



The Our American States podcast—produced by the National Conference of State Legislatures—is where you hear compelling conversations that tell the story of America’s state legislatures, the people in them, and the policies, process and politics that shape them.

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Shining a Light on Drug Prices | Aug. 28, 2022 | OAS Episode 169

Ed: Hello and welcome to “Our American States,” a podcast from the National Conference of State Legislatures. This podcast is all about legislatures, the people in them, the policies, process, and politics that shape them. I am your host, Ed Smith.

PM: *I also receive every month calls to my office of people that they can’t pay for their prescriptions. And my staff – I have someone that does constituency service outreach, she is constantly calling to see okay can we get a break at CVS, Giant. You know where are there programs that can help people. That is what motivated me. You shouldn’t have to choose between your treatment and keeping a roof over your head.*

Ed: That was Delegate Joseline Pena-Melnyk, a Democrat from Maryland. She is one of my guests on the podcast along with Representative Thomas Oliverson, a Republican from Texas. Both are joining the podcast to talk about state legislative efforts to grapple with the price of prescription drugs. When it comes to prescription drug policy, many lawmakers have focused efforts on reducing the costs of drugs to their constituents such as limiting the copayment on insulin or their state budgets as in the case of a reverse auction for pharmacy benefit management contracts. Although these policies may lower costs, they do not alter a drug’s list price. Additionally, these laws only apply to people with health insurance. For uninsured or underinsured patients, they may be responsible for the full price of the drug.

When it comes to drug pricing, legislators are considering a wide array of strategies to address this concern. Our guests are joining in to discuss two approaches. Texas, along with nearly a dozen other states, is requiring reporting from manufacturers on price increase or initial launch prices. Representative Oliverson said that approach in Texas is already revealing useful information about rebates and other issues affecting the cost to consumers.

Maryland pioneered the idea of prescription drug affordability boards or PDABs to study drug prices particularly for drugs that pose affordability issues for state, public and private programs. Delegate Pena-Melnyk explained how this sort of non-governmental agency can examine drug pricing and costs in the state and how the system has worked in Maryland since the legislation passed in 2019. Six other states have adopted similar legislation. Here is our discussion starting with Delegate Pena-Melnyk.

Delegate, welcome to the podcast.

PM: Thank you for having me. I am really honored to be with you.

Ed: Thank you for coming on the show. And we are going to talk about the costs of prescription drugs and steps legislatures are taking to address those costs. Now Maryland passed prescription drug affordability legislation and I wonder if you could just start by breaking down what is in that legislation and what it is supposed to do?

PM: So, we passed this law in 2019 and it basically responds to a big problem that I and other legislators were hearing from constituents. Drug prices were getting so high that people had to make hard choices between paying their rent, paying their mortgage, buying food or buying their medication. So, the law establishes an independent prescription drug affordability board and it was important for the legislature that it was an independent body – that no one could influence it. Their responsibility is to evaluate expensive drugs and make recommendations to address the cost. If the board finds certain drug prices are unaffordable, the board can recommend to legislature that it set reasonable upper payment limits for Maryland residents.

So, I want to tell you a little bit Ed about how this board will operate. And the board has the authority to conduct cost reviews to identify drugs as I said that may be unaffordable. And it can develop a process to set upper payment limits for certain drugs. It is a five-member board and they work with a 26-member stakeholder council with representatives from across the supply chain. And this was important for Pharma. They wanted to make sure they had a seat at the table. And we wanted to also be fair, right. To have representation from the whole supply chain. If there are signs of unaffordability, then the board must consider, for example, if a new drug is coming on the market and if it costs over \$30,000 for one year of treatment, they look at existing brand name prescription drugs whose price increases by 3,000 or more for one year of treatment. Also existing drugs, prescription drugs whose price increases by 200% or more for one year of treatment. Like who can afford that? But the board also can consider other drugs that post significant affordability issues to Marylanders. So, they have the flexibility to be able to look at whether people can afford these drugs or not.

(TM): 05:18

Ed: Well, I think we've all heard these stories about people having to make choices about food or rent or buying their medication so I can certainly understand like most of us can there is a need for this kind of legislation. I wonder, though, in particular what was it that motivated you to pursue this? Why this is an important issue to you and why you thought this was the best way to go ahead and address it?

