Oregon Prescription Drug Prices Annual Public Hearing

10 a.m. to 12:15 p.m., Thursday, Dec. 1, 2022

Sign up in the chat to provide public testimony.

Send written comments to rx.prices@dcbs.oregon.gov

DFR | Division of Financial Regulation

Department of Consumer and Business Services

Welcome

Welcome and introductions

- Andrew Stolfi (he/him), insurance commissioner and agency director, DCBS
- Ralph Magrish (he/him), Prescription Drug Affordability Board executive director, DFR, DCBS

Moderators

- Sen. Deb Patterson (she/her)
- Rep. Rob Nosse (he/him)
- Rep. Ron Noble

Drug Price Transparency Program

Program presenters:

- Sofia Parra (she/her), program coordinator, Drug Price Transparency Program, DFR, DCBS
- Numi Rehfield-Griffith (she/her), senior policy advisor, DFR, DCBS

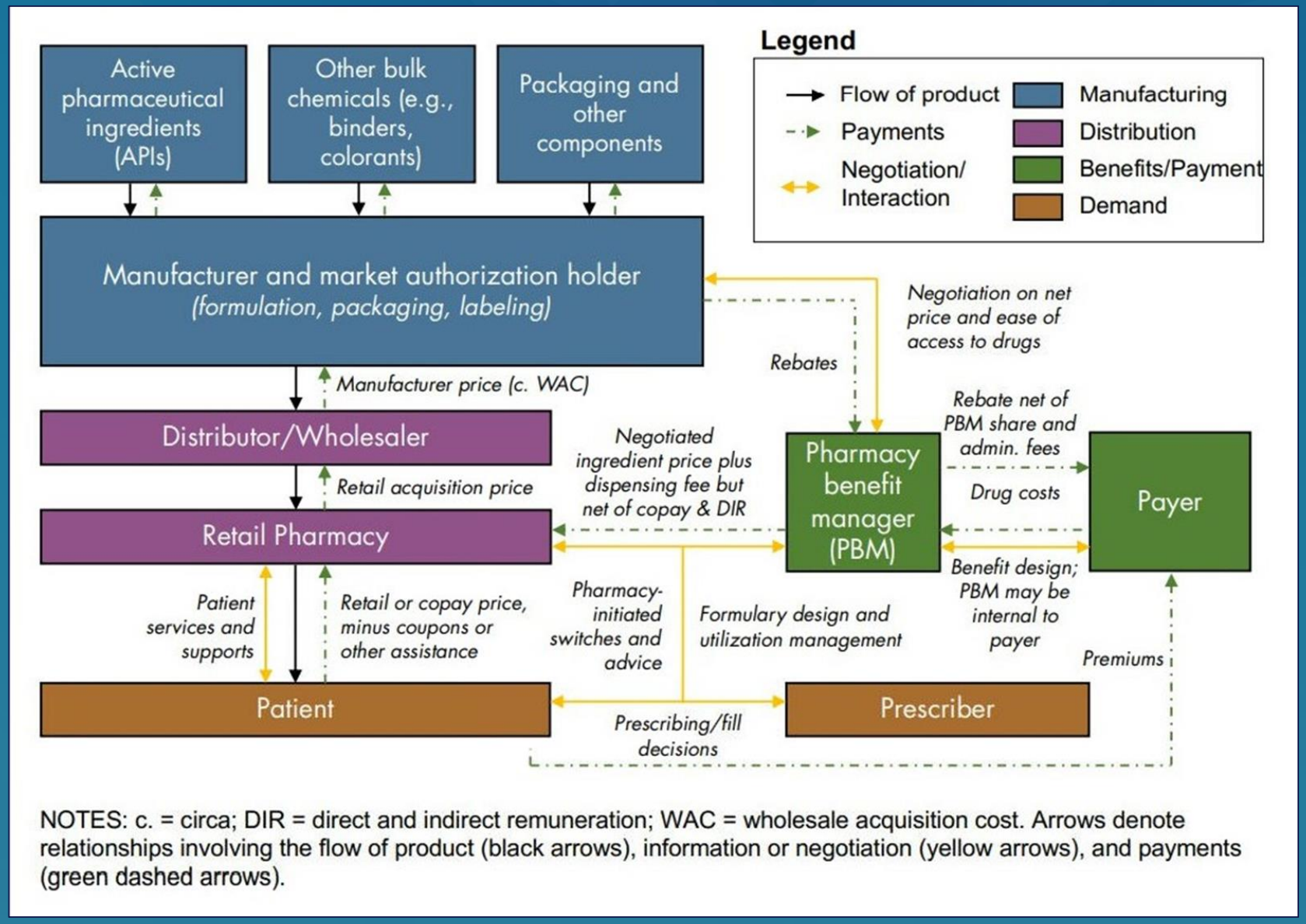
Drug Price Transparency Program

- Operates under ORS 646A.680 to 646A.692 and administrative rules OAR 836-200-0500 to 836-200-0560.

- Reporting manufacturers are required to register, file certain reports, and pay an annual billing to cover program costs.

- Reporting manufacturers are those who meet all of the following:
  - ✓ Registered with the Oregon Board of Pharmacy.
  - ✓ Manufacture prescription drugs for sale in Oregon.
  - ✓ Set the drug's price (wholesale acquisition cost – WAC).

Pharmaceutical supply chain diagram



NOTES: c. = circa; DIR = direct and indirect remuneration; WAC = wholesale acquisition cost. Arrows denote relationships involving the flow of product (black arrows), information or negotiation (yellow arrows), and payments (green dashed arrows).

Drug price transparency reporting

Program is directed by statute to receive:

- New drug reports: More than $670.
- Annual price increase reports: $100 or more and 10 percent net yearly increase.

- 60-day price increase notice: 10 percent or $10,000 increase for brand name, 25 percent and $300 increase for generic.
- Insurers report: Top 25 most costly and most prescribed drugs, and the impact of drug costs on premium rates.

- Consumers report: Personal price increase in Rx they have purchased.

Program compliance and trade secret reviews

DPT compliance

- Identifying manufacturer noncompliance and sending letters of noncompliance.
- Goal is compliance: Noncompliance letters allow 30 days to become compliant before file is referred to enforcement unit and manufacturers potentially accrue civil penalties.
- Primary areas of potential noncompliance:
  - Failure to respond to the request for additional information.
  - Failure to provide accurate and complete information in the required data elements.

DPT trade secret

- Reviewing trade secret claims of various data elements and sending trade secret determinations.
- Lengthy and complex process to review and address determinations both in agreement and in opposition to manufacturer’s trade secret claims.

