The Role of Health Insurance Providers in Keeping Prescriptions Affordable

NAIC PBM Regulatory Issues (B) Subgroup

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AGENDA

- Out-of-Control Drug Costs
- Value of PBM Partners
- Cost Savings Tools Under Attack
  - Coupon Accumulator Bans
  - Rebates
  - Markups on Specialty Drugs
- NAIC & Preemption
- Recommendations
  - For Regulators
  - For White Paper
- Q&A

High-Priced Drugs

Where Does Your Health Care Dollar Go?

AHIP
Guiding Greater Health

Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive and improves health care affordability, access and quality for everyone. **Here is where your health care dollar really goes.**

This data represents how your commercial health plan premiums pay for medical care, as well as related services and essential operations. This data includes employer-provided coverage as well as coverage you purchase on your own in the individual market. Data reflects averages for the 2018-20 benefit years. Percentages do not add up to 100% due to rounding.

Rx Spending Growing at Unsustainable Rates

U.S. spending on prescription medicines is projected to reach **up to $400 billion by 2025.**

$400 billion (2025)

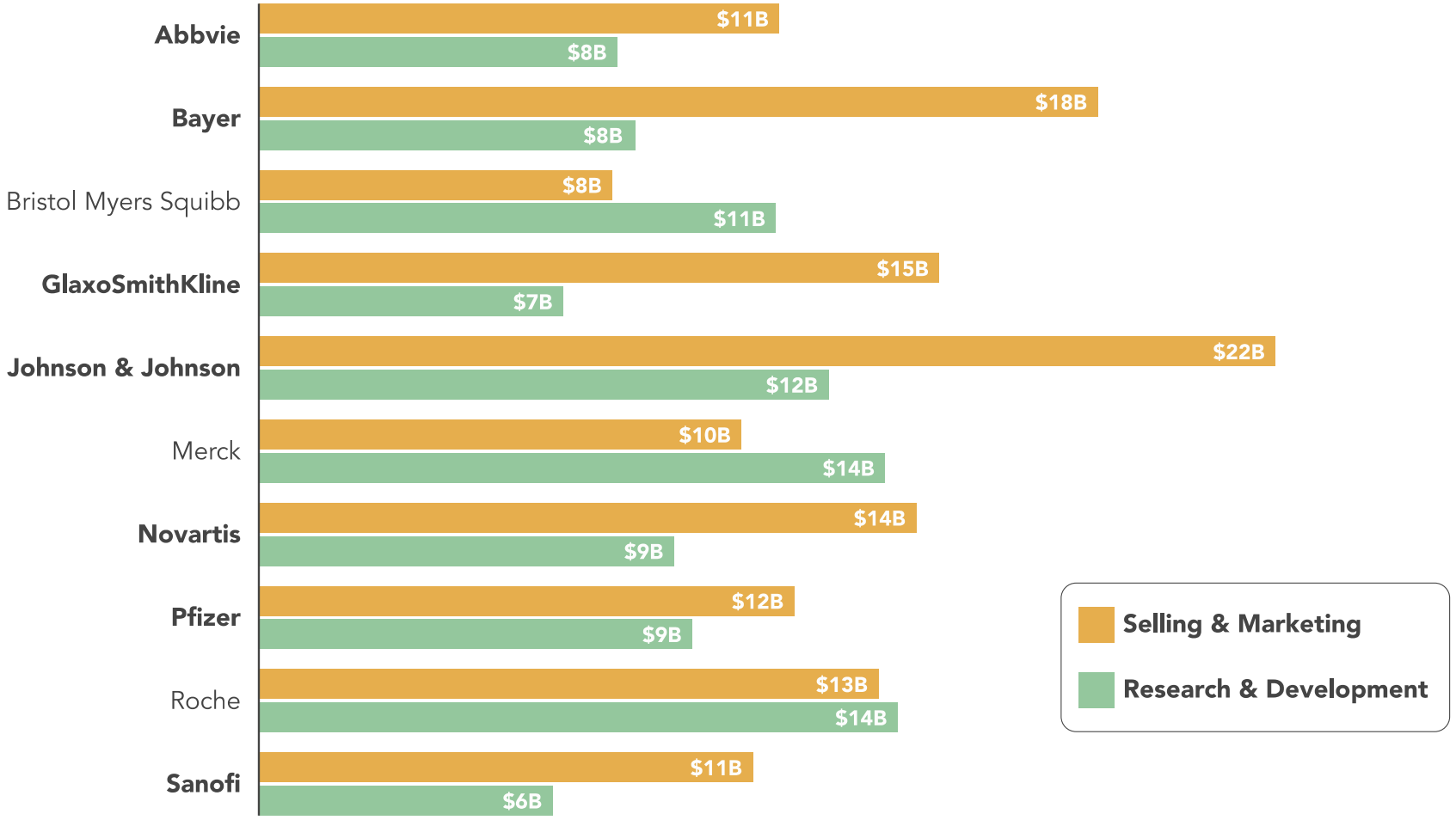
$335 billion (2018)

