Health Notes

Program Evaluation Unit
Legislative Finance Committee
Date: September 28, 2016

Prescription Drug Costs: Maximizing State Agency Purchasing Power

AT A GLANCE

In the years between 2000 and 2012, the country saw a steady but relatively gradual increase in spending on prescription drugs, at the same time as the growth rate for spending from year to year actually declined. The decline was due to a combination of the 'patent cliff,' the expiration of many drug patents at approximately the same time, and lower costs for the generic versions of these drugs.

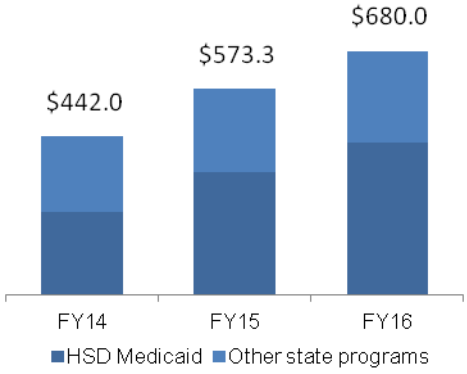
By 2014, however, the picture had changed dramatically. Spending on drugs increased by more than 11 percent due to major changes in the landscape: fewer patent expirations, rising prices for both generic and brand drugs, and expanding use of new high cost specialty drugs, particularly for cancer, hepatitis C, and multiple sclerosis. These specialty drugs can be enormously beneficial and may ultimately reduce medical costs by treating and curing conditions before they become chronic or require costly medical interventions. The cures now available for the hepatitis C virus (HCV), for example, mean not just improved quality of life for patients, but also less chronic liver disease and fewer liver transplants.

These are important advances, but they come at a cost. All indications are that the country has begun a new era of significantly expanded spending on prescription drugs, straining state budgets and leading to higher out of pocket expenses even for insured patients.

In FY16, the ten New Mexico state agencies that purchase prescription drugs spent a combined total of over $680 million, up from $442 million in FY14, or an increase of approximately 54 percent. New Mexico is under increasing budget pressure, and it is crucial to identify any areas of potential cost savings, including consideration of new ways to increase the state's negotiating power and purchase drugs more effectively.

This Health Notes brief provides an overview of prescription drug utilization and spending in the state, as well as the initiatives state agencies are engaging in, either collaboratively or separately, to contain costs. The brief also looks at cost reduction options being considered and implemented around the nation.

Chart 1: State Prescription Drug Spending
in millions



Source: Agency responses to LFC

Health Notes are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.

New Mexico Legislative Finance Committee

Rising Prescription Drug Spending

By 2015, spending on prescription drugs in the United States reached an estimated $425 billion, and accounted for approximately 17 percent of all health care costs. Net spending, taking into account manufacturer discounts and rebates, was $310 billion, up 8.5 percent from 2014; specialty drug spending was $121 billion of that, up 15 percent from 2014. The IMS Institute for Healthcare Informatics projects spending will continue to rise throughout the coming decade at between six and seven percent increase per year.

Rising prescription drug spending is the result of both increased utilization and increased prices. According to the U.S. Department of Health and Human Services (HHS), approximately 10 percent of the increase in spending on prescription drugs has been due to population growth, while approximately 30 percent is the result of more prescriptions filled per person. The country's population is not just larger, it is also experiencing an increase in chronic conditions like diabetes and obesity. According to the Partnership to Fight Chronic Disease, approximately 191 million Americans live with at least one chronic condition, over 75 million of whom live with multiple conditions.

Since implementation of Medicare Part D and the Affordable Care Act, more of the costs of prescription drugs are paid for with public funds than ever before, sharpening interest in public policy solutions to contain costs.

At the same time, new treatments are turning some diseases that once were mostly fatal within the relatively short term – some types of cancer and heart disease, for example – into chronic conditions that can be managed with medications. New specialty drugs for diseases such as hepatitis C offer such significant improvements to older, less effective treatments that patients who once by-passed any treatment at all are now coming forward. Medicare Part D and the Affordable Care Act have expanded access to health care, ensuring that more people who need prescription drugs are able to obtain them. Those policy changes also mean that more of the costs of prescription drugs are borne by the public through the Medicare and Medicaid programs – approximately 40 percent of all drug spending in the US since 2006 – sharpening the interest in public policy solutions to contain costs.

Drug prices are partly determined by the type of drug.

Understanding rising drug prices begins with understanding the different categories of drugs.

Specialty drugs are a key cost driver. Specialty drugs are used to treat complex conditions such as cancer, multiple sclerosis, and hepatitis C, as well as a wide range of rare diseases. These drugs are distinguished primarily by their high cost, but also by the fact that most are biologic drugs, which means that they are made using living systems, like plant or animal cells. They require special manufacturing, handling, and administration systems, and, to acknowledge the difficulties inherent in bringing these drugs to market, the FDA gives them a 12 year exclusive marketing period upon approval.

As a class, specialty drugs are not new, but there are more of them today. More new specialty drugs than traditional drugs have received FDA approval every year since 2010. Utilization is still low: specialty drugs made up only about one percent of all prescriptions in 2015. But costs are high: nationally, specialty drugs made up about 36 percent of all drug spending, an increase of approximately 20 percent from 2014 to 2015.

Costs for brand name drugs as a class have also increased. Brand drugs, including specialty drugs, are still under patent protection so they have no direct market competition. Brand drug utilization declined by about 42 percent between 2009 and 2015. During that same time period, prices for the most common brand drugs increased by 164 percent. Today, approximately 10 percent of dispensed prescriptions are brand drugs – yet that portion still accounts for 72 percent of drug spending.

A key factor in rising drug costs is the market protection provided to pharmaceutical manufacturers by patents and FDA-granted periods of market exclusivity.

Pricing for brand drugs is a dynamic process. Beginning with an original 20 year patent, as well as an initial period of five to seven years of market exclusivity granted upon FDA approval, manufacturers often build multiple layers of patent protection to extend their exclusive market status. Ingredients, precise formulation, dosage, and delivery systems, for example, can all receive a separate patent, which extends the amount of time before a generic version can join the market. A recent study published in the Journal of the American Medical Association (JAMA) concluded the key factor in rising drug costs is the market protection provided to pharmaceutical manufacturers by patents and FDA-granted periods of market exclusivity.

The importance of exclusivity can be seen in the price hikes that tend to occur shortly before a drug loses patent protection. According to the Wall Street Journal, list prices for 14 of the biggest selling brand drugs facing generic competition increased by an average of 35 percent during the two years before their patents expired; their cost after discounts increased an average of 22 percent. One example: the patent for Humira, a specialty drug used to treat rheumatoid arthritis and other inflammatory diseases, will expire at the end of 2016. In anticipation of coming competition, the drug's price has increased eight times over the last three years, by a total of 73 percent, and it now costs over $49,000 for a year's treatment. The discounted price increased by 49 percent over the same period.

Generic drugs have grown in both utilization and cost. Generic drugs have been generating cost savings for the U.S. healthcare system for decades, approximately $1.68 trillion in just the last ten years. Generics are chemically identical to the brand name drug they are replicating. They are less expensive to manufacture for a number of reasons, including the fact that they do not require independent clinical trials. While the generic market is generally characterized as highly competitive, keeping prices low, those lower prices often do not occur immediately, since the first generic version of a drug is granted a 180 day period of market exclusivity by the FDA before other generics can enter the market. Larger savings are realized as more generics become available.

While generic drugs are expected to continue to help hold down overall prescription drug spending, recent price hikes of some generic drugs have led to rising concerns. A 2016 U.S. HHS report on trends in generic drug prices found an increased risk for 'extreme' price increases where market concentration had occurred. One factor contributing to the lack of robust competition is the FDA's years-long backlog of applications for new generic drugs: as of July 1, 2016, there were over four thousand applications awaiting review, and the FDA is now averaging 47 months to approval.

Generic drug prices are also rising, in part due to the thousands of new drug applications waiting to be reviewed by the FDA.

Biosimilar specialty drugs are anticipated to bring the next wave of drug cost savings. There are no generic versions of biologic drugs because there is no way for other manufacturers to exactly replicate the original biological process. Biosimilar drugs – similar but not identical – hold limited promise of eventually reducing the cost of specialty drugs. Biosimilar drugs are more expensive to develop than generic drugs are, and the price difference between the original biologic drug and the biosimilar is not likely to be as large as the difference between brand drugs and generics.

To date the FDA has approved only three biosimilar drugs. Nearly a dozen more biosimilar drugs now working their way through FDA approval are anticipated to bring savings to the specialty drug arena.

Compounded medications have also been a cost driver, although that trend is slowing. Compounded medications are drugs combined to meet the specific needs of an individual patient. For example, a prescription drug may be available only in certain dosage or in tablet form, and a patient may need a different dose or a liquid version. Compounded drugs are not FDA approved and have been the subject of scrutiny due to some cases of questionable safety and effectiveness.

Prices for compounds are difficult to determine, since they have multiple ingredients with different prices. Historically, the entire product was billed based on the single most expensive ingredient. However, 2012 federal regulations mandated that compounded medications be billed at the ingredient level. Spending for compounds only increased, however, as manufacturers raised prices for many ingredients and utilization expanded. By 2014, primarily due to uncertain efficacy, health plans began putting limits on compounded medications. Express Scripts, the country's largest pharmacy benefit manager, removed most compounded medications from its national formulary and saw plan costs associated with compounded medications drop by 97 percent from 2014 to 2015.

How are drug prices actually established?

