

Midterm (Book review)

Book name: -A great American healthcare scam

Increased healthcare cost due to pharmaceutical industry.

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**Introduction**

Dr. Belk offers valuable insight into our healthcare system. In addition to billing and health insurance, Dr Belk is well-versed in practice aspects. He discussed how the U.S. healthcare system became expensive and ineffective. Additionally, he outlines why prescription drugs are more costly in the U.S. than in other countries. As a society, we should also think about the future of healthcare and how to get there. It is a helpful book for understanding healthcare in general and health insurance. (Belk, The Great American Health scam, 2020)

Throughout the book, real-life examples illustrate how out of control healthcare is. The author discusses how hospitals and doctors charge us so much, how insurance companies deduct, what Medicare pays, how pharmaceutical companies take advantage of the FDA, PBM rebates, and ASC profits from employers, and how they keep things opaque. However, the book fails to explain how PBMs take money away from pharmacies with multiple schemes and employer benefits.

The primary concern of the book was throwing light on the charges and transparency of the healthcare system with different section, medical billing, pharma and health insurance. I was more intrigued with the section pharmaceuticals in healthcare, so further I will concentrate on insights about the Pharmaceuticals in healthcare.

**Impact of pharmaceutical in Health care**

In the past few years, pharmaceutical companies have raised the prices of crucial medications, resulting in a negative impact on millions of people's health. The industry's largest firms have also increased their lobbying expenditures, and some have lobbied explicitly on drug pricing and legislation to resolve the problem. The industry's largest trade group has increased member dues for its member companies by 50% to raise $100 million for an influence campaign to prevent potential price regulation from U.S. lawmakers (A bitter pill: how big pharma lobbies to keep prescription drug prices high, 2018)). Keeping prices high is easy for Big Pharma with $263M in resources in 2021, (Cleave, 2021).Therefore, more companies are lobbying on this issue than ever before. The federal government has shown that Pharma will lobby against any reforms that threaten its bottom line in addressing this issue.

The United States spent 18.8% of its gross domestic product on health care in 2021. In 2022, the price of prescription drugs is expected to increase by 5% of prescription drugs (KHN, 2022). While both Democrats and Republicans want to lower prescription drug prices, lobbyists and campaign donors from the pharmaceutical industry may hinder efforts by federal and state governments to do so.

Approximately 90 per cent of responding hospitals said recent increases in inpatient drug prices had a moderate or severe impact on their ability to manage patient care costs; one-third said the effect was harsh. Increasing drug prices also strain government budgets, as the U.S. government pays about 43 per cent of retail prescription drug prices, (Milani, 2019). Due to budgetary restrictions and the introduction of many high-cost drugs to the market, the Medicaid prescription drug policy will likely remain an issue at the federal and state levels.

A Bentley College study found that all 210 drugs approved between 2010 and 2016 were based, at least in part, on research funded by the National Institute of Health (NIH) (Trends in hospital inpatients drug costs:Issues and challenges, 2016). Pharmaceutical firms often focus more on activities that increase profits and stock prices than on developing needed drugs. Drug makers' research and development investments do not meet the healthcare needs of the most vulnerable. Instead, they invest in cures and remedies for diseases that affect the wealthiest. Global Data research shows that Johnson & Johnson, the world's largest drug company, spends more on sales and marketing than on R&D (Anderson, 2014).

Because of this misalignment, drug makers often do not invest in research and development to treat diseases we need, like developing new antibiotics (Mazzucato, 2018), or to treat diseases that affect lower-income individuals, who cannot afford the fixed costs of drug production (Jayadev, 2010). By failing to improve these affairs, we amplify pre-existing inequalities in health outcomes, harm people of color and women disproportionately, and disincentivize development for diseases disproportionately affecting people in the developing world. The Pharma industry does not have to be profit-driven at the expense of people's health; these outcomes are not inevitable.

In the book, the author describes how evergreening and biosimilars affect patent holding and increase the cost of prescription drugs, (Feldman, May your drug price be evergreen, 2018). The pharmaceutical company feigns an effective generic medicine by changing some chemical formulas and units. By altering a few chemical formulas and units, the pharmaceutical company fabricates a better medicine. There are very few new drugs being developed, and the old ones are being redesigned. As a result, the pharmaceutical industry can leverage the patent of the drug to make huge profits due to the exclusivity provided by the patent.

