Cinco RT PF NOV 2018 Blocks

a2 AFF

Overview;

In today's round helping not just the US, but the entire world is the biggest impact in today's round on two scales:

First on scope, there are simply more people in the developing world than the US, and by keeping stable drug prices there you save more people.

Second on severity. **HPI in 2018** writes that drugs only make up 10% of US healthcare spending, because we have a ton more treatment options before using drugs, whereas in the developing world drugs make up 67% of healthcare spending, because the developing world lacks the infrastructure the US has. Here's the comparative: if you lose some access to drugs in the US you're fine as we have other treatment options. But if you lose access to drugs in developing countries, your literally facing death insofar as drugs are the only treatment option for most of the developing world.

A/2: Accessibility

Starting on the link level, three responses:

First, delink, they are making a huge deal out of a few select cases. Right now in the status quo the generic drug industry, a sector of pharma that provides cheap alternatives for expensive brand name drugs, is already providing affordable care. Indeed the Heartland Institute in 2018 finds that the generic drug industry provides medication that is 80 to 85% cheaper than their brand name alternatives which is why they find 90% of all prescriptions in the US are generic drugs. These prices are quickly decreasing with the GAO in 2016 finding that generic prices have fallen 59% and the Council of Economic Advisors in October in 2018 finding that generic drug price decreases have saved 26 billion from 2017 to july of 2018.

This means, We outweigh their case on timeframe. Even if they win the fact that drugs have become monopolized, eventually those drugs will become generics and cheap, it's just a matter of when the patent expires.

Second, Non-Unique, due to recent policy changes that have increased competition and political pressure brand name companies have been forced to decrease their prices with the Council of Economic Advisers finding that these decreases in prices have lead to 43 billion dollars in consumer welfare. That means prices are getting low right now, regardless of who you vote for ability will increase.

Here's why this is really important. These new policy changes are permanent, meaning their effect will continue into

Third, turn it. Price controls would cause massive shortages of drugs. Price controls would reduce overall revenue as Goldman of Health Affairs in 2009 writes price controls would reduce revenue within the pharma industry by over 20%. Critically, Sullivan of the Rockpoint Institute finds decreased revenue from price controls would force companies to cut down on the production of various drugs because the market is no longer as profitable and thus leading to shortages.

a) This turn outweighs on scope because not only are we affecting people who can't afford medication now by further limiting access, you also affect the whole US population by depriving them of medication.

Fourth, turn. Price Controls cause negotiating delays. **The Hill 17** writes, pharmaceutical firms have to undergo negotiating process[es] in a controlled market every time they want to sell new medication. In America, the average medicine is approved 90 days quicker than in Europe, and a year quicker than in Canada. 600,000 European deaths could be avoided each year if the continent's healthcare systems [had] timely and effective medical treatments. They conclude, this fatal foot-dragging, and price controls, must end.

a) Here's why you weigh our turn over their case, it looks at what's happened in the past, and what's happened in the past is that hundreds of thousands of people have died while companies stalled for a better price. It's a guarantee to happen.

Then on their impact:

First, delink. **Heath of Health Analytics in 2015** finds that 84% of non-adherence is credited to a patient's behaviors, such as procrastination, forgetfulness or confusion due to multiple medications.

Second, turn. The Quality of Drugs also goes down. **Atella of the NCBI in 2012** finds that price controls decrease the availability of high quality drugs because companies have less incentive to produce high quality drugs due to the lower return on incentive.

Second, delink, lets talk about the drugs they cite that are the crucial drugs that aren't generics. Here's where you extend small pharma from case. The CNBC evidence indicates that the trend right now is towards small pharma which is breaking up these giant monopolies. But here's the comparative on why you prefer the status quo trend over price controls.

1) Because small pharma is providing the competition needed to drive down the price, their only solvency is getting solved back in the long term.
2) Because you maintain the high levels of innovation that are crucial to creating these drugs, that what our 2nd contention is about.

