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Feeling the Squeeze: Prescription Drug Pricing Trends and State Policy Options

Presentation slides, event video and other briefing materials available at:
https://uwphi.pophealth.wisc.edu/programs/health-policy/ebhpp/events/index.htm

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Dr. Kevin Look: Prescription Drug Pricing Trends in America

Dr. Look provided an overview of prescription drug pricing trends in the United States. Currently, brand-name drugs (also known as single-source, or patent-protected pharmaceuticals) account for 15% of total expenditures, while generics (multi-source, or off-patent) are 85% of expenditures. Generics tend to have multiple manufacturers, resulting in increased competition, thus driving prices down. Prices have increased for both types of prescription drugs, though steeper increases are often seen in brand-name pharmaceuticals. The average cost of these drugs has grown more than three-fold nationwide between 2006 and 2015. Concern over pricing of these drugs is due to both high initial price tags, and continued annual, or one-time, price increases. Private insurance pays for 40% of total drug expenditures, followed by Medicare (29%), out-of-pocket payments in co-pays or co-insurance (15%), and Medicaid (9-10%).

Dr. Look discussed list price for pharmaceuticals, as determined by the manufacturer, and noted that "list prices do not accurately reflect the true costs of these medications." Rather, price is determined by a mix of ingredient costs, research and development, taxes, profits, lobbying efforts, settlements, and advertising. These increases often reflect what the market will bear, and may be priced on the presence and cost of other treatments or products already on the market. Some data shows that up to half of manufacturer revenue is retained as profit or used in marketing, either through detailing to prescribers or direct-to-consumer advertising, a practice only permitted in New Zealand and the United States. Dr. Look cautioned against international comparisons, however, as nations have vastly divergent health systems, and many other nations impose controls on drug pricing. He placed this discussion in the context of recent controversy on price increases in products such as treatment for Hepatitis C (where Sovaldi, a curative pharmaceutical therapy, was introduced to the market with a price tag of $84,000 for a 12-week regimen), Daraprim, EpiPens, Deflazacort, and Naloxone.

Dr. Look also described the pharmaceutical pipeline, from manufacturers to wholesalers, pharmacies, and patients. This system is further complicated by payers such as Medicare, Medicaid, and Prescription Benefit Managers (PBMs) that may add profits or negotiate discounts and rebates. Though some PBMs exercise

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transparent business practices, Wisconsin lacks comprehensive drug pricing transparency policy. Addressing costs through policy will involve balancing cost with protecting innovation, but tracking true research and development efforts and assessing benefits would be difficult.

Dr. Joe Cesarz: Specialty Pharmacy Overview and Implications

Dr. Cesarz focused his discussion around specialty pharmaceutical products and specialty pharmacies. In 2011, marketplace revenue for specialty products was 17% of total expenditures, growing to 28% in 2016, and projected to account for 42% of pharmaceutical expenditures in 2021. These products frequently have a high initial price tag, and are often aimed at treating specific complex disease states such as oncology, hepatitis, and cystic fibrosis. They also involve complex treatment regimens such as infusions, and require special handling, storage, or delivery. Even more so compared to non-specialty pharmaceuticals, they may be vitally important to a patient's health status. Drug manufacturers or health plans may elect to contract with limited pharmacies for specialty products to lower distribution costs, streamline access to utilization data, or support a perceived higher quality of patient care. Therefore, these products are not available at all pharmacies. Speciality pharmacies may provide services that traditional pharmacies do not, such as benefits investigation, co-pay assistance, or therapy management. UW Health alone employs 35 individuals for prior authorization support at their specialty pharmacies. Many of these services are not reimbursable.

According to Dr. Cesarz, the key question is: "What should the pricing of drugs be based off of?" He commented that the "benefits you see with a manufactured drug product aren't necessarily aligned with who's paying." Price may be based on ingredient inputs, acceptable profit margins, value of a particular treatment, or any number of other factors. Tackling high prescription drug prices will require a mixed approach, relying on a range of policy levers. These may include price transparency limits, including penalties for price hikes, or requiring manufacturers to submit data on inflation.

Rachel Currans-Henry: Managing Wisconsin Medicaid's Pharmacy Program

Ms. Currans-Henry described the regulatory framework for prescription drug coverage under Wisconsin's Medicaid program, along with the state's "toolbox" for approaching drug pricing. The Social Security Act requires that state Medicaid programs must cover all FDA-approved drugs for any "medically accepted indication" regardless of price or value. Only drugs that are described as "less than effective" or experimental are excluded. The program is explicitly prohibited from paying for pharmaceutical profits, and is instead only permitted to pay for cost plus a reasonable professional dispensing fee.

The state's Medicaid program serves over 1.2 million enrollees, where 700,000 are enrolled in managed care programs. Nineteen health plans administer medical benefits, though the state program oversees them and applies purchasing power to increase competition among drug manufacturers. The state also leverages selective contracting to secure lower rates for preferred agents through Preferred Drug Lists (PDLs). The Medicaid program further monitors specialty products and requires justification for use of some brand-name prescription drugs. The state's Drug Utilization Review (DUR) Board also serves a vital role in advising program management. Unlike other payers, Medicaid does use any willing pharmacy, where enrollees can access pharmaceuticals at any of over 1,600 pharmacies around the state. The Department of Employee Trust Funds (ETF), Department of Corrections (DOC), and the Medicaid program have explored ways to leverage purchasing power in some cases.

Wisconsin's Medicaid program relies heavily on rebate dollars from manufacturers, and specialty drug cost expenditures account for a growing portion of overall costs, seeing an increase of 40% in the last 4 years. Exceeding national and statewide spending trends, specialty drug costs now account for 26% of expenditures, as the Medicaid program serves a disproportionate population of individuals with complex care regiments and disability status. To address costs, the state promotes adherence of treatment and continued product efficacy. Ms. Currans-Henry comments that drug pricing transparency alone will not ensure lower costs, but that actions must follow to address findings. A current initiative to move toward value-based purchasing arrangements may be a creative solution, allowing states to pool negotiating power with pharmaceuticals that are able to show evidence-based improvement for medications.

Eileen Mallow: NASHP Pharmacy Costs Workgroup 2016 Report on Prescription Drug Pricing

Ms. Mallow reviewed findings from 2016 National Academy for State Health Policy (NASHP) Report on prescription drug pricing. The committee—composed of legislators, Governors' office staff, and state agency leadership from across the nation—was charged with investigating state policy options regarding price caps, trade policies, and purchasing strategies. The workgroup generated 11 key strategies that states may consider to work toward reducing costs, and is working to develop model legislation for several of these strategies. These policies include, among others:

1) Price transparency legislation for PBMs and manufacturers that may include reporting bodies to review significant price increase or high-introduction prices (model language here)
2) Public utility models to oversee drug pricing using public health benefit rationales
3) Bulk purchasing power for pharmaceuticals such as HIV drugs and vaccines that would involve purchase by a public health authority
4) Enforcing consumer protection laws related to misleading advertising and antitrust violations
5) Reimportation of more affordable drugs from Canada
6) Transforming states into PBMs to manage their own consolidated programs

The NASHP committee will continue to investigate these and other policy options, along with track state legislation and outcomes.