4sight Health Roundup Transcript
April 11, 2024

Will This HHS Proposal Refill Empty Pill Bottles?

David Burda:
Welcome to the 4Sight Health Roundup podcast, 4Sight Health Podcast series for healthcare revolutionaries; Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor, 4Sight Health. It is Thursday, April 11th. I hope everyone survived the solar eclipse on Monday. We watched it from the safety of our garage and driveway. I would have to say the most interesting thing that happened that I didn't expect was the temperature drop. It was noticeable even though the sun was shining and nothing else changed, the temperature dropped at least five degrees for about an hour. It reminded me of just how fragile we really are, and that's what we're going to talk about on today's show, the fragility of our drug supply chain and how that creates chronic shortages of prescription drugs. To tell us what we can do about it, our Dave Johnson founder and CEO of 4Sight Health, and Julie Murchinson, partner at Transformation Capital. Hi Dave. Hi, Julie. How are you two doing this morning, Dave?

David W. Johnson:
Nice transition. Dave. I'm in Aspen for the first of its kind MedTech CEO conference that Cain brothers is hosting. The mountains are spectacular in the spring almost makes me want to break into a John Denver song.

Burda:
Almost. Thanks. Thank goodness. Thanks Dave. Julie, how are you?

Julie Murchinson:
Well, I was in your fair city this week where you had plenty of warmth and sun. I was so appreciative and I had the opportunity to dip into Becker's for a bit and wow, a lot of health systems talking about a lot of non-strategic issues, but really important.

Burda:
Good, good. Now before we talk about drug shortages, let's talk about your eclipse watching behavior. Dave, did you watch the eclipse or do anything to mark the occasion?\

Johnson:
The peak eclipse time in Chicago was 2:06 PM; I took note of it. We weren't in the direct path of the eclipse, but it did get quite dusky in one of our cats, Benny went a little crazy. But by contrast, our podcast producers Michelle and Ezra are total eclipse hounds. They drove down to southern Illinois early to get into the direct path of the eclipse, secured a perfect camping spot for viewing in a farmer's field and then watched the full two hour show unfold. She just can't stop talking about it. Almost like we can't stop talking about healthcare.

Burda:

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It was her Woodstock.

Johnson:
Exactly.

Burda:
Thanks Dave. Julie, did you or anyone in your family watch the eclipse or celebrate it in any way?

Murchinson:
Everyone in my family did watch the eclipse, but because I was in Chicago, I had some nice fancy glasses from one of the healthcare vendors on the floor at Becker's and everyone had branded glasses on, so it was quite a scene.

Burda:
That's very cool. Hundreds of healthcare executives with solar glasses on, that would've been a great photo. Thanks Julie.

Johnson:
They've been blinded by the light for decades.

Burda:
Walked right into that. Well, the next solar eclipse to touch the US won't happen again until 2044 or not for another 20 years. I'll be 84 and we better not be talking about chronic drug shortages, but we are courtesy of a proposed drug shortage mitigation proposal put forth by HHS in the White House last week. We're going to critique the proposal on today's show, but first let me give you a summary of the plan. HHS says, market forces have created a generic drug supply chain that is shortage prone and too slow to respond to shortages that do occur. Further market failures lead to an insecure production base and a brittle supply of prescription drugs. To fix the problem, HHS wants to do two things. One, create a new manufacturer resiliency assessment program, and two, create a new hospital resilient supply program. Under the manufacturer program, HS would create a new accreditation body that would accredit manufacturers based on how well they scored on newly developed measures of supply chain resiliency. Under the hospital program, HHS would create a scorecard to rate hospitals based on their use of drug purchasing and contracting practices that promote drug supply chain resiliency. HHS would use Medicare payments to reward or penalize hospitals based on how well they do on their scorecards. Creating and running the programs would cost between three and 5 billion over the first 10 years of the initiative. Dave, what do you like about the proposal? What don't you like about the proposal? And if you ran HHS, what would you do about drug shortages?

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Johnson:
So what do I like and dislike about the programs? And if I were healthcare czar, I'm going to go even one step up from HHS secretary, I'm going to assume total powers.

Burda:
You're going full czar, right? Excellent.

