Addressing High-Cost Drugs

Prescription Drug Pricing Panel

New Mexico Legislative Health & Human Services Committee

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About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Agenda

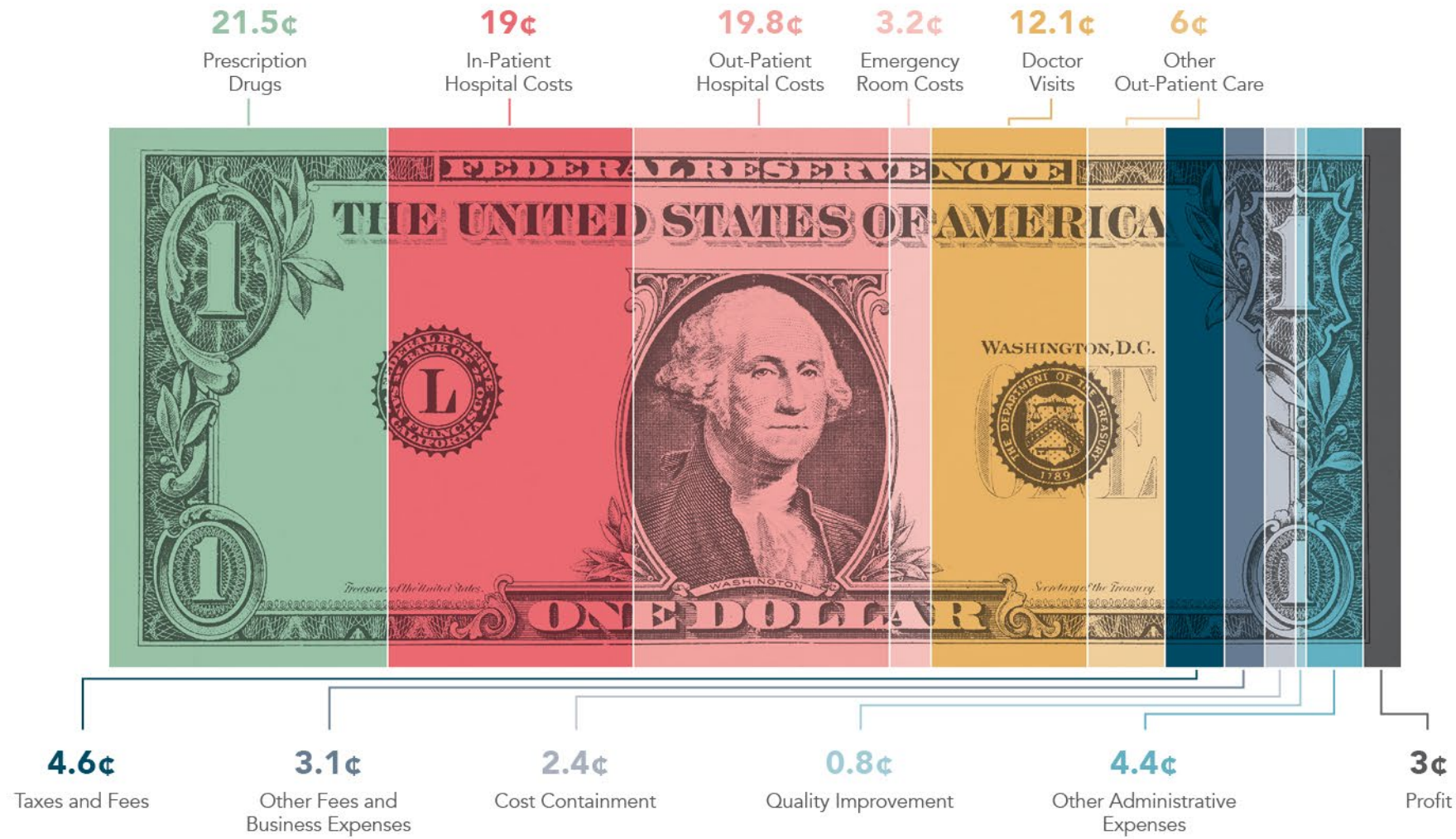
Drug Costs

Critical Topics to Be Informed On

Recommendations

Where Does Your Health Care Dollar Go?

