Prescription Drugs (Rx) – Fast Facts

- More than half of all Americans use prescription drugs
- Many products, both unique and competing:
  - US Food and Drug Administration (FDA) approved (dosages; delivery method) totals over 10,000
- 90% of prescriptions filled now are generics (2017)
- Rapid pace of new, extraordinary treatments
How Much are We Spending on Prescription Drugs?

- 10% of all health care spending went to prescription drug-related costs: $450 billion*
- 16.7% of overall personal health care spending went toward prescription drugs in 2015
- 53% of that goes to brand-name prescription drugs
- 7.6% of all drug spending is for specialty drugs ($600/month; injected or infused)
- 15% of Medicaid spending goes to prescription drugs
  - 10% for brand-name
  - 5% for generics

* See Rx Spending fact sheet for details
Growth in Spending: Rx and Health

Source: www.healthsystemtracker.org/chart-collection

down 0.7%

Generics Share of Prescriptions

Generic drugs now account for 90% of all dispensed retail prescriptions

Source: IMS Health, National Prescription Audit, Jan 2014
What are States Doing?

- Protecting coverage:
  - Essential Health Benefits and formularies
  - Access options: step-therapy and fail-first requirements
- Cost and price transparency
- Pharmacy Benefits Management (PBM) restrictions –
  - Ban gag clauses on pharmacists’ discussion with patients

What are States Doing? Part 2

- Prohibit “price gouging”
- Prescription drug importation
- Price negotiations:
  - Bulk purchasing
  - Multi-state purchasing
Rx Bulk Purchasing, Negotiations and Rebates

Medicaid State Pharmaceutical Rebates (Discounts)

Compiled by NCSL. Updated 9/1/2017. See online Report for details and status.

NCSL

Pharmaceuticals

Drug Policy Resources Center

Biologics & Experimental RX

2017-18 Additional Pharmaceutical Issues

NCSL reports available online

- Medication adherence
- “Cap the copays” to limit out-of-pocket consumer costs
- Biologics versus interchangeable biosimilars
- “Right to try” unapproved drugs
- Allow “return and reuse”
- Value-based contracts/reference pricing
- Academic detailing: objective facts generic and brand
- Preventing prescription drug abuse and illegal sales
Options for Legislatures – Prescription Drugs

- Consider what changes will affect: access, affordability and consumer choice
- Hold a briefing on Medicaid pharmaceutical policies
- Examine cost containment innovations and alternatives
- Consider the level of regulation for access and costly drugs
- Compare your state to your neighbors that are of similar size and income

Legislators balancing Cures and Costs

In Summary:
You represent your state as purchaser, as your constituents’ guardian, and as regulator.

Photo of Hepatitis C virus, electron microscopy.  
Science Source, NPR Broadcast, Oct 4, 2017
Bipartisan Budget Act accelerated closure of the Medicare Part D program, with beneficiary costs reducing to 25% in 2019

Increased percentage drug manufacturers must decrease the cost of prescriptions from 50% to 70%

Secretary of the US Department of Health and Human Services, Alex Azar, discussed the White House budget proposals to reduce prescription drug costs

Thank you!

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Medicaid in a Time of Historic Change:

Prescription Drugs and Costs –
A Medicaid Perspective

Presented to NCSL Health Seminar for Newer Legislators

April 15, 2018
Steve Fitton, Principal at Health Management Associates

Agenda

- Drug Costs and State Health Coverage
- National Medicaid Pharmacy Policy Framework
- Medicaid Budget Pressures
- State Medicaid Drug Cost Control Strategies
- The Challenges of High Cost Specialty Drugs
- Possible Strategic Directions
Drug Costs and State Health Coverage

- Drug costs impact affordability of health insurance in all its forms whether financed by government, employers, or citizens
- This impacts both direct costs to state government and health coverage of citizens with indirect uncompensated care costs
- While Medicaid has some unique pharmacy purchasing policies, it is subject to the same healthcare cost pressures of other payers (i.e., it is inescapably part of the U.S. health care system)
- Drug costs are hardly solely responsible for increasing healthcare costs but are getting considerable attention of late

