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2020 State Legislation on Prescription Drug Affordability

As our nation struggles with the coronavirus pandemic and the resulting economic crisis, high prescription drug costs are a top concern for individuals and families across the political spectrum. Even before the pandemic, 23% of adults reported not having enough money to pay for needed prescriptions,[1] and 30% of consumers could not take their medicines as directed due to cost.[2]

Now, high prices for COVID-19 treatments (and any vaccines) are expected to add to consumers' financial stress. For example, the first treatment approved to treat COVID-19, remdesivir, is priced at as much as $3,120 per five-day course of treatment.[3]

Concerns about drug affordability have been exacerbated as the nation faces a historic rise in unemployment, and with it, substantial losses of employer-sponsored health insurance.[4] Without health insurance, families face astronomical out-of-pocket prices for prescription drugs.

In the absence of concrete action at the federal level, states have stepped up to address high prescription drug costs. Most states put forward prescription drug affordability legislation in 2020,[5] totaling over 400 bills that build on strategies introduced over the past several years. The majority of bills focus on regulating pharmacy benefit managers (PBM), but increasingly legislative activity targets other dynamics in the supply chain.[6] However, the pandemic has altered legislative sessions in every state, stalling progress on these efforts. As these sessions come to an end, it is critical that states continue to enact measures in 2021 and beyond to ensure that prescription drugs are affordable for consumers nationwide.

In this policy brief, we review key state legislative actions outside of PBM regulation that advocates should watch and consider pushing for in the next legislative session.

Summary of Key State Legislative Approaches to Lower Prescription Drug Prices

Establishing Upper Payment Limits Through Independent Boards That Regulate Prescription Drug Affordability

In 2020, 13 states introduced legislation to establish a prescription drug affordability board (PDAB). This is comparable to actions taken in 2019, when 14 states proposed the creation of independent boards, and when legislation in Maryland and Maine became law. The intent of the PDAB approach is to set the maximum amount purchasers and health insurers pay for the costliest drugs, which reduces costs and increases

access for consumers and payers. Affordability boards can review information they gather from public sources and, in consultation with state payers and purchasers, establish an upper payment limit that allows an affordable way for everyone in the state who should get the drug to access it. By setting an upper payment limit, PDABs regulate in-state costs for particular drugs among state-licensed health care entities. This is common practice in the health care industry, where the upper payment limit caps what insurers can reimburse, or what can be billed to a given purchaser. And despite concerns to the contrary, PDABs do not control prices.

Though the enacted affordability boards in Maryland and Maine do not currently implement upper payment limits, they establish a foundation and provide lessons learned for other states.

Maryland: Updates to Progress Made in 2019

With advocacy efforts and support from the Maryland Citizen's Health Initiative, in 2019, the Maryland legislature passed a law[7] establishing a PDAB with five appointed positions. The board is required to examine the impact of high drug prices in the state. With additional approval from Maryland's Legislative Policy Committee, the board will have the authority to rein in prescription drug costs and can explore the establishment of an upper payment limit. Currently, these reforms apply to state- and county-level payers, with the possibility of expanding in the future. In 2023, the board will be required to recommend to the legislature how it should expand the board's role to cover all payers in the state.[8]

In order to provide a permanent funding source for the Board, the General Assembly passed in 2020, SB 669[9] which would authorize the Board to impose an assessment on drug manufacturers and wholesalers, PBMs and insurers to fund their work. Governor Larry Hogan vetoed this measure. Given the broad, bipartisan support of the measure, the legislature may ultimately override this veto when it reconvenes in January. In the meantime, the Board is moving ahead with its work with a loan from the state which the Board will repay after its permanent funding mechanism is approved. For more information about the Board's work, including its public meetings, check out pdab.maryland.gov.

Bills introduced in nine states in 2020 allowed those states' PDABs to set upper payment limits: Arizona, Florida, Illinois, Massachusetts, Minnesota, New Jersey, Pennsylvania, Rhode Island and Vermont. These states introduced bills requiring independent boards, as well as requiring stakeholder guidance to report and design recommendations for lowering prescription drug spending. None of the proposed legislation has been enacted. And New Jersey is the only state that is still in session and where negotiations are ongoing. However, the PDAB bills introduced in 2020 provide models for future legislative efforts.