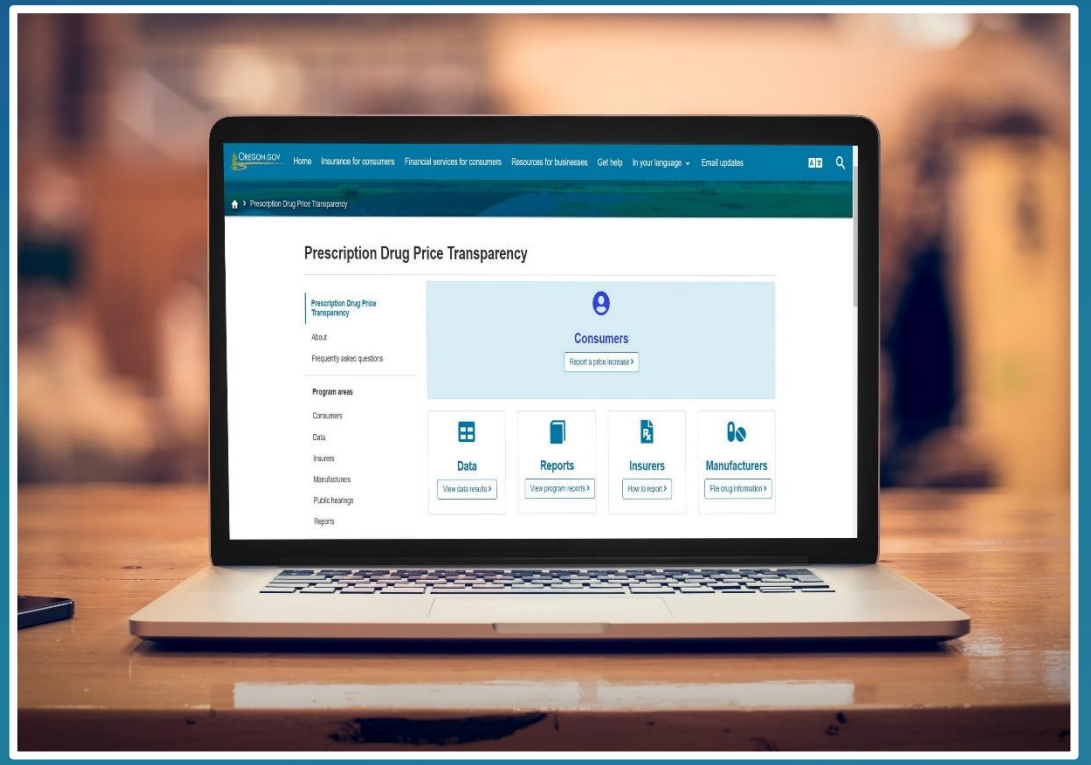
Consumers and transparency

Consumer reporting:

- Price increase reporting
- Stories and questions
- Outreach

Transparency website:

- Reported data from manufacturers (non-trade secret)
- Information from insurers
- Consumer reports submitted



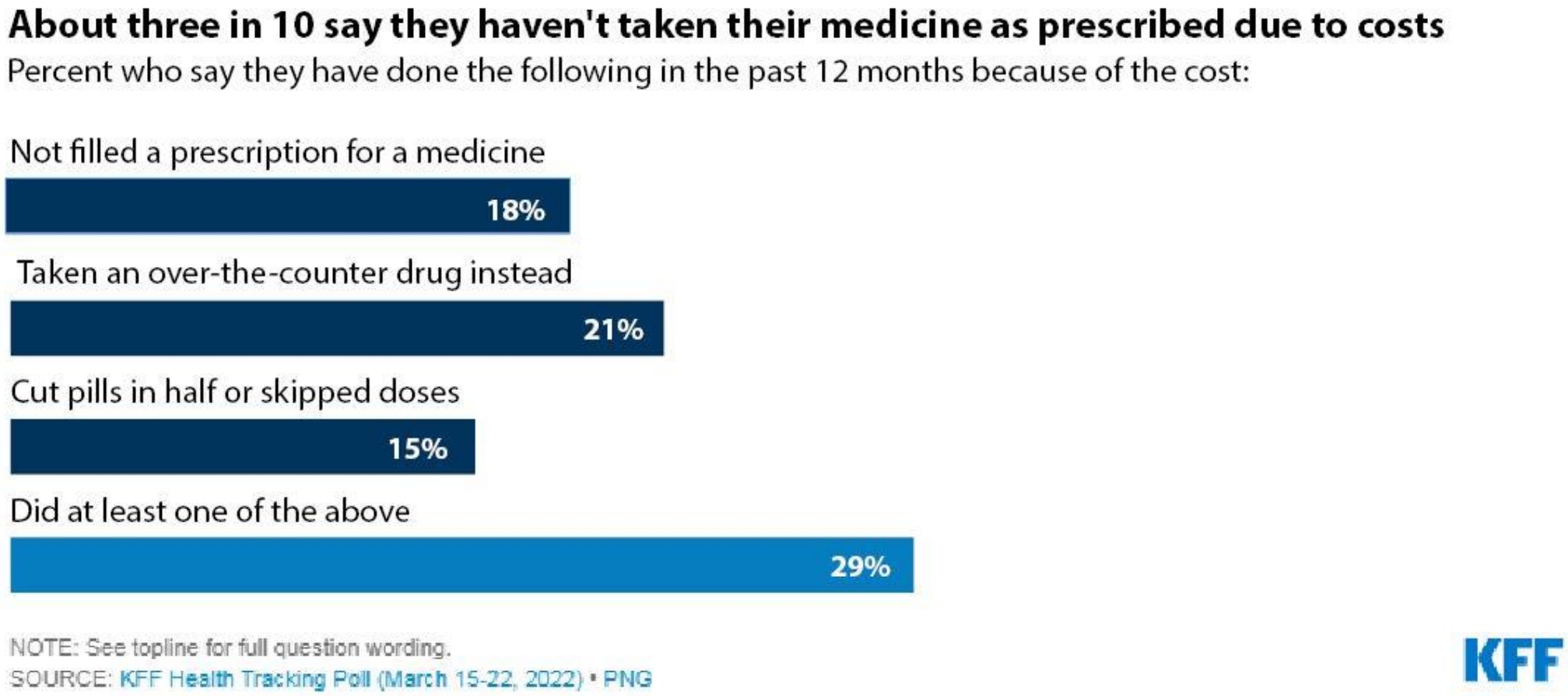
New insurer reporting enhancements – 2022