In their world, you have low prices. In our world, in the long term you have the same low prices, with the innovation needed to create the drugs that they want to increase access to in the first place.

https://www.drugcostfacts.org/us-healthcare-spending

Prescription medicines, including retail pharmacy sales and provider-administered drugs, are only about 14% of overall healthcare spending[i]—roughly the same share as in 1960. That spending has been remarkably stable, even though more than 450 new medicines have been brought to market for millions of suffering patients over the past 15 years, thanks to competition between branded drug makers in the same treatment class and the availability of low-cost generic drugs after a limited period of exclusivity for innovator products. What's more, spending on prescription drugs is projected to grow in line with overall healthcare spending through at least 2024.[ii]

Even more so, Brooklyn in 2018, literally 2 months ago, finds in an analysis that these generic drugs are seeing sharp decreases in their price. The trend is downward, and negating keeps the trend going. This has two key implications:

Third, Turn. By affirming you reduce accessibility to drugs for millions in developing countries. Currently, high American prices provide companies enough revenue to the point where they can sell

drugs at cheaper price in the developing world. Schweitzer of Health Affairs quantifies Drug companies are selling their drugs 41% cheaper in developing countries to make them more accessible. Unfortunately, Danzo of UPenn writes that if Price Controls were to be implemented companies wouldn't be able to offer cheaper prices to these developing countries and thus raise prices in the developing world, decreasing their accessibility.

Helping the developing world comes first for 2 reasons.

a) First on scope, the populations being affected by pharmaceutical outreach in the developing world will always be greater than helping the local US population.

b) On severity. Accessibility in developing nations is always worse due to the fact there is very little governmental support or safety nets for their citizens, which is why the World Health Organization finds, "Children in developing countries are ten times more likely to die before the age of five than children in developed countries."

Differentiable pricing only works with high prices in developed countries

http://sci-hub.tw/https://www.jstor.org/stable/3528839?seq=1#page_scan_tab_contents

Any institutional framework to preserve differential pricing will only work if higher income countries forego the temptation to try to reduce their prices by referencing lower prices in low-income countries. The UK Government recently committed itself not to benchmark or reference DC prices (Short, 2002). We are not aware of similar commitments by other higher income countries. However, even if governments of the G-8 countries committed not to reference DC prices, the risk would remain that other middle income governments or advocates of lower prices in high income countries would reference low DC prices if these are observable. If so, making these prices unobservable may be the best approach to achieving the lowest possible prices f

Currently, developing countries are gaining more access to life-saving medications.

Whalley of The Guardian finds that over the past 15 years, the rate of death for children under five has more than halved.

This progress is largely due to a practice called differential pricing, where pharmaceutical companies charge more for drugs in developed countries than developing countries.

In fact, according to **Schweitzer of Health Affairs**, unpatented drugs in developing countries are sold for 41% less than in developed nations.

For example, **The New York Times** finds that a daily dose of the AIDS drug sells for half the amount in Uganda than in the US.

The World Health Organization explains that the difference in price can be attributed to companies wanting to signal "that their pricing policies are socially responsible, not just geared towards maximizing profits."

Unfortunately, if the US puts price controls in place, pharmaceutical companies will no longer be able to charge less in developing countries. **Danzon of UPenn** finds that differential pricing will only be preserved "if higher income countries forego the temptation to try to reduce their prices," in which case manufacturers will be "unwilling to offer low prices to low income countries."

In fact, according to **Kolata of The New York Times**, The Pharmaceutical Manufacturers Association says themselves they wouldn't be able to charge lower prices in developing countries if "they have to extend the same low prices everywhere."

The US is of vital importance, as **Schweitzer** explains price differences between countries with different incomes "are largely due to higher drug prices in the United States."

I. The impact is decreased access to life-saving drugs.
Bate of the American Enterprise Institute finds differential pricing "increases access to drugs by a factor of four to seven."

Prioritizing drug access in the developing world is critically important as the World Health Organization finds, "Children in developing countries are ten times more likely to die before the age of five than children in developed countries."

