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Task Force on Drug Pricing

Goal is to lower out of pocket costs to New Mexicans while preserving Access and the infrastructure of health care

- 1. Listen to everyone: AHIP, PhRMA, etc.
- 2. Rely on unbiased sources: KFF, CBO, The Drug Channels Institute Academic white papers
- 3.Follow the money
- 4. Multistate and multinational corporations will not be affected by decisions in NM, but we can affect the companies that work in NM.
- 5. Our tools include legislation and a strong Superintendent of Insurance

Inflation Reduction Act

- No limitation on Launch price
- Delay of the drug board action for 9-13 years
- 10 drugs in 2026, 15 in 2027 and 2028, 20/year after that
- Ceiling price is 75% of AMP years 9-12 65% 12-16 and 40% for >16 years on market
- CBO: $62.3B from decreased spending +$38.4 B on revenue impact
- $2000 max OOP for 2025 with increase depending on cost of the program
- in catastrophic phase $0 for 2024

Drug Boards, unintended consequences

Any determination of Maximum Fair or List Price that is higher than purchase price hurts the practice or hospital who bought the drug to administer, not the manufacturer.

If the manufacturer does not lower the price, practices and hospitals will stop offering the drug

New Mexico Marketshare is not sufficient to persuade manufacturers to lower prices

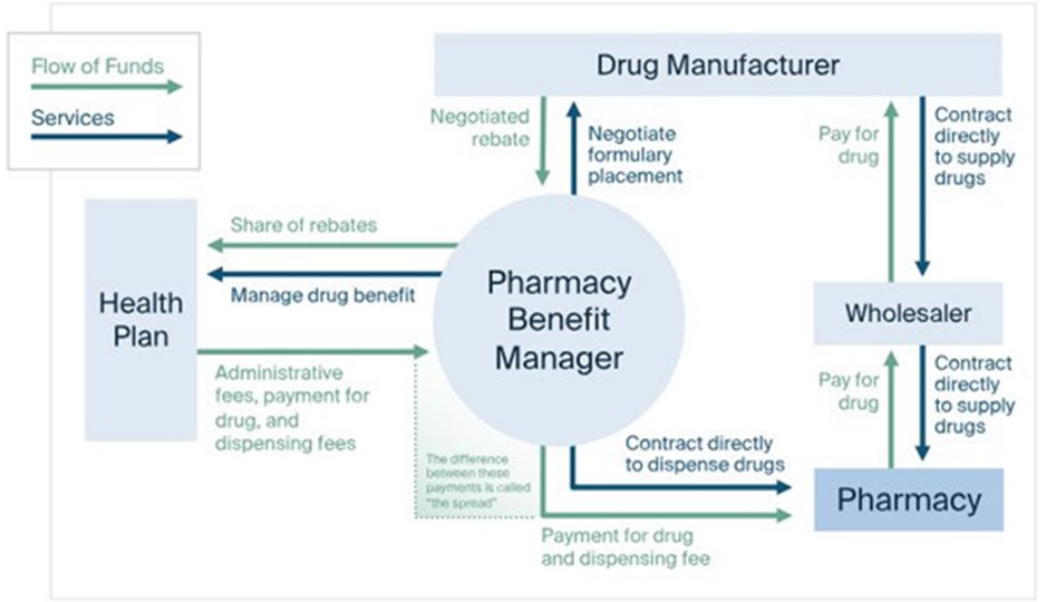
Patients don’t get the drugs they need.

Manufacturers: Transparency report 1/16 companies

- Net price declined 2.8% in 2021, 5th year in a row
- Rebates discounts and fees paid $33.9B (15.2% increase year over year)
- Rebates Discounts and fees 55% of list prices
- R&D is double the amount spent on marketing $11.9B

EXHIBIT 2

The Flow of Services and Funds in the Pharmaceutical Distribution Chain



Data: Adapted from Elizabeth Seeley and Aaron S. Kesselheim, *Pharmaceutical Benefit Managers: Practices, Controversies, and What Lies Ahead* (Commonwealth Fund, Mar. 2019).

