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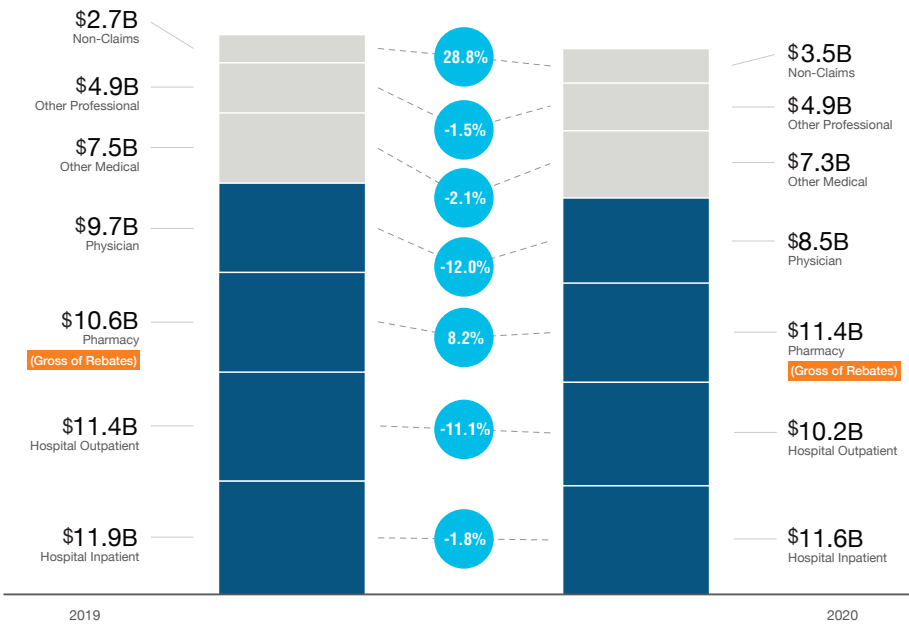
Prescription Drug Pricing: Efforts That Erode Cost-Containment Strategies

Rising prescription drug prices are one of the top contributors to health insurance premium increases and high out-of-pocket costs for consumers, placing a financial burden on patients, families, and the health care system. Nationally, the Centers for Medicare & Medicaid Services (CMS) projects that in the U.S., prescription drug spending will grow at an average annual rate of 5.3% for 2019-28 and is expected to reach $560 billion by 2028.[1]

In Massachusetts, prescription drug spending continues to account for a significant portion of health care spending. According to the Center for Health Information and Analysis' (CHIA) 2022 Annual Report on the Performance of the Massachusetts Health Care System, pharmacy expenditures are the second-largest service category of total health care expenditures. Pharmacy spending totaled $11.4 billion in 2020, an 8.2% increase from $10.6 billion in 2019.[2] See Figure 1.

Figure 1: Spending Changes Across Service Categories



From 2019 to 2020, spending decreased across all service categories except for non-claims and pharmacy.