Drug prices are the result of a complicated process that begins with the manufacturer's calculation of the cost of making the drug and the price the

market will bear, and then progresses through multiple levels of negotiations between manufacturers, wholesalers, health plans, pharmacy benefits managers, and pharmacies. Each step of the way, prices are marked up and discounted, rebates and subsidies are applied, and market forces are accounted for, based on the unique and confidential agreements between actors. Appendices A and B have two detailed infographic versions of the drug pricing process from very different perspectives, one provided to the LFC by the pharmaceutical industry and the other by Consumers Union.

Approximately 30 percent of the increased drug costs over the last five years was due to overall economic inflation, and another 30 percent was the result of higher average drug prices.

The original average wholesale price (AWP) for a drug set by the pharmaceutical manufacturer establishes the starting point that government programs and insurance plans use to determine reimbursement rates. This is why, for example, the manufacturer of EpiPen responded to the outcry over its recent price increase by offering coupons directly to consumers, without making a change to the product's AWP.

Federally-funded programs have their own pricing structures. To have their drugs included in the national Medicaid formulary, manufacturers must agree to participate in all three federal programs. These programs save the federal government a substantial amount: the Commonwealth Fund estimates Medicaid pays about a third of what commercial plans pay, the Veterans Administration pays about half, and the 340B program reduces drug costs for covered entities by about thirty percent.

New Mexico is one of only four states that have no supplemental rebate agreements in place to access drug prices even lower than guaranteed by the MDRP.

Medicaid uses the Medicaid Drug Rebate Program (MDRP), through which it is able to obtain a 23.1 percent rebate from manufacturers for brand drugs and 13 percent rebate for generic drugs, or the lowest price for which the drug is sold to other buyers. Medicaid also gets an additional rebate if the price of a drug increases faster than inflation. Originally limited to fee-for-service Medicaid, the ACA extended those rebates to managed care Medicaid MCOs. States may negotiate additional rebates using either single state or multi state rebate agreements – New Mexico is one of only four states that have no supplemental rebate agreements in place.

The US Department of Veterans Affairs (VA) and Department of Defense (DOD) use the Federal Supply Schedule (FSS), commonly referred to as VA pricing, which provides a rebate of at least 24 percent, or the lowest price paid by other buyers. Both programs can also use direct negotiations to obtain even lower prices, generally by ensuring access to their formularies.

VA pricing is only available to VA facilities, the DOD, and other federal government agencies, although one state, California, currently has a ballot initiative to require that all state agencies purchase drugs at the VA price. Questions abound about whether this approach is feasible; the Drug Price Standards Initiative will go before California voters on November 8, 2016.

The 340B drug pricing program aims to provide drug rebates that allow

covered entities to effectively spend more of their scarce federal dollars to provide more care for more people. Covered entities are non-profit health-care facilities such as federally qualified health centers, children's hospitals, cancer hospitals, critical access, disproportionate share, and sole community hospitals, tribal/urban health centers, and certain specialized clinics. 340B pricing is only for covered outpatient drugs provided to eligible patients at an outpatient facility, or a pharmacy contracted by the facility. Eligible patients must receive healthcare services other than just medications from providers who are employed by the covered entity. The 340B program is managed by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), which determines the ceiling price for each covered drug. Ceiling prices are proprietary, but the Medicare Payment Advisory Commission estimated that participants receive at least a 22.5 percent discount.

Demand for naloxone, the powerful anti-overdose drug, has surged as the federal government and some states – including New Mexico – are adopting policies to combat the opioid addiction crisis. Increased demand and rising prices resulted in an over 250 percent increase in spending on naloxone from 2011 to 2015.

Despite the strict regulations that govern it, the 340B program has grown at a rapid rate: spending under the program increased from $0.8 billion in 2004 to $7.2 billion in 2013. In response to growing concerns about potential abuse, HRSA issued a proposed 340B omnibus guidance in August, 2015.

The other side of rising drug costs: prices are rising faster than utilization.

The last few years have seen several very high-profile price hikes that have captured public – and congressional – attention. Daraprim, a generic drug used for patients with HIV/AIDS and cancer, went from $18 to $750 when the company that originated it was bought by Turing Pharmaceuticals. Daraprim is an example of a drug that serves a relatively small population but has an out-sized impact on drug spending due to its high price. Two much more widely-used life-saving drugs have seen price increases drive their costs to potentially unmanageable levels. EpiPen, the familiar treatment for severe allergic reactions, had gradually increased in price every year since 2004 in relatively modest increments which did not attract much public notice. Late this summer, the price jumped by $100 to a new price of $600, for no apparent reason other than the manufacturer's pricing strategy and dominant market position. Congressional hearings into the matter were pending at the time of this brief.

Another example: naloxone is a generic drug dating back to 1971. Used to reverse the effect of opioid overdose, police and first responders have carried injectable versions of the drug for years. Demand has surged as the federal government and some states – including New Mexico – are adopting policies to combat the opioid addiction crisis through tactics such as dispensing naloxone with every opioid prescription. The 2014 development of a nasal spray form has further driven demand. However, the drug's price has also risen steeply in the last couple of years: the most costly version, auto-injector

Evzio, was introduced in 2014 at $287, increased to $375 by late 2015, and has a current price of $2,250. Increased demand and rising prices resulted in an over 250 percent increase in spending on naloxone from 2011 to 2015.

To be clear, some of the big price hikes are outlier examples, unusual events from which the rest of the pharmaceutical industry generally tries to distance itself. But individual drug prices, both brand and generic, do change with regularity and possibly increasing frequency, and are a commonly cited concern for health plans, PBMs, government programs and consumers.

Increasing drug prices, both brand and generic, are a commonly cited concern for health plans, PBMs, government programs and consumers.

The Pharmaceutical Research and Manufacturers of America (PhRMA), the trade organization for drug manufacturing companies, explains the high cost of new medicines by stressing the numerous positive and cost-saving aspects of modern biopharmaceuticals: innovative new drugs help save lives, improve the quality of, and access to, health care, and ultimately save money by delaying or avoiding expensive hospitalizations and emergency room visits. New drugs, particularly new biologic drugs, are expensive to research, develop and produce, and only a small percentage are ever approved for use by patients. PhRMA stresses the availability of patient assistance programs, in addition to the rebates and discounts routinely negotiated by health plans and required by Medicaid, and takes the position that the price the consumer eventually pays for any given drug is not set by the manufacturer, but is actually the end result of several rounds of negotiations including manufacturers, health plans, pharmacy benefit managers (PBMs), and pharmacies.

Health plans and their associated PBMs take a different position. While health plans and PBMs have a variety of methods available to manage their drug costs, including cost sharing with members through copayments, coinsurance and deductibles, their bottom line begins with the prices they are able to negotiate with the drug manufacturers. And because all negotiations begin with the price set by the manufacturer, and any rebates or discounts are generally a percentage of the drug's list price, health plans and PBMs hold manufacturers ultimately responsible for rising drug costs.

The National Association of Medicaid Directors (NAMD) has also raised concerns about rising drug costs, which have been historically fairly well-contained by the Medicaid Drug Rebate Program (MDRP). The MDRP is a trade-off: Medicaid programs receive at least a 23.1 percent rebate for a given manufacturer's brand drugs and 13 percent rebate for generic drugs, and in return all of that manufacturer's FDA-approved drugs are covered on the Medicaid formulary. However, the MDRP is limited in the same way as discounts negotiated by health plans, in that it is a percentage based on the original price set by manufacturers. Faced with the unprecedented costs of new specialty drugs, and federal mandates that Medicaid recipients must have access to all drugs approved for the national formulary, Medicaid programs in every state are struggling.

Consumers are bearing more of the costs of prescription drugs than ever before, which may lead to incomplete medication compliance, which may lead to poor health outcomes.

Consumers are faced with rising health care costs across the board. Consumers who had insurance prior to passage of the ACA have seen their co-pays for most services increase; consumers who obtain insurance under the ACA tend to select health care coverage based on premium price, often without enough consideration of costs like deductibles and co-pays, and then find themselves faced with high out of pocket costs. Prescription drug costs are some of the most visible of those costs, given that most people who have one or more prescriptions fill them – and pay for them – more frequently than they see a healthcare provider. Many of the costliest drugs are used to treat chronic or rare and deadly diseases, and the consumers who need them are particularly vulnerable to higher prices.

As health plans search for ways to keep their own costs down, consumers are bearing more of the costs of prescription drugs than ever before, leading to rising concerns that we are turning full circle: modern medicines, heralded as cost-effective because they treat and cure diseases before they can lead to higher medical costs, have increased so much in cost themselves that health plans have turned to ever-more cost sharing with their members, which in turn may lead consumers to decide they cannot afford necessary medications, or to try to save money by skipping or reducing doses, which may then lead to the same costly medical complications the drug was meant to help avoid to begin with. Some consumers do have access to some manufacturer patient assistance programs, but using these programs can require substantial time and effort on the part of the patient.

Health plans may have relatively more or less narrow or tightly-controlled formularies, and in the commercial sector may deny access to particular drugs altogether.

Cost control mechanisms.

Medicaid has a national formulary and can require prior authorization, but must, ultimately, provide access to drugs that are shown to be medically necessary for a patient.

Health plans have a wide array of tools to contain pharmaceutical costs. Which tools are used, and to what extent, are a key part of plan design.

Formularies (preferred drug lists) are the most basic cost containment tool, and are a list of which drugs a plan will cover without requiring prior authorization. Every formulary is dominated by generic drugs, although decisions about which drugs are included in the formulary are based on medical efficacy as well as cost effectiveness.

Prior authorization is required for off-formulary or non-preferred drugs, and involves getting a determination by the provider that the drug is medically necessary, most commonly after some degree of step therapy – one (or more) preferred drug has proven not appropriate for the specific patient.