A/2: Mergers and Acquisitions

1) Turn: The LSL in 2009 finds that after the 2008 financial crisis the pharmaceutical sector was hit extremely hard, in response to the large economic downturn they find that the amount of mergers significantly increased in response to mitigate damage. This is crucial as we tell you that under a price control revenue in the pharmaceutical industry would decrease by over 20.3% this means that pharmaceutical industry will respond the same way they did in 2008 and significantly increase their rate of acquisitions. O/W historical precedent

A/2: Diminishing Lobbying Power

Non-unique for two reasons:

1) Big pharma lobbying power is decreasing in the status quo. Novak of CNBC writes in 2016 the power of big pharma is slowly decreasing. The reason is because defending big pharma's rising drug prices right now is incredibly unpopular among the American population and thus politicians are now increasingly unwilling to associate themselves with the negative spotlight associated with giving into big pharma lobbying
2) Anti-pharma policies are being increasingly passed in the status quo. The Academy of State Health Policy writes that in 2018 alone, 174 bills to reduce drug prices were introduced into state legislatures and 45 of them were passed, meaning big pharma is losing their hold on nationwide legislature if policies antithetical to their interests are increasingly being passed

A/2: Medicare Prices

Two Turns:

1) Hospitals will jack up prices for non-Medicare patients. Suderman of the Reason Foundation writes if Medicare premiums are diminished, hospitals and doctors will increase the prices for privately insured patients in order to make up for the lost revenue. This has been historically seen as he continues in the 1980s when the federal government tried reducing the amount Medicare patients had to spend on hospital costs, the hospital system simply jacked up the price of other services and outpatient medical practices. Outweighs on probability because it's historically occurred over their hypothetical argument. THE COST WILL NEVER CHANGE.
2) TURN: OVERALL PRICE GOES UP. Insurance companies will also increase costs overall, using medicare as an excuse. Archer of Health Affairs in 2013 writes because insurers have monopolized Medicare, there is no other competition in the industry so they can freely raise prices whenever they see revenues decreasing in one sector without the fear of another company offering lower prices.

A/2: Hospitals

1) Non-unique: **LaPointe of RI News** explains that currently, hospitals already have access to 340B Pricing programs that require American hospitals to have certain price ceilings.

2) Non-Unique: Hospitals are manufacturing their own drugs as **Katie Tomas of NYU in 2018** finds that hospitals and nonprofit companies, such as Department of Veterans Affairs and the largest Catholic hospital system, are working togethers to produce their own medications at an affordable price for hospitals right now.

3) Hospitals can cut-cost effectively without harming the quality of service as **Van Dyke** of the **Mayo Clinic** in 2017 outlines three ways hospitals can save money:

a) Analyzing Data: Currently, the majority of data given to hospitals comes from drug manufacturers, with the evidence skewed towards benefitting drug manufacturers. However, when hospitals complete independent research, they can isolate the most cost effective treatments and best performing drugs.
b) Directly Purchasing: Empirically, when hospitals directly negotiate prices with manufacturers, they reduce excess costs while obtaining the highest quality drugs
c) Reducing Excess Inventory: Monitoring the quantity and use of drugs is critical to lower hospital spending. In fact, the Wexner Medical Center cut its drug inventory by 800,000 dollars in just one year.

In fact, by putting these three methods to use, the Cleveland Clinic has decreased drug spending without harming quality, saving $90 million between 2010 and 2016.

4) Turn, Quality goes down when you affirm: **Pope** of the **Heritage Foundation** in 2013 explains that under a price control, competition among hospitals to provide more cost-effective care would decrease, concluding that lower prices would encourage the use of costly, unnecessary procedures and the overuse of diagnostic tests in order to make up missing revenue.