- Total dollars paid for drugs by insured and by insurer after rebates and other price concessions
- Dollars paid for drugs by insured and insurer after rebates, etc., on a per member, per month basis
- Dollars paid for drugs by insurer after rebates, etc., as a percent of premium collected
- Total dollars received by insurer in rebates and other price concessions
- All broken out by market and insurer

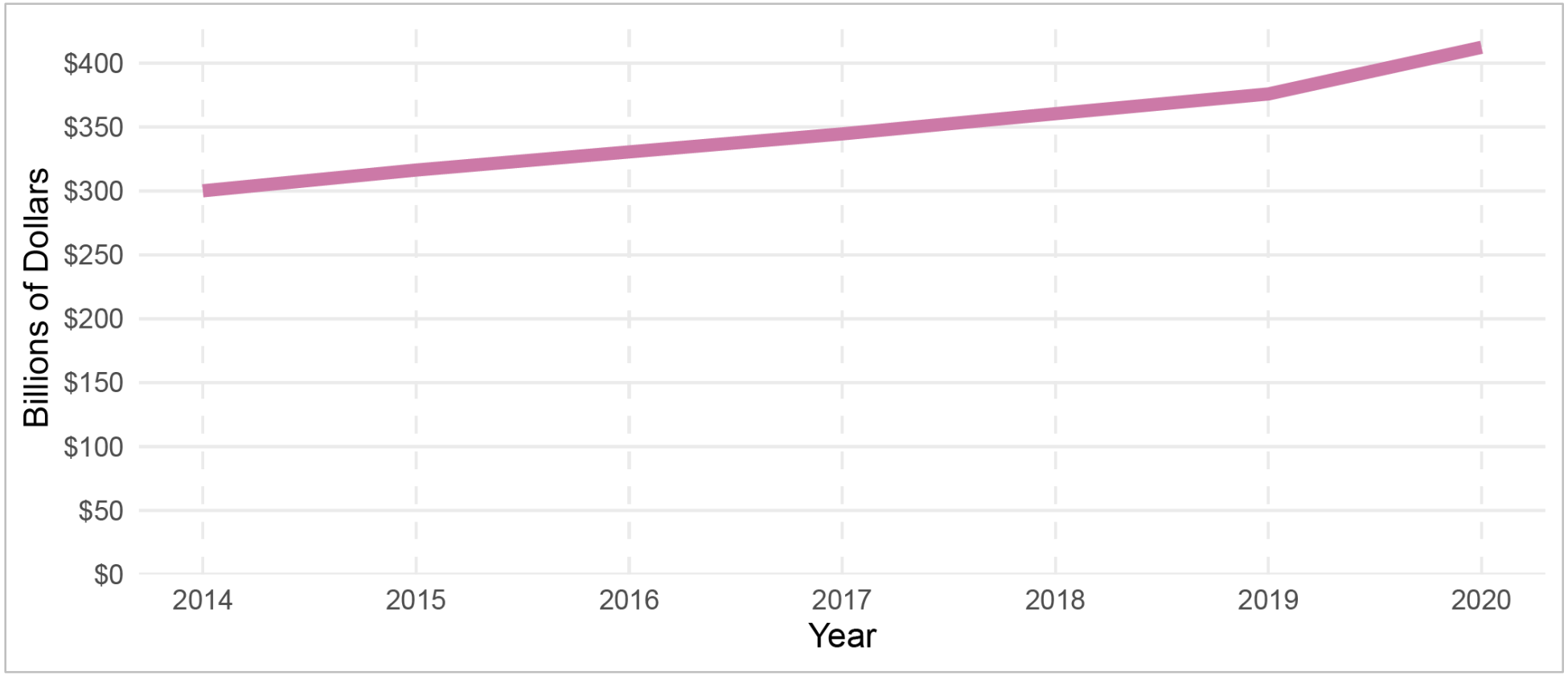
Key findings

- 193 new high-cost drugs reported (121 generic, 72 branded)
