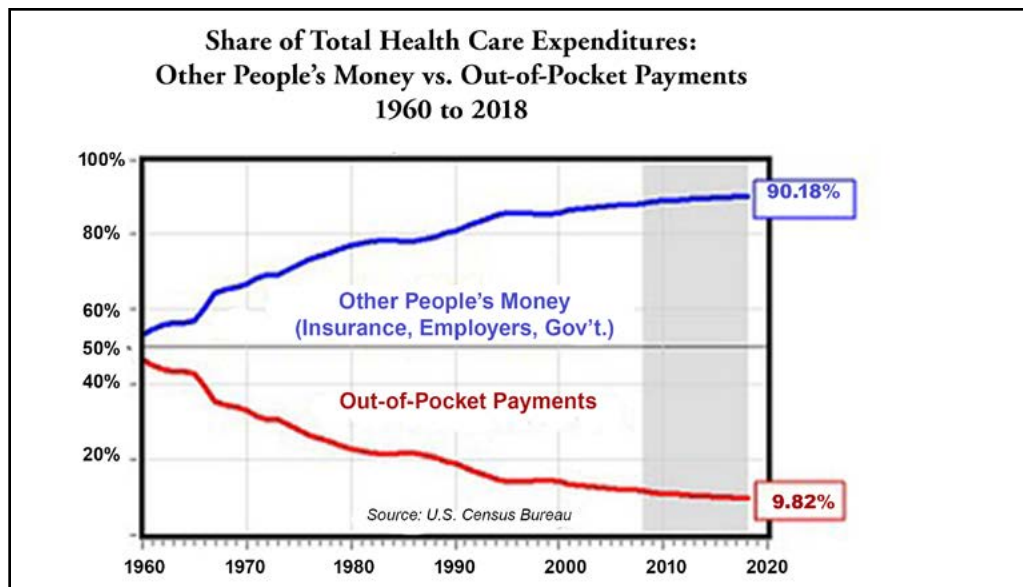
Decades ago, health care prices were about as transparent as other types of products and services. Doctors and hospitals had fees, and patients were charged for the services they used. Pharmacies had accessible prices for prescription drugs. And health insurance agents could walk clients through their insurance options and give them a price for a policy, assuming there were no major medical conditions.

But all that began changing in the 1960s, especially after the passage of Medicare and Medicaid, because for the vast majority of Americans, then and now, some third party—a health insurer, employer or the government—pays the medical bills.

Insulated from the cost, most patients didn't care how much they spent on health care—and many still don't. As a result, health care providers had little reason to make sure patients knew the costs.

But cost insulation was a recipe for exploding health care spending. [See Figure 1]

FIGURE 1



In response, the federal government adopted a system of hospital-based price controls for Medicare reimbursements in the early 1980s, referred to as the diagnosis related group (DRG) system. The DRG system, like all price control schemes, was sold as a way to reduce government spending, but that didn't happen. Government spending continued to grow.

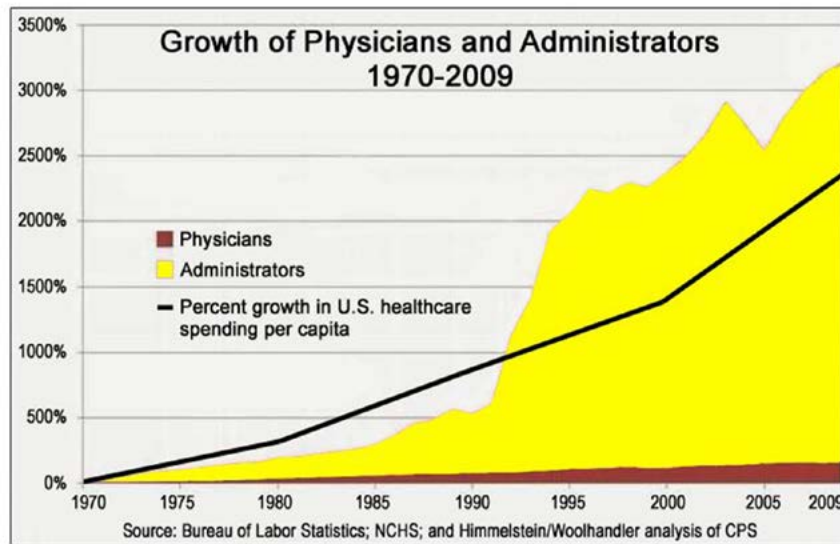
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## Here Come the Middlemen