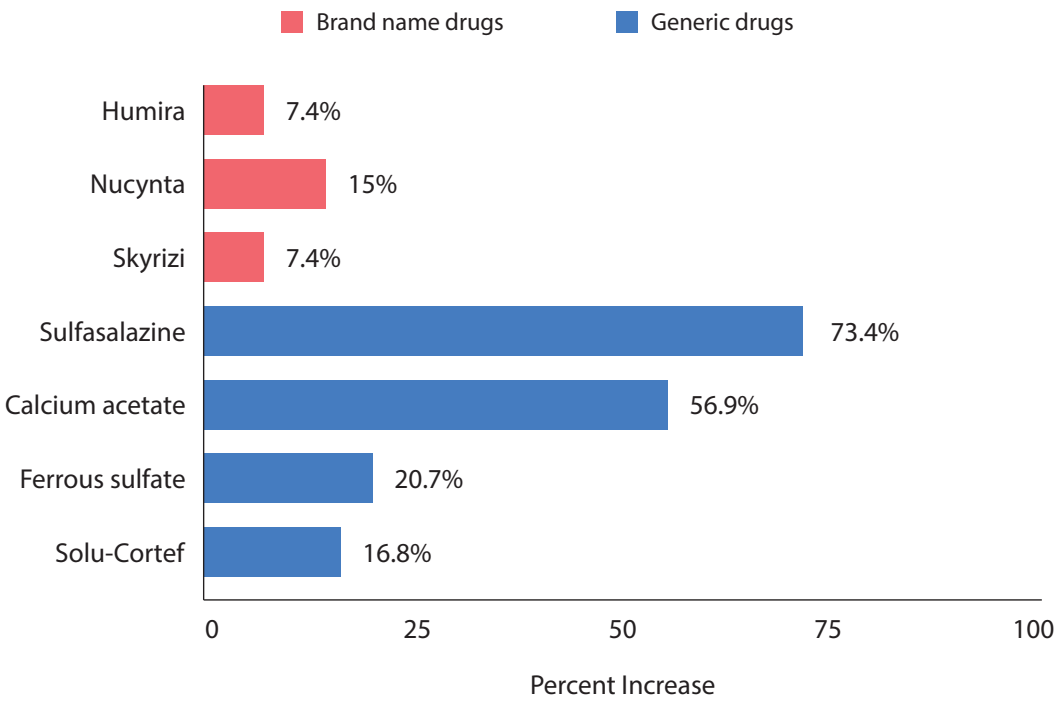
Source: CHIA 2022 Annual Report on the Performance of the Massachusetts Health Care System

In recent years, state and federal policymakers have explored a number of public policy solutions aimed at addressing rising prescription drug costs. While well-intentioned, these solutions are often aimed at limiting consumer cost-sharing rather than addressing the underlying costs of prescription drugs. This OnPoint examines the challenges associated with such an approach and offers alternative solutions to rein in prescription drug prices.

Rising Prices for Specialty, Brand-Name, and Generic Drugs

A 2022 GoodRx analysis found that a total of 810 drugs increased in price by an average of 5.1% in January. Out of these, 791 were brand-name drugs for which prices increased by an average of 4.9% and 19 were generic drugs for which prices increased by an average of 12.6%, which is three times the increase from 2021. Examples of such price increases for brand name and everyday medications include:[3]

Figure 2: Percent Increase for Brand Name and Generic Drugs



Note — Humira, a drug for inflammatory conditions in adults; Nucynta, a drug to relieve severe pain; Skyrizi, a drug used to treat plaque psoriasis; Sulfasalazine, a rheumatoid arthritis drug; Calcium acetate, a drug for kidney disease treatment; Ferrous sulfate, an iron supplement; Solu-Cortef, a drug used to treat various conditions.

Source: 2022 GoodRx Analysis

Increases in drug list prices trickle down to consumers in the form of higher cash prices, insurance premiums, and copays. This is particularly evident with specialty drugs, whose demand has led to significant increases in pharmacy costs. Retail prices for 180 widely used specialty prescription drugs increased by an average of 4.8% in 2020, more than three times the rate of general inflation for that same period (1.3%), according to the AARP's latest Rx Price Watch Report. This category generally includes drugs that are used to treat complex, chronic conditions and require special administration or handling. In 2020, the average annual cost of therapy for a single specialty prescription drug, based on the market basket used in this study, was $84,442. However, this would have been $39,068 if retail price changes for these drugs had been limited to the rate of inflation from 2006 to 2020.[4] This average was also 13 times higher than the average cost of therapy for brand-name prescription drugs ($84,442 vs. $6,604, respectively).

