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It's Still the Prices Stupid

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Protecting Health, Saving Lives—*Millions at a Time*

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It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt

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ABSTRACT A 2003 article titled “It’s the Prices, Stupid,” and coauthored by the three of us and the recently deceased Uwe Reinhardt found that the sizable differences in health spending between the US and other countries were explained mainly by health care prices. As a tribute to him, we used Organization for Economic Cooperation and Development (OECD) Health Statistics to update these analyses and review critiques of the original article. The conclusion that prices are the primary reason why the US spends more on health care than any other country remains valid, despite health policy reforms and health systems restructuring that have occurred in the US and other industrialized countries since the 2003 article’s publication. On key measures of health care resources per capita (hospital beds, physicians, and nurses), the US still provides significantly fewer resources compared to the OECD median country. Since the US is not consuming greater resources than other countries, the most logical factor is the higher prices paid in the US. Because the differential between what the public and private sectors pay for medical services has grown significantly in the past fifteen years, US policy makers should focus on prices in the private sector.

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Since 1986 the Organization for Economic Cooperation and Development (OECD) has published data allowing for comparisons of health systems across countries.¹ Over the years *Health Affairs* has published a series of articles using the OECD data. Among the articles is the 2003 “It’s the Prices, Stupid: Why the United States Is So Different from Other Countries.”² Perhaps because of the succinct title and the number of times that Uwe Reinhardt used this article in his presentations, the article and its message have become well known among policy makers and the public.

The 2003 article examined a wide range of potential explanations for the higher spending levels in the US. Using 2000 OECD data, it compared the US to other industrialized countries in

terms of the level of health care spending, the level of real resources (physicians, hospital beds, nurses, and so on) used in producing health care, the cost of administration, and other factors that were considered responsible for the higher level of spending in the US. It also examined the prices of selected goods and services. The main conclusion was that the primary factor responsible for most of the higher levels of spending in the US was the higher price for many goods and services.

As a tribute to Uwe Reinhardt, this article uses the most recently available OECD data to reflect on the conclusions made in 2003. Many articles have subsequently used the OECD data, including a recent article by Irene Papanicolaou and coauthors that compared the performance of health systems in the US and ten other high-

The US is Number 1 for the 40th year in row!

- Percent of GDP spent on health care in 2018
 - 16.9% - US
 - 12.2% - Switzerland
 - 11.2% - Germany
 - 11.0% - Sweden
 - 10.9% - Japan
 - 10.7% - Canada
 - 10.2% - Norway
 - 9.8% - UK
 - 9.3% - Australia



It is not news that the US spends the most on health care or that the main reason is health care prices



What the paper does show

- Despite many restructurings of the US and international health systems over the past 20 years
 - Prices remain the primary reason why the US spends more on health care than any other country
- On key measures of health care resources per capita (hospital beds, physicians, and nurses), the US still provides significantly fewer resources compared to other industrialized countries
- The main difference from 20 years ago is the growing differential between public and private sector prices in the US
 - 20 years ago the public and private insurers paid about the same
 - Private sector prices are now approximately double Medicare prices



Market Failure

- In most cities, there are one or two dominant health systems
- All insurers need these health systems in their network
- This gives the health systems tremendous bargaining power with the insurers and self insured companies
- As health systems have consolidated, the differential between public and private sector prices has grown
- While Medicare can hold price increases close to inflation the private sector has been unable to do so
- Hospitals and physicians will adjust their costs to reflect their revenues, so when private sector prices increase so do costs



How Other Countries Control Prices

- One payment system
- External and internal reference prices
- Monitoring volume increases and adjusting prices accordingly



One Payment System

- In some countries, the government sets the rates for all providers
- In other countries, there is one big negotiation with all insurers on one side of the table and all providers on the other side and they reach one price that applies to everyone
 - The price can vary by hospital or specialty but there is one formula
- In the US, the equivalent would be
 - allow the Medicare program to set the price for all insurers
 - allow the insurers to set a rate that is a percentage of the Medicare rate