But price controls also meant that the government was paying a lower price than health insurers. So managed care companies began forming to negotiate lower prices from doctors and hospitals. Meanwhile, pharmacy benefit managers (PBMs) began managing drug benefits for employers and insurers, negotiating lower drug prices and later restricting access to drugs through formularies.

As a result, middleman-related administrative costs as a part of total health care spending exploded. [See Figure 2] And it isn't clear that all those added administrative inputs actually lower the total cost of health care.

FIGURE 2



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## Hospital Price Transparency

If lawmakers want to hold costs down through price transparency, they should start with hospitals. At least patients can call a doctor's office or a pharmacy and usually obtain a price—whether discounted for insurance or not—for a procedure or prescription. Not so with most hospitals. Call and ask how much a CT scan, a sonogram or a morning stay for day surgery costs and most will say they just don't know.

And a consumer who is able to unearth the price of, say, a CT scan at several hospitals will likely notice a wide variation—with some facilities' prices three or four times or more than that of the lowest price.

- A 2015 report in the journal *Health Affairs* on low-risk childbirth across U.S. hospitals using 2011 data “found that the average estimated facility cost per maternity stay ranged from \$1,189 to \$11,986 (median: \$4,215).”<sup>2</sup>

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2. Xiao Xu, Aileen Garipey, Lisbet S. Lundsberg, et al., “Wide Variation Found in Hospital Costs for Maternity Stays Involving Low-Risk Childbirth,” *Health Affairs*, July 2015, vol. 34, no. 7, pp. 1212-1219. <http://content.healthaffairs.org/content/34/7/1212.abstract>

- The Centers for Medicare and Medicaid Services (CMS) conducted a survey of hospital pricing variations in 2013. As reported in *Modern Healthcare*, “joint-replacement charges ranged from \$5,300 at a hospital in Ada, Okla., to \$223,000 charged at a hospital in Monterey Park, Calif.” And “average inpatient hospital charges for services to treat heart failure ranged from a low of \$21,000 to a high of \$46,000 in Denver and from a low of \$9,000 to a high of \$51,000 in Jackson, Miss.”<sup>3</sup>

Can it really be that there is that much cost variation between different facilities? No, the problem is that hospital pricing bears no relation to what it costs to provide the service. Hospitals fabricate prices to play the reimbursement game with the government and insurers. Even so it must be emphasized that most patients do not pay the hospital “list price.” Rather they, or their insurer, pay the negotiated discount price.

As the Medicare and Medicaid programs and health insurers demanded that hospitals accept ever-larger reductions from their standard charges, hospitals raised their base charges. The spread between what a hospital lists as its charge and what insurers and the government actually pay can vary immensely. Unfortunately, the uninsured are hit doubly hard: They often have no access to lower negotiated prices and they tend to have lower incomes and can least afford the higher prices. Yet they are usually the ones forced to pay the full price, or something close to it.<sup>4</sup>

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## Health Insurance Price Transparency

The lack of price transparency in health insurance has been more a result of who buys health insurance than of any efforts by the industry to obscure prices.

About 156 million American workers and their dependents receive their health insurance from an employer.<sup>5</sup> Employers typically decide what will be available to employees with little or no input from them.

By contrast, only about 21 million people buy coverage for themselves and their dependents in the individual health insurance market.<sup>6</sup> These are the people most interested in price information.

Prior to the passage of the Affordable Care Act, there were a few private sector websites that allowed people to search for policies and prices available in their area. The creation of Healthcare.gov and some state-based health insurance portals have advanced online health insurance searches, the ability to obtain a price for coverage, and the public’s comfort with using such a system.