Cost sharing is connected to formulary design through tiers: one co-payment for a preferred generic drug and a higher co-pay for a brand, non-preferred drug. Many plans also have a third tier for specialty drugs, and many now include coinsurance for their second and/or third tiers, where the patient is

responsible for a percent of the cost of the drug, not just the co-pay.

Dispensing limits are another common tool for limiting costs. By limiting the number of times a prescription can be refilled and/or the number of days/doses may be supplied, the plan attempts to ensure the drug is being used as prescribed and that the patient is not receiving more than needed.

Drug utilization reviews and ***medication adherence programs*** are both methods for ensuring a drug is being used to its maximum benefit. Drug utilization reviews are used throughout Medicaid and commercial plans to screen for duplication, drug contraindications, drug allergies, and other factors that could lead to health complications. Medication adherence programs, which may include patient education, enhanced care coordination and/or lowering or eliminating copayments for select drugs, are expanding as more focus turns to keeping patients compliant with their medications.

All of the New Mexico Department of Health facilities and the Children, Youth and Families Department participate in the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP).

Bulk purchasing is a cost-containment method that can be used at the agency or facility level as well as at the state program level. As of 2015, there were five multistate purchasing pools as well as several single state, multiagency purchasing pools. Member states regularly report cost savings, primarily associated with more efficient use of preferred drug lists and supplemental rebates. Precise calculations of dollars saved are rarely made public, although Iowa reported savings of nearly $250 million from 2005 to 2015 through its participation in the Sovereign States Drug Consortium.

Table 1: Multi-State Bulk Purchasing Pools

Multi-state pool	State members (2015)
National Medicaid Pooling Initiative (NMPI)	Alaska, District of Columbia, Kentucky, Michigan, Minnesota, Montana, New Hampshire, New York, North Carolina, Rhode Island, South Carolina
Top Dollar Program (TOP$)	Connecticut, Delaware, Idaho, Louisiana, Maryland, Nebraska, Pennsylvania, Wisconsin
Sovereign States Drug Consortium (SSDC)	Delaware, Iowa, Maine, Mississippi, North Dakota, Oregon, Utah, Vermont, West Virginia, Wyoming
Northwest Prescription Drug Consortium (NPDC)	Oregon, Washington
Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP)	Agencies and clinics in 45 states; does not serve Medicaid or public employee programs

Source: NCSL

Pharmacy benefit managers (PBMs) are widely used by both public and private plans to manage their prescription drug programs. PBMs negotiate drug prices on behalf of the plan, based on membership size, but they may also do much more: everything from developing the plan's formulary, processing claims and prior authorization requests, developing a pharmacy network, patient and provider education, or even offering medication adherence programs of their own. Mail order pharmacy services are an expanding area of interest for PBMs, since this is an area that can potentially drive down plan costs, improve health outcomes through increased medication compliance, and at the same time increase PBM profits.

There is no question that PBMs offer their clients substantial cost savings, and the industry is constantly expanding the scope of services it offers. To a large degree the savings are driven by market consolidation: by 2015, three PBMs dominated over 80 percent of the market. Those three PBMs are structured quite differently. Express Scripts (ESI) is an independent PBM; Optum

is owned by health plan United Healthcare, and Caremark is owned by the CVS pharmacy chain. The size of the big three PBMs endows each with serious negotiating power, and also with significant profits, leading to calls that PBMs should be subject to the same sort of increased pricing transparency sought for pharmaceutical manufacturers.

New Mexico State Agency Prescription Drug Spending

All of the state agencies reviewed here are experiencing each of the prescription drug cost trends discussed earlier, adding up to a statewide spending increase of approximately 54 percent between FY14 and FY16.

This brief includes a review of prescription drug spending by 10 state agencies and entities. Seven of these provide prescription drugs as part of health insurance plans: the Human Services Department (HSD) and Medicaid; the member agencies of the Interagency Benefits Advisory Council (IBAC): Albuquerque Public Schools (APS), the General Services Department (GSD), the New Mexico Public School Insurance Authority (NMPSIA), and the Retiree Health Care Authority (RHCA); and the UNM employee and UNM Hospital employee health plans.

Another three state agencies provide prescription drugs to New Mexicans primarily through facility-based systems: the Corrections Department (NMCD), the Department of Health (DOH), and the Children, Youth and Families Department (CYFD).

Table 2: FY16 New Mexico State Prescription Drug Spending
in millions

	HSD – Medicaid	State employee and retiree health plans	NMCD	DOH	CYFD	Total
Total spending on prescription drugs	$423.7	$243.1	$9.5	$3.5	$0.2	$680.1
Change in total spending, FY14 – FY16	*83%*	*21%*	*160%*	*-26%*	*-35%*	*54%*
Total spending on brand name drugs	$185.9	$99.1	n/a	$2.5	$0.1	$287.6
Total spending on generic drugs	$121.4	$52.0	n/a	$1.0	$0.2	$174.7
Total spending on specialty drugs	$115.2	$95.6	n/a	$0.3	n/a	$211.1

Source: Agency responses to LFC

Although they serve different structures and populations, all of the state agencies reviewed are experiencing each of the prescription drug cost trends discussed earlier, adding up to a statewide spending increase of approximately 54 percent between FY14 and FY16 (Table 2). To try to deal with these steeply rising expenditures, each is making use of at least some of the listed cost control mechanisms, to differing degrees, in their efforts to manage costs within a challenging context.

Health insurance plans run by state agencies and entities

The Human Services Department (HSD) is by far the largest agency in this category, spending over $423 million in FY16 on prescription drugs for over 800,000 New Mexicans in the Medicaid program. That represents an over 95 percent increase in spending since FY13, reflecting the approximately 75 percent increase in recipients the program has experienced since Medicaid expansion in 2014. For purposes of this study, it is more useful to begin comparisons with FY14, so that the changes in expenditures and utilization more accurately reflect post-expansion trends. The differences between fee for service and managed care Medicaid on key trends are small enough that the two programs have been combined here for simplification.

Table 3: Medicaid Spending on Prescription Drugs

	FY14	FY15	FY16	Change FY14 – FY16
Spending on prescription drugs *(in millions)*	$231.7	$341.8	$423.7	83%
Spending on brand name drugs *(in millions)*	$113.5	$168.7	$185.9	64%
Spending on generic drugs *(in millions)*	$80.7	$109.1	$121.4	50%
Spending on specialty drugs *(in millions)*	$36.9	$62.9	$115.2	212%
Number of prescriptions *(in millions)*	4.4	6.2	6.6	50%
Average recipients per month	559,292	741,199	810,157	45%
Plan cost PMPM	$26.62	$29.52	$33.58	26%
Plan cost per prescription	$50.90	$57.45	$68.29	34%
Generic fill rate	86.8%	87.3%	87.4%	1%
Specialty drug percent of plan cost	16.31%	19.31%	27.22%	67%
Specialty plan cost PMPM	$4.28	$5.56	$9.13	114%
Prescription drug rebates received *(in millions)*	$148.7	$164.4	$222.3	50%

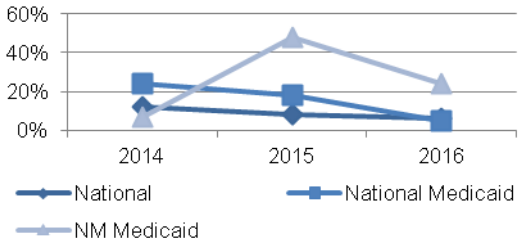
Source: Agency response to LFC

Total Medicaid drug spending from FY14 through FY16 has risen by 83 percent. The increase is driven in large part by a 50 percent increase in utilization mostly due to expanded enrollment, and also by significant 64 percent and 50 percent increases in spending on brand drugs and generic drugs, respectively, and a 212 percent increase in spending on specialty drugs, particularly hepatitis C drugs. (Table 3.)

HSD's prescription drug spending patterns are similar to other state Medicaid programs, particularly those that expanded their programs under the Affordable Care Act. Direct comparison is difficult because there is not yet a

Chart 2: Annual Growth in Spending on Prescription Drugs

national data by calendar year, NM data by fiscal year



Source: Agency response to LFC; CMS NHE

body of data available specifically for expansion states. Chart 2 shows a dramatic but not surprising 48 percent annual growth rate for FY15 as the state's Medicaid population expanded rapidly. For FY16, the state's growth rate slowed to 24 percent, still far above projected national Medicaid growth of five percent.

As the New Mexico Medicaid population stabilizes, the growth rate of prescription drug spending should also stabilize, although absolute spending should continue to rise along with drug prices.

Medicaid receives substantial drug rebates not available to any other state agency. The total rebate amount in Table 3 includes rebates for drugs from both the managed care and fee for service portions of the program. The significance of the Medicaid Drug Rebate Program (MDRP) can be seen in the 50 percent increase in rebates HSD has received since FY14. (Because the rebates lag behind expenditures, they are not a direct percent of the spending for the given fiscal year.)

On the other hand, Medicaid is not able to contain costs through plan designs like increased co-pays or coinsurance, although HSD is currently considering implementing the very limited prescription drug co-pays permitted by the federal government. HSD reports other initiatives to restrain the rapid growth of spending on medications are primarily left to the managed care organizations (MCOs), each of which contracts with its own pharmacy benefits manager (PBM) and uses formularies, prior authorizations, step therapy, and generic substitution where appropriate.

How does HSD pay for prescription drugs? In the Centennial Care managed care Medicaid program, HSD negotiates with each MCO to determine the capitated per member per month (PMPM) amount it will pay for each member. The rates are developed on a calendar year basis by HSD's actuary using historical data and a range of assumptions and projections regarding future cost and utilization; rates may be adjusted mid-year to account for changes to the program. The actuary develops specific rates for each cohort of the program: physical health, behavioral health, long term supports and services (LTSS), and the expansion physical and behavioral health groups. Pharmaceutical costs are one factor the actuary includes when building the overall rates.

