State Policies Addressing the Price of Pharmaceuticals

POLICY SNAPSHOT

Taking pharmaceuticals as prescribed are key to managing various health conditions. Depending on the prescribed medication, some are a cheaper treatment option than other health care services like emergency room visits or hospitalizations, especially if patients are able to take them as prescribed. Patients may not adhere to their medication regimen for many reasons including limited access to pharmacies and out-of-pocket costs—the latter prompting policy discussions around drug pricing.

Many factors contribute to the calculation of a drug’s price but one reason is that they are difficult to produce requiring significant investments of time and money. For a manufacturer to bring a new medicine to market it takes, on average, at least 10 years and between $113 million to $6 billion. Accordingly, the likelihood of a drug being approved by the Food and Drug Administration once it enters clinical testing is less than 12%.

Drug manufacturers set a product’s initial list price, however prices ultimately paid by consumers and by health plans are less transparent. For millions of people with health insurance, their prescription drug benefit is managed by a pharmacy benefit manager, or PBM. PBMs negotiate rebates from manufacturers for placement on a health plan’s formulary. Not only are the methods that manufacturers use to establish drug prices protected by federal anti-trust laws, but the contractual terms between PBMs, health plans, pharmacies and manufacturers are confidential.

Prescription drug prices in the U.S. are two to four times higher compared to other countries like Australia, Canada and France. The price difference is due in large part to the centralized price negotiations and regulations those nations employ, unlike the free market system in the U.S.

States face certain challenges in addressing the high list prices of drugs. For instance, the complex patenting process significantly affects a drug’s price—an aspect of the drug supply chain where states have little to no authority. Another example, unlike commercial plans, states cannot negotiate prices paid in Medicaid because of coverage requirements outlined in the Medicaid Drug Rebate Program. Even with these considerations, state lawmakers are eager to find solutions to address these issues.

State Policy Options

Lawmakers are pursuing a variety of strategies to improve prescription drug affordability, including:

- Require price and cost transparency.
- Establish a prescription drug affordability board (PDAB).
- Develop public-private partnerships to manufacture and distribute prescription drugs.
- Set drug prices to international reference prices.
- Create a state importation program.
Prescription Drug Products

**Generics** are made from small molecules and are chemically synthesized as identical equivalents to the reference product. This means generic manufacturers use the exact same process as the brand-name manufacturer, and the product has the same active ingredients, strength, dosage and route of administration as the reference product. Generics represent 90% of all prescribed drugs and account for 18% of retail spending.

**Biologics** are created from large complex molecules derived from living cells. Biologic medicines include insulin and vaccines. Biologics are often classified as specialty drugs. Since the process of making a biologic drug cannot be replicated exactly, manufacturers may create a biosimilar, which is highly similar to the original biologic. Biosimilars typically launch with initial list prices 15% to 35% lower than relative list prices of the reference products.

**Specialty drugs**, defined by Medicare as drugs that cost $670 or more per monthly supply, are frequently prescribed for complex or chronic conditions such as cancer, rare diseases and rheumatoid arthritis. They typically require special storage and handling, are often distributed via specialty pharmacies and are usually administered in a physician’s office or other clinical setting. Some drugs such as cell and gene therapies can exceed $2 million per course of treatment. Three percent of prescribed drugs are specialty but account for over half of retail spending.

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<th>POLICY OPTIONS</th>
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<td><strong>Require price and cost transparency.</strong></td>
<td>At least 13 states have transparency laws requiring data reporting from manufacturers, PBMs, health plans and/or other supply chain actors. Conditions for each program differ from state to state. North Dakota requires manufacturers of drugs that had price increases greater than 40% over the previous five years, or more than 10% over the preceding year, to provide an explanation for those increases. Utah and Texas implemented similar laws. Laws in Nevada first centered data collection on essential diabetes and asthma drugs. Legislation passed in 2021 broadened the scope to all drugs.</td>
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<td><strong>Establish a prescription drug affordability board (PDAB).</strong> A PDAB is an independent agency tasked with identifying and evaluating high-cost drugs.</td>
<td>Seven states—including Colorado, Maine, Maryland, New Hampshire, Ohio, Oregon and Washington—passed legislation to create a PDAB. Ohio established an affordability council which developed six policy recommendations. Oregon will use information collected from the state’s drug price transparency program to help inform the board. The board in Colorado has authority to establish upper payment limits for drugs determined to pose affordability challenges.</td>
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<td><strong>Develop public-private partnerships to manufacture and distribute prescription drugs.</strong></td>
<td>Legislation in California and Washington allows state agencies to enter into partnerships with any entity, such as other states or nonprofit organizations, to produce, distribute or purchase generic drugs and/or insulin.</td>
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**Federal Action**

Two historic drug pricing provisions were ushered in as part of the newly signed Inflation Reduction Act.

First, the federal government will now be allowed to negotiate prices for a certain set of older, high-priced brand-name or biologic drugs covered under Medicare Part B and D. Drugs selected for negotiation must not have a generic or biosimilar equivalent. Second, the law requires manufacturers to pay rebates to Medicare if prices increase faster than inflation. The impact of these provisions depends on several factors, one of which is the number of beneficiaries who use products selected for negotiation.

Though this law applies only to drugs covered under Medicare, states may use these prices to negotiate deals in state regulated plans such as state employee health plans, fully insured plans and plans sold on the individual market. They may also use the negotiated prices when considering establishing upper payment limits.

**Additional Resources**

- [Policy Issues and Patient-Centered Agenda](https://www.phrma.org) (Pharmaceutical Research and Manufacturers of America)