One of the insurers’ key advantages is their ability to negotiate lower prices from doctors, hospitals and other health care providers. But those agreements are proprietary, so a patient with Insurer A may pay a significantly lower price for the same care than a patient with Insurer B, and neither would know.

3. Rich Daly, “CMD Data Show Wide Variation in Hospital Billing,” May 8, 2013. <http://www.modernhealthcare.com/article/20130508/NEWS/305089960>

4. Lena H. Sun, “50 Hospitals Charge Uninsured More Than 10 Times Cost of Care, Study Finds,” *Washington Post*, June 8, 2015. [https://www.washingtonpost.com/national/health-science/why-some-hospitals-can-get-away-with-price-gouging-patients-study-finds/2015/06/08/b7f5118c-0aeb-11e5-9e39-0db921c47b93\\_story.html?utm\\_term=.258cc8ea8a1f](https://www.washingtonpost.com/national/health-science/why-some-hospitals-can-get-away-with-price-gouging-patients-study-finds/2015/06/08/b7f5118c-0aeb-11e5-9e39-0db921c47b93_story.html?utm_term=.258cc8ea8a1f)

5. “Health Insurance Coverage of the Total Population,” *State Health Facts for 2015*, Kaiser Family Foundation. <http://kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

6. *Ibid.*

But even those who pay close attention to their insurance contracts often have little idea if or how much their insurer will actually pay for certain medical procedures or prescription drugs—or if the treatment is covered at all.

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## Drug Price Transparency

While the often-high list price of prescription drugs gets the headlines, the fact is that drug manufacturers don't set the prices patients actually pay—pharmacy benefit managers, insurers, hospitals and pharmacies determine them.

Let's start with "price." What patients usually mean when they claim "drugs are too expensive" is "my co-pay and co-insurance rates are too high"—and unfortunately, they're trending even higher.

But pharmaceutical companies don't set co-pay rates. Insurance companies and PBMs do. And that's a problem because higher co-pays and co-insurance rates mean higher out-of-pocket costs for patients and directly correlate to increased non-compliance with a prescription regimen.<sup>7</sup> And non-compliance—when patients decide to stop taking their medications because, for example, they are too expensive, difficult to administer, not available, or interrupt a busy schedule—costs our health care system billions of dollars annually.

Many Americans mistakenly believe that the increase in out-of-pocket expenses is the result of higher drug costs, but other important factors play a role. When PBMs and insurance companies (both of which act as middlemen) negotiate discounts—often of 50 percent and more—the PBMs and insurers often retain most or all of that discount instead of passing it along to the consumer. For example, in a study by Berkeley Research Group (BRG), the company found brand name pharmaceutical manufacturers only retained about 63 percent of what they would have received if they had been paid the full list price for their products.<sup>8</sup> At least when insurers negotiate discounts with physicians and hospitals, the patient gets the whole discount.

In addition, while both hospitals and drug companies are pressed for discounts, drug companies are also often required to provide rebates of up to 60 percent to Medicaid, Medicare and the Veteran's Health system. And some state Medicaid programs not only require rebates, but "supplemental rebates"—in essence, rebates on top of rebates. For example, the Medicaid program uses rebates and supplemental rebates to reduce its fee-for-service prescription drug expenditures by 63 percent, from \$21.4 billion to \$8 billion in 2015.<sup>9</sup> States demanding supplemental rebates often defend their actions by claiming they use the additional money to provide more or better health care services, but many do not.