$30 billion (1980)

Sources: Prescription Drugs: Spending, Use, and Prices, Congressional Budget Office, January 2022; The Use of Medicines in the U.S., IQVIA institute, May 27, 2021.

Marketing vs New Drug Development by Pharmaceutical Industry

An AHIP study found that in 2020, **7 of the top 10** largest pharmaceutical companies **spent more on marketing than on developing new drugs.**



1. Revenues for several companies on the list include other lines of business in addition to pharmaceuticals. For all companies, pharmaceutical segment is the largest by revenue.
2. Pharmaceutical revenues include both brand and generic drugs. Brand drugs are responsible for most revenue and profits.

ICER Report On Unsupported Price Increases

- ***Unsupported Price Increases Occurring in 2020***, ICER Report (updated March 2022)
  - Identified top 10 drugs that caused greatest increase to drug spending and then reviewed for clinical evidence to justify increases
- Top 5 Findings of Drug Increases With **NO** Reason:
  - **Humira** increased net price 9.6% = an additional cost of $1,395,000,000 in 2019
  - **Promacta** increased net price 14.1% = an additional cost of $100,000,000 in 2019
  - **Tysabri** increased net price 4.2% = an additional cost of $43,600,000 in 2019
  - **Xifaxan** increased net price 3% = an additional cost of $43,560,000 in 2019
  - **Trokendi XR** increased net price 12.4% = an additional cost of $36,000,000 in 2019

  - Increases in drug costs have decreased overall; however, even small net price increases have large impacts to the national drug spend
  - Only 3 drugs were reported to have justified price increases

New Drugs Come With Out-of-Control Prices

2021

Top 5 Most Expensive Drugs

- Zolgensma = **$2,125,000** treats spinal muscular atrophy, 1 time therapy (2019)
- Zokinvy = **$1,032,480** treats Hutchinson-Gilford progeria syndrome-premature aging (2020)
- Danyelza = **$977,664** treats neuroblastoma-cancer (2020)
- Myalept = **$889,904** treats lipodystrophy-abnormal fat distribution (2014)
- Luxturna = **$850,000** treats retinal dystrophy-vision loss, 1 time therapy (2018)

Value of PBMs

PBMs Help Contain Costs

Contract Models between Health Insurance Providers & PBMs

- Administrative Fee: Health insurance providers pay the PBM via a monthly retainer, a per-claim amount, or PMPM that can fluctuate with drug costs
- Spread Pricing: Allows for a health insurance provider to have guaranteed pricing & drives the PBM to get the best deal from Big Pharma

Medication & Care Management

- P&T Recommendations: Health insurance provider may use a PBM's P&T Committee to augment their own. A P&T Committee uses clinical evidence to determine coverage of drugs. May also assist with the development of formulary designs to help enrollees obtain safe and effective medications at the best value
- Adherence Programs & MTM: Plans may use PBM programs to increase enrollees' adherence to specific medications. PBMs can gain greater discounts with Big Pharma in exchange for guaranteeing maintenance of a certain percentage of medication adherence for specific (usually chronic) populations

