THE WALL STREET JOURNAL.
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U.S.

Why the U.S. Pays More Than Other Countries for Drugs

Norway and other state-run health systems drive hard bargains, and are willing to say no to costly therapy

Kristin Svanqvist, left, heads reimbursement at Norway’s state health system, which pays for most prescription drugs in the country, controlling prices in part by weighing cost-effectiveness. Helga Festoy, an economist at the state health system, says it is ‘working quite well.’ PHOTO: SVEINUNG BRATHEN FOR THE WALL STREET JOURNAL

By JEANNE WHALEN
Updated Nov. 30, 2015 10:14 p.m. ET

Norway, an oil producer with one of the world’s richest economies, is an expensive place
The government systems also are the only large drug buyers in most of these countries, giving them substantial negotiating power. The U.S. market, by contrast, is highly fragmented, with bill payers ranging from employers to insurance companies to federal and state governments.

Medicare, the largest single U.S. payer for prescription drugs, is by law unable to negotiate pricing. For Medicare Part B, companies report the average price at which they sell medicines to doctors' offices or to distributors that sell to doctors. By law, Medicare adds 6% to these prices before reimbursing the doctors. Beneficiaries are responsible for 20% of the cost.

The arrangement means Medicare is essentially forfeiting its buying power, leaving bargaining to doctors' offices that have little negotiating heft, said Sean Sullivan, dean of the School of Pharmacy at the University of Washington.

Asked to comment on the higher prices Medicare pays compared with foreign countries, the Centers for Medicare & Medicaid Services said: “The payment rate for Medicare Part B drugs is specified in statute.”

In the U.S., few payers, public or private, cite cost as a reason to deny drug coverage, partly owing to a traditional emphasis in the U.S. on doctor and patient autonomy. “They don’t want to impinge on individual choices,” said Neeraj Sood, a health policy and economics expert at the University of Southern California.

Medicare Part B, for example, typically covers drugs and services deemed “reasonable and necessary.”

“If it’s a [Food and Drug Administration]-approved drug and prescribed by a duly licensed physician, Medicare will cover it,” said Gail Wilensky, who ran Medicare and Medicaid in the 1990s.

U.S. drug prices—showing regular increases, sometimes steep—are increasingly a focus of congressional probes and vocal criticism by insurers, doctors, politicians and consumers, who bear part of the cost.

Renee Andrews, an Oxford, Mich., resident whose son has juvenile arthritis and other conditions, said she can’t believe how low medication costs are for families overseas who post messages in her online support group. “Their out-of-pocket costs are considerably less than what we’re paying,” she said.
How Prescription Drug Prices Compare Internationally
Most branded prescription drugs cost more in the U.S. than abroad. Here are prices paid by Medicare Part B for some of its top brand-name drugs by expenditure, compared with prices paid by government health systems in England, Norway and Ontario, Canada. Prices are from the third quarter of 2015. Related Article » (http://www.wsj.com/articles/why-the-u-s-pays-more-than-other-countries-for-drugs-1448939481)

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<thead>
<tr>
<th>Drug</th>
<th>Package size</th>
<th>Medi</th>
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<tbody>
<tr>
<td>1 Lucentis</td>
<td>0.5 mg syringe</td>
<td>$1</td>
</tr>
<tr>
<td>2 Eylea</td>
<td>2 mg/0.05 ml vial</td>
<td>$1</td>
</tr>
<tr>
<td>3 Rituxan/MabThera</td>
<td>500 mg vial</td>
<td>$3</td>
</tr>
<tr>
<td>4 Neulasta</td>
<td>6 mg/0.6 ml syringe</td>
<td>$3</td>
</tr>
<tr>
<td>5 Avastin</td>
<td>100 mg vial</td>
<td>$1</td>
</tr>
<tr>
<td>6 Prolia</td>
<td>60 mg syringe</td>
<td>$1</td>
</tr>
<tr>
<td>7 Alimta</td>
<td>100 mg vial</td>
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medical practices in 2013, the latest such data available. These are mostly drugs administered in a doctor’s office. Costs of drugs sold by U.S. pharmacies are harder to compare because of discounts and rebates.

After excluding drugs that faced generic competition in 2015 and those for which prices elsewhere weren’t available, the Journal compared 2015 third-quarter prices paid in the various jurisdictions. The analysis didn’t examine Medicare’s coverage of pharmacy-dispensed drugs, known as Part D, which is run by insurance companies that don’t reveal their pricing.

Some drugs, such as for HIV and hepatitis, cost less in certain overseas markets because companies cut prices for poor countries.

Norway is a wealthy nation, with gross domestic product per capita of $97,000 last year, versus $55,000 in the U.S., according to the World Bank.

In Norway the state pays for most prescription drugs, though patients pay for some used for short periods. The government controls costs in part by setting maximum prices. To do that, it reviews prices in nine neighboring countries and takes the average of the three lowest.

Cost-effectiveness
This system automatically holds prices low because the countries consulted also have government-controlled prices.

The Norwegian Medicines Agency, or NMA,
older, for whom it appeared to work somewhat better, she said.

A syringe of Prolia cost Norway $260 in the third quarter. By the Journal analysis, that was 71% less than the $893 paid by Medicare, which doesn’t set an age test.

Amgen said, “We partner with local payers in Europe to help ensure that all appropriate patients who could benefit will have access to an important new therapy.” Glaxo referred questions to Amgen, to whom it sold Prolia’s Norwegian marketing rights in 2014.

If a manufacturer won’t budge on price, Norway might refuse to cover a drug altogether. It did that with a brand of insulin called Tresiba.

Producer Novo Nordisk A/S said Tresiba reduced nighttime dips in blood sugar better than other insulins and therefore was a good value. Ms. Svanqvist of the NMA called the documentation of this “quite lousy.”

“We think the reduction is actually quite low,” she said, and not “worth paying 70% more for.”

A spokesman for Novo Nordisk said it believes the drug provides better outcomes and is therefore cost-effective. He also said Norway didn’t ask the company to cut the price.

The way things often work, said Ms. Svanqvist, is that when drug companies are told a product isn’t cost-effective, they can provide more proof, and “if they don’t have better documentation they can only do something about the price. Very often they do something about the price.”

Denying patients access to drugs can be contentious. When Norway last year declined to cover Roche’s injected breast-cancer drug Perjeta because of its cost, “patients and physicians were on television and demonstrating a lot,” Ms. Svanqvist said. Roche agreed to a discount provided the NMA kept the terms confidential, which it grudgingly agreed to do, according to Ms. Svanqvist.

The agreement means Perjeta costs Norway less than the drug’s maximum allowed price in the country, which was $3,579 for a vial in the third quarter. Medicare paid $4,222.

Roche said Perjeta has shown strong efficacy, and the firm and Norway reached an agreement to make it available.

While U.S. payers sound dire warnings of unsustainable drug pricing, the tone in Oslo is
expensive in the U.S., according to the Journal’s analysis.

Countries with national health systems tend to feel “we are all in this together” and “we can’t afford everything for everybody at any price,” said Steven Pearson, a physician who founded the Institute for Clinical and Economic Review, a Boston nonprofit that evaluates the cost-effectiveness of health care. “In America it’s more, ‘Well, I’ve paid my insurance premium and I don’t want anyone to tell me no. I don’t want anyone to get in the way of me and my doctor.’”

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