Christopher Pope, Graduate Fellow in the Center for Health Policy Studies at the Heritage Foundation. "Legislating Low Prices: Cutting Costs or Care?", August 9, 2013, http://www.heritage.org/health-care-reform/report/legislating-low-prices-cutting-costs-or-care, SP, October 21, 2018

Overpayment. **Fixing prices tends to entrench the dominant position of incumbent firms, protecting them from new competitors that threaten to undercut their prices or to provide more focused solutions to patient needs.** Regulated pricing also prevents managed care providers from driving down costs by negotiating discounts with provider networks. Therefore, **it removes the incentive for hospitals to provide more cost-effective care in order to compete. Artificially low prices may also encourage use of unnecessary, costly procedures and overuse of diagnostic tests, which insurers may nonetheless be obliged to cover.**

Maggie Van Dyke, Mayo Clinic, "Hospitals Rein in Drug Costs for Inpatients", 6/7/2017, https://www.hhnmag.com/articles/8271-hospitals-rein-in-inpatient-drug-costs, accessed 10/19/2018, MS

Despite the challenges, Cleveland Clinic has been able to rein in drug spending without harming quality, saving $90 million between 2010 and 2016. "I was wrong," Rosner gladly admits about the savings potential. About 45 percent of the $90 million was achieved on the inpatient side by reinforcing traditional pharmacy management approaches, such as inventory control, formulary management, procurement and drug-utilization review.

Maggie Van Dyke, Mayo Clinic, "Hospitals Rein in Drug Costs for Inpatients", 6/7/2017, https://www.hhnmag.com/articles/8271-hospitals-rein-in-inpatient-drug-costs, accessed 10/19/2018, MS

Identifying unbiased information on drugs can be difficult, particularly since comparative effectiveness studies of drugs are uncommon. "Most of the data we're getting on these drugs is produced by companies selling the drugs," says Len Gray, division vice president of health system clinical services, Comprehensive Pharmacy Services. **"When we can get objective, evidence-based information**

versus marketing-based information, it becomes much clearer which medications are truly best."

Maggie Van Dyke, Mayo Clinic, "Hospitals Rein in Drug Costs for Inpatients", 6/7/2017, https://www.hhnmag.com/articles/8271-hospitals-rein-in-inpatient-drug-costs, accessed 10/19/2018, MS

Negotiating volume discounts on drugs is another key cost-saving strategy. First, pharmacists work with physicians to identify a few drugs in each drug class that will be used exclusively by the hospital, a process known as therapeutic interchange. Then, hospitals seek discounts on these first-line drugs, typically through group purchasing organizations that negotiate with drug manufacturers on behalf of their members

Maggie Van Dyke, Mayo Clinic, "Hospitals Rein in Drug Costs for Inpatients", 6/7/2017, https://www.hhnmag.com/articles/8271-hospitals-rein-in-inpatient-drug-costs, accessed 10/19/2018, MS

After weeding out unused, duplicate and low-use drugs from all medication storage areas, The Ohio State University Wexner Medical Center in Columbus cut its drug inventory by $800,000 in one year. The biggest savings came from maintaining tighter control over automated dispensing cabinets on nursing units. "Hospitals often don't monitor these cabinets or remove drugs that are no longer used," says Robert Weber, administrator of pharmacy services.

A/2: Dec. Healthcare Costs

1) **Insurance prices will continue to increase even with price controls.** The DCF writes the rising costs of doctors and hospitals are putting a greater cost on insurance companies.
a) In fact, the costs of doctors and hospitals account for two-thirds of increasing drug prices..
2) NONUNIQUE - Other factors besides drug prices are driving insurance prices up, and these factors will occur in both worlds, so don't let them tell you that their cutting drug prices down will solve the problem. There are two main factors driving insurance prices up, neither of which is drug prices.
a) Prices are increasing because *more patients are being treated*. For example, Leonard of US News explains that "new cures [for Hepatitis C] accounted for nearly $11.3 billion in overall health care spending, because the existence of the drug allowed for nearly 10 times more patients to be treated for the disease than in 2013."

b) Prices are going up because of *healthcare provider services*. "Research from Avalere [Health consulting firm] has found that spending for hospital and healthcare provider services are the largest drivers of insurance premium growth—not prescription drugs, which represent only 14% of premium growth."[1]

3) DELINK - OECD nations (all other OECD nations besides US have price controls) have higher insurance spending on drugs:

a) US Department of Commerce: "total pharmaceutical spending as a percentage of total health care spending is lower in the U.S. (12.2 percent) than the average for the 30 nations that comprise the Organization for Economic Cooperation and Development, or OECD, (16.9 percent). This is due to, in part, the prevalence of generic medicines that are more affordable here than in other OECD nations."