Pharmacy Networks

- Quality of Pharmacy Services: PBMs develop pharmacy networks that drive value to patients and plan sponsors by incorporating clinical performance standards & metrics
- Mail Order: Delivering prescriptions by mail improves affordability and convenience for patients, protects patient privacy, and helps improve patients' compliance with their therapies
- Specialty Pharmacies: PBMs may assist plans in negotiating for the most affordable and effective network solutions.

AHIP Letter to the FTC on PBMs

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May 25, 2022

Federal Trade Commission
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Submitted via regulations.gov

Re: **Solicitation for Public Comments on the Business Practices of Pharmacy Benefit Managers and Their Impact on Independent Pharmacies and Consumers**

Dear FTC Chair Khan, FTC Commissioners, and FTC Staff:

Everyone should be able to get the medications they need at a cost they can afford. When drug prices are out of control, hardworking families feel the consequences every day. Health insurance providers and pharmacy benefit managers (PBMs) are Americans' bargaining power, negotiating savings for millions of patients every day. Because of our strong commitment to making prescription drugs more affordable for every American, AHIP[1] appreciates this opportunity to comment on the Federal Trade Commission (FTC) staff's Request for Information (RFI) on the Business Practices of Pharmacy Benefit Managers and their Impact on Independent Pharmacies and Consumers.

Rising costs associated with prescription drugs represent the largest segment of health care spending, accounting for more than 21.5% of commercial premiums[2] and 12% of all Medicare costs from Part D alone,[3] with Medicare prescription drug spending increasing by 3% over the previous year.[4] It is through the concerted efforts of health insurance providers, their PBMs, and other partners – e.g., to harness competition where it exists – that these costs are not even higher, as will be discussed more thoroughly in these comments. It is clear drug prices are out of control,

Research shows:

- PBMs in partnership with health insurance providers will save clients and consumers more than $1 trillion between 2020 and 2029
- PBMs help generate savings of nearly $1,000 per enrollee per year and reduce costs by $6 for every $1 spent on their services.

Sources:

PBMS: Generating Savings for Plan Sponsors and Consumers. PCMA, Visante. February 2020.

The ROI of PBM Services. Visante on behalf of PCMA. November 2016.