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



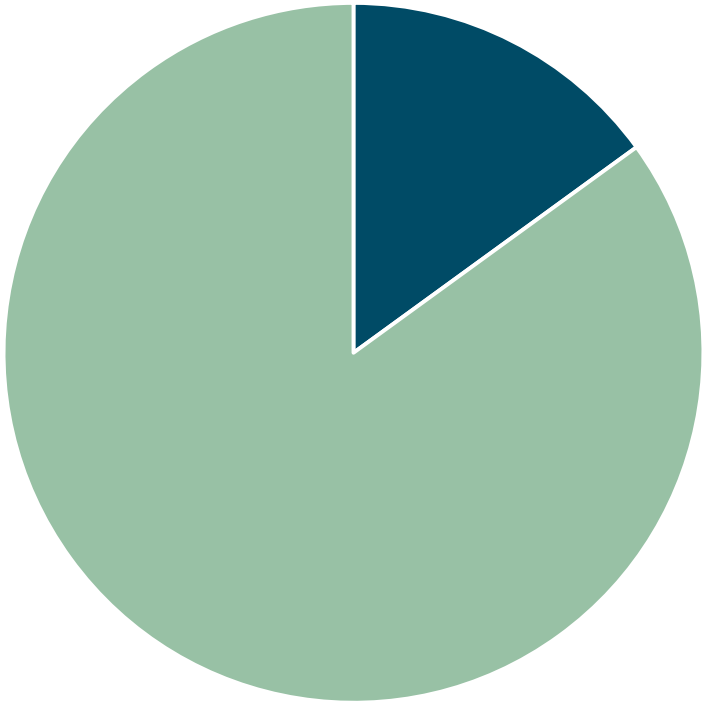
This data represents how commercial health plans spend your premiums. This data includes employer-provided coverage as well as coverage you purchase on your own. Data reflects averages for the 2016-18 benefit years. Percentages do not add up to 100% due to rounding.

Medical Loss Ratio

Administrative Costs:

- Customer service lines
- Websites & online consumer tools
- Provider engagement
- Pharmacy benefits management
- Fraud & abuse prevention
- Accreditation costs & compliance with state laws
- Agent & broker commissions
- Operating costs (salaries, facilities, IT)
- Marketing and enrollment
- Claims administration

Health Plans MLR



Medical Costs:

- Doctor's visits
- Other health care provider visits (i.e. physical therapy)
- Hospital stays
- Prescription drug costs
- Medicaid equipment and supplies
- Quality Improvement activities

If 85% MLR is not met, rebates are provided to policyholders

[Small Group & Individual Admin Costs is 20% = 80% MLR]

ICER Report Nov 2021

- *Unsupported Price Increases Occurring in 2020*, ICER Report, Nov 2021
  - Identifies top 10 drugs that caused greatest increase to drug spending and then reviewed for clinical evidence to justify increases
- Top 5 Findings of Drug Increases With No Reason:
  - **Humira** increased net price 9.6% = an additional cost of $1,395,000,000 in 2019
  - Promacta increased net price 14.1% = an additional cost of $100,000,000 in 2019
  - Tysabri increased net price 4.2% = an additional cost of $43,600,000 in 2019
  - Xifaxan increased net price 3% = an additional cost of $43,560,000 in 2019
  - Trokendi XR increased net price 12.4% = an additional cost of $36,000,000 in 2019

