THE WALL STREET JOURNAL.

http://www.wsj.com/articles/why-the-u-s-pays-more-than-other-countries-for-drugs-1448939481

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

By **JEANNE WHALEN**

Updated Dec. 1, 2015 9:27 p.m. ET

Norway, an oil producer with one of the world's richest economies, is an expensive place to live. A Big Mac costs $5.65. A gallon of gasoline costs $6.

But one thing is far cheaper than in the U.S.: prescription drugs.

A vial of the cancer drug Rituxan cost Norway's taxpayer-funded health system $1,527 in the third quarter of 2015, while the U.S. Medicare program paid

$3,678. An injection of the asthma drug Xolair cost Norway $463, which was 46% less than Medicare paid for it.

Drug prices in the U.S. are shrouded in mystery, obscured by confidential rebates, multiple middlemen and the strict guarding of trade secrets. But for certain drugs—those paid for by Medicare Part B—prices are public. By stacking these against pricing in three foreign health systems, as discovered in nonpublic and public data, The Wall Street Journal was able to pinpoint international drug-cost differences and what lies behind them.

What it found, in the case of Norway, was that U.S. prices were higher for 93% of 40 top branded drugs available in both countries in the third quarter. Similar patterns appeared when U.S. prices were compared with those in England and Canada's Ontario province. Throughout the developed world, branded prescription drugs are generally cheaper than in the U.S.

The upshot is Americans fund much of the global drug industry's earnings, and its efforts to find new medicines. "The U.S. is responsible for the majority of profits for most large pharmaceutical companies," said Richard Evans, a health-care analyst at SSR LLC and a former pricing official at drug maker Roche Holding AG .

The reasons the U.S. pays more are rooted in philosophical and practical differences in the way its health system provides benefits, in the drug industry's

MORE

- Live Facebook chat: WSJ's Jeanne Whalen answers questions about global drug prices. (https://www.facebook.com/wsj/posts/10153860751483128)
- What Is a QALY? (http://www.wsj.com/articles/what-is-a-qaly-1449007700)
- Express Scripts Finds Workaround to Avoid Using Costly Turing Drug (http://www.wsj.com/articles/express-scripts-seeks-lower-price-alternative-to-daraprim-1448946061) (12/01/2015)
- (http://www.wsj.com/articles/express-scripts-seeks-lower-price-alternative-to-daraprim-1448946061) For Prescription Drug Makers, Price Increases Drive Revenue (http://www.wsj.com/articles/for-prescription-drug-makers-price-increases-drive-revenue-1444096750) (10/5/15)
- (http://www.wsj.com/articles/express-scripts-seeks-lower-price-alternative-to-daraprim-1448946061) New Push Ties Cost of Drugs to How Well They Work (http://www.wsj.com/articles/new-push-ties-cost-of-drugs-to-how-well-they-work-1432684755) (5/26/2015)
- (http://www.wsj.com/articles/express-scripts-seeks-lower-price-alternative-to-daraprim-1448946061) Pharmaceutical Companies Buy Rivals' Drugs, Then Jack Up the Prices (http://www.wsj.com/articles/pharmaceutical-companies-buy-rivals-drugs-then-jack-up-the-prices-1430096431) (4/26/15)

political clout and in many Americans' deep aversion to the notion of rationing.

The state-run health systems in Norway and many other developed countries drive hard bargains with drug companies: setting price caps, demanding proof of new drugs' value in comparison to existing ones and sometimes refusing to cover medicines they doubt are worth the cost.

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

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 STEET JOURNAL*

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.

Research spending

The pharmaceutical industry says controls such as those seen in Europe discourage investment in research and deny patients access to some drugs. “The U.S. has a competitive biopharmaceutical marketplace that works to control costs while encouraging the development of new treatments and cures,” said Lori Reilly, an executive at the Pharmaceutical Research and Manufacturers of America, a trade association.

If U.S. pricing fell to European levels, the industry would almost certainly cut its

R&D spending, said Mr. Evans, the health-care analyst. “Does the U.S. subsidize global research? Absolutely, yes,” he said.