And then there's the "prescription price shell game." In Minneapolis, for example, a local pharmacy jacked up the price of a kidney medication from 87 cents to more than \$6 per pill.<sup>10</sup> And in North Carolina a hospital collected nearly \$4,500 for a

7. Michael T. Eaddy, Christopher L. Cook, Ken O'Day, et al., "How Patient Cost-Sharing Trends Affect Adherence and Outcomes," *Pharmacy & Therapeutics*, January 2012, 37(1), pp.45-55. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278192/>

8. "New First-of-Its Kind Study Shows Growing Share of Medicine List Prices Going to Rebates and Supply Chains," *Pharmaceutical Manufacturers of America*, January 18, 2017. <http://www.prnewswire.com/news-releases/new-first-of-its-kind-study-shows-growing-share-of-medicine-list-prices-going-to-rebates-and-supply-chain-300392611.html>

9. "Medicaid Spending for Prescription Drugs," *MACPAC Issue Brief*, January 2016, Figure 1. <https://www.macpac.gov/publication/medicaid-spending-for-prescription-drugs/>

10. Jay Olstad and Steven Eckert, "KARE 11 Investigates: Prescription Price Shell Game," February 16, 2016. <http://www.kare11.com/news/investigations/kare-11-investigates-prescription-price-shell-game/44234964>

colon cancer drug that hospitals typically buy for \$60.<sup>11</sup>

A recent study by the Pioneer Institute in Massachusetts exposed these variations.<sup>12</sup> Pioneer researchers called 44 independent and chain store pharmacies across Massachusetts and requested the cash price of several prescription drugs.

- Generic antibiotic amoxicillin ranged from \$4.00 for a 30-day prescription to \$20.99;
- Generic atorvastatin, a statin drug, ranged from \$4.00 to \$198.97; and
- Furosemide, which treats edema, varied from \$3.65 to \$25.00.

In addition, there's the PBM “claw back” practice, one of the most abusive practices—at least from the patient's standpoint. Here's how it works.

When insured patients go to the pharmacy to pick up a prescription drug, they are usually presented with their co-pay or, increasingly, a co-insurance price. They pay that price and leave, thinking they are getting a discounted price.

But in many cases the cash price for the drug (mostly generics), may be significantly less expensive than the patient's co-pay price. And the real nose-thumbing to price transparency comes in the fact that the pharmacist may, under PBM contract, be prohibited from voluntarily providing that lower-price information. That is, the pharmacy customer could ask about the cash price for the drug and receive the information, but the pharmacist may be contractually prohibited from volunteering that information.

For example, a recent WBZ TV (Boston CBS) story highlights waitress Amy Frostland, who came to believe she had been cheated for years. “If I run my insurance, it's going to cost me \$90 for a three month supply [of her prescription]; if I do it without insurance, it is \$10 for a three month supply,” she explained to WBZ. The PBM, not the pharmacy, was likely keeping most or all of that cost difference, the story explains.

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## Drugs Actually Save Money

Unfortunately, the media largely ignore such practices and fail to put health care spending in perspective, preferring to concentrate on alleged misbehavior or greed by pharmaceutical companies. But drug costs represent only 10 percent of national health care spending, and account for some of the most promising advances in treatment in decades. By contrast, hospitals represent 32 percent and physicians' services 20 percent of health care spending.<sup>13</sup>

By addressing once-untreatable diseases, symptoms and complications, pharmaceutical advances help patients avoid expensive surgeries and lengthy hospital stays, which account for a far larger share of health care spending.

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11 Ames Alexander, Karen Garloch and Joseph Neff, “Prices Soar as Hospitals Dominate Cancer Market,” the Charlotte Observer, April 22, 2015. <http://www.charlotteobserver.com/news/special-reports/prognosis-profits/article9083777.html>

12. Barbara Anthony, “Transparency in Retail Drug Prices: Easy to Obtain but Accuracy May Be Doubtful,” Pioneer Institute, October 2016. <https://www.macpac.gov/publication/medicaid-spending-for-prescription-drugs/>

13. “Moderate 2016 Health Spending Growth Continues a Slow Downward Trend,” Altarum Institute, September 9, 2016. [https://structurecms-staging-psyclone.netdna-ssl.com/client\\_assets/dwonk/media/attachments/581b/7a0a/6970/2d79/17c0/0a00/581b7a0a69702d7917c00a00.pdf?1478195722](https://structurecms-staging-psyclone.netdna-ssl.com/client_assets/dwonk/media/attachments/581b/7a0a/6970/2d79/17c0/0a00/581b7a0a69702d7917c00a00.pdf?1478195722)



Consider Sovaldi, the so-called “\$1,000-a-day pill.” The pre-Sovaldi “best practice” treatment for hepatitis C was the drug Pegasys, which requires one injection a week for 48 weeks, and doesn’t even cure the disease. As a result, very few patients saw the treatment through to completion, which meant the time and money that was spent was mostly wasted.