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

HUMIRA:
An Example of Greed

2003 ➡ 2021
$16,600 ➡ $77,000

470% increase

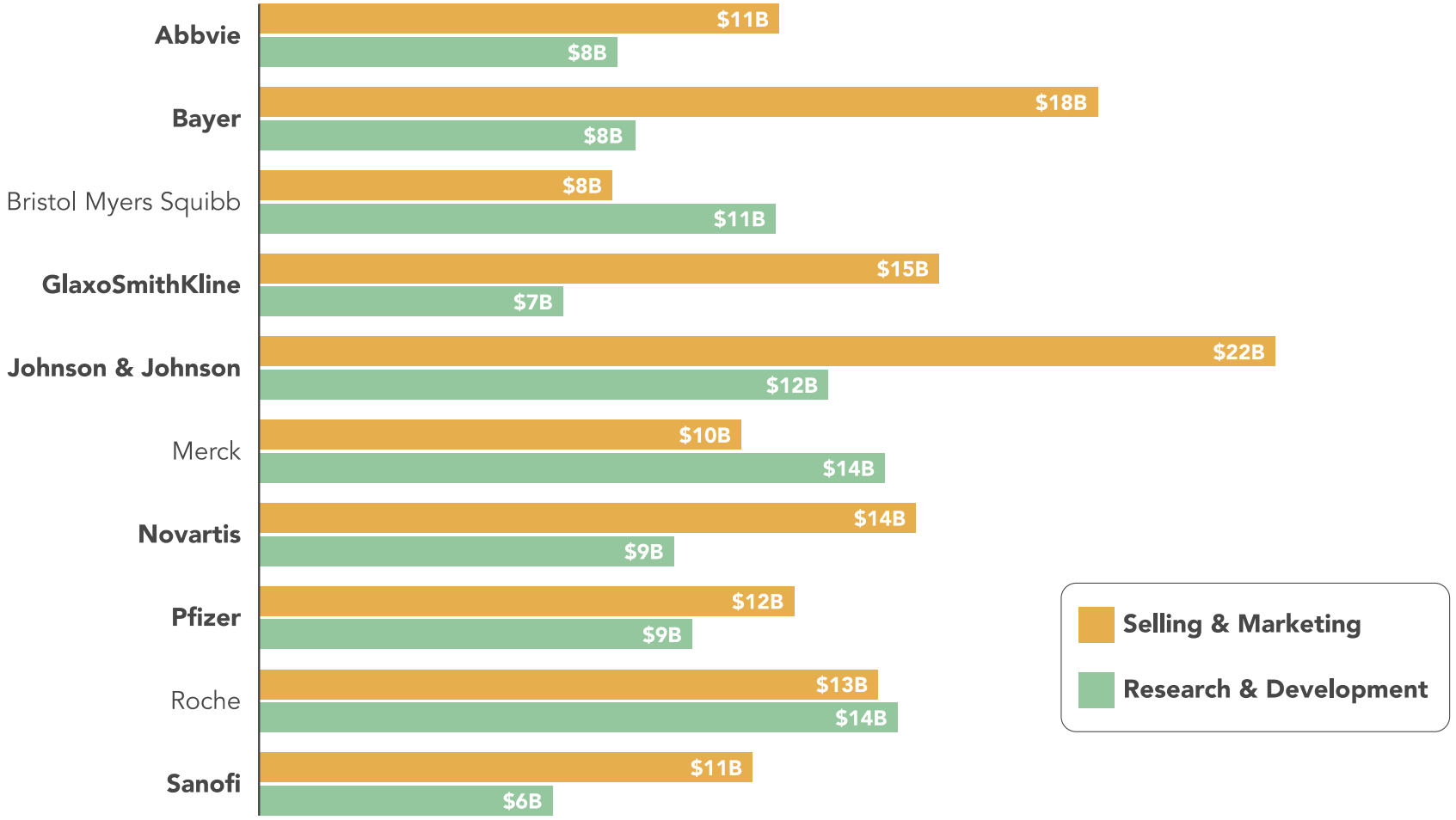
- ✕ Humira by AbbVie is #1 selling drug in the US and world
- ✕ Approved to treat Rheumatoid Arthritis (2002), Crohn's Disease (2007), Colitis (2012), adding patents to each
- ✕ In 2021, Humira costs more than $77,000 per patient annually
- ✕ In 2020, AbbVie collected $16 Billion in US net (post rebates) revenue
- ✕ 7.4% of net revenue has gone toward R&D
- ✕ Patent was to end 2016, AbbVie has blocked biosimilars by utilizing "Pay for Delay" with multiple companies until 2023 costing US consumers $19 Billion
- ✕ Competitor Amgen's Enbrel is "shadow pricing" with Humira

AARP RX Price Watch Report Sept 2021

- 2019-2020 retail prices for 180 specialty drugs increased an average of 4.8%, general inflation was 1.3%
  - Lowest % increase, but still too high
- Average cost for specialty drugs is $84,442, if kept at inflation from 2006 would be $39,068 (more than $45,000 lower)
- 2006-2020 11 drugs for chronic care have increased 234%, while general inflation rose 32%
- “Those with private health insurance will pay more in cost sharing and higher premiums”
- Higher government spending “driven by large price increases will affect all Americas in the form of higher taxes, cuts to public programs, or both”