  - Highest prices: $419,500 for Abecma, $410,300 for Breyanzi, both "CAR-T" cancer therapies produced by Bristol-Meyers Squibb
- 71 drugs reported annual price increases (40 generic, 31 branded)
  - Largest increase: 778 percent for a generic from Nostrum Labs
  - Averages: +27 percent for generics, +13 percent for brands
- 10 insurers reported information to the program
  - Humira: $93,544,597 for 19,225 prescriptions
  - 7.4 percent price increase led to $1.4B more in spending nationally

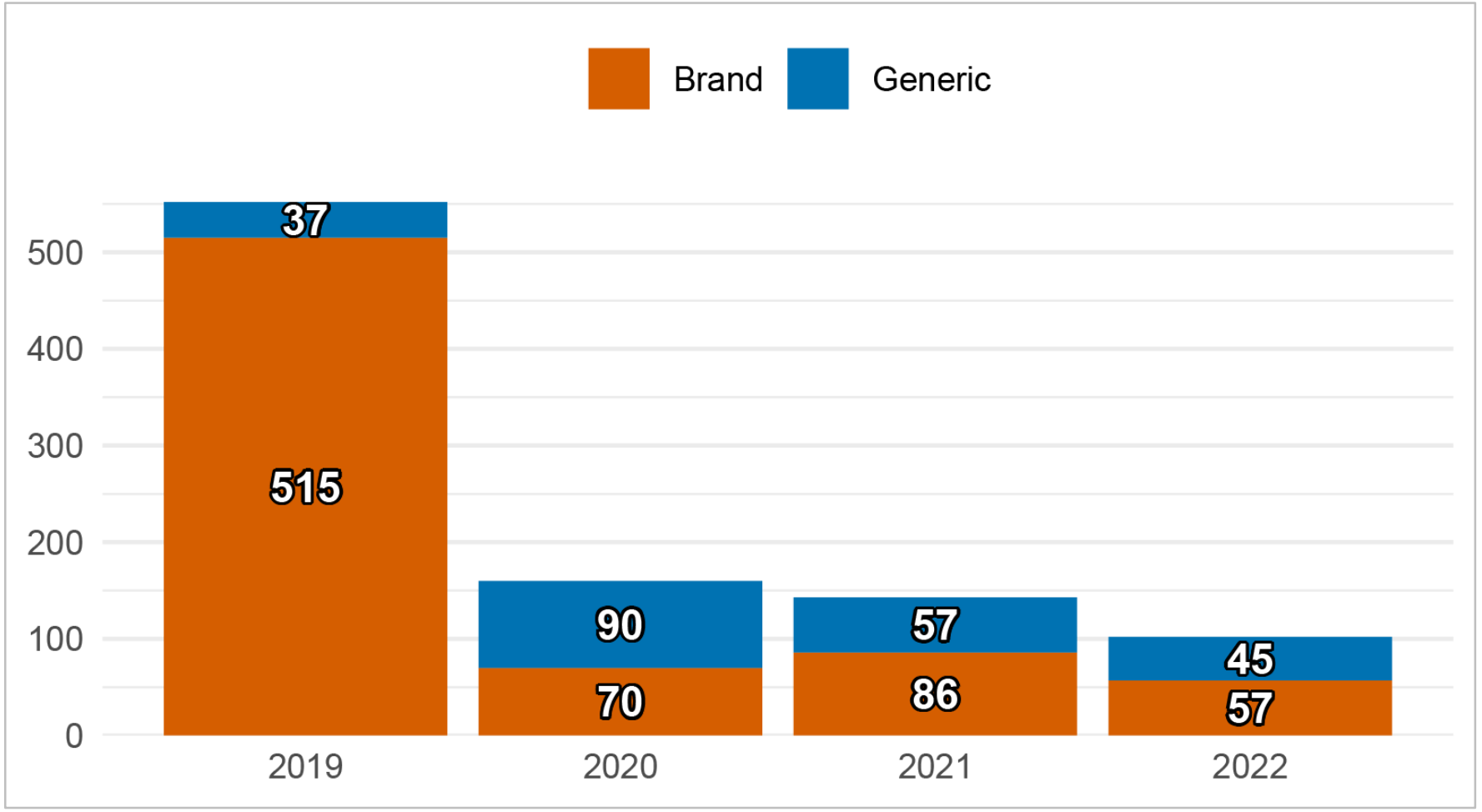
Have not taken medicine as prescribed due to cost



