How States Can Help to Address Rising Drug Costs
December 7, 2018
NCSL Insurance Taskforce

Claire McAndrew
Director, Campaigns and Partnerships
Families USA
www.familiesusa.org

Eric Ellsworth
Director, Health Data Strategy
Consumers’ Checkbook
www.checkbook.org
Consumer nonprofit: our mission is to help people make educated choices of services

Longtime advocate of transparency in the health sector

Leader in evaluating the quality of healthcare service providers

Provides data, advice, and decision support tools to help consumers select health plans, doctors, hospitals and many other services
Consumer costs reflect the entire supply chain

- Need lower list prices and less added cost across the entire supply chain

Source: McKinsey profit pool analysis
Consumer Experience – Out of Pocket Costs

- Pre-deductible/coinsurance replacing copayments for out-of-pocket drug costs
- Exposes consumers to:
  - List prices
  - Price increases
  - Variation between pharmacies
- Out-of-pocket costs are less predictable
- Consumers are twice as likely to abandon prescriptions filled in the deductible, when full price applies

Sources: PhRMA, KFF Health System Tracker
From Transparency to Predictable, Lower Costs

• Price transparency is a good start, but:
  • Paying cash is not always a good option
  • Undermines the value of paying for drug coverage
  • Consumers lose benefit of accumulation against deductible & out-of-pocket max
  • Very hard to make an educated choice

• The price of a new prescription is usually a surprise to the consumer
  • Changing to a lower-cost drug takes work!
  • Abandoning the script is undesirable but less work

• High prices and supply chain complexity make out-of-pocket costs less predictable
  • Changes to coverage or tier
  • Manufacturer assistance (card runs out, copay accumulators, etc)

Average Copays in Employer-Based Plans

<table>
<thead>
<tr>
<th>Tier</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Brand</td>
<td>$33</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$59</td>
</tr>
<tr>
<td>Specialty</td>
<td>$105</td>
</tr>
</tbody>
</table>

Source: KFF Employee Benefits Survey

Reforms should lower costs and bring predictability
• Lower list prices
• Fewer/more predictable price increases
• Automatically incorporate all rebates
Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We advance our mission through public policy analysis, advocacy, and collaboration with partners to promote a patient-and community centered health system.

Working at the national, state and community level for over 35 years
State Mechanisms for Addressing Rx Prices

- Transparency
- Anti-Price Gouging
- Pharmacy Benefit Managers
- Rate Setting Board
Goal: Make drug prices and price increases understandable to payers, policy makers, and ultimately the public.
State Examples

Connecticut: Public Act 18-41, 2018

- What drugs?
  - Up to 10 drugs that are a substantial cost to the state or critical to public health
  - Price must have increased by at least 20% in immediately preceding year or 50% in preceding 3 years
  - At least $60 for a 30-day supply

- What’s reported?
  - Factors that caused the increase a narrative description for public release
  - Aggregate company level research and development costs and other such capital expenditures

Oregon (HB 40005, 2018)

- What Drugs?
  - Cost $100 or more
  - Price increase of 10% in one year
  - Specialty Drugs

- What’s reported?
  - Production costs
  - Marketing costs
  - Research Costs
  - Clinical efficacy/rationale for increase
**Goal:** Prevent drastic price increases for prescription drugs.
Anti-Price Gouging Legislation

Proposed Approach: Assess drug manufacturers for price increases at a level beyond inflation (Pew)

Maryland Approach: Enacted 2017 anti-price gouging bill grants the AG authority to act when a wholesale price or price paid by Medicaid increases by 50% or more in one year for generic or off-patent drugs.
**Goal:** Place a ceiling on how much all payers in a state will pay for certain expensive drugs.

**Policy Details:** Create a commission to establish state-wide payment limits on specific high-priced drugs, using a model loosely based on public commissions that regulate public utilities.
State examples

MD (SB 1023, *proposed 2018*) For drugs priced over $30,000 a year, manufacturers would be required to explain the rationale for the price and the board would then set a reasonable amount to pay. MD uses a similar process to set all-payer hospital rates.

Introduced in NJ: A 586 (Moriarty, Danielsen)/ S 983 (Vitale): Introduced in January 2018
**Goal:** Ensure PBMs are not driving up prices in their role as “middlemen” between health plans and pharmaceutical companies/ pharmacies
Pharmacy Benefit Managers: Policy Options

• **Build on state and federal gag clause laws:**
  – Don’t just allow, but require pharmacists to disclose lowest costs to consumers
  – Require that cash purchases for *covered* drugs count towards out-of-pocket caps and deductibles. (CA AB 315, AB 2863; KY H 463)

• **Create a fiduciary duty for PBMs:** Hold PBMs accountable to their clients for producing the greatest drug savings possible.

• **Create strong, disaggregated transparency provisions for PBMs:** ensure transparency for how rebates flow from manufacturers, through PBMs, to insurers, and down to consumers (CT Public Act 18-41)
Takeaways

There are a menu of options for how to take action on prescription drug prices at the state level

States can start with intensive action or build up to reigning in prices with incremental steps

Momentum to address drug prices at the state level is strong and in many states bills garner bipartisan votes

State action can put pressure on federal government to take action