A risk corridor is a mechanism that cushions both HSD and the MCOs from extreme gains or losses: if MCO actual costs are higher than projected, HSD pays a portion of the higher costs; if MCO actual costs are lower than projected, HSD is able to recover the majority of its overpayment.

When New Mexico expanded its Medicaid program in 2014, there was a great deal of uncertainty about how many newly eligible people would enroll, how much health care this new population would utilize, and how much they would cost. HSD expected that the expansion population, largely people who had not previously had insurance or regular access to healthcare, might have costly unmet healthcare needs, and therefore built relatively high PMPM rates for that group. But HSD also included a risk corridor for the expansion population in its contracts with the MCOs. The risk corridor created for the

expansion population applies to the total health care costs for that group, and includes but does not separate out their prescription drug costs.

In 2015, HSD added specific hepatitis C drug rates and a new risk corridor. HSD, like Medicaid programs around the country, underestimated the impact of the 2014 release of new, more effective – and much more costly – specialty drugs for the hepatitis C virus (HCV), and no special allowance for the high cost of these drugs was made when the MCO rates for CY14 were developed. Anticipating much higher utilization and spending for CY15, HSD added up to 10.3 percent to the capitated rates that year designated just for HCV drug costs. HSD also created a separate risk corridor specific to hepatitis C expenses.

The 2015 hepatitis C drug rate did not include rebate assumptions and the projected average treatment cost of $92,000 appears to have been based on full market price for the drugs.

However, the rate development process contained assumptions that did not materialize, significantly that 1,750 Medicaid recipients would receive treatment in the first year. As Table 4 shows, in CY15 a total of only 451 patients received treatment, at an average cost of approximately $81,000.

Similar assumptions were built into the CY16 rates. HSD continued to project that 1,750 recipients would be treated for hepatitis C during CY16, at a net cost per treatment of $83,473 per patient. However, HSD reported only 301 managed care patients received HCV treatment within the first three months of FY16, at an average cost of $56,014 per patient.

Table 4: Medicaid Actual Spending on Hepatitis C

	CY14	CY15	Increase from CY14 to CY15	CY16 1/1/16 – 3/31/16
Spending *(in millions)*	$12.6	$36.5	189%	$16.9
Unique patients	148	451	205%	301
Average cost per treatment	$83,819	$80,751	-3.7%	$56,014

Source: Agency response to LFC request

Because it sets payment rates annually based on data from previous years and assumptions about the future, HSD often ends up paying more than necessary upfront, and then recovering its overpayments later. HSD reports that it paid the MCOs at least $94 million more than their actual expenditures for prescription drugs in FY15, and at least $114 million more than their actual expenditures in FY16. The FY15 MCO rates included approximately $410 million for prescription drugs across all cohorts. MCO reported expenditures for FY15 were $317 million, a difference of $94 million. FY16 figures show MCO rates included approximately $505 million for prescription drugs across all cohorts, with MCO expenditures of $392 million, a potential overpayment of at least $114 million.

There are two ways the department balances out these apparent overpay-

ments. First, there are the rebates available through the Medicaid Drug Rebate Program (MDRP). The MCOs report their actual prescription drug spending to HSD, and HSD calculates its total spending on drugs for the fee for service population. Then the department uses the MDRP to obtain the appropriate rebates from pharmaceutical manufacturers. For FY15, the department received $160.4 million in rebates, and for FY16, it received $222 million.

HSD also recovers overpaid funds from the MCOs through the risk corridors. The risk corridors function on a calendar year basis: for CY14, HSD recovered $97 million from the expansion population corridor, and for CY15, the department recovered $212 million from the expansion corridor and $27 million from the hepatitis C corridor. (Table 5)

The CY15 hepatitis C risk corridor recoupment of $27 million seems insufficient when compared to the apparent $124.5 million overpayment that year.

Table 5: Medicaid Managed Care Prescription Drug Spending and Recovery
in millions

	MCO drug spending	HSD payments to MCOs	MDRP rebates for managed care only	Expansion risk corridor[1] (CY)	Hepatitis C risk corridor (CY)
FY15	$341.8	$410	$160.4	$212	$27
FY16	$423.7	$505	$205.9	n/a	n/a

Note: Expansion population risk corridor includes all healthcare costs, not just drugs
Source: Agency responses to LFC requests

Although the MDRP rebates and the expansion group risk corridor recoupments appear to address a significant portion of payment discrepancies, the hepatitis C risk corridor recoupment of $27 million seems insufficient with the apparent 124.5 million overpayment detailed in Table 6.

Table 6: CY15 Medicaid Hepatitis C Spending Discrepancy

HSD Budget Goals	Actual Treatment and Cost	Difference
1,750 recipients at $92,000 each	451 recipients at $81,000 each	
$161.0 million	$36.5 million	**$124.5 million**

Source: Agency response to LFC

Medicaid MCOs are able to negotiate deeper discounts on their own. The MCOs receive payment for prescription drugs from HSD based on their negotiated PMPMs. But MCO are also able to use their own negotiating power to obtain additional rebates or discounts, and, in the case of HCV drugs, may enter into an exclusive purchasing agreement with manufacturers. MCOs report the supplemental rebates they obtain to HSD as part of routine financial reports, and HSD uses that information when developing the next year's MCO rates. The exclusive purchasing agreements are confidential between the manufacturer and the MCO, although HSD may make independent estimates of the value of those agreements and factor those into the next year's rates as well.

While having four distinct PBMs for the Medicaid program may seem to be a missed opportunity to negotiate better prices based on the total population, each of the PBMs is able to negotiate based on the size of their respective

MCOs, and may in fact obtain better price discounts by following that route. One MCO, Presbyterian, is also able to factor in some 340B savings because its hospital is a covered entity. However, whatever additional discounts the MCOs and their PBMs have been able to obtain are considered proprietary and confidential, and were not included in the data HSD provided to the LFC.

HSD has similar key disease cost drivers as the other public health insurance entities. The limited data provided by HSD for its top 10 conditions does not allow for direct comparison with other state agencies and entities. However, the Medicaid program has many of the same conditions driving its expenditures as do the other entities discussed later in this brief (Table 7).

The New Mexico Hepatitis C Coalition estimates there are about 45,000 New Mexicans living with chronic HCV infection.

Table 7: Medicaid Top 10 Conditions by Spending
listed by rank in CY16

	CY14	CY15	Increase CY14 to CY15	CY16 1/1/16 – 3/31/16
Hepatitis C	$12.6	$36.5	189%	$16.9
Diabetes	$32.1	$47.1	48%	$11.1
Asthma	$25.1	$29.7	18%	$5.4
Mental health	$27.8	$29.6	6%	$5.4
Other	$18.8	$23.9	27%	$5.4
Infections	$14.1	$17.1	21%	$4.8
HIV	$12.8	$17.0	33%	$3.9
Inflammatory conditions	$8.3	$13.3	60%	$3.3
Attention disorders	$11.1	$13.2	20%	$3.2
Seizures	$10.9	$13.0	20%	$2.9

Source: Agency response to LFC request

In addition, studies of other Medicaid expansion states have found that as more people obtain coverage there are significant increases in diagnosis of chronic diseases such as diabetes. This scenario appears to be true in New Mexico, as prescriptions for Lantus, a commonly prescribed diabetes drug, increased by 99 percent from FY13, pre-expansion, to FY16.

HSD estimates there are approximately 14,000 New Mexicans with HCV currently on Medicaid.

Hepatitis C is at the top of the list of Medicaid's most costly conditions. Prior to 2014, the several million Americans infected with the hepatitis C virus (HCV) had few treatment options that were either tolerable or effective. Many decided to go without treatment altogether. Many more remained undiagnosed because HCV typically has few symptoms until the disease has progressed.

For a variety of reasons HCV is particularly prevalent among lower-income

people who, prior to 2014, were uninsured. These factors together led to a large national unmet need, including many individuals with relatively advanced liver disease. Then in late 2013 the first of the new specialty HCV drugs arrived on the market: much easier to take with fewer side effects and a cure rate averaging 95 percent, and carrying list prices of between $83 thousand and $95 thousand for a single course of treatment. And in 2014, the ACA and Medicaid expansion opened new doors to health care for millions.

HSD calculates that it needs to treat 1,750 Medicaid recipients per year from 2016 through 2020 to clear the 'backlog' of recipients diagnosed with HCV.

Because of the association between poverty and untreated or undiagnosed HCV, the burden of treating HCV has fallen most heavily on public payers, primarily Medicaid, Medicare and prisons. Over 33 states responded to the sudden new costs by trying to limit access to the drugs to individuals who have the most advanced liver disease, which has led to lawsuits around the nation on behalf of prisoners and Medicaid recipients. As noted, while Medicaid programs can use a number of different mechanisms to manage prescription drug utilization, they must ultimately provide drugs determined to be medically necessary. The Centers for Medicare and Medicaid (CMS) issued a notice to state Medicaid programs in late 2015, warning against denying access to clinically appropriate HCV treatments. Lawsuits are not the only negative outcome of denying treatment: patients who qualify for treatment but are denied because their disease is not determined to be sufficiently advanced leads to sicker and ultimately more costly patients down the road.

The New Mexico Hepatitis C Coalition published a statewide comprehensive plan and profile of HCV in New Mexico in June 2016, and estimated that about 45,000 New Mexicans are living with chronic HCV infection. The Coalition noted that until directed otherwise by HSD, the Medicaid MCOs were trying to contain HCV costs not just by limiting treatment to the sickest patients, but also by denying treatment to patients who could not document that they were not using drugs or alcohol and requiring consultation with a specialist prior to treatment.