National Medicaid Pharmacy Policy Framework

- Key is the national Medicaid Drug Rebate Program (MDRP) authorized by Section 1927 of the Social Security Act
- Agreement is between the Centers for Medicare and Medicaid services (CMS) and each drug manufacturer
- It assures coverage of most of each manufacturer’s outpatient prescription drug products by state Medicaid programs
- Medicaid programs get “best price” through a fairly complex set of formulas no less than a statutory minimum percentage
- Each manufacturer also participates in 2 other federal programs: the 340B program and with the Veteran’s Administration
- CMS also limits state Medicaid agencies to federal upper limits in their drug pricing methodologies
Medicaid Budget Pressures

Source: National Health Expenditures

Medicaid Budget Pressures

Source: National Health Expenditures
Medicaid Budget Pressures

- Medicaid programs account for about 29% of a state’s total budget and 17% of state general fund budgets
- Healthcare costs in the U.S. continue to exceed state revenue and GDP growth rates
  - In 2016, U.S. healthcare spending increased 4.3% and is estimated to increase an average of 5.5% each year over the next 10 years
  - In 2016, GDP growth was 2.8% and is estimated to increase by an average of 4.5% each year over the next 10 years
  - Year-to-year and state-to-state general fund growth varies considerably; important to note that 26 states enacted general fund spending increases below 2% for FY18

Medicaid Budget Pressures - Pharmacy

- The pharmacy component of health care costs averaged double digit growth from 1980 through 2006
- Drug cost increases were very modest from 2007 thru 2013
- In 2014, national prescription drug spending increased 12.2%; in 2015 8.9%; and in 2016 1.3%
- Medicaid drug costs grew 24.3% in 2014 “as a result of increased enrollment and spending for drugs that treat hepatitis C” (should be noted that this was an unusual year)
- National prescription drug spending is projected to grow well over 6% per year over the next 10 years (specialty drugs are driving this rate of increase)
Medicaid Budget Pressures - Summary

- Medicaid programs account for a very large portion of state budgets
- Healthcare and Medicaid costs continue to exceed overall national economic and state revenue growth rates
- Pharmacy costs continue to grow at a rate that is greater than national healthcare spending or Medicaid cost growth

Medicaid Drug Cost Control Strategies – Pools

- Multi-state purchasing pools began in 2003
- Currently slightly more than half of the states belong to one of four purchasing pools
- In combination with this purchasing power, states adopt preferred drug lists to leverage price
- Pharmacy manufacturers offer supplemental rebates in addition to the federally required rebate
- Federal and supplemental rebates are now estimated to be approximately 50% of initial payments
Medicaid Drug Cost Control Strategies – Other

- Beneficiary contributions to the cost of care primarily in the form of co-payments
- Co-payments are generally very modest because of federal requirement to be nominal; occasionally they are tiered, a much more common practice in the private sector
- There is considerable emphasis on fraud, waste, and abuse issues that affect cost and population health
- Opioids are currently a major focus for Medicaid as well as the general population

Drug Cost Control Strategies – Carve Ins and Outs

- States are expanding their managed care footprint to cover additional eligibility groups and previously excluded services
- Whether drugs should be carved in or carved out is debatable
- Current practices vary considerably including mixed models where some classes are carved in and others out
- Common formularies simplify practice for physicians and hospitals in various ways including beneficiary transitions
- Carve-in argument: Drugs are an integral part of the overall plan of care and the overall cost of care (health plan “secret sauce”)
- Carve-out argument: While drugs are integral to the plan of care they are fundamentally a commodity where leveraging price should be a driver in the value proposition
**Challenges of High Cost Specialty Drugs**

- State Medicaid populations have a disproportionate number of persons with chronic diseases that benefit from new and very expensive drugs
- Of the 3.5 million persons in the U.S. believed to have Hepatitis C, about 1 million are estimated to be on Medicaid
- A Milliman analysis concluded that the Hepatitis C prevalence rate in Medicaid is 7.5 times higher than for the commercially insured
- The retail breakthrough drug price started at $84,000 for a treatment course
- California estimated that they could spend as much as $6.7 billion if all Medicaid beneficiaries and prisoners with Hep C were treated

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**An Oversimplified Reaction**

Michigan General Fund (GF) Budget = $10 billion
2017 Revenue Increase Estimated at 2.5% = **$250 M new money**
Estimated 1 million Medicaid beneficiaries with Hepatitis C
Michigan’s proportion of national estimates is typically 3.3%
1 million times 3.3% = 33,000 MI Medicaid beneficiaries with Hep C
Hep C drug cost @ $84,000 per course X 23% discount = $64,680
Maximum potential cost = 33,000 x $64,680 = $2.1 billion
Not everyone will be treated so let’s say 20% = $420 million
State GF cost is 35% (65% Federal match rate) = **$147 million**
Challenges of High Cost Specialty Drugs