Cost Saving Tools Under Attack

Coupons, Rebates & Brown/White Bagging

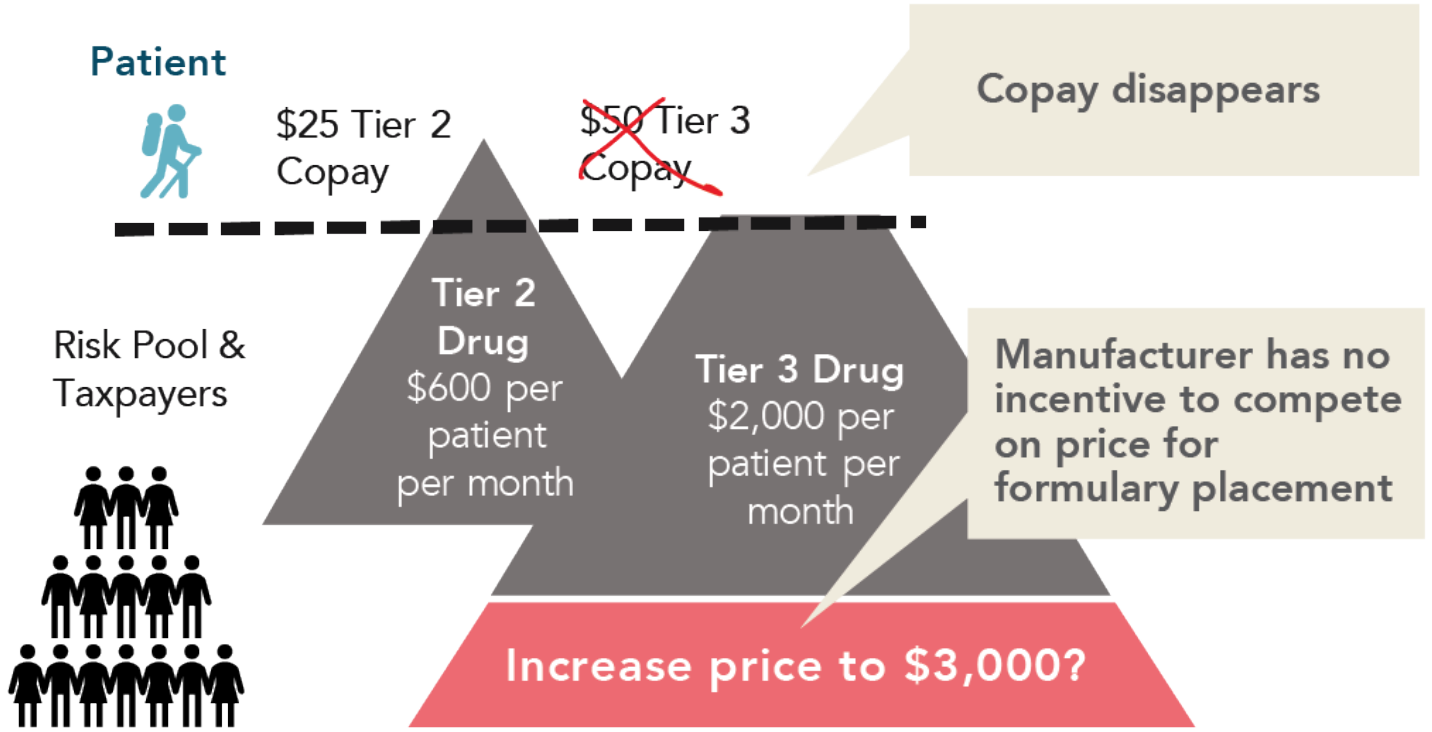
Copay Coupons Are A Kickback Keeping Drug Prices High

Coupons remove incentives for:

1. Patients to consider lower cost drugs and
2. Big Pharma to lower their prices

Coupons are **prohibited in Medicare and Medicaid.**

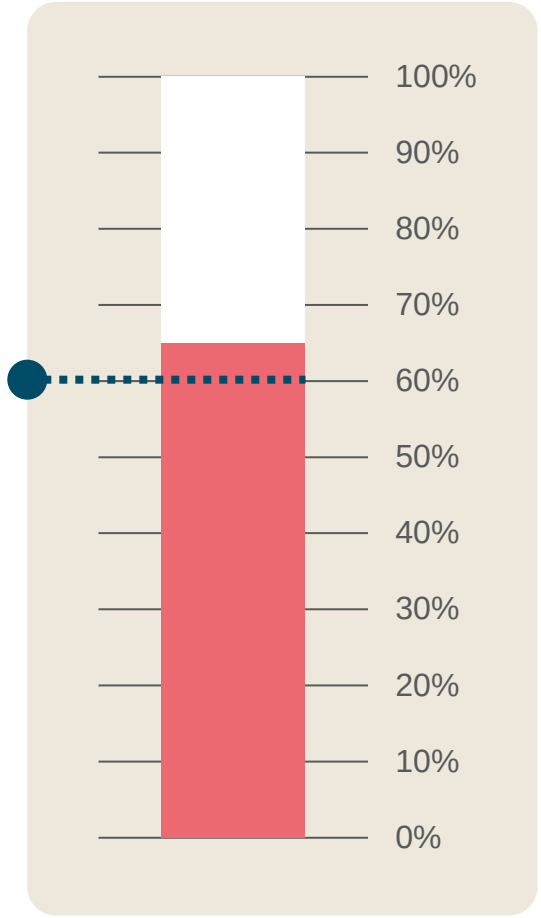
In these federal programs, coupons are **considered an illegal "kickback"** because they induce a patient to take a certain drug.