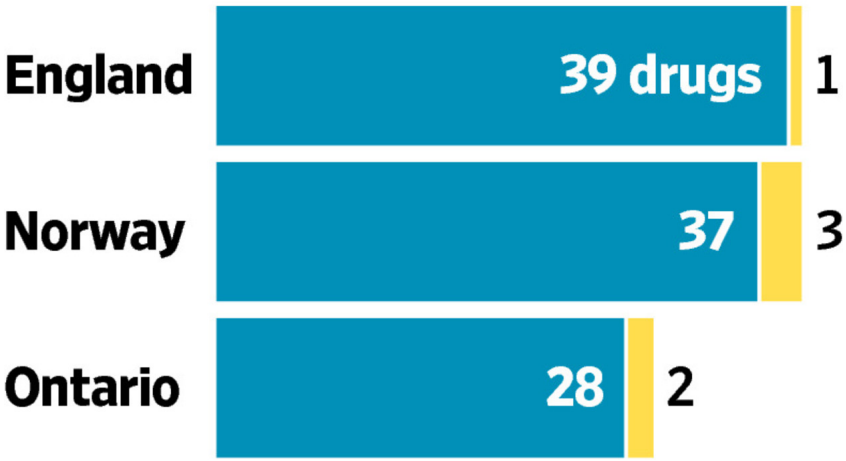
The higher U.S. prices also help drug makers afford hefty marketing budgets that in the U.S. include consumer advertising—something Europe doesn’t allow. Pharmaceutical and biotechnology companies in the S&P 1500 earn an average net profit margin of 16%, compared with an average of about 7% for all companies in the index, according to S&P Capital IQ.

For its analysis, the Journal started with Medicare Part B’s top

Premium Pricing

The U.S. nearly always pays more for branded drugs than England, Norway and Ontario, Canada, according to a WSJ analysis of top drugs by Medicare Part B expenditure.

Compared with these markets, Medicare prices are Higher Lower



Note: Includes brand-name drugs for which pricing is available for both Medicare and the comparison country

drugs by payments to 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

the comparison country.

Source: WSJ analysis of data from government agencies in each country

THE WALL STREET JOURNAL.

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, then reviews patient data to decide whether a new drug is cost-effective. Its maker must request a reimbursement price at or under the maximum Norway has set and submit a detailed comparison of the drug's cost and benefits versus existing treatments. Companies have teams of number crunchers to produce these comparisons, which can also prove useful in pitching products in the U.S.

Norway recommends that companies describe a drug's cost per quality-adjusted life year, or QALY, a gauge used by many government health systems. Medicare is barred from using this gauge as a threshold to determining coverage.

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)

Search:

Show 10 entries

	Drug	Package size	Medi
1	Lucentis	0.5 mg syringe or vial	**$1**
2	Eylea	2 mg/0.05 ml vial.	**$1**
3	Rituxan/MabThera	500 mg vial	**$3**
4	Neulasta	6	**$3**

Companies know Norway will sometimes deny coverage, and this threat is often "enough to get them to offer a discount," said Kristin Svanqvist, head of reimbursement at the NMA. If rejected, they can offer a lower price.

When Amgen Inc. and GlaxoSmithKline PLC sought coverage of the osteoporosis injection Prolia for certain women, the NMA concluded it wasn't cost-effective compared with an existing infusion called Aclasta.

Aclasta is a different type of drug, a bisphosphonate. These have an advantage in binding to the bone, the NMA said in a 2011 report on Prolia, and protect against fractures for a longer time after treatment stops.

After Norway's rejection, Amgen and Glaxo lowered Prolia's price, according to Ms. Svanqvist. The NMA then ruled the health system would provide it for women 75 or older, for whom it appeared to work somewhat

		mg/0.6 ml syringe	
5	Avastin	100 mg vial	$
6	Prolia	60 mg syringe	$
7	Alimta	100 mg vial	$
8	Velcade	3.5 mg vial	$1
9	Herceptin	Per 100 mg	$
10	Eligard	7.5 mg	

Showing 1 to 10 of 54 entries

Previous 1 2 3 4 5 6 Next

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.

