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Editorial

Financing cures in the United States

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Abstract

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Keywords

credit mar…

There are growing concerns about the financing of technological breakthroughs in medicine that provide not just incremental health benefits, but substantial leaps in patients' health in the form of cures. The introduction of Sovaldi by Gilead, which is shown to cure 80–95% of Hepatitis-C infections, highlights these issues [1], but is not a unique case. US FDA approval of Harvoni, [2], a first combination pill approved to treat chronic Hepatitis-C virus genotype one infection, and other targeted treatments in cancer and emerging health technologies like regenerative medicine and gene therapy indicates that the concerns of financing these technologies are real [3]. The concerns are not only that these cures come, and rightfully so, with a high price tag, but they are likely to be adopted by a large patient population in a short amount of time. For example, a recent analysis shows that the potential cost to Medicare of covering Sovaldi alone is a 3–8% increase in federal Part D outlays and Part D premiums [4]. Similar concerns are expressed for Medi-Cal, California's Medicaid Program about financing stem-cell therapies [5]. Payers need access to sufficient capital in order to finance such a sharp impact on their budgets. While the development of generic markets to bring down costs of a high price cure has been put forth as a solution [6], these markets appropriately take time to develop in order to preserve the incentives for innovation for the original developer of the cure. In the meantime, payers and the patients

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I argue t they are not enou disag [3] compare realized over a long ti using sector should b 's lifetime. But Phili hin the private i iaries in those pl ystem in the

A solution to this problem can be found in the economic literature dealing with externalities in the efficient provision of a public good [9]. In the US health care system, a cure can be conceptualized as a 'non-excludable' public good. That is, a cure is valued by all private and public payers, but no one payer can exclude the others from appropriating some of its value. Consequently, since no one payer can appropriate the full value of the cure, none may be willing to bear the full costs of the cure – a classic 'free-rider problem' [5], which leads to the under-provision of cures and under-investment in innovation. While collective action and consensus are often put forward as a solution to a free-rider problem [10], they may be subject to insurmountable transaction costs within the US health insurance system. Here, I propose a different solution that may lead to efficient provision of cures in the US – monetization of the public good, the trading of which can happen at a much lower transaction costs, much in line with the concept of social impact bonds but more general in its reach [11].

Monetization of cures – HealthCoin?

In Philipson's housing example, credit markets alone can solve the buyer's financing problem since a house is an 'excludable good'. If you do not want to sell the house, you benefit living in it over time and can exclude any other entity to enjoy it during that time. If y over the forgone rchases a cure. Ev s, it cannot exclude insurance plans. H f cure for these pa nt in the cure.

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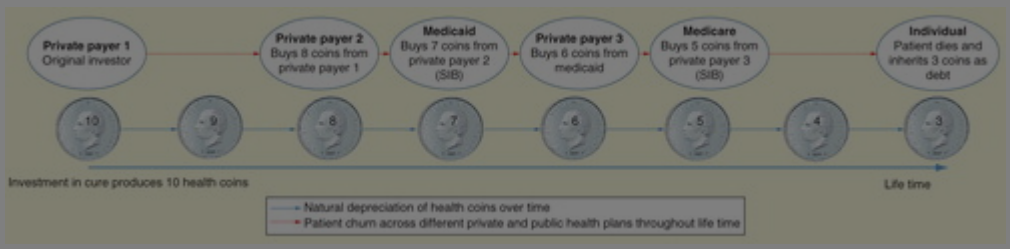
be expected that the US government would back this currency with necessary assurances. Medicare or its managed care plans would also buy the present value of the HealthCoins as patients become eligible for Medicare, much in line with the spirit of social impact bonds that are being used across the world to pay for investments that produce returns to public sector (Figure 1) [12].

Figure 1. A stylized model illustrating how health coins could be traded across public and private payers thereby generating the incentives for efficient investments in developing and utilizing cures.



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The valuation of HealthCoins for Medicare's perspectives must go beyond just the health care costs perspectives since most cures would likely increase total health care costs rather decrease them due to the extension of life. Therefore, a public insurer is assumed to take a public perspective that values life years and quality-adjusted life years ga rivate payers t ause they can sell also because e point of recruitm bsequent years. Tl ows private payers t

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lieu of patient's death these Health Coins transfer as debts to patients, which they may be able to insure against through life-insurance products. This last part, which involves some amount of risk-sharing with individual patients that they can re-insure, is important since financing the full upfront costs of cures through premiums could be prohibitive [4]. Instead, the impact on premium for private health insurance products would be more moderate with Health Coins as private payers need to distribute only the net costs of buying and selling these units. Moreover, early investments in these cures could decrease the prevalence of the disease in older life thereby reducing the budget impact of these cures for Medicare and the impact on premium for Medicare Advantage plans.

An extensive version of this currency formulation could incorporate patients engaging in proven and well-established health promotion behaviors to add to these Health Coins, which their current payers could secure through premium subsidies to the patients. Physicians would continue to play a critical role at the center of this exchange. Generating Health Coins for a payer could be used as a separate dimension of reimbursements for physicians, which could better incentivize physicians to deliver life-saving interventions at lower costs and to engage patients to invest in health promoting behavior.

Conclu

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Acknow

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Notes

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