https://oig.hhs.gov/documents/special-advisory-bulletins/878/SAB_Copayment_Coupons.pdf

How Copay Coupons Impact Drug Spending

Boosted retail sales of branded drugs by 60% or more by reducing the sales of generics



- Drugs with coupons have a **higher annual price growth** (12-13%) than drugs without coupons (7-8%).
- During the 5 years following generic entry, coupons increase spending by an estimated $30 to $120 million per drug – **increasing spending by $700 million annually, or $2.9 billion over 5 years.**
- Coupons line pharma's pockets – for one cancer drug, the manufacturer **estimated the potential rate of return for its copay assistance program was $8.90 for every dollar invested**.

https://www.hbs.edu/ris/Publication%20Files/DafnyOdySchmitt_CopayCoupons_32601e45-849b-4280-9992-2c3e03bc8cc4.pdf

https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Novartis%20Staff%20Report%2010-1-2020.pdf

Rebates Hold Big Pharma Accountable

- Health insurance providers are Americans' bargaining power, negotiating lower drug costs for everyone. Health insurance providers pass on those savings directly to consumers through lower out-of-pocket costs and premiums.
- Big Pharma only offers rebates to drugs that have competition - so they can get better placement on formularies and be prescribed to more patients.
  - The most expensive drugs – those that have no competition – do not offer rebates.
- A recent analysis compared price increases for rebated and non-rebated drugs and found that price increases were roughly the same for both groups, so **rebates were not driving higher price increases**.
- The U.S. House Oversight Committee's multi-year Drug Pricing Investigation concluded:
  - "This data, which has never before been shared with the public, **undermines industry claims that price increases are primarily due to increasing rebates and discounts paid to pharmacy benefit managers**."
  - "In addition, documents show that **PBMs secured contractual provisions that disincentivized drug companies from raising list prices. Without those provisions secured by PBMs, drug companies likely would have raised list prices more**."