Marketing vs New Drug Development by Pharmaceutical Industry

In 2020, an AHIP Study shows **7** of the top 10 largest pharmaceutical companies **spent more on marketing than on developing new drugs.**



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

CBO Study April 2021

- *Research and Development in the Pharmaceutical Industry* - CBO Study April 2021
- "Importantly, when drug companies set the prices of a new drug, they do so to maximize future revenues net of manufacturing and distribution costs. A drug's R&D costs that have already incurred in developing that drug—do not influence its price."
- Since 2009, 1/3 of new drugs approved were developed by smaller drug firms. Large drug companies have only initiated **20%** of drugs in phase 3 clinical trials. 1/5 of smaller firms have been purchased by larger firms for access to these drugs and to lessen competition

New Drugs Have Sky High Costs

2021 Top 5 Most Expensive Drugs	Zolgensma = **$2,125,000** treats spinal muscular atrophy, 1 time therapy (2019)
	Zokinvy = **$1,032,480** treats Hutchinson-Gilford progeria syndrome-premature aging (2020)
	Danyelza = **$977,664** treats neuroblastoma-cancer (2020)
	Myalept = **$889,904** treats lipodystrophy-abnormal fat distribution (2014)
	Luxturna = **$850,000** treats retinal dystrophy-vision loss, 1 time therapy (2018)

Critical Issues

Coupons & Secure, Direct Delivery

Coupons

Background:

Drug makers will provide a coupon to a patient so they can receive a discount on a specific brand drug at the pharmacy counter

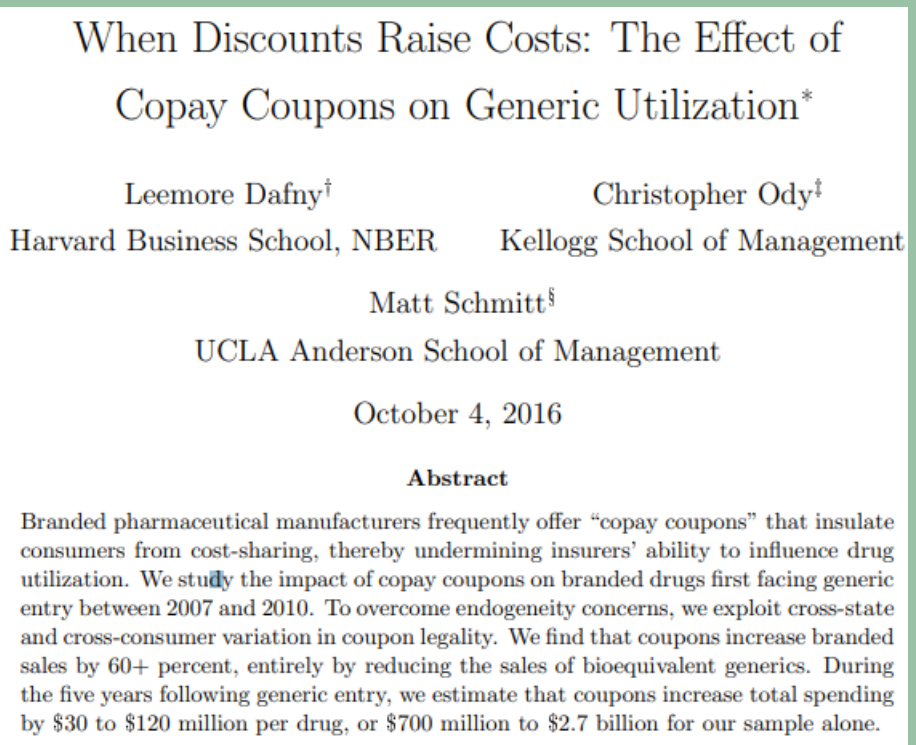
Health insurance providers use tools, such as coupon accumulators, to accurately represent out-of-pocket spending by consumers, so we are treating all consumers and their spending the same

