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Policy Update: Drug Pricing

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Agenda

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- Drug pricing stats/landscape
- Headlines
- Meet the middlemen
- Mapping the supply chain
- PBM business model
- PBMs & pricing
- The blame game
- Where does this leave patients?
- Copay assistance programs
- PBMs bite back
- Administration's blue print to address rising drug prices
- On the Hill
- Questions/comments

Level-setting

- Despite the high volume of coverage, it's not readily clear what the *real* cost of drugs is & why patients pay what they do
- Goals of session:
  - Demystify the drug pricing process & distribution chain
  - Know the *real* factors affecting drug prices for patients
  - Help you understand & navigate current policy proposals

Cost of cancer drugs is high & rising

U.S. spending on cancer therapeutic drugs has doubled since 2012, reaching almost $50 billion in 2017. Two-thirds this growth was the result of drugs launched during that period.

Spending on cancer therapies is expected to double again in the 5 years between 2017 and 2022, reaching $100 billion.

The median annual cost of a new cancer drug launched in 2017 exceeded $150,000 – up from $79,000 in 2013.

Global Oncology Trends 2018. IQVIA Institute for Human Data Science, May 2018.

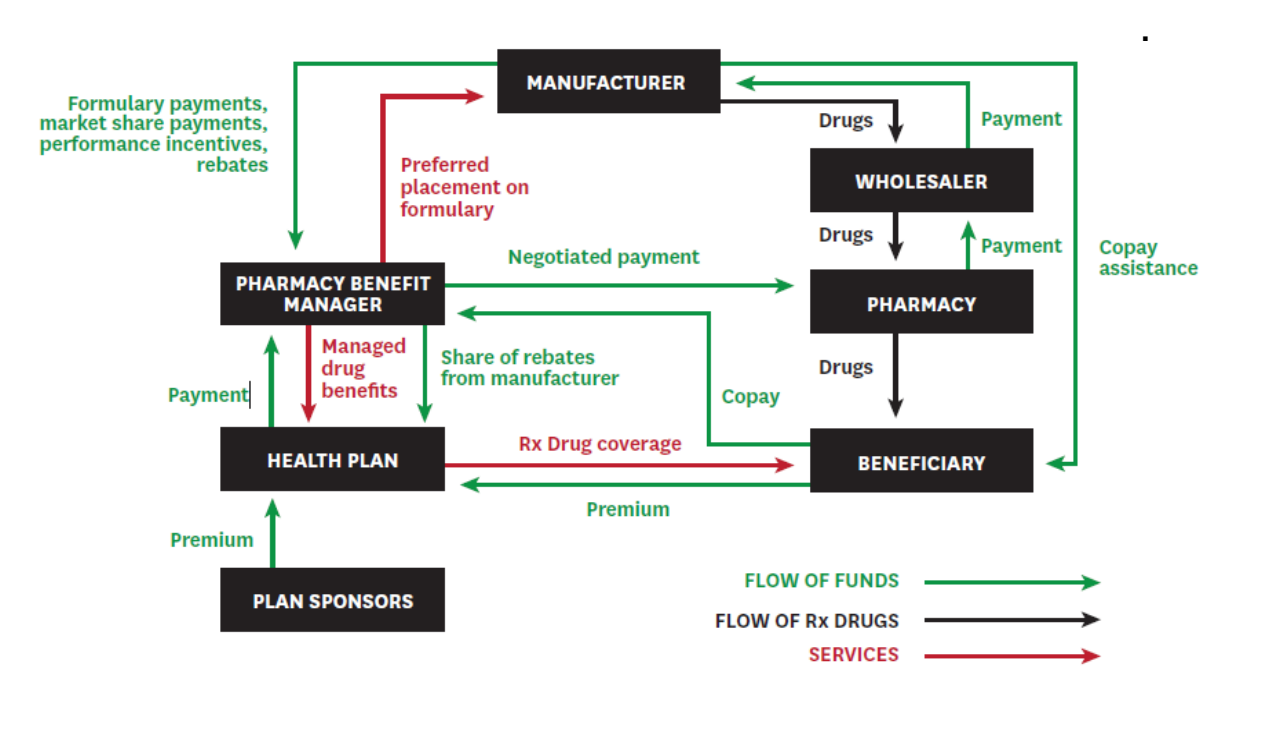
It's not just cancer drugs…

- Prescription drug costs are the fastest growing component of health care spending.
- 1 in 4 people report having difficulty paying for drugs, according to Kaiser Family Foundation polling.
- Medicare's drug spending grew nearly 90 percent from 2006 to 2015, with an annual average growth rate of 7.6 percent, according to the Pew Research Institute.