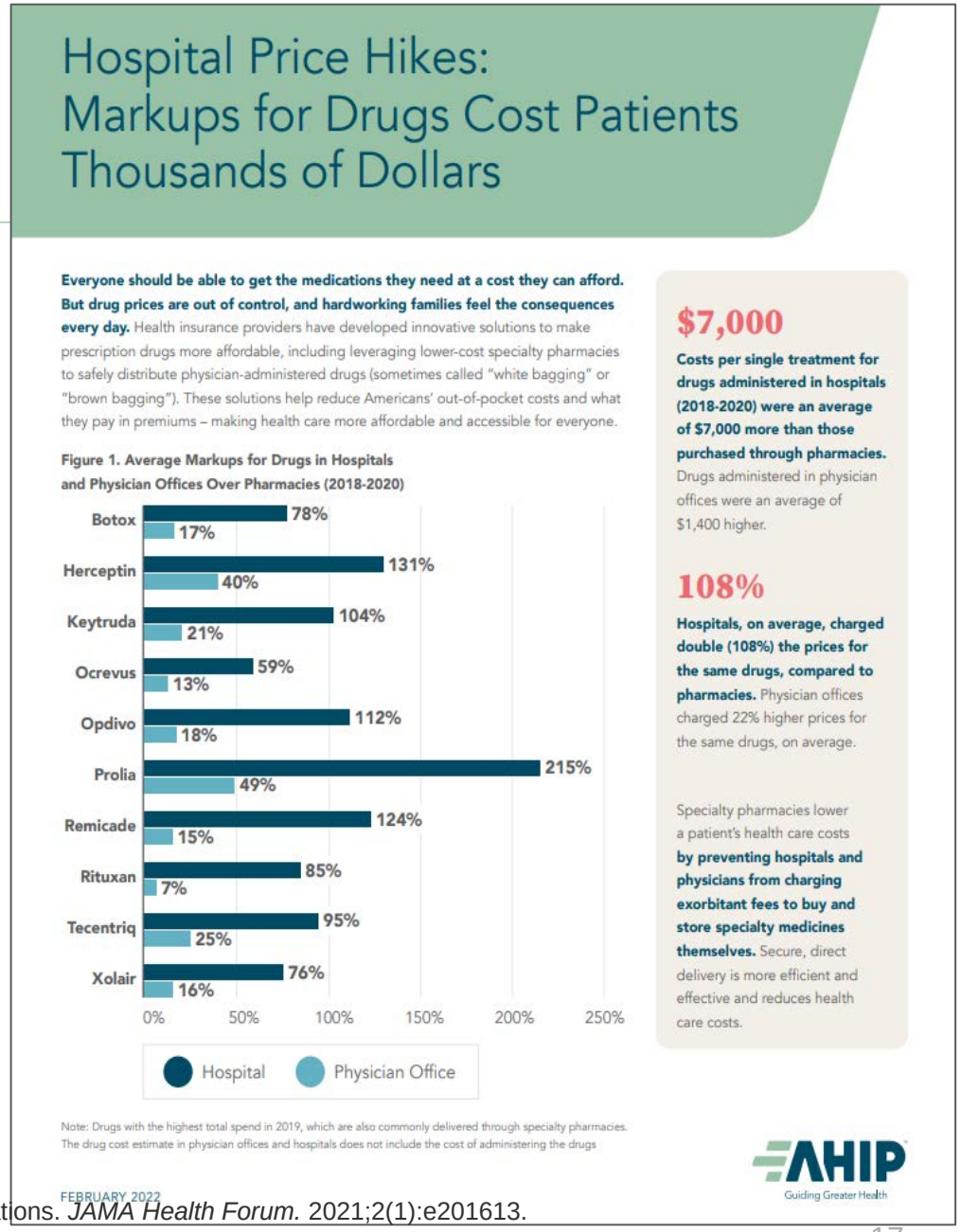
Source: Brill, Alex. 2019 "Concerns Regarding the Proposed Rule to Restrict Drug Manufacturer Rebates in Medicare Part D and Medicaid MCOS." April
U.S. House Oversight Committee. "Drug Pricing Investigation." December 2021

Rebates Benefit All Consumers

- While rebates only apply to a small percentage of prescription drugs, health insurance providers pass on those negotiated savings to all consumers through lower out-of-pocket costs and/or premiums.
- Delivering rebates to a small number of patients at the point of sale means eliminating savings and increasing costs for all plan enrollees.
- **Focusing on how savings are distributed is a deliberate tactic to avoid addressing the more serious issues surrounding the lack of competition, transparency, and accountability in drug pricing.**

The Increased Costs of Physician-Administered Drugs

- Physician-administered drugs are those that cannot be self-administered by the patient or a caregiver.
  - They are typically infused or injected by a provider in a physician's office, clinic, infusion center, or hospital.
  - These are commonly specialty drugs – high-priced medications that treat complex, chronic, or rare conditions.
- Traditionally, hospitals/facilities purchase these drugs directly and then bill the insurance provider for both the drug and the administration (often called "buy and bill").
  - JAMA noted that "physicians and hospitals face limited incentives to mitigate spending."
- The result? **Exorbitant Markups** – an AHIP study found:
  - On average, **hospitals charged double** for the same drugs, compared to specialty pharmacies; physician offices charged an average of **22% more** for the same drugs.
  - Costs per single treatment for drugs administered in hospitals were an average of **$7,000 more** than those purchased through specialty pharmacies. Drugs from physician offices were an average of **$1,400 higher**.



