2015 Year in Review: High drug prices emerge as top issue

By Harris Meyer  | December 19, 2015

High prescription drug prices pushed aside the never-ending wrangling over the Affordable Care Act as healthcare's No. 1 political and policy issue in 2015.

A bipartisan scrum of providers, insurers, patient advocates and politicians called for strong measures to curb drug costs, which rose more than twice as fast as the rest of healthcare spending over the past two years. Turing Pharmaceuticals' 5,000% price increase for a decades-old anti-infection drug merely put an exclamation point on the debate.

“That has to be noted as the lowlight of the year,” said Dr. Daniel Goldstein, an assistant professor at Emory University.

It was only one of many examples where drug companies slapped sky-high prices on new drugs, especially new specialty and oncology drugs, and levied astronomical price hikes on old ones.

To cap off the year, two mass shooting attacks against healthcare and social service workers led to renewed calls to address gun violence through a public health prevention approach. Higher spending on mental health services also garnered new support.

The partisan political war over the Affordable Care Act dragged on despite the U.S. Supreme Court's June decision in King v. Burwell, which upheld the legality of the law's premium subsidies and averted a health insurance market meltdown. By year-end, Senate Republicans had passed a bill repealing most of the ACA, which the president promised to veto.

But nibbling at the ACA's fringes became a bipartisan affair. In a year-end budget package, Congress froze three ACA taxes that helped fund the law's coverage expansions.

The ACA remained squarely in the crosshairs in the early maneuverings for the 2016 presidential nominations. Republican candidates continued to promise to repeal and replace the law if their party wins the White House and holds onto both houses of Congress next fall. Democratic presidential candidate Hillary Clinton proposed significant ACA changes to improve affordability.

Obamacare continued to receive tepid public support even though the nation's uninsured rate
hit a record low, largely due to the law’s coverage expansions. A Centers for Disease Control and Prevention survey found that only 9% of Americans, or 28.5 million people, lacked coverage as of June, down from 16% in 2010 when the law was enacted.

“This has been tremendous progress,” said Larry Levitt, a senior vice president at the Kaiser Family Foundation. “The question now is will it go lower?”

Expanded coverage came at a price. Total healthcare spending during 2015 grew faster than it had since the start of the Great Recession. The faster growth rate prompted fears of a return to high medical inflation. “It’s absolutely no surprise” that spending went up because more people were insured, said Paul Ginsburg, a University of Southern California health economist. “The purpose of covering them was allowing them to use more services.”

However, the rate of increase began to moderate over the course of the year. Some experts noted the proliferation of high-deductible health plans was forcing some consumers to limit their medical utilization.

Healthcare providers enjoyed considerable balance sheet relief in 2015 as they saw fewer uninsured patients. For most, revenue growth outpaced expenses. The financial improvement led credit-rating agencies to raise the overall outlook for not-for-profit hospitals from negative to stable.

Enticed by low rates, healthcare borrowing increased in 2015 after reaching the lowest level in more than a decade the prior year. Most of that money was earmarked to refinance older debt rather than for new capital expenditures. A number of health systems returned to bond-financed building projects. “There are still larger institutions that have new towers in mind,” said Colleen Mullaney, who heads TD Bank’s Southern healthcare division.

Health insurers decided in 2015 that they needed greater size as providers increasingly consolidated to better deliver coordinated care and gain more bargaining clout. Aetna announced it was acquiring Humana, a Medicare Advantage powerhouse, for $37 billion. Anthem agreed to acquire Cigna in a deal valued at $54 billion. The insurers said the deals would enable them to diversify their products, negotiate lower rates with providers and boost earnings.

But the mergers, which now face antitrust scrutiny, have prompted warnings about reduced competition, excessive insurer ability to dict ate rates, and higher healthcare costs. Thomas Greaney, a St. Louis University law professor, said the “sumo wrestler” theory that dominant insurers bargaining with dominant hospitals make the industry more competitive is wrong. “Sometimes we find out that the sumo wrestlers would rather shake hands than compete,” he said.

Given the political polarization in Washington, healthcare leaders didn’t expect much from the
nation's capital. But there was one major outbreak of bipartisanship when Congress overwhelmingly repealed Medicare's formula for paying physicians. The legislation created a new two-track payment system that's designed to prod doctors toward risk-based payment models.

“It was a major achievement and an example of how sensible people can do sensible things,” said Henry Aaron, a senior fellow at the Brookings Institution.

**Drugs and Devices**

Polls this year found that the public considers drug costs the nation's most pressing healthcare issue. Experts and policymakers offered solutions such as letting Medicare negotiate drug prices, basing prices on the efficacy and cost-benefit value of the products, and capping what consumers have to pay out of pocket for drugs.

“The debate over the price of drugs may have finally crossed a threshold that prompts federal and state lawmakers to pass legislation to rein in these prices,” said Dr. Michael Carome, director of the Public Citizen Health Research Group.

Yet lawmakers focused most of their attention on how to speed patients' access to innovative drugs and medical devices. In a surprise, Republican and Democratic House leaders came together to draft and win overwhelming approval for the 21st Century Cures Act.

Supporters said the bill would provide greater access to effective new treatments by streamlining the regulatory process and help reduce drug costs. The bill included $9.3 billion in additional funding for the National Institutes of Health over the next 10 years.

While critics warned the legislation could jeopardize patient safety by loosening review standards and drive up drug costs, the Senate began work on its own version of the legislation.

**Health Insurance Market**

The ACA's insurance exchanges operated relatively smoothly for the 2015 sign-up period, and so far have run glitch-free for 2016 enrollment. “This was the year when the ACA got sort of boring,” said the Kaiser Family Foundation's Levitt.