New medications are entering the market at astoundingly high prices. For instance, described in the book (Belk, The Great American healthcare scam), Marathon's muscular dystrophy drug debuted in the United States at $89,000 for a drug that is reportedly available elsewhere for $1500. Gilead's hepatitis C treatment costs $84,000 to treat one patient. Costs like these can make products affordable. For example, treating all infected Veterans in the VA with Gilead's hepatitis C drug, Sovaldi, would cost the Department of Defense more than 20% of its $57 billion medical budget in fiscal year 2014, It is exceptionally expensive to produce medications intended for small patient groups, and pharma companies are racing to enter this market.

In order to provide patients with access to pharmaceutical products, pharmacy benefit managers (PBMs) have become increasingly important. PBMs set retail prices for pharmaceutical products, negotiate rebates from manufacturers based on sales volumes, and receive payments from pharmacies in the form of post-sale concessions. There has been an untransparent flow of funds among clinicians and patients during these activities. By charging manufacturers rebates for being on their formularies, PBMs increase drug costs by almost 30%. Consumers pay nearly 30 cents more per dollar for prescriptions as a result of PBM rebates, which totaled $143 billion in 2019, (The Truth About Pharmacy Benefit Managers: They Increase Costs and Restrict Patient Choice and Access , 2019).

Prices for drugs have become increasingly unaffordable for millions of Americans, who are forced to make tough decisions around finances. The reasons include people skipping prescriptions, taking less than prescribed dosages, splitting pills, sharing prescriptions, and taking expired medications if their drug costs have increased. With drug prices rising, even health care providers are faced with tough decisions. Despite, this exceptional spending, the United States remains behind other developed countries regarding health outcomes.

The real benefiters of rebates are the PBM. It is in the PBMs' best interests and their executives' benefit. CVS Health, owner of one of the largest PBMs, paid the CEO of CVS Health $36.5 million in 2019. That's roughly 700 times higher than the median income in the United States, (Kevin A. Schulman M. a., 2018).  The PBM has DIR fees come in numerous forms, including penalties and other charges often unknown to the dispensing pharmacy. DIRs are assessed as a “claw back” - the pharmacy doesn’t “pay” the PBM, the PBM deducts these fees directly from the pharmacy’s bank account or by reducing future reimbursements without notice and weeks after the initial transaction.  DIR fees can also take the form of service fees, network access fees, administrative fees, reconciliation, etc. consequently, pharmacies must stick to PBM price list has they are not allowed to tell the generic drug cost to the consumers.

It is a different case with Medicare and Medicaid program. The Medicare and Medicaid program influenced the use of generic drugs which cost lesser than prescribing brand name drugs. In the Medicare Part D program, the average net price of a prescription decreased from $57 in 2009 to $50 in 2018, and in the Medicaid program, it dropped from $63 to $49. ( (Prescription drug:spending, uses , and prices, 2022). This results in the use of lower-cost generic drugs increased, but the rise in brand-name drug prices partially offset that trend and the average net price of brand name prescription drugs has risen substantially over that period: from $149 to $353 for Medicare Part D and from $147 to $218 for Medicaid. The average price of generic drugs covered by Medicare Part D and Medicaid declined over this period.

**Conclusion**

The Health Research Institute (HRI) of PwC projects a 6.5% medical cost trend in 2022, a decrease from the 7% trend in 2021 and an increase from 2016 to 2020, (Medical cost trends behind the numbers:2022). In recent years, the pharmaceutical industry has made a fortune from increasing the prices of medications vital to the health and well-being of millions of Americans. Although the federal government is trying to deal with this issue, Big Pharma has demonstrated its willingness to use its considerable resources to lobby against any reforms perceived as a threat to its profitability. Even if the government cannot find a solution to rein in drug prices, the drug industry will undoubtedly do everything in its power to prevent it.Studies have shown that manufacturer net income has grown disproportionally to payments over the past five years. In terms of the flow of funds through intermediaries, there is a lack of transparency. Even if this market structure is characterized by the return of a fixed proportion of rebate dollars to payers, as claims PBM, it may appear to benefit intermediaries. As a result, patients pay their full point-of-sale price for pharmaceutical products and do not benefit directly from manufacturer payments. This is a very unfair market.