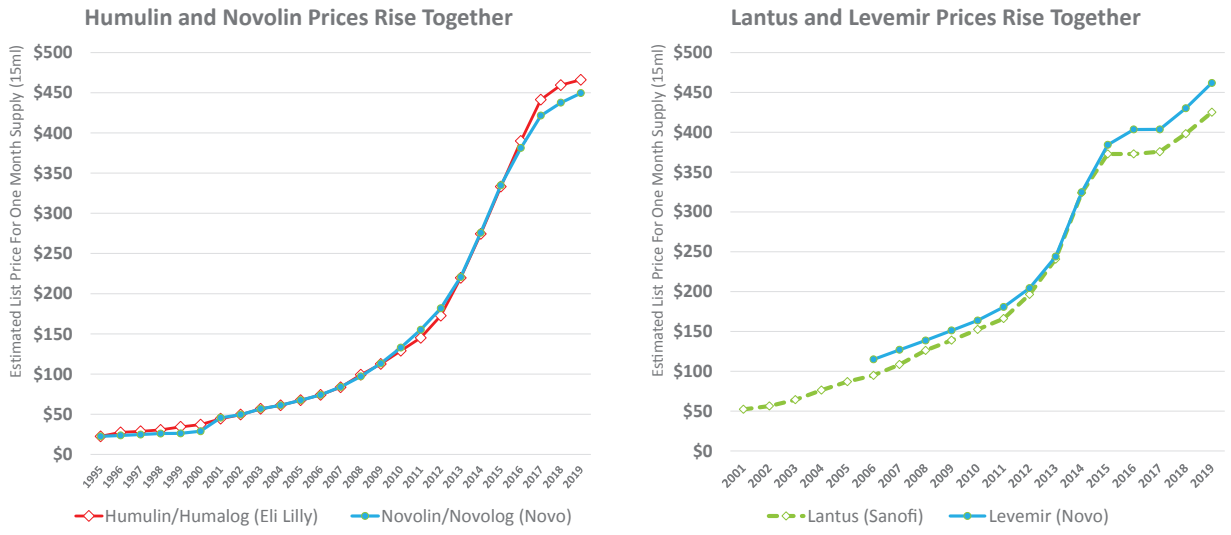
Public Policy Efforts That Erode Cost-Containment Strategies

Capping Prescription Drug Cost-Sharing Does Not Solve the Problem of High Drug Prices

MAHP and our member health plans strongly believe that consumers should have access to comprehensive health care coverage that includes preventive care and management of chronic health conditions like diabetes. We are deeply concerned about the rising cost of prescription drugs, like insulin products, which are the direct result of lack of competition, transparency, and accountability in the prescription drug market.

In response to rising drug prices, lawmakers understandably look for solutions that help address the out-of-pocket costs that consumers are paying. To date, several states have passed legislation that implements some type of monthly copay cap for prescription drugs, particularly for insulin and other diabetes products. Although this approach is intended to provide consumers relief from high drug prices, it does not actually address the underlying problem—the rising costs of drugs. The price of insulin has risen inexplicably over the past 20 years at a rate far higher than the rate of inflation. For example, one vial of Humalog (insulin lispro), which used to cost $21 in 1999, costs $332 in 2019, reflecting a price increase of more than 1000%.[5]

Figure 3: Skyrocketing Insulin Prices



Source: Visante estimates and analysis of SSR Health data, 2020.

Copay caps prevent consumers from understanding price increases. Capping patients' out-of-pocket costs may lessen consumers' financial burden, but it does not address the underlying drug price increases, which are ultimately passed on to consumers in the form of higher premiums.

- Copay caps are supported by drug manufacturers to ensure that consumers are unaware of the underlying increases in the costs of drugs.
- When there is a copay cap in effect, consumers become unaware of any increases in their drug prices since their out-of-pocket costs will not increase at the point of sale.
- As consumers become blind to the increases in drug prices, there is no public disapproval and pharmaceutical companies can continue to raise prices or accelerate increases knowing that consumers will not be made aware of this.
- The costs of prescription drugs are shifted to health insurance plans, which ultimately results in everyone paying more for their health care, including those individuals who are not taking prescription medications because premiums will be impacted for all insured individuals.

Copay caps benefit drug manufacturers. Prescription drug manufacturers deflect blame for skyrocketing drug costs by falsely claiming that the high costs of drugs are a "coverage" problem that would be solved by implementing copay caps and other restrictions on plan design. But they fail to mention that by capping out-of-pocket costs, physicians choose more expensive brand-name drugs over lower-cost generics that are equally effective. This creates the cycle of price increases.

Health plans use drug tiers to incentivize consumer engagement in medical decision-making. Through the use of drug tiers, health plans require higher out-of-pocket costs for more-expensive drugs. When copay caps are in place, the decision-making process health plans use to provide patients with access to lower-cost but equally effective alternatives, including generics, is disrupted.