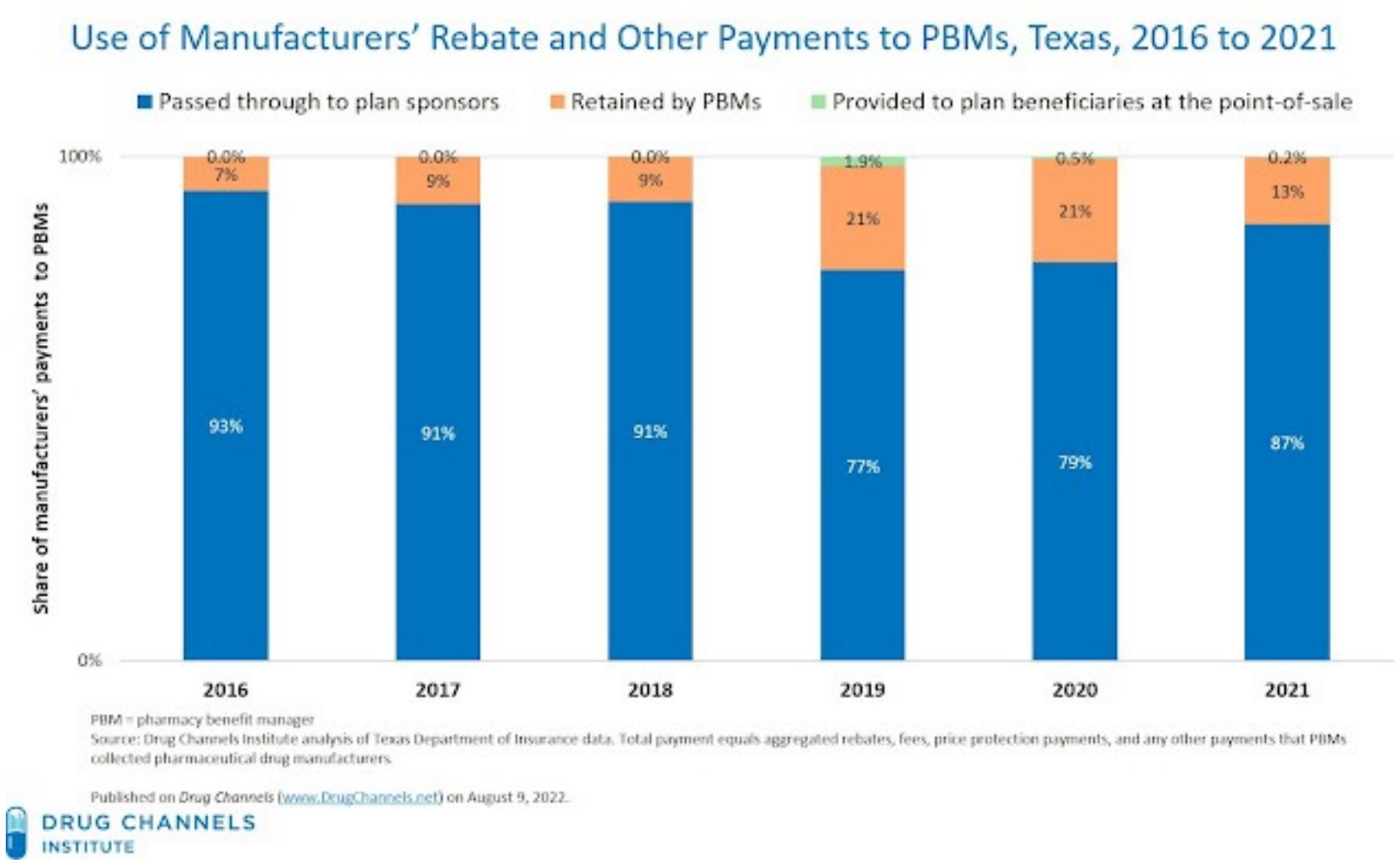
Source: Elizabeth Seeley and Surya Singh, *The Role of Pharmacies in Making Drug Purchasing More Efficient and in Promoting Access to Preventive Care* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/g749-h298

PBMs in Texas: From the Drug Channels Institute. Total annual rebate payments

2016	$558M
2019	$857M
2020	$2.4B
2021	$5.7B

COULD WE HAVE THE REBATES GO TO PATIENTS?

PBMs: Where do the Rebates go?



Insurers Determine Patient Out-of-Pocket Costs

The Congressional Budget Office (CBO) recently acknowledged that "it is unlikely that the average net price of a prescription has increased considerably in recent years...," [17] yet patients face growing cost-sharing (or out-of-pocket costs) obligations because of insurance benefit design, and in some instances, are getting less access to needed medicines.

Commercial insurers and PBMs often, and more increasingly, base patient cost-sharing on list price and not the lower net price negotiated with drug companies. Commercial insurers and PBMs are also implementing more restrictive utilization management programs. [18]

One example of more restrictive utilization management programs is the increasing use of

"Exclusion Lists"

which in some instances, prevents patients from accessing a growing list of medicines.