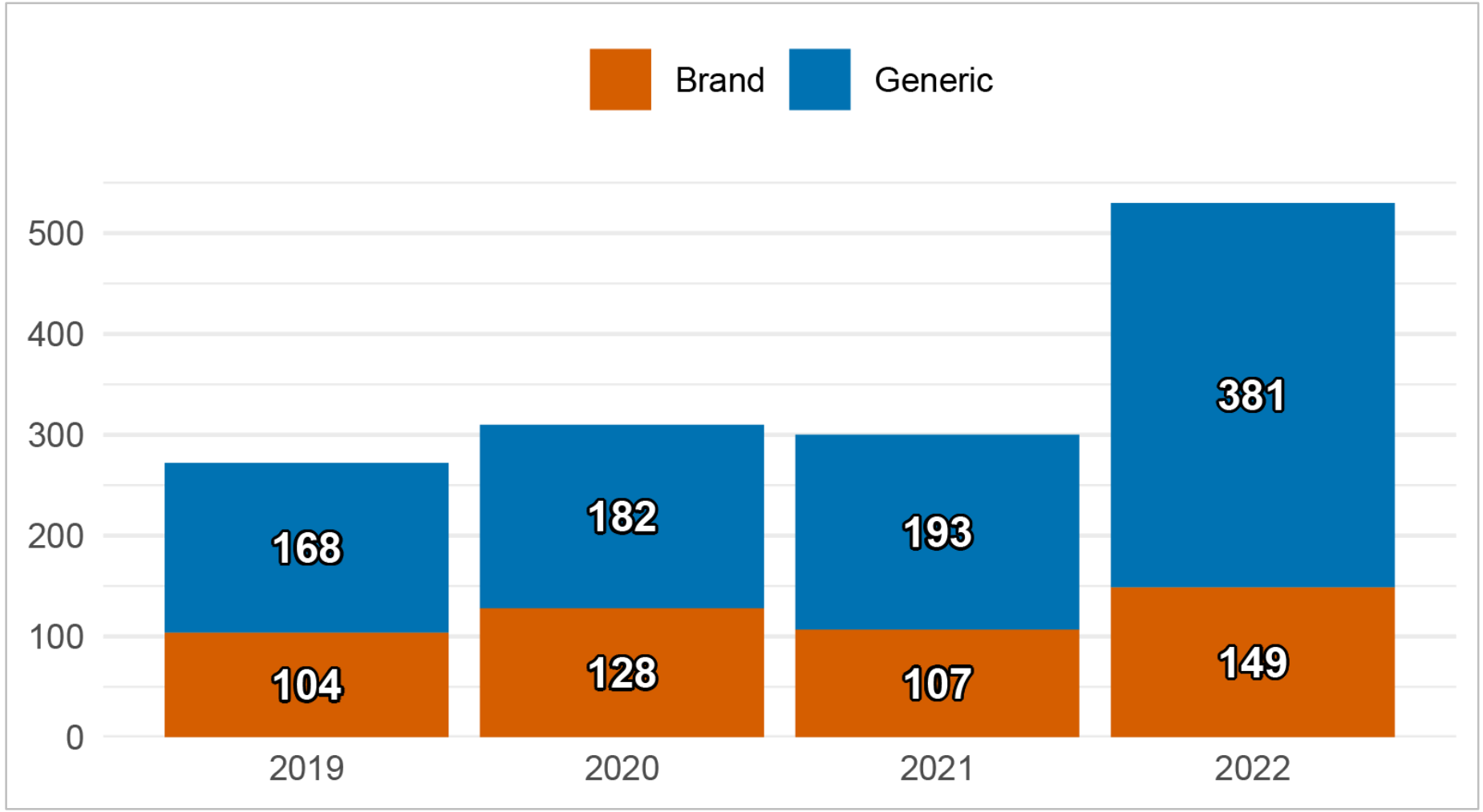
Estimated expenditure on retail prescription drugs in U.S. (2014 to 2020)



