Driving Down Healthcare Costs

With moderator NEIL GREENBERG, Editor, Healthcare Sales & Marketing

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Few topics get discussed more often these days than the overall cost of healthcare in the U.S. We have the most expensive system in the world, spend more per patient than any other country, and don’t always have the outcomes you’d expect from that kind of investment. The Kaiser Family Foundation has some pretty staggering statistics about our system: people who have used up all of their savings paying for care, the cost of treating various diseases, the anticipated growth of coverage costs. With a total bill of over $3 trillion, and an increase of 11.7% last year in government spending on healthcare, what do we need to do to rein in this beast? The Commonwealth Fund has rated us dead last in overall healthcare compared to other industrialized countries (the UK, Switzerland, Sweden, Australia, Germany, The Netherlands, New Zealand, Norway, France and Canada) on measures of quality, access, efficiency, equity and healthy lives.

Something needs to be done. To shed a little light on some of the causes and possible cures, we enlisted a number of people who have seen this situation from different perspectives and have insights into what can be done. We can cover only a portion of this vast issue, but here’s what our panelists have to say.

**What are the primary drivers of healthcare costs in the U.S. today?**

**Bill Soucie:** The U.S. spends more on healthcare than any other industrialized nation. Unfortunately, the U.S. is ranked 50th in life expectancy, and last compared to the next 19 richest nations. A primary driver of cost is organic and that’s the aging of our nation’s greatest generation, the baby-boomers. Every day for the next 19 years, 10,000 people will become Medicare eligible and as a result will incur more healthcare costs. In 1941 there were 6.1 workers over the age of 20 for every retiree. Today, there are 2.7 workers for every retiree, creating a major funding issue. The over-use of expensive technologies and procedures is another contributor to rising healthcare costs, much of which occurs to protect physicians from malpractice lawsuits, underlining the need for tort reform. For example, MRIs in the United States occur twice as often compared to other developed nations. The growing burden of chronic diseases adds significantly to escalating healthcare costs. Researchers predict a 42% increase in chronic disease cases by 2023, adding $4.2 trillion in treatment costs and lost economic output. Much of this cost is preventable, since many chronic conditions are linked to unhealthy lifestyles. Wasteful spending accounts for about one-third of all U.S. healthcare spending. PriceWaterhouseCoopers (PWC) calculates that up to $1.2 trillion, or half of all healthcare spending, is the result of waste. One big area of excess is defensive medicine, including redundant, inappropriate or unnecessary tests and procedures. Another is administrative costs. Our healthcare system has considerable administrative overhead. Studies have determined that it’s significantly more than most other industrialized nations. Other key drivers are end-of-life care, provider consolidation, payer consolidation, Affordable Care Act, fragmented and uncoordinated care, and fee-for-service. The solutions to such root causes are complex, controversial, and difficult.

**Peter Pitts:** The primary driver of healthcare costs is patients. Disease, whether chronic or acute, pediatric, mid-life, end of life, or brought on by unhealthy lifestyles, is the only relevant driver. Everything else is commentary. And a key strategy to lower the cost of patient care is to expedite positive therapeutic outcomes on as personalized a basis as possible. Getting the right treatment to the right patient as early as possible saves money, saves lives, and will be the foundational strategy is reinventing the American healthcare system in the 21st century. It’s not just about short term “cost.” It’s about long term “value.”

**Ben Locwin:** Pragmatically speaking, the main drivers are the unit cost of physicians, facilities, and new equipment. In the populace, the main driver is unhealthy behaviors - as well as non-adoption of healthful behaviors. It’s both people choosing to pursue behaviors that are actively unhealthy, as well as NOT pursuing behavioral choices that are healthy. For medical technologies and drug therapies, the main drivers are trying to balance what a treatment
can generate financially, which is sensitive to the physician/patient adoption rate. When companies try to maximize shareholder value, they set pricing to return margins that allow continued research and development. If these margins seem too high in the market, the market will react negatively in the press and in sales; though there isn’t always a correlation between negative pricing perception and reduction in prescriptions sold.