Sovaldi usually cures the disease when taken once a day over 12 weeks, eliminating the risks and the costs of liver transplantation. When patients have access to more effective medications, their overall health improves, even as their overall medical expenses go down. That, in turn, reduces national health care spending and boosts the economy.

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## PBM Transparency

Pharmacy benefit management (PBM) companies are big business. PBM-administered plans cover more than 266 million Americans insured through employers, unions or government programs like Medicare Part D.<sup>14</sup> They design and maintain drug formularies—i.e., the lists of medications available under particular health plans. And they use their immense purchasing power to negotiate large discounts from pharmaceutical manufacturers.

Compare the total revenues of some of the largest PBMs—Express Scripts Holdings, CVS Health and UnitedHealth Group’s OptumRx—to, say, the drug companies.<sup>15</sup> [See table below]

Notice that the top five health care companies by revenue are health insurers and PBMs—and UnitedHealth Group includes its PBM, OptumRx. These companies don’t actually make anything. Express Scripts took in about twice the money (\$102 billion) as the largest pharmaceutical manufacturer, and yet Express Scripts doesn’t cure any disease. It’s a fair question to ask whether total consumer health care spending would be less if billions of dollars weren’t absorbed by middlemen.

COMPANY	REVENUE (BILLION \$)
UnitedHealth Group	157.0
CVS Health	153.0
Express Scripts	101.6
Aetna	60.0
Humana	54.0
Roche Group	52.0
Novartis	51.0
Pfizer Inc.	48.9
Sanofi	41.5
Merck	39.5

*Express Scripts took in about twice the money as the largest drug manufacturer and yet it doesn’t cure any diseases.*

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14. “Pharmacy Benefit Managers: Generating Savings for Plan Sponsors and Consumers,” Visante, February 2016. <http://thatswhatpbmsdo.com/wp-content/uploads/2016/02/visante-pbm-savings-study-Feb-2016.pdf>

15. Fortune Magazine’s Global 500. <http://beta.fortune.com/global500/list>

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## PBM Restrictions

PBM profits come in part from retaining rebates from drug makers that they don't pass on to pharmacies and insurers or, most importantly, to patients. PBMs are beginning to restrict access to certain drugs. In 2015 Express Scripts announced it planned to save \$1 billion, not by flexing its purchasing power, but by excluding 66 medicines from its list of covered drugs.<sup>16</sup>

As recently as 2012, Express Scripts excluded no medicines from its list of covered drugs, while CVS Caremark (the second largest PBM) excluded about 30. In 2016, Express Scripts denied coverage to 124 medicines and CVS Caremark banished an additional 14.<sup>17</sup>

In 2015, compounding pharmacies sued Express Scripts over its “scheme to deny all claims” for certain customized medications. The suit stated, “The scheme is forcing patients to go without treatment, jeopardizing their health and causing bodily harm, or forcing them to pay out-of-pocket sums that they may or may not be able to afford for basic healthcare needs that have been prescribed by their doctors.”<sup>18</sup>

PBMs have also stopped paying for many cutting-edge cancer treatments. CVS won't cover Tasigna or the revolutionary prostate cancer treatment Xtandi. Meanwhile, Express Scripts has stopped covering Zyclara, a cream that can help prevent skin cancer.

Ironically, this strategy will end up raising health care costs in the long run. If doctors can only prescribe less-effective treatments, patients will get sicker, will be hospitalized more frequently, and will require more expensive care. That demand will drive up overall health care costs and overwhelm doctors and hospitals with waves of new patients.

