State Approaches to Addressing Prescription Drug Costs

A CLOSER LOOK AT WHAT STATES ARE DOING TO CONTROL DRUG COSTS

AUGUST 23, 2018

Jennifer Reck
National Academy for State Health Policy (NASHP)
NASHP

- Non-profit
- Non-partisan
- Portland, ME & WDC
- 31 years
- Academy: cross-agency group of state leaders
- Annual conference: state officials from 50 states
- Pharmacy Cost Work Group
  - Funded by Laura and John Arnold Foundation
  - Issued 11-point policy proposal in October 2016
Why Are States Acting?

A. Costs
   - Rx costs rapid & unpredictable; specialty drug-driven
   - State Medicaid Rx spend 25% 2014, 14% 2015
     - CMS predicts 6% growth 2016 – 2025

B. Balanced Budget Requirements

C. States Lack Commercial Tools
   - Closed Formularies and Co-pays

D. States Can’t Wait For Feds
   - Blueprint on Drug Prices not likely to bring relief to states
     - Demo’s require states to opt out of MDRP entirely
Drug Spending in Context

Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group
How Are States Approaching Rx Costs?

1) Legislation
2) Medicaid initiatives
3) Take-aways
How Are States Approaching Rx Costs?

• 2018 Session: 160 Bills
• 24 States Passed 37 New Laws:
  • PBMs – 84 Bills (26 laws in 18 states)
  • Transparency – 26 Bills (7 laws: OR, VT, ME, NH, CT, CA*, NV*)
  • Importation – 8 Bills (1 law: VT)
  • Price Gouging – 12 Bills (1 law: MD*)
  • Rate Setting – 3 Bills: MD, NJ, MN

(*= enacted in 2017)
PBMs

Common provisions for state regulation of PBMs:

- Ban gag clauses prohibiting pharmacists from offering consumers the lowest price
- Require state licensure of PBMs
- Require PBMs act as fiduciaries
- Require PBMs to report rebates
PBMs: Lessons Learned

- Define rebates as all payments between manufacturers and PBMs

- PBMs are part of the problem, not the problem
Transparency Laws

- **CA (SB17)** – Requires advance notice of price increases /60-day notice by manu’s of increases >16% within previous 2 yrs. / Insurers report top 25 drugs (frequently prescribed/spending/cost increases) / PhRMA challenged; implementation in progress since Jan. 2018
- **NV (SB539)** – Essential diabetes drugs only / PhRMA and BIO challenged (disclosure of proprietary info.)
- **OR (HB 4005)** – Similar to CA; rule-making in progress
- **CT (HB 5384)** – Threshold: 20% in 1 yr or 50% in 3 yrs; / Insurers report top drugs (cost/cost increases)
- **VT (S 92)** – update to 2016 law
- **ME (LD 1406) and NH (HB 1418)** - Studies
Transparency: Lessons Learned

- Proprietary information:
  - Don’t collect unless necessary
  - Create mechanisms to protect

- Make sure the information is actionable

- Don’t “demonize” industry; work collaboratively to avoid undue reporting requirements to ensure compliance
Price Gouging

- **Maryland law (MD 631):**
  - Allows AG to take action against “unconscionable” price increases and impose fines & refunds for consumers if AG determines price gouging took place
  - Generic/off-patent drugs
  - AAM challenge: 4th Circuit ruling; MD AG deciding whether to appeal to SCOTUS (Oct.)

- **Lessons Learned:**
  - Define “unconscionable”
  - Make clear law applies to drugs sold within state only
Rate Setting / Drug Affordability Review

- Similar to a public utility rate setting model
- Would establish a drug affordability review commission to review high cost drugs and, when necessary, set rates state will pay

- Maryland (HB 1194/1023)
  - 5 person drug cost review commission
  - Passed House; stalled in Senate
Wholesale Importation from Canada

- Passed in VT (S175)
- Study in Utah

- NASHP TA to VT:
  - Designing a program to meet safety and cost-savings requirements for approval by fed’s
  - Azar recently signaled support for importation
  - VT must approve program design including funding mechanism
  - State will contract with a wholesalers
Medicaid Initiatives

- MA: Waiver to enable closed formulary was denied
- NY: Drug spending cap with process to negotiate supplemental rebate contracts
- OH: PBM rebates must be passed through to Medicaid health plans

NASHP Grantees:
- OK: APM for prescription drug through existing rebate structure; SPA approved July 2018; 1st contract signed
- CO: APM for physician-administered drugs (PADs)
- DE: Cross-agency formulary
1) Transparency is a first step, necessary but not sufficient.

2) Transparency is needed across the entire supply chain

3) States need policy approaches with teeth:
   - Anti-price gouging measures
   - Rate setting / drug affordability review
   - Commercial sector tools to enable negotiation
Find the status of state legislation to curb prescription drug costs on NASHP’s tracker:

- [https://nashp.org/state-legislative-action-on-pharmaceutical-prices/](https://nashp.org/state-legislative-action-on-pharmaceutical-prices/)

Other available resources include:

- Model legislation on Transparency, Rate Setting, Importation & PBMs [https://nashp.org/model-legislation/](https://nashp.org/model-legislation/)
- Legal Resources: [https://nashp.org/legal-resource-center/](https://nashp.org/legal-resource-center/)
- Glossary of Rx Terms: [https://nashp.org/glossary-of-pharmaceutical-terms/](https://nashp.org/glossary-of-pharmaceutical-terms/)
Questions?

Jennifer Reck, MA
NASHP
jreck@nashp.org