Johnson:
Well on how would I deal with the drug shortages? Let me talk first about what I like. There's clear market failure. Evidently the private market programs to address these drug shortages, think of Civica RX and Mark Cuban's cost plus program, just haven't been enough to overcome these supply issues. They're helpful, but they haven't been enough. So in the presence of market failure, even though I'm a markets guy, it's appropriate for the government to intervene to restore supply demand equilibrium. Think of the strategic oil reserve that we have. And when the oil markets get out of whack, the government releases oil to try to bring rationality to oil prices. The program itself uses very well. Well-developed mechanisms from Medicare's previous experience relating to pricing incentives and ratings to nudge the system toward desired behaviors. Will it be enough? Time will tell. And execution as always is key. I just love that Thomas Edison quote where he said that innovation without execution is delusion. So let's hope our government officials aren't delusional here. But my guess is that on balance, the drug programs will improve availability of these critical drugs. That's good, but it will come at a cost that's bad. The question is whether the trade off is worthwhile. Time will tell on that. What don't I like? By definition, generic drugs are commodities and they should be in ample supply. We never run out of toothpaste. Companies like Walmart and Target have supply chain down to a science. And so we can always buy toothpaste at competitive prices. We never worry that we're overpaying for those. And I guess I worry that these proposals aren't really attacking the root causes of the shortages, which are monopoly pricing practices by manufacturers and rampant profiteering by all the intermediaries, drug wholesalers, PBMs, pharmacies, the den of thieves. So what would I do if I were drug czar? The first thing I would do, Dave, is I would assemble a blue panel of retail experts to study the problem and make recommendations to address it. Walmart, target, Costco. Your country needs you. Let's figure this out. I then, and because I'm sure this would come out of their recommendations, I'd attack the opaque pricing and market manipulation of the manufacturers and intermediaries through transparency regulations and active antitrust enforcement. I'd use Medicare's market power to make sure that there are adequate supplies of vital but lesser used drugs that might be an appropriate place for intervention. And then I'd go door to door to sell the program. Our generic drug shortages in this country is a manufactured market failure that benefits selected incumbents. It has no business existing. We need level field competition, transparent pricing and light touch, government intervention. Get rid of the middlemen. Come on. Revolution baby.

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Burda:
And look at that. That was a couple minutes and that didn't cost three to $5 billion.

Johnson:
Yep. No trade off there. All good.

Burda:
All value from Dave. That's a great analysis. Julie, any questions for Dave?

Murchinson:
So Dave, do you want to give some examples of how government intervention has distorted market function? I know you can have fun with this.

Johnson:
Yeah, it's one of my favorite topics. Before there were podcasts, there were the great courses program. And I remember driving down to Indianapolis probably 20 years ago, and I was listening to a lecture about Friedrich Hayek and the Austrian economic School. You can tell how I like to have fun. And there was a pretty vigorous debate after World War II when Hayek was at his most influential about whether a market socialist economy or a free market capitalist economy could work better. The debate made sense because arguably, world War II was a manifestation of kind of extreme capitalism and communism and fascism resulted from unbridled capitalism. And so Hayek sort of in talking about all of this, really emphasized the power of prices for him. They had the power of language to send signals between buyers and sellers, things we all know. And an example he used was the price of tin. And in a capitalist economy, the price of tin goes up. Manufacturers look for substitutes, they try to become more efficient, they raise prices. But pretty soon you get back to equilibrium and the market goes on In a market socialist economy, you have an army of bureaucrats that figure out first why did the price of tin go up? They then establish priorities for the uses of tin. They assign prices and then they have to enforce those prices through policing. And it gets pretty complicated pretty quickly. And before long you have too many tin cups and not enough tin pans. And by this point, I was driving into Indianapolis, which was in the process of building three new cardiac surgery hospitals at a time when the need for cardiac surgery was actually decreasing because of really effective drugs. And I sat there thinking about market socialism and Hayek and all this, and I said, holy cow, that's Medicare. And Medicare, because of the way it pays for surgeries is incentivizing the building of these surgery centers. Even though what we should be doing is using more drugs to control the problem. So anytime the government gets actively involved in setting prices, actively intervening in the marketplace, it creates distortions. I mean, honestly, the whole creation of commercial health insurance originated out of wage and price controls during World War II. And so they couldn't give wage increases. So they started offering health

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insurance. I mean, that's how we got commercial health insurance. So it's ever present in health care and rampant in its impact.

Burda:
Thanks. Julie. Let me ask you to critique what HHS wants to do. What do you like about the plan? What don't you like? And what would you do from a market perspective to end chronic drug shortages?