4) DELINK - Drugs make up an extremely small portion of the health care bill, making price controls effectively useless.

a) Lakdawalla of the New York Times: prescription drug spending makes up roughly one-tenth of America's total bill for health care. Lopping 20 percent off drug prices by negotiating prices would thus shave all of 2 percent off our total health care bill.

A/2: PBMs

3 Responses overall:

First, the entire argument is Non-Unique as PBMs are becoming more transparent in the status quo. **DT in 2017** writes that the amount of transparent PBMs, which are much more open about their businesses have increased to 40% of the overall market. Even besides producing transparent PBMs, DT furthers that this large increase in competition has forced big companies to also become more transparent. For example, CVS is now disclosing a ton of stuff that they weren't before. We are solving back already.

Second, Non Unique, the government is already cracking down on these abusive companies. **The Washington Post writes in 2018** that 33 states have already starting creating legislation that cracks down on PBMs. Even moreso, even Trump is working on this by signing the gag clause that forces PBMs to be transparent. They are overblowing an issues thats already getting solved.

Third, even if you buy their link that PBMs increase in our world, you can turn it.

PBMs are good because they save millions of dollars, as **Shepherd of Scholarly Law** writes that PBMs force companies to give generic drugs in place of extremely expensive brand name drugs when needed. That's why **Roddey** concludes that over the next ten years, PBMs are projected to save 654 billion dollars for American patients and help preventing millions of fatal diseases.

Shepherd of Scholarly Law- PBMs have successfully *reduced drug spending* by requiring substitution of generic drugs for brand name drugs when clinically appropriate.

Roddey "Over the next 10 years, PBMs are projected to save $654 billion dollars on drug costs on behalf of 266 million Americans nationwide. PBMs help prevent 480,000 heart failures, 180,000 strokes and 230,000 cases of kidney disease annually. By restricting PBMs' ability to negotiate for lower drug prices, [there could be the] unintended consequence of raising drug prices for patients."

a)
https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/05/21/the-health-202-states-are-targeting-a-key-middleman-in-the-drug-pricing-chain/5aff300430fb0425887995b4/?noredirect=on&utm_term=.8d2678bf2ca5 State lawmakers have introduced at least 83 bills targeting PBMs across 33 states either being considered or tha thave been enacted, according to the National Academy for State Health Policy. They range from bills requiring disclosure about PBMs's business relationships to measures that outlaw "gag clauses" preventing pharmacists from telling consumers about cheaper drug options.

A/2: Opioids

3 responses:

1. Non-Unique. Federal policy has already been enacted. **Sotomayor** [1] **of NBC news in 2018** explains that the federal government passed the Opioid Crisis Response Act which limits the availability of prescription and illegal opioids, which will help to decrease addiction in the long-term.
2. Non-Unique. States are working too. **Kaku** [2] **of the Pharmacist Magazine in 2018** explains that all 50 states have enacted laws that increase access to naloxone. This has increased access, has the **NIH** [3] **in 2018** explains that naloxone prescriptions has increased twelvefold in one and a half years and the number of people saved has more than doubled.
3. We Pre-req their entire argument. Innovation is the only way to produce a long term solution. **The Biotechnology** [4] **Innovation Organization** explains that the long term solution to stopping the opioid crisis relies on the innovation and development of new painkiller drugs. In fact, the status quo trend is towards solving this problem. Silicon Republic writes that new medication is less addictive while solving the epidemic. But, by

affirming and removing innovation, you risk reversing this trend. They prevent the root cause of the problem from ever being solved.