Below are brief descriptions of the PDAB legislation in some of these states.

- **Arizona** - SB1387[10]: This bill was introduced to establish a prescription drug affordability board and upper payment limits. The board would identify and report any prescription drug product costs and affordability issues based on analyzing drug spending data. And when it identifies an affordability challenge, it must set an upper payment limit. In addition to establishing the PDAB, the bill establishes a prescription drug affordability fund that annually assesses each manufacturer based on its relative share of gross revenues from drug sales in the state.
- **Illinois** - HB3493[11]: The bill would establish a PDAB to research and identify high-cost prescription drugs and conduct cost reviews. The cost reviews include research related to manufacturers' selection of introductory prices or price increases, lifecycle management, product revenue, and estimated value and cost-effectiveness of the product. If the board identifies an affordability challenge for the state or patients, the board can set an upper payment limit for all purchasing and reimbursement of that drug. Additionally, the board would study generic drug operations and prices, as well as their effects on cost-sharing in public health insurance programs. The board would then conclude by providing a special report to the state's General Assembly. Funding for the board comes from the state's general fund and assessments on all manufacturers.
- **New Jersey** - A2418; S234/A3049; A1477/S 1142[12]: Three New Jersey bills that are currently in committee would establish a PDAB tasked with developing a list of drugs for which manufacturers will be required to report certain information that would allow the board to determine whether the prices of those drugs are excessively high. Two bills provide the board with authority to establish a maximum price for drugs meeting the state's threshold. The third bill requires the board to study the entire pharmaceutical distribution and payment system in the state, and in other states and countries, for both the brand-name and generic markets. The board would then identify drugs that create affordability challenges and provide recommendations to the state legislature. These recommendations may include establishing upper payment limits, using a reverse auction marketplace (in which a state agency engages pharmacy benefit managers in multiple rounds of bidding for the state contract), instituting a cost review of drugs that cause affordability challenges, authorizing importation of prescription drugs from other countries, and implementing a bulk purchasing process.

By setting an upper payment limit, PDABs regulate in-state costs for particular drugs among state-licensed health care entities.

- **Pennsylvania** - HB 2212[13]: This bill establishes a PDAB to identify high-cost drugs that cause affordability burdens using specific criteria and requires the board to recommend or set an upper payment limit when such a burden is identified. Those limits will apply to all purchases and payer reimbursement for the drug in the state and allows for importation if the manufacturer refuses to sell at that rate. The board would conduct cost reviews with input from the PDAB stakeholder council and conduct a study on the U.S. generic drug market to review generic drug costs effect on premium changes for both public and private insurers.
- **Rhode Island** - S2320/H7121[14]: This bill establishes a PDAB to study the state's pharmaceutical distribution and payment system, as well as strategies to lower the cost of pharmaceuticals (including upper payment limits, reverse auction marketplaces, and implementing a bulk purchasing processes). The board would perform cost review analyses and determine which drugs create an affordability challenge. For drugs that meet that threshold, the board may set an upper payment limit.
- **Vermont** - S0246/H785[15]: This bill authorizes the Green Mountain Care Board (the state's independent board created to ensure a high-quality, accessible and sustainable health care system) to evaluate the costs of certain drugs and to evaluate their affordability according to a number of criteria. In the event that spending on a drug has caused or may lead to an affordability challenge, the board will set an upper payment limit that applies to all purchases or payer reimbursements for that drug when dispensed or administered in the state.

In addition to the states discussed above, a 2020 New Hampshire bill includes development of a PDAB but does not set an upper payment limit.

- **New Hampshire** - SB687[16]: The bill establishes a PDAB and advisory council to determine annual spending targets for prescription drugs purchased by public payers and for prescription drugs that cause affordability challenges to enrollees in public coverage plans. The board would recommend state prescription drug spending targets and develop strategies to make drugs more affordable.

State Agency Collaboration on Prescription Drug Purchases

In 2019, New Mexico and Delaware passed laws designed to increase state savings by establishing multi-agency (or bulk) purchasing approaches to lower costs for prescriptions purchased by public payers and the government. In 2020, activity on multi-agency purchasing included both legislative and executive action.