**Recommendations**

As for consumers, they can increase their use of generic drugs by shopping around for prices in different pharmacies or on GoodRx before purchasing the drugs. Physicians can prescribe more generic drugs than brand name drugs. In order to obtain patent status, the FDA could increase the clinical formula by 50%-60%. Lobbying for pharmaceutical pricing should be controlled and made into legislation; consumers and taxpayers should contact their legislators to demand stricter laws be passed that require PBMs to be monitored, regulated, and prosecuted for breaking those laws. Overpricing in healthcare should be controlled by benchmarking. Individuals can obtain health insurance privately rather than via their employers.

**References**

**Book reviewed-** (Belk, The Great American Health scam, 2020)

Anderson, Richard.2014. “Pharmaceutical industry gets high on fat profits.” BBC News. November 6,2014 (<https://www.bbc.com/news/business-28212223>)

John Morgan, “A BITTER PILL How Big Pharma Lobbies to Keep Prescription Drug Prices High”. Citizens of responsibility and ethics in washington. <https://www.citizensforethics.org/reports-investigations/crew-reports/a-bitter-pill-how-big-pharma-lobbies-to-keep-prescription-drug-prices-high/>

Robin Feldman, 2018. “May your drugprice be evergreen”, Journal of Law and the Biosciences.

<https://academic.oup.com/jlb/article/5/3/590/5232981>

Katy Milani, Devin Duffy, 2019.” Profit over patients: how the rules of our economy encourage the pharmaceutical industry’s extractive behavior.” Rooseveltinstitute.org: <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Frooseveltinstitute.org%2Fwp-content%2Fuploads%2F2020%2F07%2FRI_Profit-Over-Patients_brief_201902.pdf&clen=169081&chunk=true>.

Kevin A. Schulman, MD, a and Matan Dabora, MD, MBA, 2018.” The relationship between pharmacy benefit managers (PBMs) and the cost of therapies in the US pharmaceutical market: A policy primer for clinicians”. <https://www.sciencedirect.com/science/article/pii/S0002870318302485>

## “Medicaid Outpatient Prescription Drug Trends During the COVID-19 Pandemic”

<https://www.kff.org/medicaid/issue-brief/medicaid-outpatient-prescription-drug-trends-during-the-covid-19-pandemic/>

Mazzucato, Mariana, Heidi Chow, Saoirse Fitzpatrick, Andrea Laplane, Tiziana Masini, Diarmaid McDonald, Victor Roy, and Ellen ‘t Hoen. 2018. “The People’s Prescription.” UCL Institute for Innovation and Public Purpose.[https://www.ucl.ac.uk/bartlett/public-purpose/sites/public-purpose/files/peoples\_prescription\_report\_final\_ online.pdf](https://www.ucl.ac.uk/bartlett/public-purpose/sites/public-purpose/files/peoples_prescription_report_final_%20online.pdf)

“Medical cost trend: behind the numbers 2022”, PwC

<https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html#:~:text=Where%20is%20the%20medical%20cost,was%20between%202016%20and%202020.>

NORC. 2016. “Trends in Hospital Inpatient Drug Costs: Issues and Challenges.” National Opinion Research Center at the University of Chicago. October 11, 2016,.

<https://www.aha.org/system/files/2018-01/aha-fah-rx-report.pdf>

Olivier J. Wouters, PhD, 2020. “Lobbying Expenditures and Campaign Contributions by the Pharmaceutical and Health Product Industry in the United States”. JAMA Internal Medicine

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2762509>

Olson, Peter, and Louise Sheiner. 2017. “The Hutchins Center Explains: Prescription drug spending.” Brookings Institution. April 26, 2017, <https://www.brookings.edu/blog/up-front/2017/04/26/the-hutchins-center-explainsprescription-drug-spending/> .

“The Truth About Pharmacy Benefit Managers: They Increase Costs and Restrict Patient Choice and Access” National community pharmacy association. 2019. <chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fncpa.org%2Fsites%2Fdefault%2Ffiles%2F2020-09%2Fncpa-response-to-pcma-ads.pdf&clen=817505&chunk=true>

“Prescription Drugs: Spending, Use, and Prices.” Congressional budget office.

<chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fwww.cbo.gov%2Fsystem%2Ffiles%2F2022-01%2F57050-Rx-Spending.pdf&clen=1107211&chunk=true>

Stiglitz, Joseph, and Arjun Jayadev. 2010. “Medicine for Tomorrow: Some Alternative Proposals to Promote Socially Beneficial Research and Development in Pharmaceuticals.” Columbia University Academic Commons. May 25, 2010. <https://academiccommons.columbia.edu/doi/10.7916/D87W6NXD>