Silicon Republic - AT121 is a pain medication in development said to be much less addictive, while also taking a smaller dose. Medication in development like this can solve the opioid epidemic

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https://www.nbcnews.com/politics/politics-news/senate-passes-sweeping-legislation-combat-opioid-epidemic-n908901
https://www.uspharmacist.com/article/expanding-access-to-naloxone
https://www.drugabuse.gov/publications/medications-to-treat-opioid-addiction/naloxone-accessible
https://www.bio.org/sites/default/files/BIO-Opioid-Infographic-Official.pdf

Turn: overprescription increases, cause now they are just gonna move to another drug. This is proven true:

1. CVS Chief Medical Officer Dr. Troyen Brennan: "pharmaceutical manufacturers have a strong financial incentive to get people to take high priced medications."

Turn: Innovation Pre-req

R&D solves for the opioid epidemic because less addictive drugs are being developed right now

1. Silicon Republic - AT121 is a pain medication in development said to be much less addictive, while also taking a smaller dose. Medication in development like this can solve the opioid epidemic

A/2: Black Market

1. **Williams of US Pharmacist in 2014**[1] reports that only one percent of global counterfeit drugs are sold in the US. It ain't a big deal.

2. Turn. Root cause of counterfeiting is drug shortages! **Bichell of NPR in 2017**[2] reports that drug shortages open up the door for counterfeits to fill the gap. Price controls lead to drug shortages. **Shepherd of USNews in 2016**[3] finds that price controls contribute to drug shortages, because at a below-market price, the demand for drugs exceeds the amount of drugs that manufacturers are willing or able to sell.

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https://www.uspharmacist.com/article/counterfeit-meds
https://www.npr.org/sections/goatsandsoda/2017/11/29/567229552/bad-drugs-are-a-major-global-problem-who-reports
https://www.usnews.com/opinion/blogs/policy-dose/articles/2016-03-30/medicare-price-controls-on-drugs-will-harm-the-patients-it-aims-to-help

A/2: Value Based Pricing

First, Non-Topical. Shouldn't even be talking about VBP. No political probability of being implemented. Washington Post in 2018 writes that literally everyone doesn't approve of VBP. It ain't gonna be implemented. Instead the system we should look to is regular Price Caps, bc thats whats in every other countries.

Delink: Even if their argument was true, in the status quo even compared to every country the US has the least Me-too drugs. Kneller in 2010 of University of Tokyo writes that the US still proportionally creates the least amount of me-too drugs in the world. The current system is the best system in the world, and is the only way to have true innovation.

Turn: Amount of Me-too drugs increases in a world with VBP.

Harvard in 2018 writes that in other countries with VBP, yes companies are rewarded for new drugs but at the end of the day Me-too drugs are also new drugs, which is why he concludes that the me-too abuse effect is EVEN WORSE in these countries. Legit link turns entire contention.

Pref this ev bc it looks a) what's happening in other countries and b) historical

If they say INDIA:

EVEN WITH THEIR VBP IN INDIA, TIMES OF INDIA WRITES THAT INDIAN INNOVATION HAS DEC. 75% IN THE SQUO, THEY AIN'T SOLVING.

https://timesofindia.indiatimes.com/india/Pharma-price-control-has-stunted-innovation-study-finds/articleshow/48077550.cms

Washington post:

But the proposal will most likely face fierce political resistance from drug makers, some health care providers and some Republicans in Congress, and it could also be subject to legal challenges.

1. https://dash.harvard.edu/bitstream/handle/1/8889453/Fiorenzo.pdf?sequence=1
    1. What seems to have happened, especially in Japan and France is that regulators do grant a higher price for new drugs, but without regard to their innovative properties. This has created further incentives to develop many new drugs that merely tweak existing drugs, so as to reap the benefits of the new drug allowance, but still not one that is generous enough to reward innovative R&D.54 So many critics are right in saying that a host of the new drugs developed by American pharmaceutical companies are not innovative. However, in regimes with price controls, this “me-too” effect is even more pronounced, because price regulated systems create perverse incentives not to innovate, but to tweak the drugs of your competitors. When it comes to imitative drugs, it may be bad here, but its far worse elsewhere.

https://www.uclalawreview.org/wp-content/uploads/securepdfs/2018/07/65.4.3-Lamm.pdf
Referen e pricing often leads to high prices—in some cases, even higher than the price point that the drug company would set itself.2