- Medicaid covered 4 in 10 persons with HIV/AIDS and financed almost half (47%) of those estimated to be in regular care and this was prior to implementation of the Medicaid expansion
- Medicaid covered about one-third of persons with hemophilia before ACA expansion; clotting factor is very expensive
- Human growth hormone is disproportionately covered by Medicaid/CHIP due to high coverage of children and EPSDT
- Medicaid and State Assistance Programs cover 44% of persons with cystic fibrosis (CF) and recent breakthrough drugs are costly

Challenges of Pharmacy as an Atypical Market

- Last year, Turing Pharmaceuticals acquired a 62-year-old generic drug that treats HIV/AIDS and other immune compromised patients and raised the price from $13.50 to $750 per tablet
- There was no competing drug with the same clinical effect
- Martin Shkreli, the CEO of Turing and mastermind of this price increase is a uniquely unethical individual but there was no law or other constraint that prohibited this; where there is no competition, it is open season for pricing
- Shkreli was sent to jail for 7 years but for securities fraud
- In a slightly less dramatic example, Mylan Pharmaceuticals raised the price of EpiPen from $100 in 2009 to $600 in 2016
Possible Strategic Directions for Medicaid Programs

- Continue and enhance current efforts with purchasing pools and preferred drug lists
- Leverage price by carving drugs out of managed care contracts but require Pharmacy Benefit Management (PBM) functionality to inform integrated care planning
- Carve drugs into managed care contracts but require common formularies to leverage volume at the state level
- Get a waiver to exit the Medicaid Drug Reimbursement Program (MDRP) and allow Managed Care Organizations (MCOs) to aggressively manage formularies
- Policy focus to reduce abuse of opioids and other drugs
- Lobby Congress to change the rules of the game for legalization of drug imports or other new approaches to drug pricing

Discussion
Medicines Are Expected to Account for a Stable Share of Total Health Care Expenditures Through the Next Decade

*US Health Care Expenditures Attributable to Retail and Nonretail Prescription Medicines, 2008-2025*  
*Source: Altarum Institute*  

*Retail prescription medicines are those filled at retail pharmacies or through mail service. Nonretail prescription medicines are those purchased through physicians’ offices, clinics, and hospitals and are typically administered to the patient by the provider.*
Prescription Medicine Spending Growth: 2008-2020

Government actuaries project prescription drug spending growth to remain between 6% and 8% through 2025, in line with overall health care spending growth.1

![Graph showing prescription medicine spending growth from 2008 to 2024.]

2014 saw a record 41 medicines approved by the FDA including a number of transformative medicines for debilitating diseases—as well as 15.7 million Americans gaining coverage through the Affordable Care Act.2,3

Sources: PhRMA analysis of CMS data; RAND Corporation; FDA

Generics cost a fraction of the price of the initial brand medicine.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIOVAN VCT®</td>
<td></td>
</tr>
<tr>
<td>Hypertension (2010)</td>
<td>85%</td>
</tr>
<tr>
<td>THEN</td>
<td>$13</td>
</tr>
<tr>
<td>Generic NOW</td>
<td>$87</td>
</tr>
<tr>
<td>LIPITOR®</td>
<td>95%</td>
</tr>
<tr>
<td>Cholesterol (2010)</td>
<td></td>
</tr>
<tr>
<td>THEN</td>
<td>$4</td>
</tr>
<tr>
<td>Generic NOW</td>
<td>$85</td>
</tr>
<tr>
<td>PLAVIX®</td>
<td>97%</td>
</tr>
<tr>
<td>Blood Thinner (2015)</td>
<td></td>
</tr>
<tr>
<td>THEN</td>
<td>$5</td>
</tr>
<tr>
<td>Generic NOW</td>
<td>$166</td>
</tr>
<tr>
<td>SEROQUEL®</td>
<td>97%</td>
</tr>
<tr>
<td>Schizophrenia (2010)</td>
<td></td>
</tr>
<tr>
<td>THEN</td>
<td>$3</td>
</tr>
<tr>
<td>Generic NOW</td>
<td>$87</td>
</tr>
<tr>
<td>ZYPREXA®</td>
<td>98%</td>
</tr>
<tr>
<td>Schizophrenia &amp; Bipolar Disorder (2010)</td>
<td></td>
</tr>
<tr>
<td>THEN</td>
<td>$8</td>
</tr>
<tr>
<td>Generic NOW</td>
<td>$893</td>
</tr>
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Note: Figures represent the average annual price for 30 pills of the most commonly dispensed form and strength. “THEN” price represents the average price in the year prior to generic entry. “Now” price represents the average price in CY 2014. Source: IMS analysis for PhRMA, May 2015.
$103 billion of U.S. brand sales are projected to face generic competition.