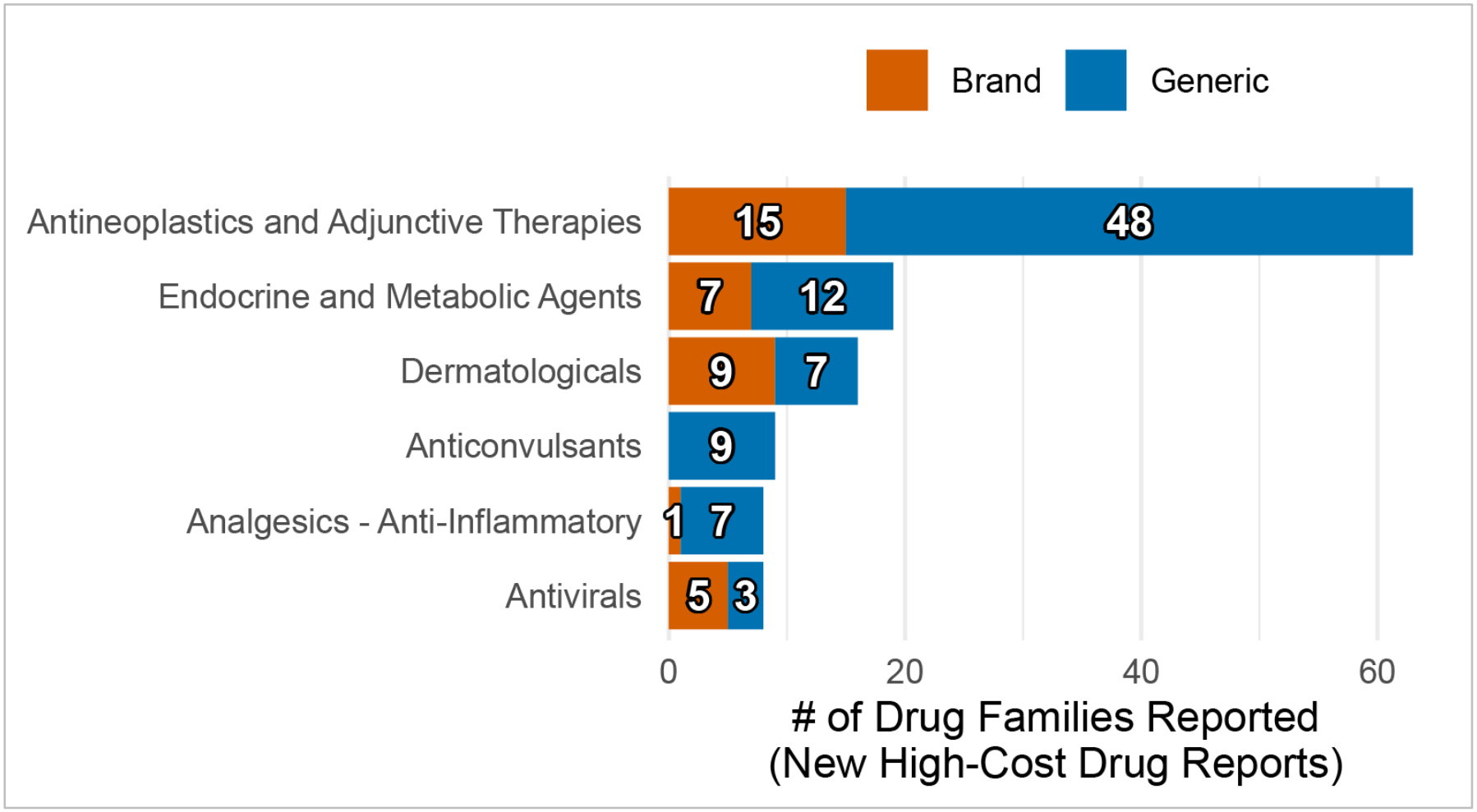
Annual price increase reports from manufacturers 2019-22