- Coupons are prohibited in Medicare and Medicaid as federal govt considers them an illegal “kickback” as they induce a patient to take a certain drug
- Coupons mask prices and price hikes from consumers
- Drug makers use coupons as an **incentive for patients to use branded drugs** instead of less expensive generics or therapeutically similar drugs - they know carriers will continue to pay for the drug after the coupon ends

$ Impact of Copay Coupons

Academic Study reviewed the impact of copay coupons on branded drugs

Also compared MA who has coupons v. NH which had banned them



When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization*

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October 4, 2016

Abstract

Branded pharmaceutical manufacturers frequently offer "copay coupons" that insulate consumers from cost-sharing, thereby undermining insurers' ability to influence drug utilization. We study the impact of copay coupons on branded drugs first facing generic entry between 2007 and 2010. To overcome endogeneity concerns, we exploit cross-state and cross-consumer variation in coupon legality. We find that coupons increase branded sales by 60+ percent, entirely by reducing the sales of bioequivalent generics. During the five years following generic entry, we estimate that coupons increase total spending by $30 to $120 million per drug, or $700 million to $2.7 billion for our sample alone.

- When branded drugs offered coupons, use of generic alternatives was reduced by 3.4% for all ages
- When branded drugs offered coupons for adults older than 65, generic usage was reduced by 6.3%
- Coupons INCREASED drug spending by $700 million annually – a total of $2.9 billion over 5 years
  - an average windfall of $30 to $120 million per drug
- Coupons reduce the use of generic drug competitors and increase brand drug sales by more than 60%

Secure, Direct Delivery of Specialty Drugs

- AARP: In 2020 specialty drugs were 13x more expensive than brand prescription drugs $84,442 v. $6,604
- JAMA Article Jan 2021: Specialty drugs are a leading contributor to drug spending growth… "physicians and hospitals face limited incentives to mitigate spending, and there is weak provider negotiating power for price concessions from manufacturers."
- ***Background***: To lower specialty drug costs, health insurance providers may contract with certain specialty pharmacies to distribute very expensive specialty drugs at negotiated lower costs. If a patient is getting treatment in a hospital, the drug will be shipped to the hospital to be administered and it can also be shipped to a patient's home
  - As these drugs historically come in white paper bags to the doctor, this issue is sometimes called "**white bagging**"
- ***Hospitals*** want to disallow this as they can place exorbitant markups on physician administered specialty drugs and have no incentive to lower costs
- ***Health Insurance Providers*** are careful and specific on which specialty drugs they will provide through Secure, Direct Delivery during hospital contract negotiations and choose drugs which do NOT pose any safety issues

Recommendations

States Have a Role in Lowering Drug Costs

- Review any proposals from both the individual consumer perspective AND the overall cost to the health care system
- Consider passing bills to increase transparency for
    1. Patient assistance programs that advocate on drug legislation to report on percentage of $ received from pharmaceutical supply chain,
    2. Require pharmaceutical stakeholders to disclose the amount they spend annually on patient assistance programs.
    3. Require pharmaceutical reps to disclose drug prices to physicians of drugs they are offering samples to.
- Any person (drug companies) offering any amount of $ for a covered prescription drug:
    1. Must offer for the full plan year
    2. Must notify the enrollee prior to an open enrollment period if the financial assistance will be discontinued in a subsequent play year; AND
    3. May not condition the assistance on a specific type of health plan
- THANK YOU – for passing mandated generic substitutions!

Questions?

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Appendix

Marketing v R&D Study – AHIP Methodology

To construct the dataset, we identified ten largest pharmaceutical companies by revenues in 2020. For each pharmaceutical company on the list, we obtained the annual reports (form 10-K or 20-F) submitted by the company to the U.S. Securities and Exchange Commission (SEC). For companies that were not required to submit 10-K or 20-F forms to the SEC, we supplemented our dataset with the annual reports published on the companies' websites.

Using the annual reports, we recorded companies' spending on *Research and Development* (includes both in-house and acquired Research and Development expenses) and *Selling and Marketing* (also marked as *Selling, General and Administrative* or as two separate categories *Selling* or *Marketing and Distribution*, and *General and Administrative*. In the latter case, the two categories were combined).