HSD has developed an extensive HCV action plan. The department estimates there are approximately 14,000 people with HCV currently on Medicaid, about 7,100 of whom either have been diagnosed or will be diagnosed as the result of enhanced screening by MCOs. Because about 20 percent of people who get HCV recover from the disease with no treatment at all, HSD has calculated that it needs to treat 1,750 people per year from 2016 through 2020 to clear the 'backlog' of identified HCV Medicaid recipients.

As noted in the previous discussion of MCO rates, the department plans to continue funding for the full 1,750, even though the MCOs had only treated 301 Medicaid recipients for HCV by the end of March, 2016. New cases will emerge going forward, of course, but the costs of those should be more manageable.

HSD has worked with the MCOs to implement its action plan, and in November of 2015 issued a letter of direction (LOD) to the MCOs with detailed guidance about HCV treatment criteria, intensive care coordination, provider outreach and education, and enhanced HCV screening. The LOD required the MCOs to retroactively reconsider all previous denials in light of the new criteria. The directive appears to have been effective, as seen by the increases in patients receiving treatment from 2014 through early 2016 (Table 4).

HSD directed the MCOs to lower their average HCV treatment costs with the program-wide goal of a 25 percent reduction from FY16 to FY17.

A follow-up LOD in July 2016 provided additional clarification of the department's policy. In this LOD, HSD noted the entry into the market of two new, lower cost HCV drugs, and directed the MCOs to lower their average HCV treatment costs with the program-wide goal of a 25 percent reduction from FY16 to FY17. The LOD also included revised contract language requiring the MCOs to treat at least 50 percent of their HCV target, which is in turn the basis of a new Delivery System Improvement Fund (DSIF) established to provide financial incentives to the MCOs for exceeding that 50 percent target.

The IBAC and UNM and UNM Hospital employee plans have also experienced rapid rises in prescription drug spending.

The four member agencies of the Interagency Benefits Advisory Council (IBAC) together spent approximately $220 million on drug coverage in FY16 for about 175,000 school and state government employees, state retirees, and their eligible dependents. The IBAC agencies include Albuquerque Public Schools (APS), the General Services Department (GSD), the New Mexico Public School Insurance Authority (NMPSIA), and the Retiree Health Care Authority (RHCA). The four agencies each run their own self-funded healthcare plans and each is able to design its plan independently, but they are required by law to combine the negotiating power of their populations and issue joint request for proposals (RFP) for health care and pharmacy benefit management services. The IBAC estimates that it saves approximately $25 million per year through joint purchasing savings, about $10 million of which is associated with pharmacy spending. The current IBAC pharmacy benefits manager (PBM) is Express Scripts.

The IBAC estimates that it saves approximately $25 million per year through joint purchasing savings, about $10 million of which is associated with pharmacy spending.

The University of New Mexico (UNM) and UNM Hospital (UNM-H) have separate health insurance plans, combined here to help streamline the discussion: in FY16, together they covered over 18,700 employees and dependents and spent close to $24 million on prescription drugs. UNM also contracts with Express Scripts for PBM services, while UNM-H contracts with Prime Therapeutics, a PBM owned by Blue Cross Blue Shield.

APS, GSD, NMPSIA, UNM and UNM-H all have populations that are relatively similar demographically, except that NMPSIA's membership is mostly located in rural communities outside of Albuquerque. All manage their prescription drug costs through similar measures with roughly comparable outcomes, as

Table 8: FY16 Prescription Drug Spending for IBAC Agencies and UNM and UNM-H Employees
spending is in millions

	APS	GSD	NMPSIA	RHCA Pre-Medicare	RHCA Medicare	UNM	UNM-H
Total spending on prescription drugs	$16.1	$48.9	$52.8	$31.1	$70.6	$15.8	$7.8
Total increase FY13 – FY16	*34%*	*17%*	*29%*	*32%*	*31%*	*42%*	*76%*
Total spending on brand drugs	$7.4	$17.4	$21.7	$11.9	$28.4	$6.0	$6.4
Total spending on generic drugs	$2.8	$11.0	$11.0	$6.1	$15.9	$3.7	$1.4
Total spending on specialty drugs	$5.9	$20.6	$20.0	$13.1	$26.2	$5.9	$3.7
Specialty increase FY13 – FY16	*127%*	*100%*	*138%*	*120%*	*132%*	*160%*	*223%*
Total number of prescriptions	182,674	621,695	562,371	334,038	528,688	128,611	79,051
Total covered lives	16,434	64,525	52,684	17,758	22,849	13,507	5,262
Members using prescriptions/month	82.4%	74.6%	81.6%	94.8%	99.9%	77.3%	35.7%
Plan cost PMPM	$81.69	$63.26	$83.46	$146.05	$257.40	$97.34	$119.99
Plan cost per prescription	$87.58	$78.79	$78.58	$93.17	$111.38	$122.67	$98.69
Generic fill rate	84.6%	88.7%	86.1%	86.5%	87.0%	84.2%	86.8%
Member cost share	10.8%	12.4%	8.9%	12.3%	12.6%	8.2%	11.1%
Specialty drug percent of plan cost	37.1%	42.0%	37.9%	42.2%	37.2%	38.0%	47.3%
Specialty percent increase FY13 – FY16	*69%*	*71%*	*84%*	*67%*	*78%*	*83%*	*83%*
Prescription drug rebates and/or subsidies received	$2.9	$7.5	$8.9	$5.2	$18.6	$1.6	N/A

Source: Agency responses to LFC

Table 8 shows. RHCA has higher costs due to the more extensive medical needs of its older population.

Each of these entities is pursuing cost containment options that primarily focus on increasing cost sharing with their members through some degree of expanded co-pays, coinsurance, and out of pocket maximums; some are also implementing agency-specific options. The entities that contract with Express Scripts share the benefits of that company's large market share, including its ability to obtain price discounts for hepatitis C treatments by including only a single HCV drug on its formulary, its plans to take similar actions with other high-cost specialty drugs, and its unique price-stabilizing inflation guarantees.

Albuquerque Public Schools has one of the lower generic fill rates, most likely explained by the high number of members who are using brand-name drugs for arthritis and diabetes; it has the third-highest rate of prescriptions per member. Yet overall it has the lowest specialty drug percent, possibly the result of 2014 plan design changes that added tiers and coinsurance for specialty drugs.

General Services Department has both the lowest per member per month (PMPM) cost and the highest generic fill rate, which the agency attributes to the combination of incentives for mail order refills and the positive impact of

its wellness clinics. GSD already has one of the higher levels of member cost sharing, but plans further increases to cost sharing through implementation of a three tier co-pay and coinsurance for specialty drugs.

New Mexico Public School Insurance Authority's spending indicators fall in the middle of the group on all measures. The agency is nonetheless concerned about the 29 percent increase in spending it has experienced since 2013, particularly the nearly 24 percent increase in spending on diabetes driven by utilization and the high cost of diabetes specialty drugs. NMPSIA has focused on implementing diabetes management programs and increasing member cost sharing in a variety of ways. The agency estimates an annual savings of approximately $5.7 million from these plan changes.

Retiree Health Care Authority has the highest prescription drug spend in this category and covers two distinct populations of retirees. It provides regular health plan coverage to its pre-Medicare age members, and an Employer Group Waiver Plan (EGWP) for its over-Medicare age members. The EGWP plan is a Medicare Part D plan, but also covers members' Medicare Part A deductible and Part B co-insurance. As Table 8 shows, the two RHCA populations have the highest utilization of prescriptions and the highest plan costs per member; they also have two of the highest member cost shares.

University of New Mexico employee health plan representatives commented during discussions with LFC staff that their membership has high expectations about their health plan. The plan design reflects this: there is no requirement to use generic drugs or Express Script's mail order pharmacy, resulting in the lowest generic fill rate and highest plan cost per prescription among this category. The plan also has the lowest member cost share and the second-highest increase in total costs from FY13 to FY16.

University of New Mexico Hospital employees comprise the smallest group in this category, and have the narrowest health plan: members are limited to participation in the UNM Health System. In a cost containment strategy unique to the UNM-H setting, the plan is considering ways to encourage members to use only the hospital's out-patient pharmacies, which could potentially allow some access to 340B pricing. This small plan demonstrates the impact that just a few very sick individuals can have on overall plan spending: in FY16, about 10 members were treated for hemophilia or hepatitis C, for a combined cost of over $1.8 million, or 24 percent of the plan's total drug spending dedicated to only 0.2 percent of plan members.

Key disease cost drivers highlight both the prevalence of certain diseases in New Mexico and the very high costs of drugs to treat those conditions. Prescription drug spending across all agencies is driven by the combination of unfortunately common diseases like diabetes and asthma, which impact a relatively large number of people and have moderately high cost medications, and less wide-spread diseases like cancer, inflammatory condi-

Diabetes, cancer, multiple sclerosis, and inflammatory conditions, such as rheumatoid arthritis, have been in the top ten medical conditions, ranked by plan cost, for at least the last four years.

tions, hemophilia, and multiple sclerosis, which impact a smaller number of people but which also require much more expensive drugs.

Increased spending for diabetes is due to the persistently high cost of patent-protected brand name drugs and the failure to bring generic options to market.

Diabetes. For state agencies, the cost of treating diabetes has risen far faster than utilization: between FY14 and FY16 the agencies saw a combined three percent increase in patients being treated for diabetes, yet experienced a 61 percent increase in spending on diabetes drugs.