**Matt Wallach:** Of all the articles I read about the cost of healthcare in the US, I still haven’t seen one that focuses on the fact that Americans live unhealthy lifestyles as a key driver. Yes, our indirect payer system creates strange incentives that don’t help the situation. But if you just look around, we are eating at McDonald’s, drinking Frappuccinos, driving and texting, and generally treating our bodies poorly. So I believe the main driver of healthcare costs in the US is the poor health of our citizens. To that end, I applauded Mayer Bloomberg’s controversial policies during his time in New York City, and other similar measures. If we were healthier, our healthcare costs would surely be lower.

**What are the main efforts of government to control these? How has the ACA been effective or ineffective?**

**Peter Pitts:** The ACA is not legislation designed to lower costs. It is insurance reform designed (in theory) to expand coverage. Expanded coverage has resulted in increased consumption of healthcare services while not impacting the cost of those services.

**Ben Locwin:** The government has been effortful in insuring more people, the theory then being that there are fewer people who would face unsubsidized prices (and therefore not receive medical treatment). Higher percentages of uninsured people leads to a higher healthcare burden for more expensive interventions.

**Matt Wallach:** The growth rate of healthcare expenditures has slowed significantly since the ACA went into effect. It is hard to argue that it has been anything but effective.

**Bill Soucie:** Although controversial, the Affordable Care Act is designed to underwrite those who cannot afford health insurance. It has been a double-edged sword. Eliminating pre-existing condition exclusions was a very important and much needed reform. Allowing children to remain on their parent’s health insurance until the age of 26 was another. The economy has been challenging for those in that age group. The labor participation rate for people ages 16-24 has declined 17.4% since 2000, greater than any other age group. Student loan balances have increased 665% since 2007. Without that reform many young people would not be able to afford health insurance, even in the exchanges. On the flip side, the ACA works only if an army of healthy people participate to offset the least healthy 20% whose average healthcare expenditure is $35,000 per year. Not to mention an increase in payroll tax, penalties on the uninsured and businesses, and a host of other taxes.

**Ben Locwin:** The pursuit of a state where more people are insured...
mandatorily seems to level the healthcare playing field a bit, but the overall impact has been lacking. Last year, the number of uninsured people had been reduced by about a quarter (−25%). This is significant, but maintaining the gains is a critical, but separate, issue. More patients in the system paying (in an economics sense) beats not having people in the system - because you have the win-win of more people paying for treatment, and therefore also fewer uninsured potentially burdening the system later with a condition which is more significant. There are also more insurance payers in the system covering more people.

**Peter Pitts:** The ACA is a very complicated piece of legislation, with long-term goals, and defining success or failure at this juncture is necessarily going to be inaccurate and mere guesswork. We can only assess what impact certain elements have had to date, and wait for its other provisions to be instituted in order to have a reasonable understanding of its long-term usefulness. As always with an effort this size, adjustments will be made as we measure progress or lack of it.

**What initiatives do you know of that you think are working at other companies or organizations?**

**Bill Soucie:** Innovation in drug development is going on behind the scenes that will have a positive impact on reducing healthcare expenditures in the future, most of which are focusing on cures moving beyond symptomatic treatments. The advances that have been made in Hepatitis C are a good example. Other areas gaining researchers’ attention are the long-term remission or cure for Hepatitis C and HIV/AIDS, and modulation of the immune system. One of the new industry catch phrases is “beyond-the-pill.” This evolving strategic approach involves offering services that address stakeholder needs along the patient pathway, leading to better health outcomes, while at the same time, providing a source of competitive advantage and higher value to patients, physicians and payers. Some examples are patient support programs, the partnership between Novartis and Proteus involving an ingestible sensor for tracking medication intake, and collaborations between pharma and payers through integrated care models and solutions that facilitate shared decision making between patients and physicians.

**Ben Locwin:** Anything that gets more people to act has a probability of improving the current state of affairs, both in terms of pre-existing conditions, or preventing future health issues. What we'll see is short-term trends that appear to show dramatic improvements in certain areas—but these are mostly “noise” and not “signal” in the system. If you look at any very complex system in nature, there are always pieces you can zoom in on and see particular trends—but only in its entirety is the whole system described. Only when we have a substantial proportion of the population in the system, will our system then be able to gauge overall health status of the nation and apply treatments. This means we’ll see particular surges in conditions and costs, and over time the system will exhibit hysteresis and settle to a more predictable state.