But there are growing concerns about the sustainability and affordability of the reformed markets. Average premiums for silver-level benchmark plans sold on the federal exchange were up 7.5% for 2016. In addition, insurers generally raised deductibles and out-of-pocket costs.

Plans also continued to narrow their provider networks, which led to a growing number of situations in which patients faced surprise medical bills when they were unwittingly treated by out-of-network providers. Some states either implemented or considered new rules to protect patients from such bills.
Some observers warned that higher premiums and out-of-pocket costs will slow enrollment growth and dim the chances that the ACA will cover the many millions of remaining uninsured Americans. Out of caution, the Obama administration low-balled its 2016 enrollment projection at 10 million.

The failure to make inroads among healthier young people made the Obamacare market more costly and less appealing to insurers. UnitedHealth Group's CEO announced in November that his company had lost lots of money on its exchange business and may exit the exchanges in 2017.

Another blow to the law was the financial failure of 12 of the 23 not-for-profit co-op health plans that were established through ACA loans to create more insurance competition. The law's opponents cheered, saying the collapse of the co-ops proved that the ACA markets were not viable. But co-op plan leaders said the key factor was the federal government's failure to deliver promised “risk-corridor” payments designed to compensate plans that attracted a disproportionate share of sicker-than-average members.

**Medicaid Reforms**

To the disappointment of hospitals, Republican and Democratic elected officials in Florida, Tennessee, Utah, Virginia and Wyoming tried and failed to enact Medicaid expansion in 2015 due to continuing opposition from many Republicans.

But the CMS approved Indiana's Medicaid expansion plan, which requires beneficiaries to make modest premium payments. Montana and Alaska followed with expansions, bringing the total number of expansion states to 30 plus the District of Columbia. Louisiana's newly elected Democratic governor also pledged to extend Medicaid. So far, the Medicaid expansion has covered nearly 8 million adults.

By year-end, Republican governors in Alabama and South Dakota were signaling their interest in expansion models with features such as premiums and work requirements. Patient advocates watched nervously to see how far the Obama administration would go in approving such “personal responsibility” provisions.

The CMS also proposed sweeping new regulations of Medicaid managed-care plans that would cap administrative costs and profits. The agency also wants more rigorous supervision of network adequacy and state quality-rating systems.

**Information Technology**

The healthcare industry pulled off the mandatory, thrice-delayed switch to the ICD-10 coding system relatively smoothly. Most hospitals, health plans, claims clearinghouses, information technology vendors and physician office practices converted on Oct. 1 with only scattered problems. “Part of it may have been a bit of good luck, but a lot of it was good preparation,” said Stanley Nachimson, a health IT consultant.
But the industry didn't fare well on the security front. The three largest healthcare data breaches recorded by HHS' Office for Civil Rights occurred in 2015, with four of the top six breaches involving cyberattacks. Combined, they compromised over 104 million patient records.

That included the worst healthcare breach in history at Anthem, whose 78.8 million members' records were allegedly hacked from China.

The year “should have been a wake-up call for everybody,” said computer security consultant Michael McMillan. But “we’re still not spending enough on the problem and we don’t have a handle on it.”

Value-based Payment

January brought the announcement by HHS Secretary Sylvia Mathews Burwell that Medicare would increase the amount of nonmanaged-care spending in value-based contracts to 50% by 2018. She said these goals would “drive transformative change.”

Eleven months later, Medicare required hundreds of hospitals in 67 metropolitan areas to accept bundled payments for hip and knee replacement. Until then, provider participation in bundled-payment programs had been voluntary.

In the private sector, the Health Care Transformation Task Force, including major commercial insurers, health systems, employers and patient groups, said its members would shift 75% of their business into risk-based contracts by 2020.

But Deep Banerjee, director at S&P Ratings Services, said, “Unfortunately, fee for service is still the prevalent method in the industry.”

Quality and Safety

Hospitals and physicians continued to protest the profusion of questionable quality measures used to rate and financially penalize providers. “Wherever I go, people complain about the burden of measurement,” said Derek Feeley, who is taking over as CEO of the Institute for Healthcare Improvement.

Only one-quarter of more than 3,400 hospitals avoided fiscal 2016 Medicare penalties for high rates of preventable readmissions, renewing concerns about that metric. Other studies found tying physician pay to quality has not had the desired impact.

In November, the Joint Commission halted one of its most popular hospital performance award programs to redesign the program. “It's fair to characterize the current environment as chaos,” said CEO Dr. Mark Chassin.

There also were mounting concerns about the need to improve post-market surveillance of
drugs and devices, including stronger use of registries to track problems. One product that came under the spotlight this year was the Essure permanent birth control device marketed by Bayer, which has prompted thousands of complaints from women and was the subject of a special FDA forum in September.

—With reporting by Joseph Conn, Virgil Dickson, Melanie Evans, Bob Herman, Steven Ross Johnson, Beth Kutscher, Shannon Muchmore and Sabriya Rice

**Harris Meyer**

Harris Meyer oversees news and feature coverage for the magazine. Meyer has covered healthcare and law since 1983, most recently as a freelance writer for Health Affairs, Kaiser Health News, the Oregonian, Medscape and other publications. He previously served as law editor at the Daily Business Review in Miami; a staff writer at the New Times alternative weekly in Fort Lauderdale, Fla.; senior writer at Hospitals & Health Networks; national correspondent at American Medical News; and health unit researcher at WMAQ-TV News in Chicago. Meyer has a bachelor’s degree in communications from Northwestern University. In 2000 he was a winner of the Gerald Loeb Award for Distinguished Business and Financial Journalism. He joined Modern Healthcare in 2013.