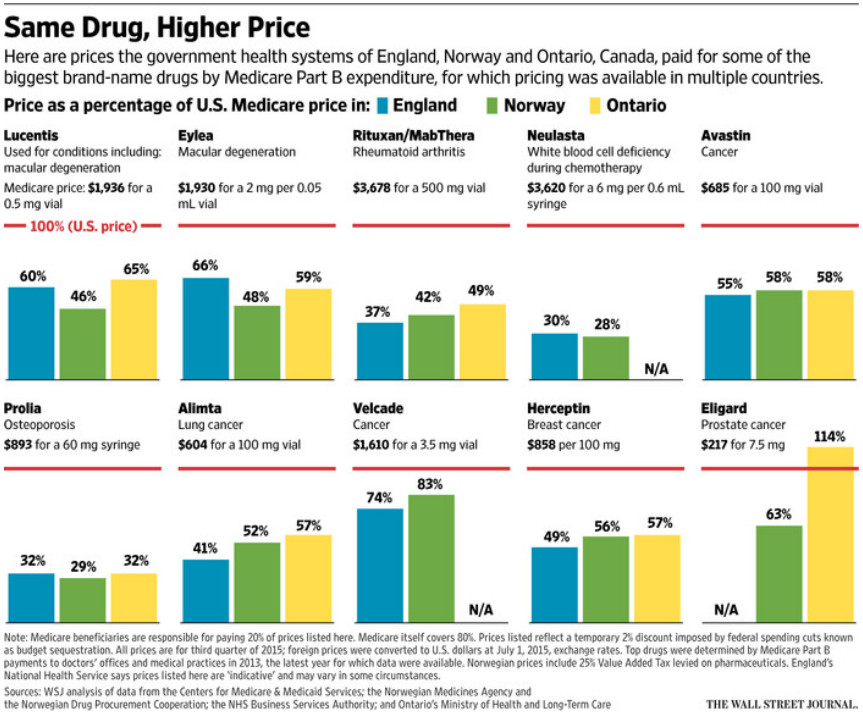
Amgen said, "We partner with local payers in Europe to help ensure that all appropriate patients who could benefit will have access to an important new therapy." Glaxo referred questions to Amgen, to whom it sold Prolia's Norwegian marketing rights in 2014.

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 much calmer. “We have a system that has been working quite well,” said Helga Festoy, an economist at the NMA.

Norway’s cost-effectiveness reviews sometimes cite the work of England’s health-care cost watchdog, known as one of Europe’s toughest. England’s National Institute for Health and Care Excellence, or NICE, conducts extensive analyses and recommends that the taxpayer-funded health system not cover drugs providing low value. Sometimes after one is rejected, its maker offers a discount.

England also controls prices by capping the level of National Health Service spending on drugs each year and requiring the pharmaceutical industry to reimburse the NHS for any spending over those limits.

Of 40 branded drugs covered by Medicare Part B and also available in England in the third quarter, 98% were more expensive in the U.S., according to the Journal’s analysis of data from Medicare and the NHS’s Business Services Authority.

For instance, two syringes of Cimzia, an anti-inflammatory for rheumatoid arthritis and other diseases, cost England’s health-care system $1,117—less than half the $2,357 Medicare paid, the Journal found. An NHS spokeswoman said prices it publishes are “indicative,” and vary in some situations.

Cimzia is sold by Belgian company UCB SA. It didn’t respond to requests for comment.

Canada doesn't have a single large pharmaceutical payer, but drug prices are substantially lower nonetheless, held in check by regulation.

A federal agency called the Patented Medicine Prices Review Board sets a maximum price for new drugs, based on factors including their therapeutic benefits and the prices in seven other countries—the U.S. and six European ones. Once a drug's maximum price is set, the maker can't raise it faster than the national inflation rate or above the highest price in the seven other countries.

A separate body, the Canadian Agency for Drugs and Technologies in Health, recommends whether provincial and other government health programs should cover new drugs for the elderly or for low-income residents. Government agencies in Canada don't cover most drug costs for most other people.

One such program is run by Ontario's Ministry of Health and Long-Term Care. Of 30 drugs that both it and Medicare Part B covered in the third quarter, 93% were more 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.' "

Write to Jeanne Whalen at jeanne.whalen@wsj.com