HJR 17: Prescription Drug Pricing

State Legislation to Control Costs

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Background

As prescription drug prices have outpaced inflation and steep hikes in some medications have made headlines, state legislatures across the country have discussed ways to rein in costs or shine more light on the drug pricing system.

This briefing paper summarizes laws that have passed in the last two years that are specific to bringing more transparency to drug pricing or to controlling drug prices.

Maryland: Targeting Price Increases for Generic Drugs

Earlier this year, the Maryland Legislature passed a bill to allow the attorney general to investigate potential price-gouging involving generic and off-patent drugs. Under House Bill 631, the attorney general may:

- ask a drug manufacturer to itemize the costs of producing a specific drug, identify circumstances causing the price increase, and produce relevant records; and

- ask a court to compel a drug manufacturer to provide the information, issue a restraining order to prevent a violation of the law, or fine a company for violating the law.

The governor allowed the bill to go into effect without his signature, saying concerns over the bill's definition of "unconscionable increase" in price and its attempt to regulate prices set in other states could create constitutional concerns for the bill.[1] "Unconscionable increase" was defined as an increase that "is excessive," that is not justified by the cost of producing the drug or expanding access to the drug, and that resulted in consumers being forced to buy the drug at that price because it was important to their health or no alternatives were available.

The trade group representing generic drug manufacturers, the Association for Accessible Medicines, filed suit against the law on July 6 saying it was both unconstitutional and vague.[2] The group has asked that the law be placed on hold while the suit is pending; a hearing on the request is set for Sept. 13.[3]

New York: Capping Medicaid Drug Spending

In New York, lawmakers enacted a cap on prescription drug spending for the Medicaid program with passage of SB 2007. Spending is limited to the cost of medical inflation plus 5 percent, minus a savings target of $55 million in Fiscal Year 2018 and $85 million in FY 2019.

If spending exceeds that level, the state health commissioner may ask makers of high-cost drugs to provide additional rebates, or discounts, for their drugs. If a company declines to do

so, the state's Drug Utilization Review Board could review pricing factors for the drug and suggest a target additional rebate for the manufacturer to pay to the Medicaid program. If the drugmaker doesn't agree to pay a higher rebate, the state could require that a patient receive prior authorization for using the drug before it can be dispensed.

Nevada: Focusing on Diabetes Drugs

Nevada lawmakers this year approved a bill to improve transparency of prices and marketing practices related to drugs for treating diabetes, including insulin. Senate Bill 539 requires the Department of Health and Human Services compile a list of drugs considered essential for treating diabetes, as well as a list of diabetes drugs for which the wholesale acquisition cost has increased equal to or greater than medical inflation in the previous year or twice the rate of medical inflation in the preceding two years.

For any drug on the list of essential diabetes drugs, manufacturers have to report certain information, including the cost of producing and marketing the drug, the profit earned from the drug, the amount of financial assistance the manufacturer has provided to patients purchasing the drug, and a history of any wholesale acquisition cost increases in the previous five years. For drugs that have increased at a rate equal to or greater than medical inflation, the manufacturers must also report on each factor that contributed to the increase and the degree to which each factor led to the higher costs, along with any other information required by rule.

The bill also imposed reporting requirements on pharmacy benefit managers and limits on pharmaceutical sales representatives.

Ohio: Going to the Voters

Voters in Ohio have taken the issue of prescription drug costs into their own hands by putting Issue 2 on the ballot this November. The measure would prevent the state from paying a net price for any prescription drug that is greater than the lowest price that the U.S. Department of Veterans Affairs pays for the same drug. The requirement applies to any drugs for which the state is the ultimate payer, whether through Medicaid, the state employee health plan, or other programs.

Vermont: Reporting on High-Cost Drugs

Vermont passed a price reporting requirement for drugs dispensed under state-run health programs in 2007 and expanded on the requirements last year to require greater transparency. Among other things, SB 216 of 2016 required the state to identify up to 15 drugs on which it spends "significant health care dollars" and for which the wholesale acquisition price went up by 50 percent or more in the past five years or 15 percent or more in the last 12 months. Makers of the drugs must provide the attorney general with all information that justifies the increase. The attorney general must report on the information to the Legislature and the Vermont Health Access Department. The attorney general can file suit if drugmakers fail to provide the information.

In December 2016, the attorney general reported that the state had identified 10 drugs that met the criteria. Each of the 10 manufacturers submitted the required information. They said their

pricing decisions were based on factors such as the cost effectiveness of the drug, the size of the patient population purchasing the drug, the investments made and risk undertaken in developing the drug, the cost of ingredients, and competition. They also took issue with using the wholesale acquisition price of the drug as the benchmark for reporting purposes, noting that rebates often lower the wholesale price significantly.[4]

Washington: Focusing on Patient Costs

The Washington Legislature passed substitute SB 6569 in 2015, creating a task force on out-of-pocket costs for prescription drugs. The task force was to evaluate the factors that contributed to out-of-pocket costs and also look at how patient compliance to drug regimens is affected by the cost of drugs. The task force was to complete and report on its work by Dec. 1, 2016.

Members of the group agreed not to try to reach consensus decisions.[5] Instead, the task force reported on the various perspectives and positions taken by the different stakeholders on the task force as they considered ways to reduce:

- out-of-pocket costs for patients with conditions that require "extremely expensive drugs;"
- costs for people who can't afford to buy their prescriptions; and
- the impact that large out-of-pocket costs have in the first three months of the year.[6]

The group developed a variety of options for legislative consideration, ranging from standardized benefits for all insurance plans to regulating the list of drugs for which an insurer provides coverage and setting specific limits on the out-of-pocket costs a patient would have to pay for a prescription.

West Virginia: Repealing Reporting Requirements

In 2009, the West Virginia Legislature passed a law requiring information on prescription drug advertising costs to be reported to the state. The information submitted by drug companies was confidential, but aggregate information could be made public.

The Legislature repealed the reporting requirement in 2015 when it passed SB 267.

NASHP: Tackling the Big Picture

The National Academy for State Health Policy (NASHP) created a Pharmacy Costs Work Group in 2016. NASHP is an independent organization that works on health policies at the state level. The work group looked at ways for states to lower prescription drug prices in all types of state programs. The group identified 11 options for state action, ranging from increased price transparency to bulk purchase of high-cost drugs that protect public health and seeking the ability for individual states to re-import drugs from Canada.[7]

NASHP has since set up the Center for State Rx Drug Pricing Action, to work on its state-based agenda, and has developed model legislation for some of the work group ideas. CI0425 7237soxa.

Endnotes

1. Veto message. Gov. Lawrence J. Hogan, Jr. May 26, 2016.

2. Complaint for Declaratory and Injunctive Relief. *Association for Accessible Medicines v. Brian E. Frosh, et al.* Civil Action No. MJG-17-1860, United States District Court for the District of Maryland. July 6, 2017.

3. Scheduling Order. *Association for Accessible Medicines v. Brian E. Frosh, et al.* Civil Action No. MJG-17-1860, United States District Court for the District of Maryland. July 18, 2017.

4. "Report of Attorney General to the Legislature Regarding Pharmaceutical Cost Transparency Pursuant to 18 V.S.A. § 4635." *Vermont Attorney General's Office.* Dec. 1, 2016.

5. "SSB 6569: Patient Out-of-Pocket Costs Task Force Report." *Washington State Department of Health.* Dec. 1, 2016. P. 2.

6. Ibid.

7. NASHP's Pharmacy Costs Work Group. "States and the Rising Cost of Pharmaceuticals: A Call to Action." *National Academy for State Health Policy.* October 2016. P. 5.