Copay caps benefit brand drug manufacturers and prevent payers from effectively managing drug costs. They shift costs from patients to health plans, which then are required to increase premiums to compensate for the higher costs. Ultimately, all insured individuals bear the higher costs through higher premiums.

The Slippery Slope of Capping Cost-Sharing. We are concerned that if a legislation is passed eliminating cost-sharing for one condition, like insulin for diabetes, it will encourage further legislation to eliminate consumer cost-sharing for other conditions. There are currently more than a dozen bills before the Massachusetts Legislature that seek to eliminate or restrict cost-sharing on broad categories of drugs or allow coupons and cost-sharing assistance from drug manufacturers to count toward a member's deductible. Consumer cost-sharing is an important and necessary tool to reduce waste in the health care system, protect patient safety, and slow down health care cost growth.

These bills will hamper the ability of health plans to effectively manage drug costs. We recognize the challenges that consumers face due to the rising costs of prescription drugs, but we caution that these legislative approaches that limit consumer exposure are not effective for the following reasons:

- They do not address the exorbitant increases in the prices pharmaceutical companies charge for prescription drugs and will likely lead to increased premiums.
- They permanently assist drug companies in selling high-cost brand-name drugs at the expense of more cost-effective generics.
- They shift the waived costs charged by pharmaceutical manufacturers to employers and consumers through increased monthly health insurance premiums.
- They impact the actuarial value of health care products sold in Massachusetts.
- They impact providers' prescribing patterns, as they will likely choose more expensive brand-name drugs over lower-cost generics that are equally effective.

If legislation to cap cost-sharing is not combined with efforts to rein in drug prices, it will lead to drug pricing abuses, result in increased premiums, and exacerbate health care affordability issues for everyone. In Massachusetts, the high cost of prescription drugs will continue to jeopardize the ability of the state to meet the cost growth benchmark. At a time when health plans are being held accountable for keeping health care costs down, we should be concerned about advancing any policies that will have the opposite effect on premiums.

Use of Manufacturer Drug Coupons Leads to Higher Drug Costs

Drug coupons are funded by pharmaceutical manufacturers of prescription drugs and are used to lower or eliminate the out-of-pocket costs that patients pay at the pharmacy for specific brand-name drugs. The health plan's costs for the drugs remain unchanged, as does the impact of the drugs' costs on health plan premiums.

In Massachusetts, drug coupons are only allowed to be used for drugs where there is no generic alternative available. Drug coupons were originally allowed under a provision of the state's FY2013 budget, which was intended to sunset in 2015 but has since been extended every year. It is now set to sunset in July 2023.

A manufacturer may offer a coupon for a brand-name drug that reduces the copay for that drug and makes it cheaper than the copay for a competitor's drug. However, encouraging individuals to switch to a higher-cost drug through the use of coupons adds to prescription drug costs.

- Coupons reduce the effectiveness of tiering and cost-sharing as tools health plans use to contain spending.
- Coupons diminish price competition among drugs and limit health plans' ability to discourage the use of certain drugs via tiered formularies.

A new report from the National Bureau of Economic Research found that drug copay coupons drive consumers to more expensive branded drugs when lower-cost alternatives may be available. This increases health care system spending that is ultimately passed on to consumers in the form of higher premiums.[6]

Findings from the Health Policy Commission's (HPC) 2020 Study on Prescription Drug Coupons concluded that drug coupons increase utilization and spending for a number of drugs with lower-cost generic alternatives that would be clinically appropriate for many patients, which may result in higher premiums.[7]

Eliminating Health Plan Tools to Address Prescription Drug Prices Leads to Increased Premiums for Consumers

Utilization management tools like formulary development, network development and management, and prior authorization and step therapy programs are aimed at lowering the costs of prescription drugs, promoting the use of generics and more affordable brand-name prescriptions, improving quality and medication adherence, and keeping costs down for consumers.