Consider the 2010 comments of George Paz, chairman and chief executive of Express Scripts: “The cheapest drugs is (sic) where we make our profits.” And just who is “cheaper” better for? “Our whole model is switching people to lower-cost drugs. The more money my shareholders make, the more money I make.”<sup>19</sup>

Since 2003 the company has increased its profits per prescription by 500 percent, according to David Balto writing in *The Hill*. He adds, “Often PBMs are making more on prescriptions than the pharmacy, crushing small businesses and driving up health care costs across the board.”<sup>20</sup>

Of course, there's nothing wrong with companies making healthy profits. It just highlights the fact that a lot of money is made in the health care system by middlemen that don't actually treat patients. And yet the media and critics spend most of their time focusing on a smaller segment of the health care system that is also one of its most innovative.

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16. “Express Scripts Press for Expansion of Drugs It Won't Cover,” *Business Insurance*, December 24, 2014. <http://www.businessinsurance.com/article/00010101/NEWS03/141229942/ CVS-Health-warns-new-cholesterol-treatments-and-specialty-drugs-could-overwhelm-health-care-system>

17. David Goldman, “Here Are All the Drugs CVS Is Dropping, Including Viagra,” *CNN Money*, August 6, 2015. <http://money.cnn.com/2015/08/06/news/companies/cvs-viagra/>

18. Sheena Harrison, “Express Scripts Suit Over Compounded Drugs Signals Future Challenges,” *Business Insurance*, December 7, 2014. <http://www.businessinsurance.com/article/00010101/NEWS08/312079967/ Employers-should-lead-scrutiny-on-compounded-drugs%2C-physician-dispensing>

19. Jim Doyle, “A Prescription for Growth,” *St. Louis Post Dispatch*, June 11, 2010. [http://www.stltoday.com/business/a-prescription-for-growth/article\\_5b8b0a4c-0484-5fe8-a08d-d6f2a99bda8f.html](http://www.stltoday.com/business/a-prescription-for-growth/article_5b8b0a4c-0484-5fe8-a08d-d6f2a99bda8f.html)

20. David Balto, “How PBMs Make the Drug Price Problem Worse,” *The Hill*, August 31, 2016. <http://thehill.com/blogs/pundits-blog/healthcare/294025-how-pbms-make-the-drug-price-problem-worse>



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## What Are States Doing?

State policymakers keep referring to double-digit price increases for biopharmaceuticals as a reason to take action. However, the percentage increase they point to is not the actual increase in price incurred by the health care system since it does not take into consideration the considerable rebates and discounts offered by the pharmaceutical companies.

For example, Express Scripts, the largest PBM, reports, “Despite brand-name list price increases of nearly 11 percent, Express Scripts kept unit cost increases for employers to just 2.5 percent across all prescription drugs.”<sup>21</sup> Other PBMs likely had similar minimal increases.

The impression conveyed in Express Scripts’ press release is that the company “saved” consumers and the health care system 8.5 percent—the difference between the 11 percent list price and the 2.5 percent cost increase. In fact, the PBM may have absorbed a portion of those “savings.”

Several states are considering and others have passed legislation that they refer to as prescription drug “price transparency” laws, but that term is basically a euphemism for a slippery slope towards price controls. For example:

- One approach is a price control bill that requires prescription drug makers to reimburse payers for the cost of a drug that exceeds a specific threshold and to provide a 60-day advance notice if a drug’s price will increase by more than, say, 3.4 percent.
- Some states are considering legislation intended to keep drug companies from “price gouging” the Medicaid program—even though by law drug manufacturers must give Medicaid programs the lowest price—by imposing a surcharge on drug manufacturers that charge more than a specified amount.
- Several states want drug makers to disclose their R&D costs and justify significant price increases and take legal action if they are deemed to be price gouging.
- A fourth approach is legislation that would require health plans to report on such issues as the most prescribed and most costly drugs, and for drug companies to provide notice about future price increases.
- And some states want state agencies to pay no more than the Veterans Administration pays for drugs.