Longtime coming

- A series of high-profile large price spikes in drug costs to patients in recent years → Sustained public outrage
  - **"Gilead to raise price for new hepatitis C drug above $84,000"** (**Reuters**, 9/12/2014)
  - **"Drug Goes From $13.50 a Tablet to $750, Overnight"** (New York Times, Sept. 20, 2015)
  - **"Why Did Mylan Hike EpiPen Prices 400%? Because They Could"** (Forbes, Aug. 21, 2016)
  - **"This old drug was free. Now it's $109,500 a year."** (Washington Post, Dec. 18, 2017)

Mapping the supply chain



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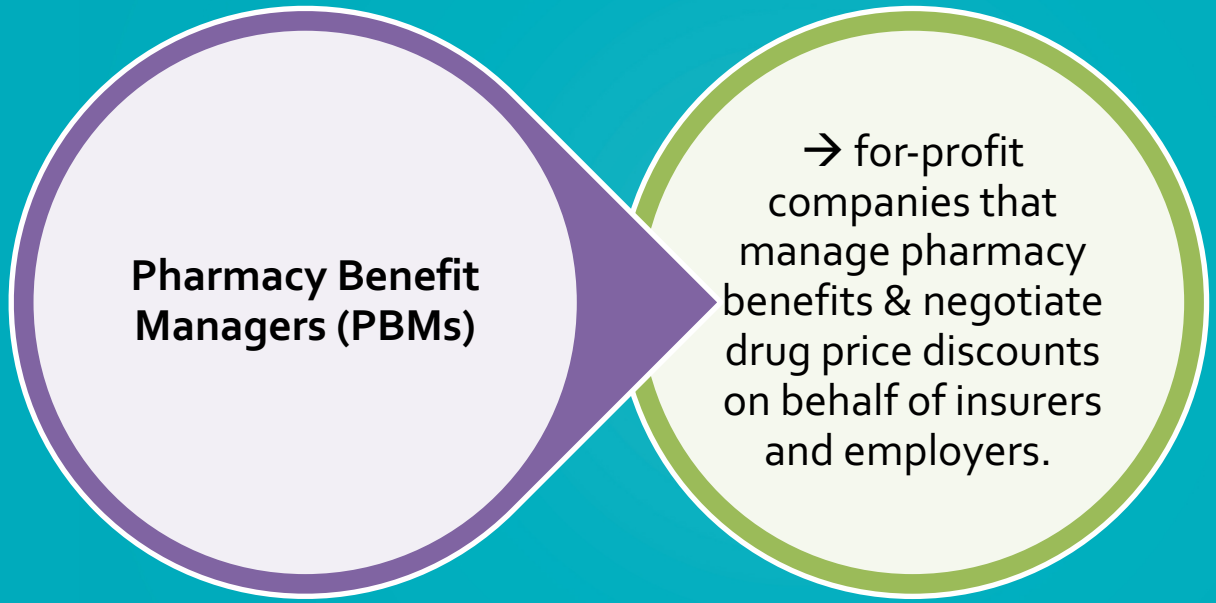
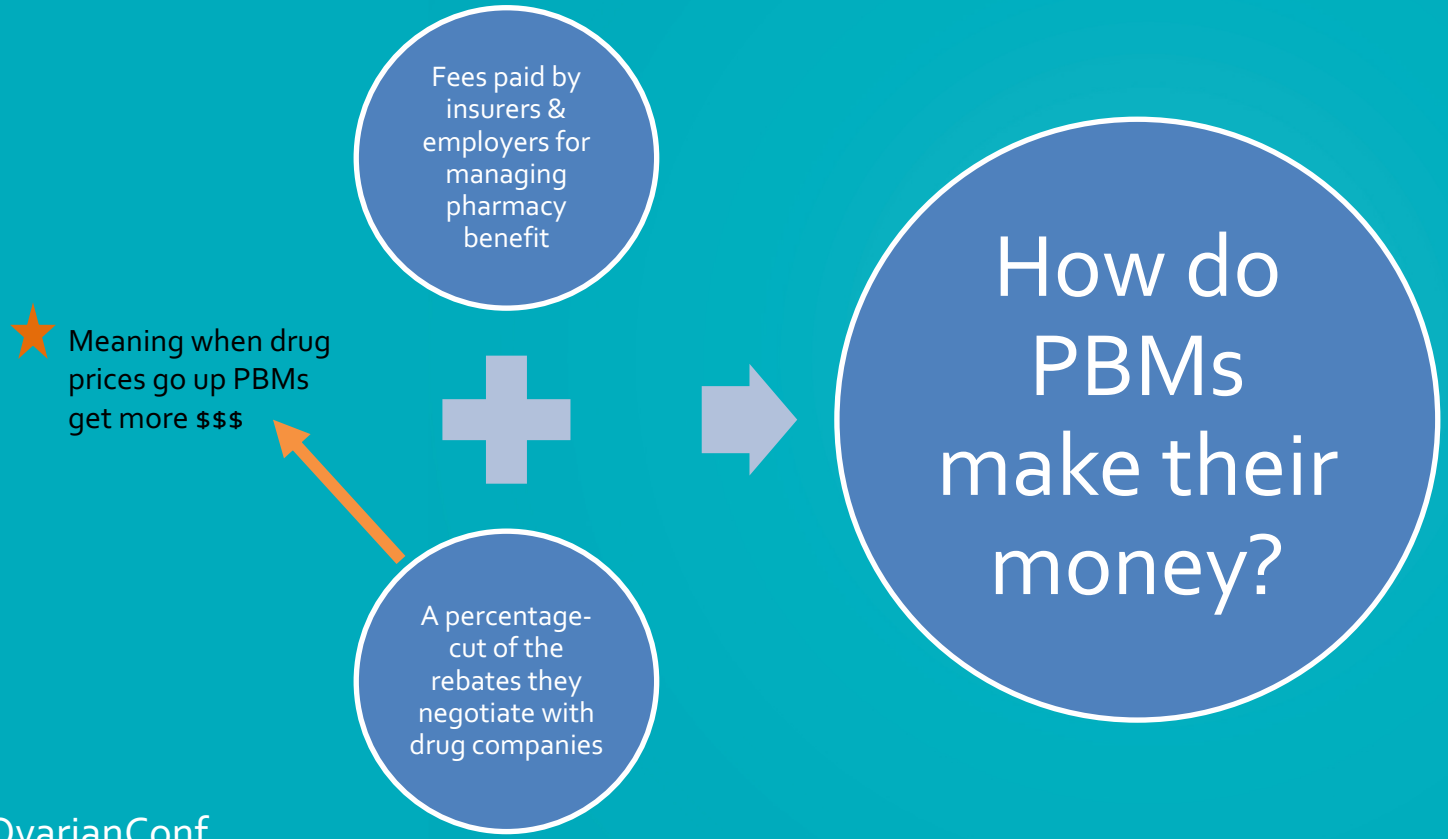
Meet the middlemen