PM: You know I was motivated particularly by one person that I met whose son, young man, was dying of cancer. Now this individual had means. He is a developer. And he said that the cost of those drugs for his son were \$36,000 a month and he used his Black American Express to pay for it. But even for him who can clearly afford it, he knew that he could not sustain that. Imagine and that is someone that is very wealthy. I also receive every month calls to my office of people that cannot pay it. They can't pay for their prescriptions. And my staff – I have someone that does constituency service outreach and she, Edith, she is constantly calling to see okay can we get a break at CVS, Giant. You know, where are there programs that can help people. That is what motivated me. You shouldn't have to choose between your treatment and keeping a roof over your head. It is just not right. So, high, you know, drug costs also raise health care costs for all Marylanders. I see that in my committee all the time. We all see it in insurance premiums and in the health care costs that the state pays for treating the uninsured, which is a lot of money. When people show up at the ER and they don't have insurance, they can't pay for their health care. They are not going to survive if they are very sick. So, Ed, we could not afford to not fight this fight. In the U.S., we are forecasting that we will spend \$576 billion on prescription drugs in the year 2027. That is huge.

Ed: You mentioned earlier trying to get industry to sit down. But I know this is also an area where there are a lot of competing points of view and I'm sure that you encountered some challenges in trying to get this legislation passed. And I wonder if you could talk a little bit about that because I think legislators in other states would probably be interested in what your experience was.

PM: So, this was very difficult. It was very hard to get through. And we knew that this legislation this board had to be independent. There had to be a transparent way to examine drug costs and to find a fair way to control the costs. So, we tried to balance all of those issues. We compromised with them and we basically what you have in front of you this piece of legislation it's a compromise. It's not what I wanted. It is not what they wanted. So, we must have done something right. In the end, we were successful because we had strong bipartisan support. We basically brought people to the table to

be our voice. We had support from the public – very strong support. And we had a lot of personal stories when people spoke about their illnesses whether it's cancer, Alzheimer's, Parkinson, MS. Those are very expensive drugs. And who does not have a loved one that has been affected by cancer or by an illness that is so serious that threatens to take your loved one away. Everyone has.

Ed: Well, I think what you are describing is how very difficult it is to get good legislation passed. People often don't appreciate that it is not just the opinion of one side of the aisle or the other, but there's constituents. There's people in industry. There's lots of interest groups. And it sounds like, as difficult as it was, you came out with a good result. Maybe not everything you wanted, but it sounds as though it is an effective piece of legislation.

Now this was a few years ago this passed. Where does the board stand now? What's it done so far?

PM: So, the board has been meeting since 2019. It's a lot of work, Ed, to stand up an independent entity. Many people right. Many opinions and it takes a lot of time and work in the frontend. I think it will be worth it in the long run because it guarantees independence from outside influence. The board will be publishing their first report with policy recommendations for the state shortly. They created policies to develop the upper payment limit action plan. They also developed a transparency program to better understand the issues making prescription drugs unaffordable and insulin affordability program for the uninsured also was created. So, they are doing their work. They are working really hard and they have open meetings and people can come and give opinions. And the whole supply chain is participating as well so they have a voice. And I think that as long as people have a voice, they feel that you treat them in a fair way, right. And they are at the table and their concerns are being taken into consideration and that's what this board is trying to do.

Ed: Well, I'm sure your colleagues in other states are going to be interested to see that as they begin to look at legislation of this sort. Of course, a lot of states have taken action in a lot of different areas, but in Maryland you were upfront with this legislation so it will be interesting to see how that develops. I wonder after you went through this, do you think you kind of got it right? Would you have done things differently?

(TM): 11:45

PM: I think we got it right and I mean that in a humble way because it was a very difficult bill to get through. In the end, we presented the human aspect right. People have empathy for the human pain. I think we did it right because we compromised and the law as it's

now, it is a pilot that applies to Maryland employees only. And then if we can show that it works, then it would apply to all Marylanders, which we have more than 6 million people. Eventually that is the goal to expand it.

Ed: Well, a perfect concept always sounds like a good way to go then you have real evidence to point to if you want to try to expand the legislation. I wonder finally what kind of advice you would have for legislators in other states that might be looking at passing just this sort of transparency legislation?

PM: We at the state level have to be active. We cannot wait for the federal government. The federal government is not moving on this issue so I would say put the legislation forward in your state. Be brave. Just do it. It is the right thing to do for our constituents.

Ed: Well, that is a great note to end on and I thank you so much for your time and for sharing your experience there in Maryland with us.

PM: Well, thank you for caring about this important issue.

Ed: And I'll be back right after this with Representative Tom Oliverson from Texas to discuss transparency legislation in that state.

(TM): 13:17 advertisement/music

Representative, welcome to the podcast.

TO: Thanks Ed. It's a pleasure to be with you.

