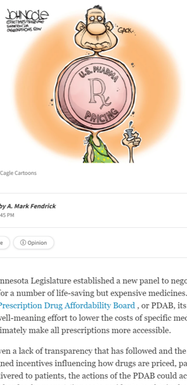
OPINION COLUMNS

Statewide View: New Minnesota board could make some medicines harder to get

From the column: "Focusing solely on drug prices obscures the reality that innovative new medicines, while sometimes expensive initially, offer tremendous clinical value."



John Cole/Cagle Cartoons

Opinion by A. Mark Fendrick
Today at 1:45 PM

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The Minnesota Legislature established a new panel to negotiate prices for a number of life-saving but expensive medicines. Known as the Prescription Drug Affordability Board , or PDAB, its creation was a well-meaning effort to lower the costs of specific medicines — and ultimately make all prescriptions more accessible.

But, given a lack of transparency that has followed and the misaligned incentives influencing how drugs are priced, paid for, and delivered to patients, the actions of the PDAB could actually make it harder for many Minnesota residents to obtain the prescription drugs their clinicians feel are best for them.

That's because the primary focus of the Prescription Drug Affordability Board seems to be the amount spent on medications rather than their clinical value.

By negotiating lower prices for certain selected drugs, the board assumes every patient with a given condition will benefit most from the same treatment. However, as every clinician can attest, that's seldom the case. This is why we are fortunate to have many medication options to treat high blood pressure, depression, diabetes, and more. Specific genetic, lifestyle, social, financial, and medical factors help determine the most appropriate course of action. Clinicians balance all these considerations when deciding which medicine to prescribe.

Despite this important nuance, the PDAB seems to operate on the premise that if the government sets a lower price for the drug on which the most money is spent in a diverse class of therapies, all patients will benefit.

Some patients, especially those for whom the negotiated drug is the best clinical choice, might benefit. But others, for whom an alternative medicine is preferred, may have a harder time accessing the treatment that works best for them.

For instance, if the PDAB assigns lower prices for one or two drugs used to treat a specific condition, health plans and pharmacy benefit managers may steer patients toward those medicines, even though clinicians may recommend different treatment options for certain patients.

Further, focusing solely on drug prices obscures the reality that innovative new medicines, while sometimes expensive initially, offer tremendous clinical value over a long period by preventing or reducing complications of the diseases they treat. The Prescription Drug Affordability Board's approach fails to consider this.

Consider breakthrough oral drugs for the treatment of hepatitis C virus. When they first came on the market in 2013, much more attention was paid to their launch price of $80,000 per course of treatment rather than to their remarkable clinical benefits. But untreated hepatitis C can require a liver transplant in some patients, which can cost nearly $1 million.

In fact, a 2024 Congressional Budget Office report estimates that "a 10 percent peak increase in the hepatitis C treatment rate among Medicaid enrollees during a five-year program would result in averted spending on (the) treatment of complications from hepatitis C of about ($700 million) over 10 years."

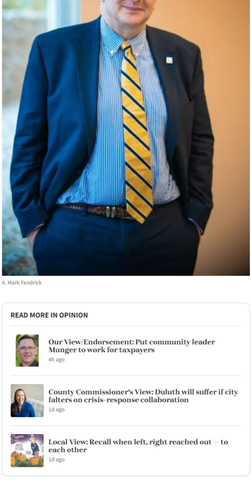
Moreover, prices tend to drop naturally in the years after a drug is introduced due to competition entering the market. Within just a few years after approval, the price of medications used to treat hepatitis C virus dropped by over 70%.

Meanwhile, while PDABs threaten to decrease access to essential medications by potentially limiting choice to available alternative treatments, they do little to address the widespread use of low-cost care, defined as services providing little or no clinical benefit to patients — and can even harm them. In one study of four states, low-value services ranging from screening for vitamin D deficiency to prescribing antibiotics for upper-respiratory and ear infections cost almost $900 million annually, and about 10% was paid directly by patients.

Luckily, the state of Minnesota has established itself as a national leader in the effort to reduce wasteful health care spending. One example is the 2023 State Employee Health Plan Request for Proposals included the reduction of low-value services (including vitamin D testing) as a plan-performance measure.

The Prescription Drug Affordability Board's exclusive focus on drug prices — and not similarly concentrating on enhancing the health of Minnesotans — is short-sighted. We need to shift our efforts from mere cost-cutting (how much we spend) to a clinically driven approach that encourages patients and clinicians to use more high-value services and fewer low-value ones (how well we spend).

Dr. A. Mark Fendrick is director of the Center for Value-Based Insurance Design (vbidcenter.org) at the University of Michigan in Ann Arbor. He is also a professor in the departments of internal medicine and health management and policy at the university. He wrote this exclusively for the News Tribune.



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