Health plans implement pharmacy benefit management programs to promote quality, patient safety, and lower costs. For instance, health plans implement tiered formularies to provide consumers with flexibility in their pharmacy benefits while encouraging the use of cost-effective medications, such as generic drugs and preferred brand names, through varied copays. Through these arrangements, consumers have access to medications and prescribing decisions are left to physicians, and health plans and their pharmacy benefit managers (PBMs) can negotiate discounts with manufacturers in exchange for higher volume. Health plans develop pharmacy networks, which are lists of pharmacies that specific plans contract with to provide medications and care to health plan members at lower prices. Networks include retail pharmacies, specialty pharmacies, and mail-order pharmacies which provide access and choice to members to fill their prescriptions. Network pharmacies must meet requirements for quality and safety and demonstrate compliance through credentialing and accreditation requirements.

A Growing Concern: The Impact of Pharmaceutical Manufacturers on Patient Advocacy Efforts

Unlike payments to providers, pharmaceutical manufacturers are not legally required to disclose donations to patient advocacy organizations (PAOs). The Kaiser Prescription for Power Database offers insight into the financial relationships between the pharmaceutical industry and PAOs. In 2015 alone, Kaiser found that 14 pharmaceutical companies gave over $116 million to 594 patient groups.

In Massachusetts, PAOs with Kaiser-tracked donations from pharmaceutical manufacturers have lobbied extensively on bills to eliminate important health plan utilization management tools like step therapy.

Without transparency into these payments, policymakers and the public are blind to the incentives provided and the potential conflicts of interest between pharmaceutical companies and PAOs.

Step therapy programs are one of the tools that health plans use to ensure quality, protect patients from harm, and control costs. Step therapy is used for a limited number of conditions with the goal of ensuring that consumers receive a safe clinical outcome with lower-cost options. Step therapy protocols are performed when there are other drugs in the class of drugs initially prescribed by a clinician that have lower cost, and may have fewer potential risks or side effects, and are indicated as the first-line medication options by medical guidelines. All medications have side effects or place patients at risk of other adverse situations, and neither payers nor providers intend to have patients use drugs that are not useful or effective.

The newest drug to market may not be the necessary starting point to treat a disease; therefore, in developing their step therapy policies, health plans work with disease state and drug experts, including physicians and pharmacists, as part of their pharmacy and therapeutics committees and review national studies and clinical criteria to ensure their policies conform to up-to-date medical evidence and practice guidelines. Step therapy programs have been used in the Medicare program since 2019, when CMS issued new guidance that allows Medicare Advantage (MA) plans to use step therapy for physician-administered and other Part B drugs, recognizing that MA plans may use this tool to control the utilization of services in a manner that does not create an undue access barrier for beneficiaries.[8]

Utilization management programs ensure that doctors consider medically appropriate alternatives before settling on a course of therapy for a specific patient, which can improve the quality of care for a patient on multiple medications. Drugs with a high risk of abuse or overuse, such as powerful pain medications and antipsychotics, are good candidates for step therapy to encourage the use of lower cost, first-line, medically appropriate therapies. For example, according to the established treatment protocols, a shorter-acting morphine sulfate product should be tried before moving to longer-acting products like OxyContin. Physicians should not be initially prescribing very powerful pain medications but rather adhering to a progression of management. In addition to being cost-effective, step therapy assists with the abuse potential of these products.

Finally, while utilization management tools like step therapy are an important to ensure patient safety and control health care costs, MAHP and our member health plans support efforts to promote continuity of care for patients and avoid interruptions in drug therapies for health plan members, such as the establishment of a transition period to promote continuity of care and avoid interruptions in medication.

Specialty pharmacies improve health care affordability while protecting patient safety. Health plans selectively contract with specialty pharmacies to ensure access to safe, high-quality, and cost-effective specialty medications. Specialty pharmacies require a higher degree of organization, care management, and clinical knowledge about rare disorders and biologic products than are often available in retail pharmacies. Specialty pharmacies are subject to national accreditation standards requiring adherence to much higher safety standards and 24-hour customer service standards and have clinical staff on call to provide assistance to patients. Because specialty pharmacies often serve patients with complex medical needs, they are equipped with staff to provide services that improve patient adherence and continuity of care and provide clinical support.