While rising prescription spending for inflammatory conditions and cancer is largely driven by the high cost of new specialty drugs, increased spending for diabetes is due to the persistently high cost of patent-protected brand name drugs and the failure to bring generic options to market.

Table 9: Diabetes Utilization and Cost
FY14 – FY16

Agency/plan	Number of members treated for diabetes			Change from 2014 - 2016	Plan cost for diabetes medications *(in millions)*			Change from 2014 - 2016
	2014	2015	2016		2014	2015	2016	
APS	1,064	1,087	1,112	5%	$1.7	$2.4	$3.0	76%
GSD	4,264	4,252	4,359	2%	$4.0	$4.9	$6.7	67%
NMPSIA	4,063	4,099	4,226	4%	$6.4	$7.9	$9.7	52%
RHCA – pre-Medicare	2,627	2,588	2,628	0.03%	$3.1	$3.9	$4.9	58%
RHCA – Medicare	5,043	5,064	5,153	2%	$6.5	$7.9	$9.8	51%
UNM employees	416	354	451	8%	$0.8	$1.7	$1.7	112%
UNM-H employees	423	436	451	7%	$0.5	$0.7	$1.2	140.0%
Totals	**17,900**	**17,880**	**18,380**	**3%**	**$23**	**$29.4**	**$37.0**	**61%**

Source: Agency responses to LFC data request

Cancer. Cancer was consistently in the top ten conditions by drug spend for FY14 through FY16 for five state agencies; the remaining two agencies saw the condition enter their top ten by FY16. Cancer drugs are, by definition, specialty drugs, due to the combination of their cost, their handling requirements, and their specialized administration methods. They are primarily biological therapies, which makes it difficult to develop generic versions.

An example of the effect of the high and rising prices of these drugs: RHCA's EWIP plan averaged a plan cost for one of the top drugs, Revlimid, of $4.21 per member per month (PMPM) in FY14. By FY16, for the same drug the plan cost PMPM was $7.73. Incidence of cancer in the population covered by the listed state agencies has increased by only three percent, yet the cost of cancer therapies for those patients has increased by 74 percent. (Table 10.)

Table 10: Cancer Utilization and Cost
FY14 – FY16

Agency/plan	Number of members treated for cancer			Change from 2014 - 2016	Plan cost for cancer medications *(in millions)*			Change from 2014 - 2016
	2014	2015	2016		2014	2015	2016	
APS	157	154	169	8%	$0.4	$0.6	$0.9	125%
GSD	504	510	530	5%	$2.6	$2.7	$2.7	4%
NMPSIA	527	508	525	-0.4%	$1.9	$2.6	$3.0	58%
RHCA – pre-Medicare	378	387	376	-0.5%	$2.2	$2.4	$2.7	23%
RHCA – Medicare	893	914	919	3%	$5.0	$7.1	$10.6	112%
UNM employees	n/a[1]	19	23	21%[2]	n/a	$0.5	$0.9	80%[2]
UNM-H employees	n/a[1]	n/a[1]	13	n/a[1]	n/a[1]	n/a[1]	$0.2	n/a[1]
Totals	**2,459**	**2,492**	**2,555**	**3%**	**$12.1**	**$18.1**	**$21.0**	**74%**

[1] Cancer was not in the top ten conditions for FY14 or FY15, but that does not indicate that there were no cancer patients or costs. Without this additional data, totals for those years therefore are lower than true numbers/costs. [2]Change from FY15 to FY16.
Source: Agency responses to LFC data request

Inflammatory conditions. Inflammatory conditions, including rheumatoid arthritis, psoriatic arthritis, juvenile idiopathic arthritis, Crohn's disease, and ulcerative colitis, are a persistent driver of increased costs for all of New Mexico's state-based insurance programs. Enbrel and Humira, two costly specialty drugs used to treat inflammatory conditions, account for all of the costs detailed in Table 11. Both drugs were approved by the FDA over a decade ago, and are good examples of the staying power of biopharmaceutical drugs for which there are no generic alternatives. Rising demand and few alternatives give manufacturers great leeway to set the prices of these drugs.

From 2014 through 2016, the number of plan participants treated for inflammatory conditions with Enbrel or Humira increased by five percent, but plan costs for the medications increased by 52 percent.

Even GSD, which had fewer members receiving treatment in 2016 than in 2014, experienced double-digit cost increases.

Table 11: Inflammatory Conditions Utilization and Cost
FY14 – FY16

Agency/ plan	Number of members treated for inflammatory conditions			Change from 2014 - 2016	Plan cost for inflammatory condition medications *(in millions)*			Change from 2014 - 2016
	2014	2015	2016		2014	2015	2016	
APS	96	112	115	18%	$1.2	$1.8	$2.5	102%
GSD	404	381	393	-3%	$4.2	$4.9	$5.9	41%
NMPSIA	378	378	390	3%	$4.4	$5.3	$6.4	45%
RHCA – pre -Medicare	215	221	235	9%	$2.5	$2.9	$4.2	69%
RHCA – Medicare	376	390	398	6%	$3.8	$4.5	$5.5	44%
UNM employees	55	53	64	16%	$1.2	$1.4	$1.7	47%
UNM-H employees	30	33	43	43%	$0.5	$0.7	$0.8	64%
Totals	**1,554**	**1,568**	**1,638**	**5%**	**$17.9**	**$21.6**	**$27.1**	**52%**

Source: Agency responses to LFC data request

Table 12: Hepatitis C Utilization and Cost
FY14 – FY16

Agency/plan	Number of members treated for Hepatitis C			Change from 2014 - 2016	Plan cost for Hepatitis C medications			Change from 2014 - 2016
	2014	2015	2016		2014	2015	2016	
APS	3	10	9	200%	$263,009	$828,595	$740,751	182%
GSD	8	50	38	375%	$580,003	$4,309,005	$3,301,343	469%
NMPSIA	10	24	33	230%	$556,453	$2,433,135	$2,842,677	411%
RHCA – pre-Medicare	10	26	21	110%	$897,188	$2,532,859	$1,422,431	58%
RHCA – Medicare	0	0	25	n/a	$0	$0	$2,422,119	n/a
UNM employees	12	27	20	67%	$409,049	$1,416,540	$765,391	87%
UNM-H employees	4	11	7	74%	$269,112	$1,068,406	$672,405	150%
Totals	**47**	**148**	**153**	**226%**	**$2,974,814**	**$12,588,540**	**$12,167,117**	**309%**

Source: Agency responses to LFC data request

Hepatitis C. The availability of new specialty drugs to cure hepatitis C virus (HCV) has resulted in significant increases in spending. Most of the increase has been borne by HSD and the NM Corrections Department (discussed below), but all public health plans have been impacted. No agency reported HCV in the top ten conditions or drug spending categories for FY13, the year before the first new hepatitis C drug was approved by the FDA. However, the health plans in this category had an aggregate increase of over 106 percent in individuals receiving HCV drugs from FY14 through FY16. (Table 12.) This increase does not reflect a precipitous rise in prevalence of the disease itself, but rather an increased interest in diagnosing and treating patients now that there are curative drugs available for the first time.

From FY14 through FY16, the public health plans experienced an increase of over 300 percent in spending on HCV drugs, which grew from between one and four percent of their overall drug spending to between four and six percent. The IBAC agencies and the UNM employee plan, which contract with Express Scripts, shared in the savings from the PBM's decision to include only second-generation HCV drug Viekira Pak in its formulary beginning January 1, 2015. That decision both improved Express Script's negotiating position with the manufacturer, and encouraged other manufacturers to consider lower prices to make their own drugs more competitive, and may contribute to lower costs going forward.

Three other state agencies provide prescription drugs to New Mexicans primarily through facility-based systems.

The Corrections Department (NMCD) covers all of the health care needs for inmates, including prescription medications. The Department of Health (DOH) includes six divisions/facilities that purchase prescription drugs: Ft. Bayard Medical Center, the Behavioral Health Institute, Public Health Division, Turquoise Lodge Hospital, the State Rehabilitation Hospital, and the State Veterans Hospital. The Children, Youth and Families Department (CYFD) provides largely behavioral health medications to the youth in their juvenile justice facilities.

State correctional systems around the country are facing lawsuits for failing to provide timely HCV treatment.

If NMCD has a strategic plan for treating inmates and avoiding litigation, it did not share that plan with the LFC.

NM Corrections Department has significant expenditures for prescription drugs but appears unable to fully account for its spending. NMCD's contract with Corizon Health ended in May, 2016, amidst concerns about the quality of healthcare the company had been providing inmates. NMCD did not provide full data requested by LFC for this study, reporting first that it had the data from Corizon but doubted its validity, and then that it could not get the Corizon data because the contract had ended.

Review of Corizon data the LFC obtained prior to this report for a separate audit shows pharmaceutical cost totals slightly lower than what NMCD reported to LFC for this brief; the analysis here relies on both data sets, as identified. Given these issues, the State Auditor's Office should follow up to validate NMCD received services as specified as part of the agency's financial statement audit.