That time is quite evidently not now—and anyone who claims that the current state of enrollments, treatments, and costs is predictable is patently misguided.

**What has your company or organization done to keep healthcare costs down?**

**Ben Locwin:** Generally, offering a balance of subsidized coverage on plans that tend to suit most people's needs has a positive effect. Beyond this, however, having wellness programs brought in to offer education on better nutrition, fitness, sleep hygiene, and so forth are what really impacts preventive care. Additionally, offering vaccination clinics where employees can be immunized either for free or very inexpensively pushes people over the inertia of avoiding them, thinking that they don’t have time or interest to pursue them on their own.

**Matt Wallach:** At Veeva, the best way we deal with healthcare costs is to put things in place that help to keep our employees healthy. Good health translates into lower health care costs for both Veeva and the employee—and everyone. Health and wellness is a key focus area for us and we are committed to contributing to the overall physical, mental, and financial wellness of our employees through benefits like fitness membership subsidies, yoga and meditation classes on site, and an employee-run healthy kitchen with daily free lunch. We want to empower employees to focus on their well-being so that they can perform at their best, both personally and professionally.
**How are the values of healthcare technologies being measured against the initial costs?**

**Peter Pitts:** In 1950, Americans spent about 5 percent of their income on health care. Today the share is about 16 percent. According to Harvard University economist N. Gregory Mankiw, “many pundits take the increasing cost as evidence that the system is too expensive. But increasing expenditures could just as well be a symptom of success.” And he hits a home run with a clear, concise, and common sense explanation. “The reason Americans spend more than their grandparents did is not waste, fraud and abuse, but advances in medical technology and growth in incomes. Medical science has consistently found new ways to extend and improve lives. Wonderful as they are, they do not come cheap.” When it comes to health care reform, this is not even the end of the beginning. We need to keep our eye on the prize, innovation that focuses on creating a chronic health care culture that embraces prevention and prophylactic care. We will not survive as a nation of obese, hypertensive diabetics. Rather than wasting time on beltway spin, redoubling our efforts on innovation is far preferable. New treatments are a bargain. Disease is always much more costly.

**Matt Wallach:** True. Innovation drives cost down. In healthcare, sometimes innovation tends to push direct costs higher in the short term, but with longer term savings measured over years. For example, the approval of Sovaldi, the breakthrough cure for Hepatitis C, caused healthcare costs to soar for payers everywhere, causing budget shortfalls and harsh headlines about drug pricing. However, billions of dollars will be saved for decades due to the fact that millions of people will be able to avoid liver failure and other serious complications from the disease, not to mention the improved quality of life that comes with the irradiation of this terrible condition. In today’s political climate, there will continue to be pressure on anything that drives up near term costs, but we must not lose the innovation that strives to improve health for all of us.

**Ben Locwin:** Not very well, on average. I recently was co-author of a textbook about developability of biotherapeutics, and in it there is a substantial body of very advanced thinking about in silico models for appraising risk and likely effectiveness of new candidate therapies. Almost none of this type of next-generational thinking is robustly applied to the question of the value derived from new healthcare technologies, especially in the context of their initial (launch and adoption) costs. Economies of scale only start working when technologies actually pass a certain threshold of market penetration.

**Are most of the initiatives about keeping down costs for companies, or are savings truly being passed on to patients?**

**Ben Locwin:** The companies are generally taking a majority of the health cost burden, and so proportionally more of the initiatives are directed at helping companies absorb this burden—but for sure there are savings which the patient sees. Unfortunately, it’s also very dependent upon the conditions faced by the patients—not every disorder or disease state has normalized, uniform cost models.

**Peter Pitts:** Let’s take Pharmacy Benefit Managers (PBMs) as an example. Donald Trump, Hillary Clinton and Bernie Sanders all think that health care is too expensive. But they’re looking in the wrong places for savings. In 2012, the CEO of the nation’s largest pharmacy benefit manager, Express Scripts, earned about $1 million every week.