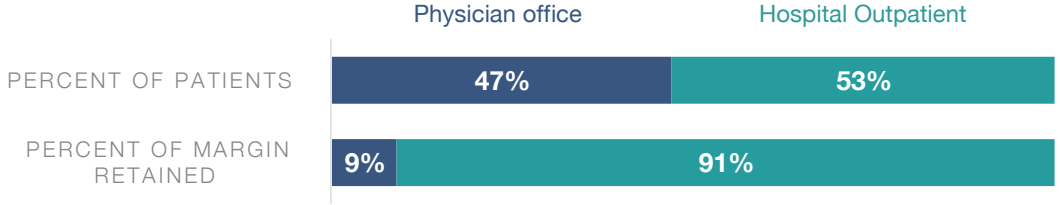
Specialty pharmacies also have the scale to negotiate lower prices with manufacturers of specialty drugs and are able to provide greater discounts in exchange for higher patient volume. Policies that disrupt the ability of health plans to develop and utilize specialty pharmacy networks would result in higher costs and impact quality. While specialty pharmacy networks may include hospital-owned pharmacies, policies that prohibit the use of the health plan's specialty pharmacy network and require buy-and-bill programs within hospitals or clinics have a direct impact on the cost of care.

The prices charged to the health plan vary widely based on site of service. For instance, a survey of MAHP member health plans noted that less than 1% of prescription claims accounts for over 30% of prescription drug spending in Massachusetts. A recent analysis comparing costs for physician-administered drugs purchased from a specialty pharmacy to physician-administered drugs purchased from a hospital found that some hospitals mark up prices on more than two dozen medicines by an average of 250%.[9]

A research report by the Partnership for Health Analytic Research noted that injectable and infused drugs—such as those for rheumatoid arthritis and oncology—are typically administered in an outpatient setting by physicians, either in the physician's office or at a hospital outpatient clinic. Research indicates that commercial payers reimburse hospital clinics at a higher rate than they do physician offices.[10] Hospitals and physician offices charge commercial insurers whatever price they negotiate, and they retain any difference between the negotiated price and the cost of acquisition.[11]

The findings of the report indicate that physician offices and hospital clinics treat similar numbers of patients in the commercial market, but hospitals receive a larger share of the gross profits. Hospitals collect 91% of the gross profit margin while serving 53% of patients receiving physician-administered medicines.[12]

Figure 4: Hospital Margin Analysis Report



Source: Estimation of Hospital Share of Gross Profits for Physician-Administered Medicines Reimbursed by Commercial Insurers

A 2019 HPC report on specialty pharmacy use for clinician-administered drugs noted that drug prices were substantially lower when billed through a health plan's specialty pharmacy than when the hospital purchased the drug and billed the health plan (buy and bill).[13] The state should not be setting policies that erode cost-containment strategies but instead should encourage policies and solutions that address the rising prices of prescription drugs. MAHP supports the utilization of specialty and mail-order pharmacy networks, as they yield savings and reduce the cost of care for health plans, employers, and consumers.

AHIP Study Findings on Hospital Prices

An AHIP study examined data from 2018 to 2020 and analyzed the cost of 10 drugs that are purchased, stored, and administered in a health care setting. It found that:

Costs per single treatment for drugs administered in hospitals were an average of $7,000 more than those purchased through specialty pharmacies.

- Drugs administered in physician offices were an average of $1,400 higher.
- Hospitals, on average, charged double the prices for the exact same drugs compared to specialty pharmacies.
- Prices were 22% higher in physicians' offices for the exact same drugs, on average, compared to specialty pharmacies.

High drug prices and costs for hospitals and physicians aim to produce higher reimbursement rates and higher payments. Moreover, these costs are in addition to the fees hospitals and physicians are paid to administer the drugs to patients.[14]

Recommendations

The best way to lower costs for consumers is to take a strong approach to address the out-of-control price increases imposed by prescription drug manufacturers. Robust solutions are necessary to ensure that consumers in Massachusetts are able to access affordable medications, including:

1. **Require Transparency in Prescription Drug Pricing** – The HPC, in collaboration with CHIA, should identify a list of prescription drugs for which the state spends significant health care dollars and for which prices have increased significantly over certain time periods, as well as drugs that are new to the market that have significantly impacted the cost growth benchmark. The HPC should require those drug manufacturers to provide an explanation for the increases, including disclosures of research, development, marketing, and manufacturing costs, as well as the profits attributable to those drugs. Likewise, pharmaceutical companies that propose to raise their prices by 10% or more should be required to provide notice to the HPC 30 days before the new prices are to take effect, explaining the rationale for the increase so that consumers, employers, providers, health plans, and the state have notice before the increase takes effect.