Note that *none of these efforts would actually lower drug costs for patients*. They would either require companies to notify payers of a coming increase or take money from some companies and hand it over to others. Mostly, they are meant to get votes.

What’s even more disturbing is the history of price controls enacted in other countries. They have always resulted in reduced access to medicines for serious and life-threatening diseases.<sup>22</sup>

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21. “Express Scripts Fights Back Against Irresponsible Drug Pricing,” PR Newswire, February 6, 2017. <http://www.prnewswire.com/news-releases/express-scripts-fights-back-against-irresponsible-drug-pricing-holds-us-drug-spending-increase-to-38-percent-in-2016-300402306.html>

22. Merrill Matthews, Grace-Marie Turner and Julian Morris, eds., “The Dangers of Undermining Patient Choice: Lessons from Europe and Canada,” Institute for Policy Innovation and the Galen Institute, October 2006. [http://www.ipi.org/ipi\\_issues/detail/the-dangers-of-undermining-patient-choice-lessons-from-europe-and-canada](http://www.ipi.org/ipi_issues/detail/the-dangers-of-undermining-patient-choice-lessons-from-europe-and-canada)

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## What Is Washington Doing?

Surprisingly, there is better news coming out of Washington, D.C. Senator Ron Wyden (D-OR), the ranking member of the Senate Finance Committee, has proposed legislation to lower drug costs by targeting PBMs.

The bill would mandate that patient co-pays or co-insurance for drugs in Medicare Part D be based on the negotiated price of the drug, not the higher list price. The bill also requires more transparency by mandating that PBMs publicly disclose aggregate rebates and the amount of those rebates passed on to health plans, as well as the difference between what a PBM pays a pharmacy for a drug and what the PBM charges a health plan for the drug.

In the House of Representatives, Doug Collins (R-GA), Buddy Carter (R-GA), Dan Loebsack (D-IA), John Sarbanes (D-MD) and John Duncan (R-TN) have introduced the Prescription Drug Price Transparency Act. It is designed to:

- Safeguard patient information collected by a PBM (which can be used to steer patients to PBM-owned/preferred outlets);
- Prohibit PBMs from requiring patients to utilize a PBM-owned pharmacy (including specialty pharmacy);
- Require maximum allowable cost transparency; and
- Apply these standards to both Tricare and the Federal Employee Health Benefits Program.

In sum, the bill would establish a far more competitive marketplace for branded and generic products and lessen the monopsony of the large PBMs.

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## What Patients Care About

Consumers are understandably angry about rising health care costs. But their anger is misdirected at pharmaceutical manufacturers. The high prices are mostly a result of the way we pay for health care (i.e., through a third party) and the laws and restrictions that have grown up around that system. For example, the median time for the U.S. Food and Drug Administration (FDA) to approve a generic drug—not a new brand name drug, but generic—is 47 months.<sup>23</sup> Why on earth would it take four years to approve a drug whose brand name version has been on the market for years? During his Senate confirmation hearing, FDA Commissioner Scott Gottlieb promised to expedite applications for single source generics. This accelerated competition is just what the doctor ordered for lower priced, off-patent medicines.

What most patients care about is having information about the highest quality (i.e., outcomes) and lowest possible price for a medical procedure, medical device or prescription drug that still ensures those products and services—and even improved ones—will be available in abundance in the future.

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23. Sidney Lupkin, “Outcry over EpiPen Highlights FDA’s Long Backlog of Generics,” Kaiser Health News, September 6, 2016. <http://khn.org/news/epipen-controversy-fuels-concerns-over-generic-drug-approval-backlog/>

While there is some pricing data available for various health care sectors, most of it is irrelevant or hard to access. For example, consumers may be able to find the list price for a prescription drug, but that price doesn't tell them the price the insurer or PBM actually paid for it after discounts. And that discounted price may not include rebates that go back to the insurer or PBM—and that very seldom go to the patient.