Sources: Conti RM, Turner A, Hughes-Cromwick P. Projections of US Prescription Drug Spending and Key Policy Implications. *JAMA Health Forum.* 2021;2(1):e201613. doi:10.1001/jamahealthforum.2020.1613
Hospital Price Hikes: Markups for Drugs Cost Patients. AHIP. February 2022

Health Insurance Providers Are Making Physician-Administered Drugs More Affordable

- An AHIP study details the markup of 10 physician-administered drugs – **markups ranged from $204 to $19,803** per treatment.
- To combat the growing price of specialty drugs and exorbitant markups, insurance providers are innovating new solutions.
- This includes contracting with specialty pharmacies to distribute these physician-administered drugs at lower costs, while still reimbursing the provider for administering the medication.
- **Patient safety is paramount.**
  - Specialty pharmacies must meet extremely stringent safety requirements.
  - Health insurance providers only use these programs when the drugs can be safely dispensed this way and only when the patient is an appropriate candidate for such dispensing.
  - Health insurance providers build in additional safeguards to ensure the process is seamless for patients.

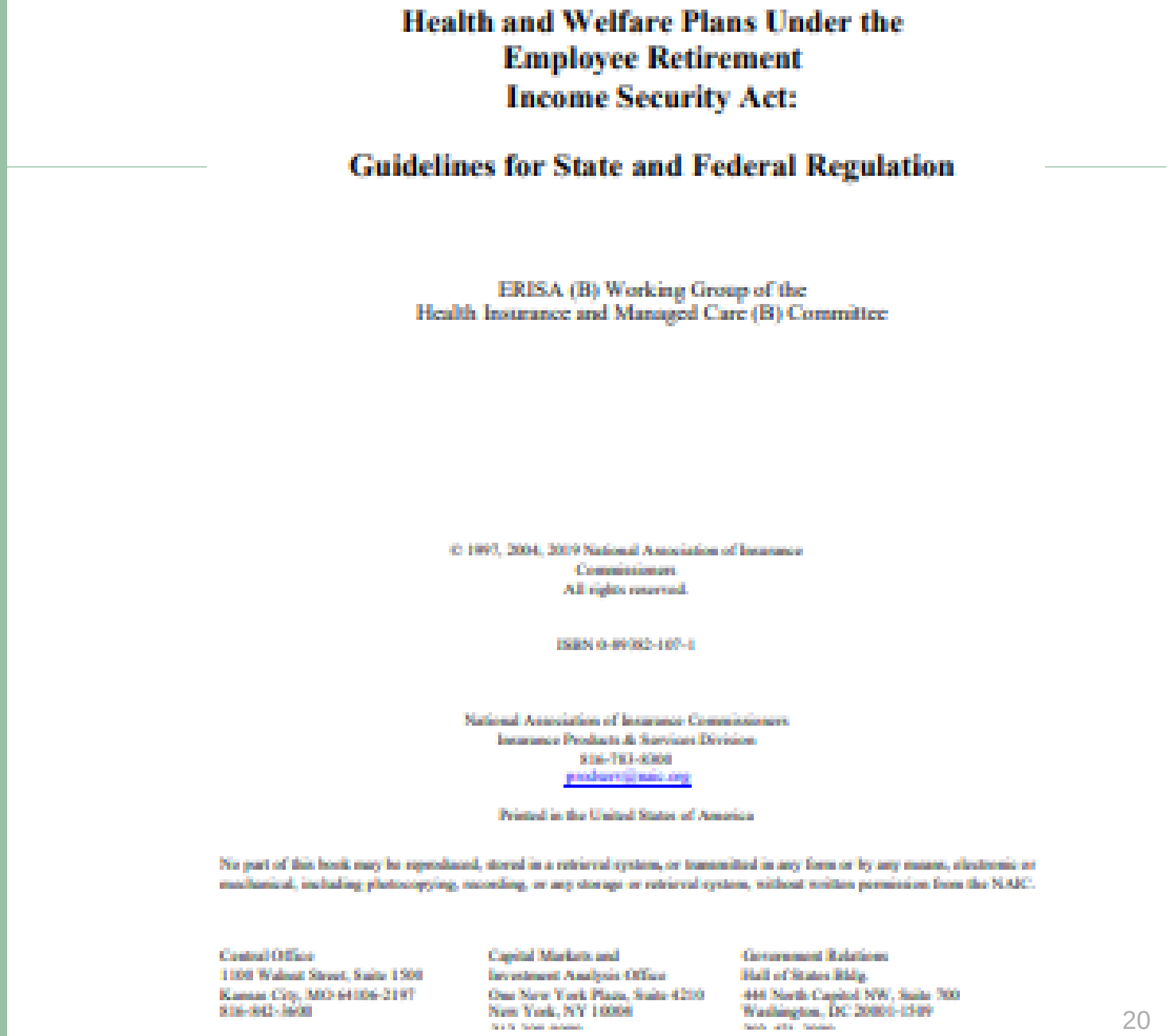
Drug	Indication	Physician Office Markup	Hospital Markup
Botox	Chronic Migraine	$204	$935
Herceptin	Cancer	$1,875	$6,091
Keytruda	Cancer	$2,031	$9,956
Ocrevus	Multiple Sclerosis	$4,433	$19,803
Opdivo	Cancer	$1,166	$7,442
Prolia	Osteoporosis	$607	$2,657
Remicade	Crohn's Disease & Psoriasis	$695	$5,601
Rituxan	Rheumatoid Arthritis	$625	$7,926
Tecentriq	Cancer	$2,304	$8,623
Xolair	Asthma	$349	$1,654
Average		**$1,429**	**$7,069**