Ed: So, we are going to talk today about state efforts to grapple with the price of prescription drugs. And in Texas, you decided to pursue a drug transparency law and I wonder if you could talk about why you took that route and what's in the legislation? How does it work?

TO: Health care costs I think are, if you didn't know, is the fastest growing segment of cost right now. The phase at which health care cost is growing even outstrips the rising costs in the college tuition, which is pretty surprising. And whether you are a company. Whether you are a city. Whether you are a state or whether you are just a family or an individual, the increase in cost in covering your health care needs is I think something that everybody relates to. So, within that big global picture, I think as a subset of that, we see that pharmaceutical costs or drug costs, prescription drug costs, is one of the fastest growing segments of health care costs as a total. And so we look at that, you

know, the question is why. And one of the problems that we have in health care in general I would say is a general market failure as a segment of our economy that we don't have very good price transparency and so patients who are the end users of health care goods and services are, unfortunately, unable to shop as consumers like they would be if they were buying life insurance or automobile insurance or buying a car or groceries or even shopping for an internet provider. And so it has I think grossly led to an inflation in price, which is not always commensurate with an increase in quality.

Now in prescription drug costs, we see something even more hyper acute, which is that because of the way that prescription drug benefit plans are constructed, there are several layers of what we call middlemen between the manufacturer of the drug and the actual end user of the drug, which adds to the complexity and the inability for the consumer to actually figure out what the cost is going to be ahead of time. And so what we did in Texas is we undertook a legislation to basically try to sort of pin down some of these costs in a more global sense. We began with our Price Transparency Bill by really focusing on two big components sort of as I talked about the middlemen between you know the actual manufacturer of the drug and the individual that is actually taking the prescription drug. Really looking at what is it on the manufacturer's side that leads to increased prescription drug cost. In other words, why does a drug that has been on the market go up and up year after year or does it? Does it remain stable? Does it go down? I think many would argue that it actually goes up and so the question is why. And then similarly, we looked at sort of the next step in the process, which is sort of the health plan that provides the benefit and the agents that they use which actually negotiate the prescription drug benefit more specifically, which is typically the pharmacy benefit manager, and try to get a handle on what their costs are, and where the prices and user might actually experience how the role of the PBM and the health plan may impact either positively or negatively that price.

Ed: So, not surprisingly, there are differences of opinion on the best way to reduce prescription drug costs as there are differences of opinion about so many kinds of public policy approaches. In this instance, critics of transparency laws say that the initiatives have a limited impact on the price itself. They don't directly affect the price. So, what is your thought on that and how is the law playing out in Texas? Do you think it is doing what you want it to do?

(TM): 19:05

TO: I think it is actually Ed. I think what we've seen so far in the basically the two years since the law has been on the books, we've started to get some reports. And we've seen some rather interesting things. One of the things we knew we would find which is something we were trying to drill down on is to really get a handle on the value of

manufacturer rebates and how they affect the actual price that the end user or the consumer of the prescription drug pays. Because just like buying a car, you know the manufacturer suggested retail price at least until, you know, recently in this recession that we are in was not the price you expected to pay when you went to the dealership. There was usually some price that was negotiated below that and the same is true in the world of prescription drugs where a manufacturer might have what's called a wholesale acquisition cost or a WAC. But that's not necessarily the price that the consumer is going to pay when they go to the counter to fill the prescription assuming that they have a prescription benefit plan. So, what has been the effect of the rebates in how prescription drug costs are actually played out and actually seen by the consumer. And I will tell you one of the interesting things that we saw is that at least in Texas our initial reports that we've gathered show that a relatively small percentage -- less than I believe it was 5% of manufacturer rebates -- actually make it back to either the employer or the consumer. The vast majority of the rebates are actually retained either by the pharmacy benefit manager or the health insurance plan themselves. And so that, obviously, is something you know that's one point in time. We need a few more reports to kind of figure out if this is a trend or if that was an isolated thing and what does that mean. But that was certainly surprising to find. I would have thought that at least 50% of the value of these rebates was getting into the pockets of consumers. It turns out that is not the case necessarily.

Ed: Our audience of course is legislators, legislative staff and others interested state policy. And I wonder from your experience what sort of lessons learned you've had or what tips you might share with them if they were interested in pursuing similar legislation as you did in Texas?