Unlike pharmaceuticals, there is very little data available on health outcomes for hospitals and physicians—and what is available is difficult to access. And even that data may be misleading because of what is measured. For example, measuring hospital outcomes by the number of readmissions doesn't actually say much about the quality of care. And measuring physician utilization rates also doesn't tell us much about outcomes.

As much as prescription drugs get faulted for lack of head-to-head effectiveness comparisons, the reality is that there is much more data comparing drugs to one another than there is comparing Hospital A to Hospital B or Physician A to Physician B. Doctors can often tell a patient the likelihood a specific drug will help based on scientific evidence; that's almost impossible to do with hospitals.

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## What Lawmakers Care About

What most lawmakers care about is saying they have made health care more accessible and affordable—because they know that's what the public wants. But their efforts seldom result in lower prices; they almost always result in reduced access.

The most recent example is Obamacare. It was sold on the notion that patients could keep their doctor and their health insurance. Both claims were demonstrably false. Access to affordable health insurance in the individual market is evaporating, as more and more Americans discover they cannot afford Obamacare options, even with the taxpayer-provided subsidies, and providers and health insurers refuse to participate.

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## Ways to Lower Prices and Increase Transparency

There are ways to increase transparency in the health care system and lower costs that won't also threaten access to needed care and products.

***Fire the Middlemen.*** Bloomberg News, for example, reports a way to “fire the middlemen.”<sup>24</sup> Caterpillar moved away from its PBM, suspecting that a quarter of the manufacturer's \$150 million annual drug bill was being wasted. The company began negotiating its own drug discounts and deals with pharmacies.

***Promote Transparent PBMs.*** Bloomberg also reports that some companies are switching to “transparent PBMs” that charge flat fees for negotiating drug discounts. And some states are embracing a “fiduciary standard,” requiring PBMs to put their clients' interests ahead of the company's interests.<sup>25</sup>

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24. Neil Weinberg and Robert Langreth, “Drug Costs Too High? Fire the Middleman,” Bloomberg Businessweek, March 3, 2017. <https://www.bloomberg.com/news/articles/2017-03-03/drug-costs-too-high-fire-the-middleman>

25. Ibid.

*Reduce the Regulatory Burdens.* President Trump has made it a key part of his presidency to reduce onerous regulations. The Food and Drug Administration would be a good place to start. FDA Commissioner Scott Gottlieb is well aware of the agency's regulatory roadblocks and could address them soon.

*Allow New Payment Models.* Several experts have proposed new payment models that should be considered. For example, the pharmaceutical manufacturers are interested in exploring a value-based payment approach for some of the most expensive branded drugs, where the price of the drug depends on how successful it is.

Another option, which is currently available but receives very little attention, is life insurance with a critical care component. This is traditional term life insurance, but it allows policyholders facing high medical costs the ability to draw on part or all of the value of the policy to pay for medical expenses. It's not a loan; the face value of the policy is reduced accordingly. But it is a way to have both life insurance and a safety net in case the policyholder has a major medical incident.<sup>26</sup>

Both approaches mean fewer laws and regulations that bottleneck the health care system and make transparency so difficult. And they try to increase competition and put the consumer in charge once again.

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## Conclusion

The term “price transparency” has become something of a mantra among health system reformers, but it is often simply a euphemism for more government control over health care coverage, providers, services and products—especially pharmaceuticals.

While health care prices are hard to access, that's true of the whole health care system—especially hospital care. There is legislation being proposed by Senator Wyden and a different bill by Representative Collins, et al, that would help with one health care sector, PBMs. But real price transparency will likely only come when consumers demand it because they control more of their health care dollars, just as they do in every other sector of the economy.

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26. Merrill Matthews, “A Surprising Health Insurance Option for Those Who Refuse Obamacare,” Forbes.com, June 27, 2013. <https://www.forbes.com/sites/merrillmatthews/2013/06/27/a-surprising-health-insurance-option-for-those-who-refuse-obamacare/#698f2b934127>

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