Table 13: NM Correction Departments Spending on Pharmaceuticals by Selected Conditions

Condition	FY13	FY14	FY15	FY16	Change from FY13 – FY14[1]
Hepatitis C	$78,722	$159,074	$82,885	$6,017,833	7,544%
Other	$1,765,382	$2,078,955	$1,526,053	$1,561,563	-12%
HIV	$693,638	$706,196	$738,009	$707,573	2%
Mental health	$298,396	$407,432	$466,973	$427,243	43%
Respiratory	*n/a*	*n/a*	$239,826	$308,657	29%
Cancer	*n/a*	*n/a*	$240,666	$289,580	20%
Cardiovascular	$142,356	$153,381	$153,683	$163,997	15%
Gastrointestinal	$131,240	$140,359	$117,808	$117,631	-10%
Diabetes	*n/a*	*n/a*	$70,638	$85,360	21%
Totals	**$3,109,735**	**$3,645,398**	**$3,636,540**	**$9,485,300**	**187%**

Note: percent change for some conditions is FY15 – FY16
Source: Agency response to LFC data request

A seven thousand percent increase for hepatitis C is the key driver behind a nearly two hundred percent increase in NMCD prescription drug costs. Corizon reported that there were a total of 3,101 known cases of HCV in the NMCD system as of December, 2015; from the data provided by NMCD, it is likely that fewer than 100 of these inmates received treatment in FY16. NMCD did not report how many inmates are receiving treatment or what price per treatment NMCD has negotiated. Without that information, it is not possible to determine how much it would cost the department to treat the entire population of inmates with hepatitis C, but the cost would surely run well over one hundred million.

Several state correctional systems, including Massachusetts, Minnesota, and Tennessee, are facing lawsuits for failing to provide timely HCV treatment. NMCD contracts with the University of New Mexico's Project Echo to provide training and consultation for hepatitis C treatment; the contract mentions NMCD's strategic plan for treating inmates but the department did not share that plan with the LFC.

NMCD's contracts with Centurion and Boswell lack meaningful enforcement provisions that could support improved department oversight.

Other important areas of rising costs are a 43 percent increase in spending on psychotropic drugs between 2013 and 2016, and large 2015 to 2016 increases for respiratory conditions, cancer and diabetes. However, despite the one-year increases for these three conditions, the agency's spend on each is quite low when compared to the spending of the other agencies reviewed above, particularly given the demographics of the prison population and the statewide prevalence of diabetes. These comparisons, presuming the data is relatively accurate, raise serious questions about whether inmates are receiving the medical treatment they require.

NMCD's substantial increase in pharmaceutical spending has been driven mostly by rising drug prices – primarily for the very expensive hepatitis C drugs being provided to a small number of inmates – rather than by generally increased utilization. The agency did not provide any cost per inmate or per prescription data, but Corizon reports show a 57 percent increase in per inmate per month cost from CY2012 to CY2015. For the same time period, the Corizon reports show relatively stable percents of inmates receiving prescription drugs, about 76 percent, and a decline of about 7.5 percent in the number of prescriptions.

NMCD has now contracted with Centurion Correctional Healthcare, and subcontracted with Boswell Pharmacy Services to manage prescription drug services for the agency. The Boswell contract includes typical PBM tasks such as formulary development and drug regimen review prior to any new prescriptions, as well as a range of appropriate reports. NMCD provided the LFC with prescription drug spending reports from Boswell for June through August, 2016, just as this report was going to print. From this information it would appear that, with sufficient oversight, NMCD will be better informed about its drug utilization and expenditures in the future. However,

neither the Centurion nor the Boswell contracts appear to have meaningful enforcement provisions that could support improved department oversight. There are, for example, no apparent penalties for missing or inaccurate reports.

There may be options for reduced pharmacy costs that NMCD has not explored, such as participation in the Minnesota Multistate Contracting Alliance for Prescriptions (MMCAP), or some other group purchasing pool.

The most noteworthy portions of the new contractual arrangement are in the primary contract with Centurion. That contract first states all prescription medications will be purchased through the subcontractor and Centurion will have no financial responsibility for medications at all. In practice, this could lead to situations where Centurion providers feel free to select higher cost medications. Other sections of the contract specifically carve out the costs of 'any and all' HIV and hepatitis C medications, to be paid for by NMCD. Lastly, the contract requires Centurion to obtain 340B pricing for medications for HIV, hepatitis C, cancer, hemophilia, and dialysis, as well as certain psychotropic medications, through federally qualified health centers and/or disproportionate share hospitals, within six months from the effective date of the contract.

While the agency should be encouraged to investigate all possible cost savings ideas, there are a number of legal barriers to correctional facilities obtaining 340B pricing. The contract devolves the responsibility for figuring out how to clear those barriers to Centurion with no details about NMCD's participation in, or oversight of, the process. To date, the only state that has successfully linked corrections facilities to 340B pricing is Texas, where the University of Texas Medical Branch provides full medical care, including pharmacy services, for inmates.

Prescription drug purchasing at the Department of Health (DOH) appears to have declined by approximately 25 percent between FY14 and FY16. DOH provides prescription drugs through the Public Health Division, and through five of its facilities: Ft. Bayard Medical Center (Ft. Bayard), New Mexico Behavioral Health Institute (NMBHI), New Mexico Rehabilitation Center (NMRC), New Mexico State Veteran's Home (NMSVH), and Turquoise Lodge Hospital. DOH drug purchasing is not centrally coordinated or monitored, and the LFC was not able to obtain comparable data for all years from all facilities, so the totals provided in Table 14 are approximate.

Table 14: FY16 Prescription Drug Spending for NM Department of Health

	Ft. Bayard	PHD	NMHBI	NMRC	NMSVH	TLH	Totals
Total spending on prescription drugs	$962,714	$1,425,310	$820,538	$33,499	$254,502	$71,057	$3,567,620
Total change FY14 – FY16	*73%*	*-49%*	*-20%*	*-17%*	*17%*	*-19%*	*-25%*
Total spending on brand drugs	$748,359	$1,295,907	$331,792	$11,705	$71,260	$20,148	$2,479,171
Total spending on generic drugs	$214,355	$129,403	$488,746	$17,794	$183,241	$50,909	$1,084448
Total spending on specialty drugs	$122,724	included	$143,671	$3,999	$14,597	$0	$284,991

Source: Agency responses to LFC

The PHD and the five facilities serve very different populations and would be difficult to compare under any circumstances; lack of full data from DOH, due to reporting limitations, for this brief prohibited anything other than very general comparisons. General analysis of the top ten drugs by spending shows increases in medications to treat behavioral health conditions, diabetes, and, for Ft. Bayard, a nearly 170 percent increase in spending on hepatitis C just between FY15 and FY16. Many of the patients at the DOH facilities have insurance of some sort – Medicaid, Medicare, or commercial – and so much of their prescription drug costs are reimbursed by a third party.

Although drug purchases are handled independently by each facility, all contract with the same wholesaler, and all are members of the Minnesota Multistate Contracting Alliance for Prescriptions (MMCAP) purchasing collaborative.

The agency reportedly had a taskforce to explore standardization across the facilities, but there does not seem to have been much progress yet towards that goal in the area of pharmacies. The pharmaceutical spending at the facilities is handled independently by each pharmacy manager, with two commonalities that help each to contain costs: all contract (separately) with the same wholesaler, and all are members of the Minnesota Multistate Contracting Alliance for Prescriptions (MMCAP) purchasing collaborative.

Much of the NM State Veteran's Home prescription drug spending is reimbursed by the Veteran's Administration, Medicare or Medicaid. As of March, 2016, the facility is reportedly no longer able to access the VA federal wholesaler because it is not on the state contractor list. NMSVH was able to purchase hospital supplies and other necessities, in addition to prescription drugs at VA prices, through the wholesaler. The facility is currently tracking costs to determine the financial impact of this change. NMSVH continues to purchase prescription drugs through its MMCAP contract.

The Public Health Division provided data showing most of its spending is on contraceptives, HIV drugs and rabies vaccines. The New Mexico Hepatitis C Coalition report discussed earlier noted that the Southwest Region PHD office treated at least 40 patients in 2015; medication costs for these patients were covered through their insurance or through drug manufacturer patient assistance programs. PHD reported that the majority of its drug purchases

Table 15: Prescription Drug Spending for CYFD Juvenile Justice Facilities

	FY13	FY14	FY15	FY16
Total spending on prescription drugs	$364,403	$342,333	$260,736	$222,843
Total spending on brand drugs	$126,990	$149,558	$83,278	$72,154
Total spending on generic drugs	$237,412	$192,775	$177,457	$150,688
Average daily population	242	232	217	213
Members using prescriptions/month	43%	38%	32%	37%
Generic fill rate	67%	56%	68%	60%
Prescription drug rebates and/or subsidies received	$8,519	$16,983	$5,039	$7,558

Source: Agency response to LFC data request

are bought at 340B prices, and HIV drugs are generally subsidized through the Ryan White AIDS Drug Assistance Programs. The division did not provide further details, but both of these factors would result in substantial cost savings.

CYFD reduced its pharmaceutical costs by nearly 40 percent from FY13 to FY16, primarily through changes to prescribing practices. From FY13 to FY16, CYFD's total prescription drug spend dropped from about $364 thousand to just over $222 thousand, and utilization declined from about 43 percent of clients receiving prescriptions each month to 37 percent (Table 15).

CYFD juvenile justice treatment facilities serve a unique and very small population, slightly over 200 youth per month; most of its spending is on medications for behavioral health conditions. Because of the select population involved, CYFD does not share any of the condition drivers reported by other state agencies, other than asthma and fewer than a dozen youth with diabetes, nor has it experienced similar issues with high cost specialty drugs. The agency has a relatively low generic utilization rate, due to the fact that many of the psychotropic and asthma medications it uses are available only as brand name drugs and are not available as generics.

CYFD has reduced its use of opioid pain medications and some psychotropic drugs as standards of practice have shifted focus away from using drugs for their sedative effects and towards more limited use of drugs with established therapeutic benefits.

The department reported to the LFC that the decline in its prescription drug spend is an indirect result of quality control initiatives taken primarily to improve the overall health of its population. CYFD has reduced its use of opioid pain medications and some psychotropic drugs as standards of practice have shifted focus away from using drugs for their sedative effects and towards more limited use of drugs with established therapeutic benefits. The department also reported changes instituted to reduce the misuse or overuse of medications, including increased medical director oversight of all prescribing, improved accuracy of diagnosis, and new nursing protocols.