PBMs can afford such rich compensation because they increasingly refuse to pay for patients’ medicines. This year, Express Scripts will deny coverage to 124 medicines—up from 95 drugs in 2015. America’s second largest PBM, CVS Caremark, announced that it will banish an additional 14 drugs from its 2016 list of covered medications, in addition to the 66 forbidden medicines in 2015. By refusing to cover specialized drugs, Express Scripts and CVS Caremark aren’t just denying patients access to lifesaving medication. They’re also driving up health care costs for patients. PBMs negotiate large discounts from pharmaceutical manufacturers. Their profit comes from pocketing double digit rebates they extract from drug makers that they don’t pass on to patients.
What should be done that isn’t being done?

Bill Soucie: Everything being done to today to improve healthcare and reduce costs is well intentioned. However, some important opportunities are not part of the current narrative. For example, researchers estimate that waste and the total healthcare spend. Reducing the practice of defensive medicine through tort reform will save billions by eliminating unnecessary tests and procedures. Another way to reduce unnecessary tests and procedures is to move away from the fee-for-service reimbursement model. Hospitals and physicians are reimbursed for every service they provide, which often leads to a focus on volume instead of a focus on care. A reimbursement model based on patient outcomes, combined with coordinated care, would make a significant impact on healthcare costs.

Today the pharmaceutical industry is focused on the patient. Unfortunately, there have been a couple of instances this year that may cause some to question that, but they are outliers. All of the innovation in drug development and thinking “beyond-the-pill” is leading to better outcomes, and better outcomes reduce costs to the system and the patient. I have always believed that if you take care of the patient, the business will take care of itself.

Ben Locwin: A lot of the neuroscience work I’ve been doing to help organizations lately has been teaching them ‘behavioral nudges’ to encourage employees to comply with best healthcare practices. Whether that’s preventive work as I’ve mentioned earlier, or better health screening adherence, or even if they get to a point of needing some treatment—compliance with treatment regimens is astonishingly low (under 50% for some conditions); As former Surgeon General C. Everett Koop opined in the 1980s, “drugs only work in people that take them,” (though I’m phrasing it in the positive, instead of the negative of his original quote). This is as true today as it was then; but we know more now about how to target non-compliant individuals and devise plans which absolutely increase their adherence status. Some of this same work is being done by DJ Patil in the White House to nudge consumers to be more active in pursuing their healthcare coverage. It needs to happen at the policy level and at the practice level to actually move the needle in a sustainable way.

Peter Pitts: Here’s my short list:

• The importance of understanding and rewarding incremental
innovation.

- The price/value debate. Rather than focusing on the short-term costs of healthcare, what are the long-term benefits to both patients and society?
- Value-based insurance design. How a more personalized approach to reimbursement matches up well with advances in personalized medicine.
- The dynamic and distressing link between co-pays and outcomes and how this relationship must be understood and recalibrated.
- The urgent need for transparency in insurance choices within the Affordable Care Act in order to provide the right medicine to the right patient at the right time in a transparent and affordable manner.
- How to reach best clinical practice more swiftly through electronic pre-authorization and the increasing empowerment of physicians.
- Addressing the problem of medication compliance through innovative approaches such as apps and more user-friendly patient education.
- How “the story of innovation” can be more clearly and powerfully communicated to various constituencies so that we can narrow the “misperception gap.”

We cannot afford, in terms of dollars or lives, to continue the blame game. In order to deliver on the promise of affordable and quality healthcare for all citizens, all the players in the healthcare debate must work together. At the end of the day, we should unite against our common enemy—disease.

Shortly before his death, I had the privilege of a private meeting with Nobel laureate Joshua Lederberg. We talked about the state of applied science, the prioritization of development science, biomarkers, and a host of other future-oriented issues. At the end of the meeting he put everything into perspective in a single sentence. He leaned over the table and said, “The real question should be, is innovation feasible?” Let’s hope so. Innovation equals hope.