   MAHP supports the drug pricing review process proposed in Governor Baker's 2022 health care bill, An Act Investing in the Future of Our Health, which would allow the HPC to require drug manufacturers to disclose information on the pricing of drugs, including the wholesale acquisition costs, research and development expenditures, and factors contributing to increases. MAHP also supports similar provisions in the PACT Act, An Act Relative to Pharmaceutical Access, Costs and Transparency, to increase prescription drug pricing transparency. Additionally, if passed, the PACT Act would require the inclusion of pharmaceutical manufacturing companies in the annual HPC health care cost trends hearings, which have been instrumental in increasing transparency in health care costs for payers and providers.

2. **Limit Drugmakers' Ability to Increase Prices and Establish Penalties for Price Gouging** – The state has seen evidence of price increases of branded, generic, and specialty drugs nationally and locally, which contributes to spending by health plans and employers. In 2020, prices for 260 commonly used medications whose prices AARP has been tracking since 2006 increased 2.9%, while the general rate of inflation was 1.3%, according to a recent AARP Rx Price Watch Report. To prevent such increases, policymakers must support legislation that limits the annual cost of prescription drugs, require drug companies to report and justify increases in drug prices, and face financial penalties for unjustified increases.

MAHP supports provisions in Governor Baker's health care bill that address rising prescription prices and affordability. It would establish a penalty on drug manufacturers (80% of the excessive price increase for each unit) for excessive prices and excessive price increases and authorizes the HPC to issue monetary penalties for these excessive prices and increases.

MAHP also supports provisions in the PACT Act, which would require the HPC, in consultation with stakeholders, to establish a process for identifying drug price changes that pose a public health risk. The provision authorizes the HPC to identify high-cost drugs and essential public health drugs with large price increases and determine the drug's proposed value. It would further impose monetary penalties on drug manufacturers for noncompliance.

3. **Protect Health Plans Tools Used to Control Prescription Drug Costs** – Consumer cost-sharing and drug tiering are important tools that help health plans reduce waste in the health care system, protect patient safety, and slow down health care cost increases. The use of equivalent generic drugs can save money for both the patient and the health plan or employer. Restricting the patient's out-of-pocket expense in all categories of drugs removes the patient's incentive to choose the lower-cost alternative. Consumer protections already exist to insulate insured members from cost-sharing liability—each enrollee's out-of-pocket costs for health care, including all member spending for prescription drugs, may not exceed a certain dollar amount every year.

4. **Support Utilization of Specialty and Mail-Order Pharmacies** – Health plans require that specialty pharmacies meet important national accreditation standards to be included in their networks to ensure quality and consumer safety. "Any willing pharmacy" laws assume that all pharmacy services are the same, no matter who provides them or how they are organized, which has a direct impact on health care costs and quality of care for consumers. Specialty pharmacies require a higher degree of organization, care management, and clinical knowledge of complex medical conditions. Mail-order pharmacies can achieve significantly lower prices through higher volume. These savings are then passed along to consumers through lower cost-sharing. During the COVID-19 pandemic, access to mail-order pharmacies proved to improve quality, convenience, and medication adherence for patients with restricted mobility and limited access to transportation. MAHP supports the utilization of specialty and mail-order pharmacies as they yield savings and reduce the cost of care for health plans, employers, and consumers while providing high-quality medications.

5. **Require Transparency in Patient Advocacy Organizations** – PAOs play an important role as representatives of patients and caregivers. Federal legislation introduced in 2018 (the Patient Advocacy Transparency Act) would expand the Physician Payments Sunshine Act to include reporting of financial ties between PAOs and the pharmaceutical industry. Also requiring financial transparency on the state level would shed light on potential conflicts of interest. Increased regulation and transparency on pharmaceutical company contributions would allow PAOs to operate with no potential underlying motives and policymakers to assess the pharmaceutical financial ties with PAOs. MAHP supports state-level legislation to require PAOs to disclose contributions from pharmaceutical companies.

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