CYFD has taken direct steps to contain pharmacy costs, including joining the Minnesota Multistate Contracting Alliance for Prescriptions (MMCAP) purchasing collaborative to obtain lower drug prices, and purchasing its medications in floor stock quantities rather than for individual patients.

Conclusion

Rapidly rising spending on prescription drugs is a national issue, as those expenditures are a key driver in rising costs of health care across the country. New Mexico is no exception, as this overview of state agency drug spending shows. Prescription drugs carry the promise of improved health outcomes and the avoidance of the need for more complex and expensive health care, but at the same time, if drugs become so expensive that health plans and state agencies can only contain their costs by shifting more of the burden to

consumers, they do so at the risk of leading their members to cut their own out of pocket costs by refusing to fill prescriptions to begin with, or by extending drugs by methods such as skipping doses. If patients are non-compliant with necessary medications due to costs, then the original promise of improved outcomes and cost savings disappears.

If patients are non-compliant with necessary medications due to costs, then the original promise of improved outcomes and cost savings disappears.

Health Notes are informative briefs and do not include specific policy recommendations. In general, it appears that solutions to the rising prices of prescription drugs through any sort of restructuring of market incentives, patent protections or other means would need to be made at the national level. Medicare has announced plans to investigate the feasibility of applying the results-based pay for performance approach that is taking hold in other areas of health care to prescription drugs, which could have implications for Medicaid programs as well.

Another, perhaps unexpected, source of price restraint could be pharmaceutical manufacturers themselves. In the wake of controversy over EpiPen's price increase, one manufacturer recently published a 'social contract with patients,' and pledged to limit price increases to no more than single digit increases, no more than once a year. In an industry under increasing scrutiny from Congress, this type of internal regulation could prove attractive.

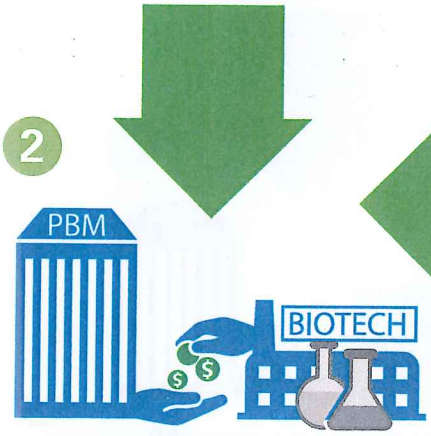
States can address ever-increasing drug prices through policies to increase pricing transparency, and they can increase their negotiating power through collaborative purchasing arrangements.

What states can, and are, doing is two-fold: increase pricing transparency through laws such as the one recently passed in Vermont; and use a variety of options to increase negotiating power through collaborative purchasing arrangements like the IBAC, or joining purchasing pools like the Minnesota Multistate Contracting Alliance for Prescriptions (MMCAP). New Mexico state agencies have achieved some savings by using both these techniques, but the continuing rise in prescription drug spending suggests that there are additional savings to be had, possibly through further consolidation or perhaps by taking a new approach to purchasing costly hepatitis C drugs. The LFC's inability to gather complete and comparable spending data from the state agencies included in this report also suggests that there are opportunities for better state agency oversight, reporting, and transparency.

The Complicated Way We Pay for Medicines

The way we pay for medications is far more complex than a simple sound bite. It is an intricate chain as medicines wind their way from manufacturers to patients and their doctors. Wholesale Acquisition Cost (WAC) is the list price paid by a wholesaler to acquire a brand name drug. Price concessions by manufacturers, such as rebates and discounts are contractually negotiated with purchasers to substantially lower the ultimate price paid for the drug. In 2015, discounts, rebates and other price concessions offset the price growth of brand drugs by an estimated 77–81%.

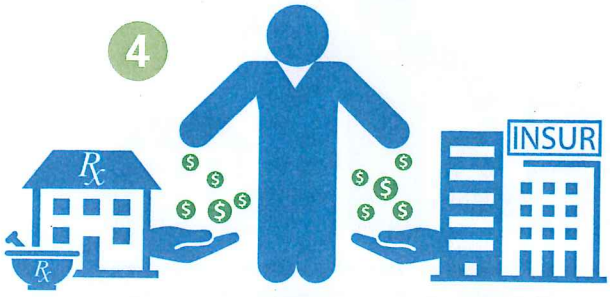
Insurance companies contract with pharmacy benefit managers (PBMs) to handle prescription benefits for patients.



PBMs negotiate discounted prices which include, but are not limited to, **rebates** from pharmaceutical companies. PBMs also extract **access fees** from manufacturers to get certain medicines on the formulary.

PBMs reimburse pharmacies, providing a dispensing fee for each drug sold.

Pharmacies are often subject to a network fee to be included in a restrictive network.



Patients pay a premium to insurance companies. They must also pay **out-of-pocket deductibles, copays** and **coinsurance** for their prescription medicines.

The Cost of Innovation

Medicines save lives and preserve quality of life, but they are expensive to manufacture. A new medicine can cost $2.6 billion and take more than 15 years to develop.

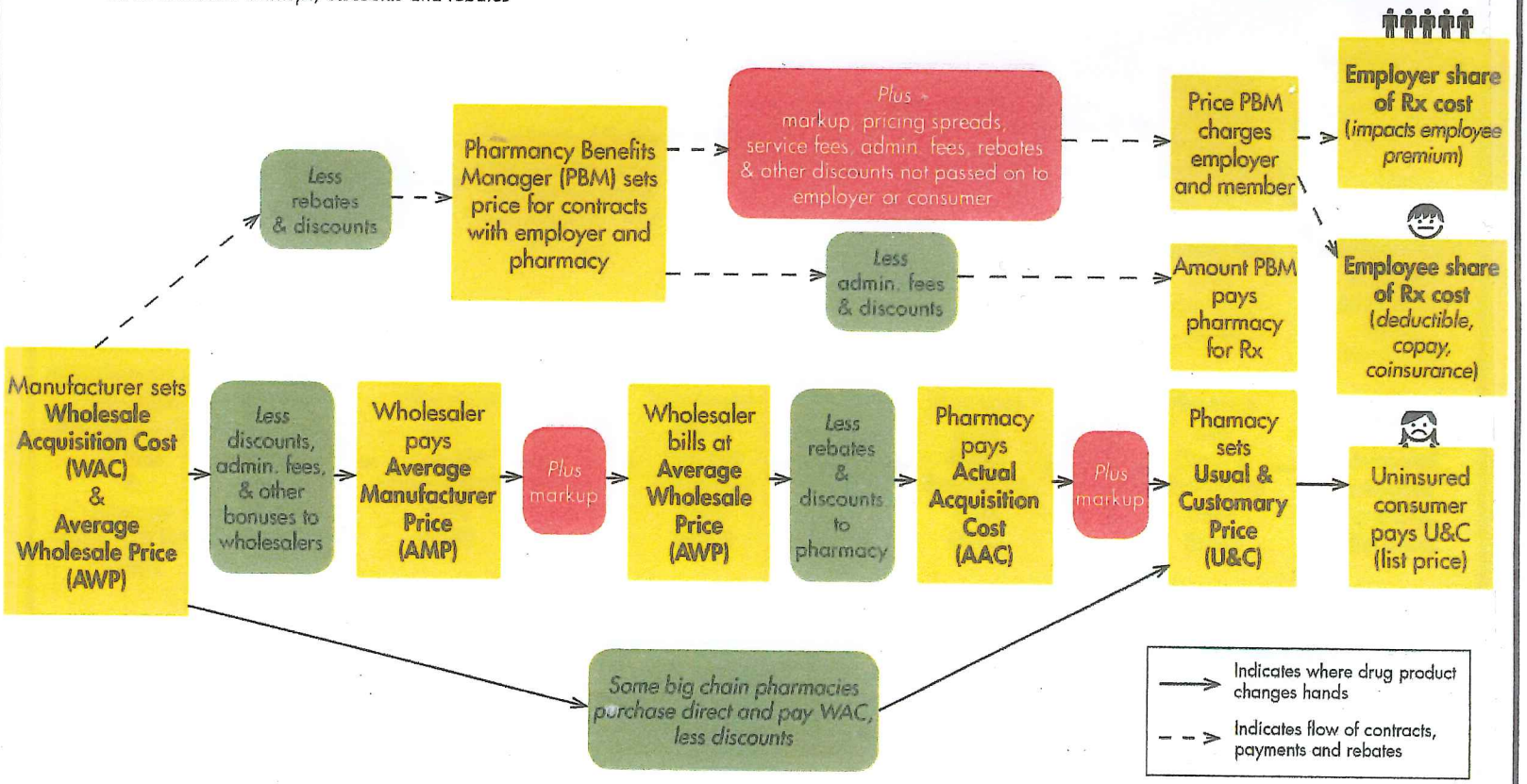
Learn more at CALifeSciences.org/Innovation.

CLSA
California Life Sciences Association

ConsumersUnion®
HEALTH CARE VALUE HUB

Rx Pricing Along the Supply Chain

This chart shows how prescription drugs move along the supply chain to consumers. For a typical employer-sponsored drug benefit, the price at each step involves hidden markups, discounts and rebates



Note: This graphic is intended as a simplified overview of the drug pricing supply chain, showing how important pricing concepts fit together. As such, it does not reflect myriad other connections between parts of the system. Source: Adapted from The Prescription Drug Supply Chain Black Box: How it Works and Why You Should Care, *Eickelberg, H.C., American Health Policy Institute (2015).*