PBM business model



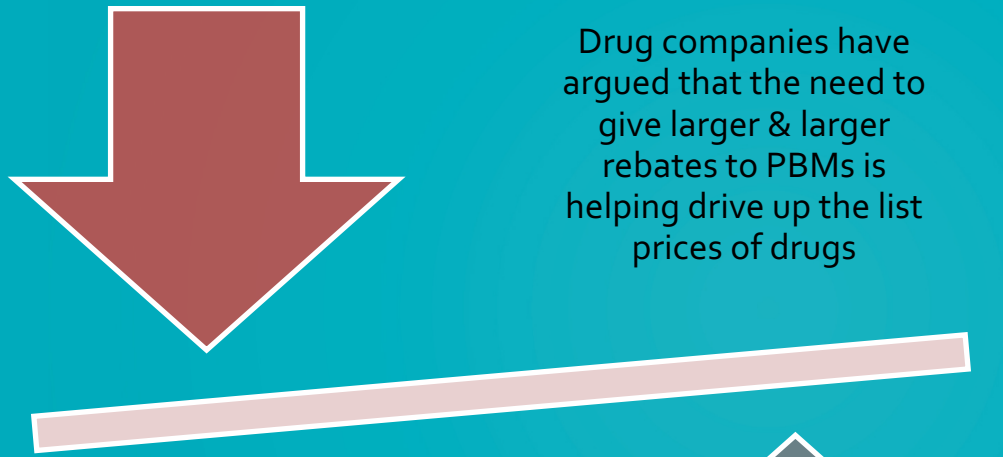
PBMs & pricing

Drug price is *not one* number. Drugs have published list prices – but few pay them (it's used more as a reference point).

Drug companies & PBMs establish an agreed price thru negotiations that are hidden from consumers.

How much the patient pays at the pharmacy counter depends on their insurance plan.

The blame game



Drug companies have argued that the need to give larger & larger rebates to PBMs is helping drive up the list prices of drugs

PBMs say that drug companies are the ones raising prices & that they typically pass along 90% of the savings they negotiate to customer

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Where does this leave patients?