Sources: Hospital Price Hikes: Markups for Drugs Cost Patients. AHIP. February 2022

Legal Overview

ERISA (B) Working Group

- New *Rutledge v PCMA* Summary in ERISA Handbook; adopted Summer 2022



Health and Welfare Plans Under the Employee Retirement Income Security Act:

Guidelines for State and Federal Regulation

ERISA (B) Working Group of the
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Recommendations

Recommendations for Lowering Drug Prices

Transparency

- Reporting of Drug Cost Increases & Launch of New High-Priced Drugs – How Much & Why (passed in multiple states)
- PBM & PSAO Registration and/or Licensure (passed in MD and multiple states)
- Patient assistance programs which receive Pharma contributions report on that funding (NV)
- Require pharmaceutical stakeholders to disclose the amount they spend annually on patient assistance programs (NV)
- Require pharmaceutical reps to disclose drug prices to physicians of drugs they are marketing (LA)

States listed in parenthesis () are where related laws have passed

Cost Saving Measures

- Coupons:
  - Ban the use of coupons when there are lower cost alternatives (CA)
  - Make allowable coupons equitable & consumer friendly by offering them to all consumers, requiring them to be offered for the full plan year, and increasing transparency
- Specialty Drugs: Prevent harmful markups & increased costs by protecting the use of specialty pharmacies
- Rebates: Allow rebates to pass through and benefit all enrollees through lower premiums and cost sharing
- Substitutions:
  - Ensure substitution laws do not create barriers to accessing more affordable drugs, such as biosimilars
  - Mandating the usage of generic substitutions (multiple states)
- Patent Gaming: Ban pay-for-delay tactics (multiple states)

Recommendations for the Development of the White Paper

Overall Cost to the Health Care System

- Any policies included in the White Paper must consider both the individual consumer perspective AND the overall cost to all people in the risk pool and health care system.

Inclusion of All Stakeholders

- Consumer Advocate Groups
- Drug Manufacturers
- Patients
- Payors: Employers, Health Insurance Providers, Unions, States, HHS/DOL, etc.
- PBMs
- PSAOs & Delivery Systems
- Providers/Hospitals

Provide All Perspectives on Issues Equally

- Each drug issue has multiple perspectives; each perspective needs to have equal representation within the paper.

Healthier People Through Healthier Markets

Solutions to Improve Health Care Affordability and Access for Every American

View Additional Competition Resources

New AHIP Initiative

Questions & Answers

Thank you!

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