2012-2016: $91.2 Billion
2017-2021: $102.8 Billion

Projections exclude biologics, which will face competition from biosimilars entering the market.

Insurers and PBMs have a lot of leverage to hold down medicine costs.

Negotiating power is increasingly concentrated among fewer pharmacy benefit managers (PBMs).
In fact, after discounts and rebates, brand medicine prices grew just 3.5% in 2016.

In the midst of incredible scientific progress, medicine cost growth is declining nationally.

<table>
<thead>
<tr>
<th>2016 Data</th>
<th>2017 Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS</strong></td>
<td><strong>Express Scripts</strong></td>
</tr>
<tr>
<td>9% 2015</td>
<td>5% 2015</td>
</tr>
<tr>
<td>1.3% 2016</td>
<td>3.2% 2016</td>
</tr>
<tr>
<td>Below 1% 2017 First Half</td>
<td></td>
</tr>
</tbody>
</table>

Source: CMS, CVS Health, Express Scripts, Prime Therapeutics.
And too often negotiated savings do not make their way to patients.

More than half of commercially insured patients’ out-of-pocket spending for brand medicines is based on the full list price.

Cost sharing for nearly 1 in 5 brand prescriptions is based on list price.

Follow the Dollar: How the Supply Chain Shapes Brand-Name Medicine Prices

- Robust commercial market negotiations between PBMs and biopharmaceutical companies have resulted in substantial rebates, discounts and fees paid to supply chain entities. These price concessions have continued to increase despite a slowdown in brand-name drug list price growth.

- In some cases, patient cost-sharing may exceed the price the health plan actually pays for a medicine. When this occurs, cost-sharing payments in excess of the medicine’s cost are retained by health plans and PBMs—not by biopharmaceutical companies.
Follow the Dollar: How the Supply Chain Shapes Brand-Name Medicine Prices

• Some industry observers and government agencies have questioned whether insurers and PBMs are more focused on the size of rebates than on achieving the lowest possible costs and best outcomes for patients

• This report highlights the need to evolve our current system to better reward results and ensure patients more directly benefit from the significant price negotiations

Flow of Payment for a $100 Blood Pressure Medicine

• Over a third of the list price of medicine is returned by the manufacturer in rebates and discounts
• Janet pays slightly more than the health plan for her medicine

Assumptions:
• $100 list price per prescription
• 25% base rebate
• Patient pays a $40 fixed-dollar copay
Flow of Payment for a $400 Insulin

- Since Scott hasn’t reached his deductible, his insurer does not cover any of his costs
- Scott pays more than the list price of his medicine
- The PBM and health plan pay nothing, and actually earn $292.75 on this prescription
- Due to industry consolidation, the PBM, health plan, and even the pharmacy are often part of the same parent company

**Assumptions:**
- $400 list price per prescription
- 65% base rebate
- Patient pays full undiscounted price of medicine

Flow of Payment for a $3,000 HIV Medicine

- Diane’s coinsurance is calculated based on the medicine’s full undiscounted price, meaning she pays over $100.00 more than if her coinsurance was based on the insurer’s actual cost
- Specialty pharmacy is owned by the PBM, so the PBM earns a total of $522.25 on Diane’s prescription ($308.00 + $214.25)

**Assumptions:**
- $3,000 list price per prescription
- 20% base rebate
- Patient pays 20% coinsurance
UnitedHealthcare Says It Will Pass On Rebates From Drug Companies to Consumers

“In response to growing consumer frustration over drug prices, UnitedHealthcare, one of the nation’s largest health insurers, said on Tuesday that it would stop keeping millions of dollars in discounts it gets from drug companies and share them with its consumers.”