Through his first Executive Order, **California** Governor Newsome initiated a public-private group purchasing approach across state agencies and is open to potential collaboration with counties and other local entities, private payers, other states, self-insured individuals and others.[17] A 2020 California resolution (ACR 105) also encourages the state to partner with Washington and Oregon to collectively lower drug prices.

Four other states introduced legislation on cross-agency and intergovernmental purchasing designed to increase each state's negotiating power, including Illinois, Massachusetts, Minnesota and New Jersey. Those establishing new bulk purchasing programs are summarized below.

- **Illinois** - HB5340: This bill creates the Illinois Pharmaceutical Collaborative Act, which requires the Illinois Pharmaceutical Collaborative to convene and coordinate the efforts of state and local governmental entities to identify and implement opportunities for cost savings in the purchase of pharmaceuticals.
- **New Jersey** – S1067/A3301: These companion bills require the director of the Division of Purchase and Property to review all state pharmaceutical purchasing arrangements and develop options to maximize the state's bargaining power. Additionally, they require the director to maintain a list of drugs and devices appropriate for bulk purchasing, including the 25 highest-cost drugs in the state. The director will implement bulk purchasing arrangements for those drugs deemed high priority and will establish processes for other entities to benefit from the state bulk purchasing agreements (including local governments, private purchasers, health benefits plans, and self-insured entities and individuals).

Improving Price Transparency

Nine states have passed and implemented laws that require drug pricing information from manufacturers related to high launch prices and price increases since 2017.[18] The 2020 legislative sessions included 61 additional bills on transparency across about half of the states. Of the 61 bills, three states (Minnesota, Utah and West Virginia) enacted legislation that requires comprehensive research and reporting of information that contributes to high prices. This information includes investments in research and development vs. marketing, rebates passed through to insurers,[19] supply chain analyses, manufacturer pricing trends, and sharing gross revenues of drug sales. Such information would help state payers understand the current drug pricing system and its financial impacts on public, private, and government payers, as well

as understand how costs are passed to individual consumers (for example, through insurance premium increases).

Below we briefly discuss examples of 2020 state price transparency legislation that have been signed into law.

- **Minnesota** - SF1098[20]: The Prescription Drug Price Transparency Act requires drug manufacturers to submit pricing information on certain drugs that have been newly introduced to the market and on drug price increases that meet certain criteria. The bill also requires the commissioner of health to post certain reported information publicly. Additionally, it requires an annual legislative report that would promote transparency in pricing for public and private payers, assess spending trends, and assist payers in managing related costs.
- **Pennsylvania** - HB 2426/SB1091[21]: These companion bills establish an independent board to develop recommendations for addressing affordability burdens affecting individuals, public and private payers, providers and other stakeholders. The board receives pricing information from manufacturers for certain high-cost drugs and submits an annual report to the legislature that includes pricing trends and other information. Additionally, manufacturers would report all rebates provided to insurers and pharmacy benefit managers within the last three years, as well as existing financial assistance programs for patients. This board will be funded through a special fund in the Pennsylvania State Treasury.
- **Utah** – HB272[22]: Under the Pharmacy Benefit Amendments Act, drug manufacturers are required to report pricing information to the Insurance Department for drug price increases that exceed a specific threshold. And insurers must provide annual reports on the top 25 drugs that account for the greatest spending (after adjusting for rebates). Additional provisions address the remainder of the supply chain.
- **West Virginia** – HB4583,[23] SB689[24]: Similar to Utah, under the Requiring Accountable Pharmaceutical Transparency, Oversight and Reporting Act, manufacturers are required to report annually pricing information for prescription drugs (brand-name, generic and specialty) under certain conditions. In addition, health plans must submit reports listing the 25 most frequently prescribed drugs, as well as information related to prescription drug spending, premium increases, specialty drug utilization management approaches, and costs vs. savings.

Capping Out-of-Pocket Costs

Since 2017, two in three adults reported increases in their prescription drug costs.[25] Moreover, one in five Americans said lowering prescription drug costs for as many people as possible is a top health care issue that Congress should prioritize. People across the political spectrum shared this belief, as is reflected in legislative efforts.[26]

Over half the states have introduced legislation that addresses the burden of high-priced drugs by controlling out-of-pocket costs for consumers. High copayments in general are a concern for many consumers. However, due to heightened national attention, state lawmakers have focused on insulin and other diabetes products to explore solutions that tackle high out-of-pocket costs. In 2019, Colorado became the first state to sign into law an insulin copay cap. In January 2020, Illinois passed similar legislation. **Connecticut, Delaware, Maine, Minnesota, New Mexico, New York, Utah, Virginia, Washington** and **West Virginia** followed quickly behind, signing into law insulin cost-sharing requirements in July.