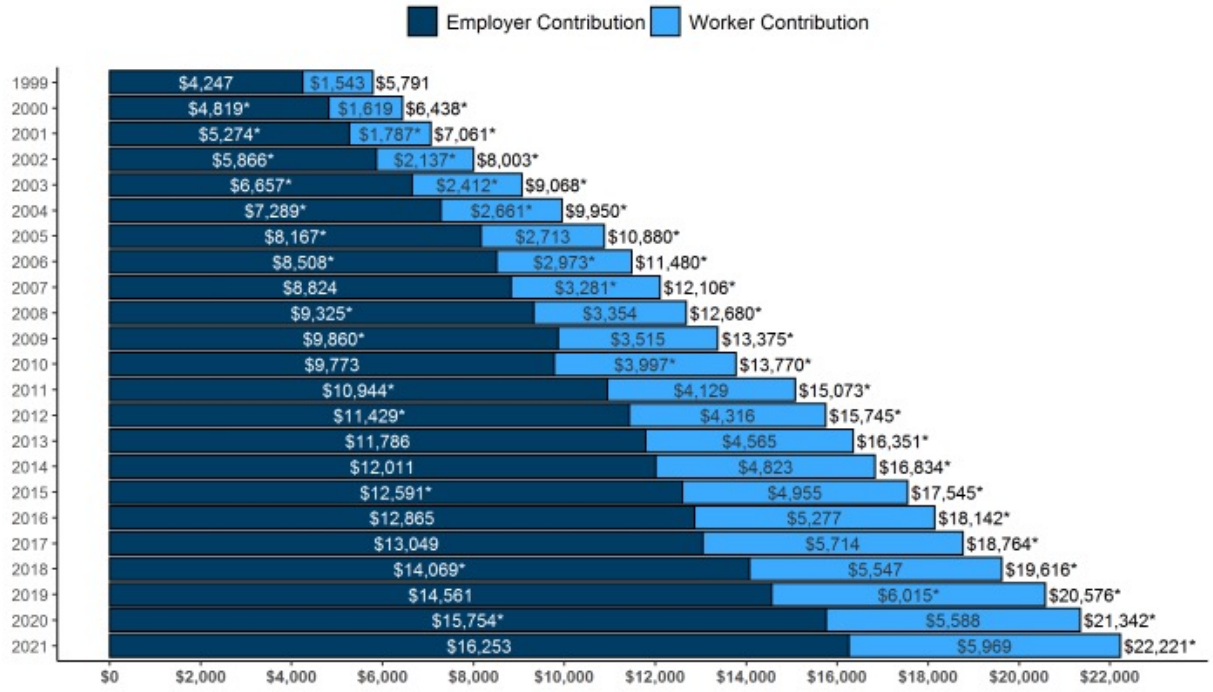
Since 2014,

these "exclusion lists" have grown more than **675%**[15] to include more than **846 unique products**.[16]

References 15. Xcenda. "Skyrocketing Growth in PBM Formulary Exclusions Raises Concerns About Patient Access." September 2020 link. 16. Fein, A. "Five Takeaways from the Big Three PBMs' 2022 Formulary Exclusions." Drug Channels Institute. January 19, 2022. https://www.drugchannels.net/2022/01/five takeaways-from-big-three-pbms-2022.html. 17. The Congressional Budget Office, "Prescription Drugs: Spending, Use, and Prices." January 2022. https://www.cbo.gov/publication/57772 18. Howell, S., Yin, P. and Robinson, J. "Quantifying The Economic Burden Of Drug Utilization Management On Payers, Manufacturers, Physicians, And Patients." Health Affairs. August 2021https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00036.

Kaiser Family Fund: payment for family insurance

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2021



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Industry Myth: Copay cards circumvent plan benefit design

Fact Check: Copay Assistance helps patients pay for their prescriptions; Issuers and PBMs have designed plan designs that construct financial barriers to access

- Issuers have **shifted more costs to patients** by raising deductibles (up to $7000+ in Florida) and applying 30% - 50% coinsurance for specialty medication cost sharing[4]
- Issuers & PBMs already use formulary tiering, step therapy, and prior authorization to control costs and direct patients to "preferred" drugs

[4] K. Hempstead, *Marketplace Pulse: Cost-Sharing for Drugs Rises Sharply at Higher Tiers* (Robert Wood Johnson Foundation, March 1 2019). https://www.rwjf.org/en/library/research/2019/03/cost-sharing-for-drugs-rises-sharply-at-higher-tiers.html.