TO: I would totally encourage them to do that. I personally think and I'm going to speak from a 10,000-foot overview more globally in the health care market and full disclosure I am a health care provider. I'm an anesthesiologist so I see this not just with my state lawmaker hat on, but I also see how it affects my patients, how it affects the places that I provide care at. You know sort of that whole nexus of care that we do and are we doing a good job and how could we do better. And I will tell you that I believe that transparency legislation was the single most important thing that any lawmaker regardless of big states, small state, red state, blue state, it is the most important thing you can be pushing for in your state. And by that, I don't just mean pharmaceutical price transparency, but I mean full price transparency on providers as well. I think that's critically important because as I said earlier, you have a genuine market failure in health care that pretty much doesn't exist in any other marketplace you have. And that is that unfortunately the end user of the product, the consumer which is the patient, has several layers between them and the actual provider so there is really no ability to

calculate value. There is no ability to get pricing upfront to know what you are going to pay ahead of time. And there's no way to reference that back to some statement about quality. The only exception that we see to this in the entire field of health care, quite frankly, is cosmetic surgery. And what we see in cosmetic surgery, because there is no insurance plan that pays for cosmetic surgery, is that prices are fiercely competitive. And consumers are constantly getting a good you know a value; a good deal return on their investment and there's a variety of price points depending on what people are looking for. You know it's almost like, and I love to use the example of the lack of transparency in health care has created a marketplace that is so dysfunctional, it's almost like as if you went to go buy a car. Let's say I was a car dealer and I was going to sell you a car and I said to you, Ed, I'm going to sell you this car, but I'm not going to tell you how much you owe me until 30 days after you start driving. You would never purchase that car from me, but yet that's how almost all health care transactions are conducted and it's crazy. And so we wonder why is health care so expensive in this country and why does it continue to outpace inflation and wage growth and pretty much every other economic sector in terms of increased cost. And I think it's because unfortunately the patient is unable to function as a consumer and that has to change.

Ed: Well, that's a very colorful and easy way to understand what the problem is. As we wrap up, I wonder if you have any thoughts about what the next steps might be to address drug pricing in Texas.

TO: So the next steps and we've kind of already ventured out into this space, but the next steps really are I think what we've determined is that a significant source of cost with respect to drug prices in Texas and in other states as well has to do with manufacture rebates and the fact that those dollars are basically sort of exchanged between the drug manufacturer and the health plan/PDM and then they pass that on in some form or fashion you know however they see fit. Maybe to the employer; maybe not. Maybe to the state, whatever. That's almost like a monopoly money kind of situation where people have gotten to the point where they are not actually negotiating on behalf of the consumer anymore. They are negotiating to maximize the rebate dollars that they are going to get back at the end of the year, which may or may not actually make it into the consumer's pocket considering that most of these health care plans are employer sponsored plans. And so when we look at ways to lower prescription drug costs, I think the people I feel very sorry for and the people that I'm working really hard right now for are the people that don't have a prescription drug benefit plan. Because that wholesale acquisition cost that I talked about, those rebate dollars are baked into that cost. So, the actual fair market value of that drug may be inflated by as much as 50 to 70% above, and so the wholesale acquisition cost for somebody with no insurance and no coverage may be 150 to 170% of what they ought to be paying because that rebate dollar is baked into the equation. And then, unfortunately, the consumer can't access that.

I have looked at this in Texas and we passed legislation in 2021 to see if the state could establish its own prescription drug benefit program for the uninsured where the state uses its power of negotiating to go out and grab manufacturer rebates and use the full value of those rebates to lower the cost of the prescription drug at the point of sale for the consumer with a replenishing trust fund. So, in other words, the state advances the dollars to the consumer at the point of sale and then the rebate dollars come back to the state so that the trust fund is evergreen. And we are not agreeing to pay people's prescription drugs, but we are agreeing to lower their prescription drug cost by the maximum amount that we can by negotiating these manufacturer rebates for our uninsured Texans. That's kind of something that we are still up and working on getting that up and running. Obviously, there are a lot of moving parts there. You saw that insulin now has sort of become an issue where there have been a lot of different mechanisms whereby people have sought to lower the price of insulin. Everything from actually capping the price out of pocket that people could pay to now you have health plans and manufacturers that are they are self-capping. And so that's great to see, but there are many other prescription drugs out there that remain out of the reach of consumers that, unfortunately, find themselves in that uninsured category and we got to do better than that.

Ed: Well representative thanks so much for walking us through this. And we will keep an eye on Texas to see where you go on those other issues.

TO: Absolutely. Thank you, Ed.

Ed: And that concludes this episode of our podcast. We encourage you to review and rate NCSL podcasts on Apple podcasts, Google Play, Pocket Casts, Stitcher or Spotify. We also encourage you to check out our other podcasts: *Legislatures: The Inside Story* and the special series *Building Democracy*. Thanks for listening.

(TM): 26:17