**Moderator:** Thank you, Peter, for helping us go out on that positive note. And thanks to all of our panelists for tackling a broad, complex and controversial topic. We hope it inspires discussion among our readers, and further insights into how we can tame this problem.

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**MEET OUR LEAD PANELIST**

**PETER PITTS**
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He is a Visiting Lecturer at the École Supérieure des Sciences Économiques et Commerciales, and has served as an adjunct professor at Indiana University’s School of Public and Environmental Affairs and Butler University.

**The Center for Medicine in the Public Interest** is a nonprofit, nonpartisan research and educational organization that seeks to advance the discussion and development of patient-centered health care.
MEET OUR OTHER EXPERTS

**BEN LOCWIN, PHD, MBA, MS, President, Healthcare Science Advisors**

Ben is a highly sought-after speaker for healthcare topics, and an author of a wide variety of scientific articles for books and magazines. He is an expert contact for the American Association of Pharmaceutical Scientists (AAPS), a committee member in the American Statistical Association (ASA), and a consultant in many industries including biological sciences, aerospace, psychological, and academic. [ben.locwin@healthcarescienceadvisors.com](mailto:ben.locwin@healthcarescienceadvisors.com). Connect on Twitter at [@BenLocwin](https://twitter.com/BenLocwin)

Healthcare Science Advisors offers advisory to hospitals, clinical healthcare settings, and the pharmaceutical industry on risk management practices, data analysis, performance measurement practices, and operational improvement.

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**BILL SOUCIE, Vice President of Market Access, XenoPort**

Bill began his career as a peptide chemist providing him with a strong clinical base when he transitioned into the pharmaceutical industry more than 20 years ago. Since then, he has held various positions in the market access arena and has specialized in working with start-up and rebuilding organizations. He has been responsible for developing the pricing and payer strategy for the successful launch of 14 unique products across multiple therapeutic classes and has become an expert in the area of effectively communicating HEOR evidence. Utilizing insights from patients, payers, providers, and other stakeholders, Bill continues to develop creative value propositions and successful payer strategies for Vice President of Market Access. [bill.soucie@xenopord.com](mailto:bill.soucie@xenopord.com)

**XenoPort, Inc.** is a biopharmaceutical company focused on commercializing Horizant in the United States. XenoPort has entered into a clinical trial agreement with the NIAAA under which the NIAAA has initiated a clinical trial evaluating gabapentin enacarbil as a potential treatment for AUD. Regnite™ (gabapentin enacarbil) Extended-Release Tablets are being marketed in Japan by Astellas Pharma Inc. XenoPort has granted exclusive world-wide rights for the development and commercialization of its clinical-stage oral product candidate, arbaclofen placarbil, to Indivior PLC for all indications. XenoPort’s other product candidates include XP23829, a novel fumaric acid ester prodrug that is a potential treatment for patients with moderate-to-severe chronic plaque-type psoriasis and potentially for patients with relapsing forms of multiple sclerosis, and XP21279, a prodrug of levodopa that is a potential treatment for patients with idiopathic Parkinson’s disease.

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**MATT WALLACH, Co-Founder and President, Veeva Systems**

Matt Wallach has over a decade of product management, marketing, and general management experience in both traditional enterprise software and Software as a Service (SaaS). In 2007, Matt was named to the PharmaVOICE 100, which recognizes the 100 most influential people in the life sciences industry and has been published numerous times over the years in various industry trade magazines including *CRM Magazine*, *Pharmaceutical Executive*, *Pharmaceutical Commerce*, *Pharmaceutical Representative*, *PharmaVOICE*, and *Med Ad News*. Since Veeva’s inception, he has helped it grow into the leading SaaS CRM provider in the market, with six of the top 10 pharmaceutical companies as clients. Previously, he was Chief Marketing Officer at Health Market Science, a leading healthcare data services company. Matt also spent six years at Siebel Systems, where he was the General Manager of the Pharmaceuticals & Biotechnology division. Almost half of the pharmaceutical sales reps in the world use the products created during his tenure at Siebel. [matt.wallach@veeva.com](mailto:matt.wallach@veeva.com).

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