While copay caps help consumers at the pharmacy counter, there are limitations to this strategy: This approach shifts prescription costs to health insurers and may cause increases in premiums for individuals covered in such plans, even for consumers who do not take or purchase the drugs that have the cost caps. But the main limitation is that copay caps and other forms of lowering cost-sharing do not affect the prices set by manufacturers, nor do they help people who are uninsured or who are not covered by participating plans.

On their own, copay caps let pharmaceutical companies continue unfair and abusive practices that raise drug prices at egregious rates. States that implement copay caps should combine them with the kinds of additional legislation we have discussed in this legislative wrap-up to protect all consumers from high and rising drug prices immediately and in the long term. Read more on copay caps in our report, Insulin and Other Prescription Drug Copay Caps: Helpful Solution or Playing Right into the Hands of the Pharmaceutical Industry?

In April 2020, Minnesota enacted HF 3100[27] the Alec Smith Insulin Affordability Act which requires certain insulin manufacturers to provide insulin to eligible low-income and uninsured Minnesotans in urgent-need for insulin. It also requires manufacturers to increase access to their patient assistance programs to certain individuals. On the eve of implementation, the Pharmaceutical Research and Manufacturers of America filed a lawsuit, arguing constitutionality[28]. The court's decision is still awaited.

In a related effort, California's legislature approved a measure (SB-852), consistent with a similar provision in the governor's budget proposal, that directs the state to partner with one or more drug companies to make or distribute a range of generic or biosimilar drugs – including insulin. If enacted, California would be the first state to develop its own generic drugs, an effort that would bring prices down and could also address drug shortages.

Conclusion

The coronavirus pandemic has spurred the largest recession and national public health emergency seen in over a century. As consumers and families across the nation try to cope with multiple devastating impacts of these crises – waiting for their unemployment benefits, struggling to get enough food, find child and elder care, and meet other basic needs – the high costs of prescription medications, long a significant financial stressor for families, is even more urgent.

Unfortunately, prescription drug costs continue to rise, and new drugs launch at staggering prices.[29] Moreover, despite early promises of reasonable prices for COVID-19-related treatments and vaccines, those promises have been broken – exacerbating the access and affordability problems that everyday Americans experience. For example, the first treatment approved to treat COVID-19, remdesivir, has a price tag of more than $3,100 for privately insured patients.[30] And now private investors are waiting to profit off of an effective vaccine.[31] In light of these facts, lawmakers must act to ensure that pricing issues do not limit access to lifesaving treatments and vaccines going forward.

With federal action stalled, there is no time for states to waste. Over the past several years, state action to address high prescription drugs prices has increased exponentially. While transformational, comprehensive drug pricing measures require federal action, states can continue to chip away at the problem. Fortunately, there are several models states can follow that protect their residents from high prescription drug prices now and in the future.

For more information on the progress states have made toward tackling high prescription drug prices during their 2020 legislative sessions, see the National Academy for State Health Policy (NASHP) legislative tracker.[32]

Endnotes

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This publication was written by:
Hannah Markus, Strategic Partnerships Coordinator, Families USA
Sandra Wilkniss, Director of Complex Care Policy and Senior Fellow, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):
Kimberly Alleyne, Senior Director, Communications
Justin Charles, Digital Media Associate
Stan Dorn, Director of the National Center for Coverage Innovation and Senior Fellow
Nichole Edralin, Senior Manager, Design and Publications
Raven Gomez, Partnerships Coordinator
Lisa Holland, Senior Communications Manager
Lisa Hunter, Senior Director of Strategic Partnerships
Adina Marx, Communications Associate
Justin Mendoza, Senior Partnerships Manager

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THE VOICE FOR HEALTH CARE CONSUMERS

1225 New York Avenue NW, Suite 800
Washington, DC 20005
202-628-3030
info@familiesusa.org
FamiliesUSA.org
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twitter / @FamiliesUSA

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