Public Option

- Colorado and Washington are using Medicare rates to determine what providers can charge the public option insurer



External Reference Prices

- Most other countries use the prices for drugs paid internationally as a guide for determining what they pay
- It is one of many factors that they use
 - It has been proposed for Medicare Part B



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Using External Reference Pricing In Medicare Part D To Reduce Drug Price Differentials With Other Countries

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ABSTRACT Many countries use external reference pricing to help determine drug prices. However, external reference pricing has received little attention in the US—perhaps because the US is often the first adopter of drugs. External reference pricing could be used to set prices for drugs that were already established in the market. We compared the price differentials between the US and the UK, Japan, and Ontario (Canada) for single-source brand-name drugs that had been on the market for at least three years. We found that the prices averaged 3.2–4.1 times higher in the US after rebates were considered. The price differential for individual drugs varied from 1.3 to 70.1. The longer a drug remained on the market, the greater the differential. The estimated savings to Medicare Part D of adopting the average price of drugs in the reference countries was \$72.9 billion in 2018. Medicare could use external reference pricing in Part D to improve affordability for patients.

President Donald Trump recently proposed using external reference pricing to lower Medicare Part B prescription drug spending.¹ External reference pricing is the practice of using drug prices in foreign countries to help set domestic prices.² Although there is some debate over the unintended consequences of using external reference pricing in the US,^{3,4} external reference pricing is used by many industrialized countries.⁵

Despite its prevalent use internationally, little attention has been paid to external reference pricing in the US until recently. One possible reason is that the US is often the first country where drug companies sell the drugs, so there might not be any external reference price available for a new drug. Several years later, however, nearly all brand-name drugs are often purchased at significantly higher prices in the US than in other industrialized nations because the price often increases in the US, while it generally declines internationally.^{6,7} Thus, external reference

pricing has potential for use in the US within the market for established drugs. Using external reference pricing to inform the US government and insurers about international prices would allow for greater price transparency and could suggest which specific drugs are outliers in the US compared to international prices.

This study examined which drugs have the largest price differentials and possible contributing factors. While President Trump's proposal focuses on Medicare Part B, we focused on Part D, given that it accounts for 3.4 times greater Medicare spending compared to Part B.⁸ We discuss possible policy options regarding the implementation of external reference pricing for established brand-name drugs in the Medicare program.

Study Data And Methods

SAMPLE SELECTION We identified single-source brand-name prescription drugs that had been on the US market for three or more years (“estab-



Summary of Findings

- On average, brand name drugs that do not have a generic competitor are 3-4 times more expensive in the US
- There are 79 of these drugs that account for over ½ of all Medicare spending
- Some of these drugs are only 30% more expensive while others are 7000% more expensive
- The longer the branded drug remains on the market the greater the price differential



Internal Reference Pricing

- Most countries use some variant of cost effectiveness to determine drug prices
- Medicare is prohibited from doing so

NICE National Institute for
Health and Care Excellence

IQWiG Institute for Quality
and Efficiency in Health Care



Monitoring Prices and Adjusting Accordingly

- Japan looks at volumes and determines if the payment system is causing volume increases in certain procedures
 - Japan will lower prices if determines that prices are responsible for the volume increases
- Japan sets a price for a drug
 - Japan asks the pharmacy or hospital what it actually paid for the drug
 - The price paid is always lower than the reimbursement amount
 - In the next year the reimbursement amount is based on the amount paid plus 2%
 - As a result, the prices always go down following the drug's launch



Three Conclusions

- Is possible to use Medicare as a platform to determine rates for all providers
 - In most communities there is market failure
 - Could be a percentage of Medicare rates
 - States are using Medicare rates in the public option
- Other countries are using approaches that Medicare and other US insurers could use to control prices
 - Internal and external reference prices
 - Monitoring volumes and adjusting prices accordingly