Adherence issues – Patients make dosage adjustments/skip meds altogether

Medical debt – possibly leading to "financial toxicity"

Financial assistance vis-à-vis drug companies thru copay assistance programs

Copay assistance programs

- **“Copay Assistance Programs” are designed to help get patients to reach their annual deductible or out-of-pocket maximum cap *triggering full coverage**

PBMs bite back

- → with the creation of "**Accumulator Adjustment Programs"**
  - **These programs** makes it such that the only cost-sharing that count towards a patient's deductible is their own payment at the pharmacy counter → making copay assistance programs defunct
  - PBMs claim that this get-around is by design → drug companies want rebates at the pharmacy counter (not thru drug companies via copayment assistance programs) because it allows them to continue to charge a high price for drugs.
  - PBMs are marketing programs toward larger employer/insurers → increasingly adopted as cost-containment measure

President Trump tees up

- President Trump repeatedly called for lower drug prices while campaigning in 2016 & has maintained the drumbeat
  - In January 2017, Trump put drug companies on notice, accusing them of "getting away with murder."
  - In his 2018 SOTU address, Trump announced: "I have directed my Administration to make fixing the injustice of high prices one of our top priorities. Prices will come down."
  - When swearing in newly-minted HHS Secretary Alex Azar, Trump promised Azar is "going to get those prescription drug prices way down" at Azar's January 2018 swearing in ceremony.

Administration's blue print

- **May 11, 2018:** President Trump & HHS Secretary Alex Azar roll out a 39-page blue to deliver on longtime promise to lower drug prices
  - 50 "ideas" → criticized as "light on substance"
  - Handful got ppl talking:
    - 1) Restructuring the way PBMs deal with drug companies.
    - 2) Reconsidering how Medicare pays for some high-priced drugs administered at doctors' offices.

(1) PBM restructure

- Remember that PBMs get a percentage-based rebate from drug companies
  - E.g., a drug company may offer something like 30% off the list price of their drugs in exchange for a favorable spot on their preferred drug lists
    - → When prices go up, PBMs often make more $$$ as rebates grow

- As part of the Administration's plan, Azar said he –
  - (1) intends to force PBMs to write contracts based on a set price for drugs, not a percentage-based rebate; and
  - (2) is looking to ban PBMs from making any money *at all* from drug companies → meaning PBMs would only earn money from fees paid by the insurance companies/employers who hire them.

"They're [PBMs] taking money from both sides," Azar said. "They've built into their system a regime where they get more money when the list price goes up."

(2) Reconsidering Medicare Part B Drugs

- Moving high-priced drugs under Medicare Part B (like cancer drugs) administered by injection/infusion at doc's office to Medicare Part D
- WHY? → Under Part D, the government contracts with private health insurance companies to manage the benefit and negotiate discounts with drug companies.
  → There is no such negotiation for the drugs covered by Part B
- "This move from B to D gives us the power to negotiate against drug companies," Azar said. → the rationale is that it will increase competitive & drive down prices

Impact of Part B/D flip

- Cost-shifting onto patient → 20% vs. 30%+
  - Part B → patients are generally responsible for 20% of the Medicare-approved charges for drugs and doctors' services, but the most popular Medigap policies cover the beneficiary's share.
  - Part D → patients may be responsible for 30% or more of the cost of some drugs depending on the terms of coverage set by their drug plan.
  - Medigap policies are not allowed to cover Part D expenses.

- ALSO: Nine million Medicare beneficiaries who are enrolled in Part B do not have drug coverage under Part D. → The WH has not said how their drug bills would be paid (???)

A few more things

- In rolling out the plan, HHS Sec. Azar said it will reduce prices "over weeks, months, and years"
- Azar's "bully pulpit" strategy → "This pen," he said, "has a lot of power."
- Will this actually reduce cost of drugs for patients?
  → *Not likely*
  – Criticized for doing nothing to get at reducing list prices – rather it nibbles around the edges of the issue

What's going on the Hill

- Trump proposal slammed by Democrats/ praised by Republicans
- House hearing in December 2017
- Legislation that also "nibble around the edges"
  - Oral parity bill → targets benefit design
  - FAIR Act → Proposal calling for transparency standards when prices increase
  - Proposals to remove barriers to cheaper generic drugs

OCRFA's bottom line

- We represent patients.
  - We are invested in these drug pricing reform insofar as our patients are impacted. We support proposals that expand patient access to the drugs they need & we oppose those that restrict access.

In application, this means that:

- We support **Copay Assistance Programs – which we recognize as a lifeline for our patients.**
- We oppose so-called Copay Accumulators Programs & other initiatives that undermine patient access to the drugs they need.
- **We support policy proposals like oral parity that "may nibble around the edges" at the larger issue – but spare patients burdensome costs while policymakers figure out a more comprehensive overhaul.**

Questions/Comments

Please don't hesitate to reach out.

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- We're always looking for patient stories about drug pricing – so please reach out if you or someone you work with has an impactful story.

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