Copay Accumulators: Industry Myths and Fact Checks

Industry Myth: **Manufacturer copay cards drive consumers to more expensive drugs and discourage generic substitution**

Fact Check: **Most copay assistance is for drugs with NO generic equivalent**

- 87% of copay assistance programs are for Rx that have **no generic equivalent**[1]
- One study showed that **only 0.4% of purchases** made with copay assistance between 2013-2017 had a generic equivalent available[2]
- CMS has stated copay coupons are **not distorting the market** when there is no generic equivalent available[3]

[1] Karen Van Nuys, Geoffrey Joyce, Rocio Ribero, and Dana Goldman, *Prescription Drug Copayment Coupon Landscape*, (USC Schaeffer Center, February 7, 2018). https://healthpolicy.usc.edu/research/prescription-drug-copayment-coupon-landscape/

[2] IQVIA. *An Evaluation of Co-Pay Card Utilization in Brands After Generic Competitor Launch.* https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization

CO Pay Accumulators

Manufacturer funds 501cs Foundations to pay patients copays or coinsurance until the total out of pocket amount is reached, and the insurer is to assume the total cost
With accumulators, Insurers designate the Foundation donation as not part of True Out Of Pocket Expense
The patient, if they can afford it, must then pay the second round of copays until (and If)the out of pocket Maximum amount is paid.
Patient Adherence drops
Payers get the benefit of 2 rounds of copays.

Industry Myth: Banning Copay Accumulator Programs will drive up premiums

Fact Check: States that have passed laws banning copay accumulators saw premium rate increases/decreases comparable to other states

- VA had an overall premium rate decrease of 6.9% in 2021 with 5/8 issuers decreasing rates[5]
  - AZ had an overall premium rate increase of 5.45% with 2/5 issuers decreasing rates[6]
- No issuers attributed rate increases to having to count copay assistance toward a beneficiary's cost sharing

[5] Louise Norris, *Virginia health insurance*. December 16, 2020. https://www.healthinsurance.org/virginia/
[6] Louise Norris, *Arizona health insurance marketplace: history and news of the state's exchange*. December 16, 2020. https://www.healthinsurance.org/arizona-state-health-insurance-exchange/

Co Pay accumulators in New Mexico Courtesy of The Aids Institute

- Federal rules allows insurers to keep the copay assistance provided to patients by PhRMA Foundations
- 4/5 NM Insurers have a copay accumulator
  - BCBS, Molina, Truehealth, Western Sky
- Other states have laws that require insurers to count donated copays toward the true Out Of Pocket expense

Medicaid effect

- Current guidance allows MA plans, including D–SNPs, to not count Medicaid-paid amounts or unpaid amounts toward this maximum out-of- pocket (MOOP) limit, which results in increased State payments of Medicare cost-sharing and disadvantages providers serving dually eligible individuals in MA plans

- CMS MA proposed rule

CO Pay Maximizers

- Plans designate specialty drugs as “non-essential health benefits” thus removing these drugs from the ACA essential Health Benefit requirements for out-of-pocket maximums
- PhRMA Foundations pay until the maximum value of the copay is reached
- Patients’ Out-of–Pocket maximum is defined to equal the value of the Foundation contribution but is spread evenly over the entire year.
- The insurer gets the benefit of the Foundation support
- Some plans do not require copays by patients
- Carve outs of specialty drug coverage allows manufacturer foundations to pay, but usually there is a requirement to buy from PBM’s SP.

Prevalence

- 80% commercial insured have a plan with an available copay accumulator in the design.
- 61% of commercial insureds have a plan with a maximizer in the design.
- 43% of plans have implemented the accumulators
- 45% of plans have implemented the maximizers

Other States have PBM reform laws, W VA and OK are good models, but we suggest:

1. Transparent pricing of entire supply chain

2. Rebates should go to patient at the point of care

3. PBMs are paid a fee for negotiation of prices, not a Percentage

4.Insurers can raise prices the same amount they lowered them when PBMs started

5. No spread pricing, Accumulators or Maximizers, or gags

6. No Steerage of patients to higher priced drugs or to PBM owned pharmacies: protect patient choice and the delivery system

7. No fees collected for inappropriate quality measures, or retroactive clawbacks

Questions?

We will continue working on a bill to bring to you.

If you wish any of our references we are glad to provide them

If you have other information you wish us to consider we will gladly do so.