Murchinson:
Well, I agree with Dave. Drug shortages have been a problem for decades and there's so many people touching drugs, the middlemen are rampant. And this word transparency that we talk about here all the time, I think a big part of the problem I have to say when I read this, I had to dig back into Civica and Dave mentioned this. And one thing I don't like about what I read here is that Civica works directly with hospitals, which is great, but this a HS release talks about penalties for hospitals. And I'm not so sure that actually should be part of what's happening here. It feels like A bad party to actually [00:32:30] really penalize in all this. But Dave, maybe we should talk more about that. But if you read a lot of what's here, it's straight out of Pacifica's testimony to Congress. And if you look at what they say, Civica recommends long-term purchase and supply contracts that obviously add the stability that we need the market maintaining a six month buffer of inventory, that's a lot of inventory, that's a lot. But for hospitals to carry, but maybe for some Medicare, I don't know that whenever possible drugs should be manufactured in the EU and Canada straight out of Civica testimony because of course they don't source from China. They call for better quality over suppliers cost plus pricing, which of course doesn't happen today to, and they work, as I said, directly with hospitals. So somehow I do feel like that's, the president don't like hospitals getting penalized, but I feel like HHS just ripped their testimony and dropped it into this white paper. So that feels a little bit strange to me, to be honest. But Dave, to your point, Civica and Mark Cuban and perhaps a couple other innovative models have at least demonstrated what is possible. And the problem here really is around the injectable drugs and not all the drugs that Mark Cuban's been able to manufacture along the way. So there's a lead time for those drugs and there's a lead time for FDA approval of the generic manufacturer if they haven't created that drug in the past. So we're in a tough period here for what the reality is of at least the injectable drug shortages.

Burda:
So Julie, your criticism is, and to borrow Dave's analogy, you're blaming the customer who buys the toothpaste or problems in the toothpaste supply chain. And in this case, the hospitals are the customers and they're getting more of the regulation.

Murchinson:
Good analogy.

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Burda:
Yeah. I've got a six month supply of toothpaste here.

Murchinson:
Yeah, we go to Costco too.

Burda:
Dave, any questions for Julie?

Johnson:
There's already enormous profiteering occurring by companies exploiting perverse economic incentives. Is this new drug supply program just one more opportunity for the private sector to fleece American society? And if it is, how will we tell and then adjust?

Murchinson:
Oh, ouch. Dave. Harsh, harsh read. Okay. So one set I read was that there's a bunch of different factors around why drug shortages happen and how to predict them, but the strongest factor for future drug shortages, whether the drug has been in shortage previously. I thought that was kind of interesting actually, because they also say shortages directly affect predominantly the generic sterile injectable products. So it seems to me like with those two pieces of information, we could very easily predict where things are happening and utilize private market mechanisms to address that. One of the things I read was really focusing on grant programs and we've used grant program as another areas to encourage the growth of sectors where we have a need and why can't we do that here, especially if we can predict it based on where there's been previous shortage. So it does seem like there's a mechanism here to try to smooth out the supply. But Dave, I want to about your toothpaste. I mean, last I checked, my tub of toothpaste costs more than four bucks. So I realized that we're talking about incentives from manufacturers to create things that do not have a large margin, but if we've driven prices so low for some of these, there's got to be a good buoy here. And I do think this is a place where we have to make deals with our private sector. We're not getting it done any other way. And if you look at all these cost plus providers like Mark Cuban, this stuff is working actually, so why aren't we doing more of it?

Burda:
I don't even know where to start, but I think the right financial incentives and better functioning markets are a good start. Now let's talk about other big news that happened this past week. It wasn't all bad. Was it Julie? What else happened this week that we should care about?

Murchinson:

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Well, also talking about drugs, I saw an Evercore survey on what consumers are willing to pay out of pocket for our favorite new drug category GLP1s. And the majority, nearly 60% of those with an annual income of more than 250,000 said the max they'd be willing to pay out of pocket is, well it said more than 300. Which is funny because the survey options are three to 500 a month or 750 a month, so it's more than 300 a month. And about four to 5% of those with annual incomes of less than 75,000 said the same thing, would be willing to pay the same thing, which is kind of amazing. And of that group, more than 60% said they'd be willing to pay $50 per month or less. So income obviously has a lot to do with this, but people are really willing to pay for GLP1s.

Burda:
More than they're willing to pay for statins or blood pressure medication.

Murchinson:
Yeah.

Burda:
Interesting. Interesting. Dave, what other healthcare news blipped on your radar this week?

Johnson:
Well, everywhere I've been this week, people can't stop talking about Chris Ham's articles in last Sunday's, New York Times that reported on how big insurers and this intermediary company, multi-plan are exploiting out of network care delivery mechanics to generate huge profits for themselves. It's the opposite of surprise billing, but both self-insured employers and consumers like with surprise billing are getting screwed in the process. So it stinks. Intermediaries reign supreme, and they're just wreaking havoc everywhere they go.

Burda:
Yeah. Talk about market manipulation. That was a great piece. Thanks Dave, and thanks Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4Sighthealth.com. You can also subscribe to the roundup on Spotify, Apple Podcast, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4Sight Health.