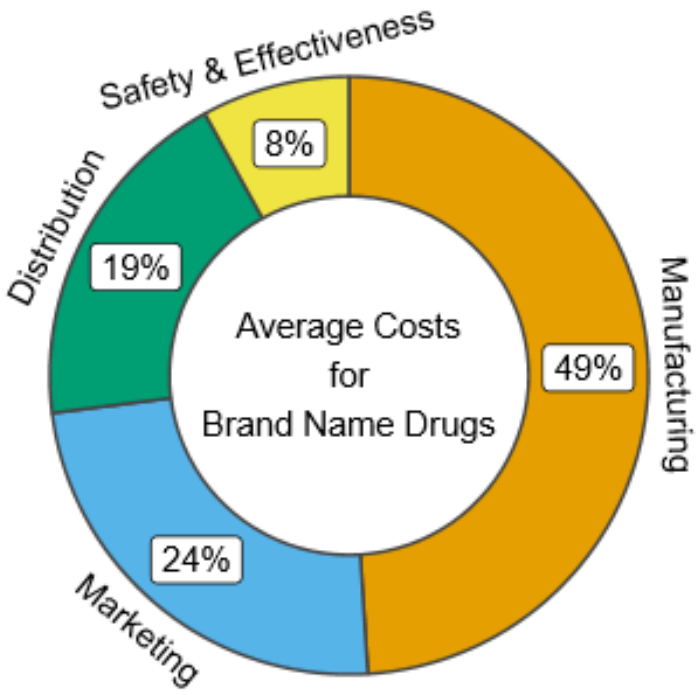
New prescription drug price increase reports 2019-22

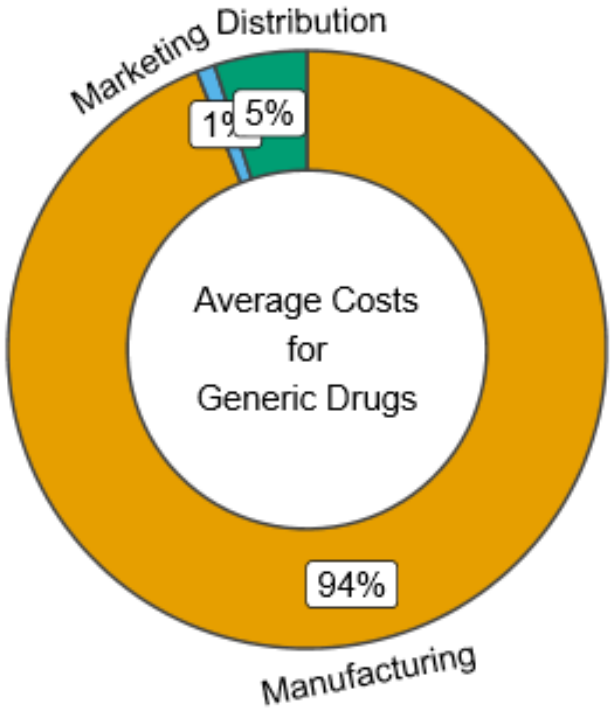


Distribution of new high cost drugs by common classes

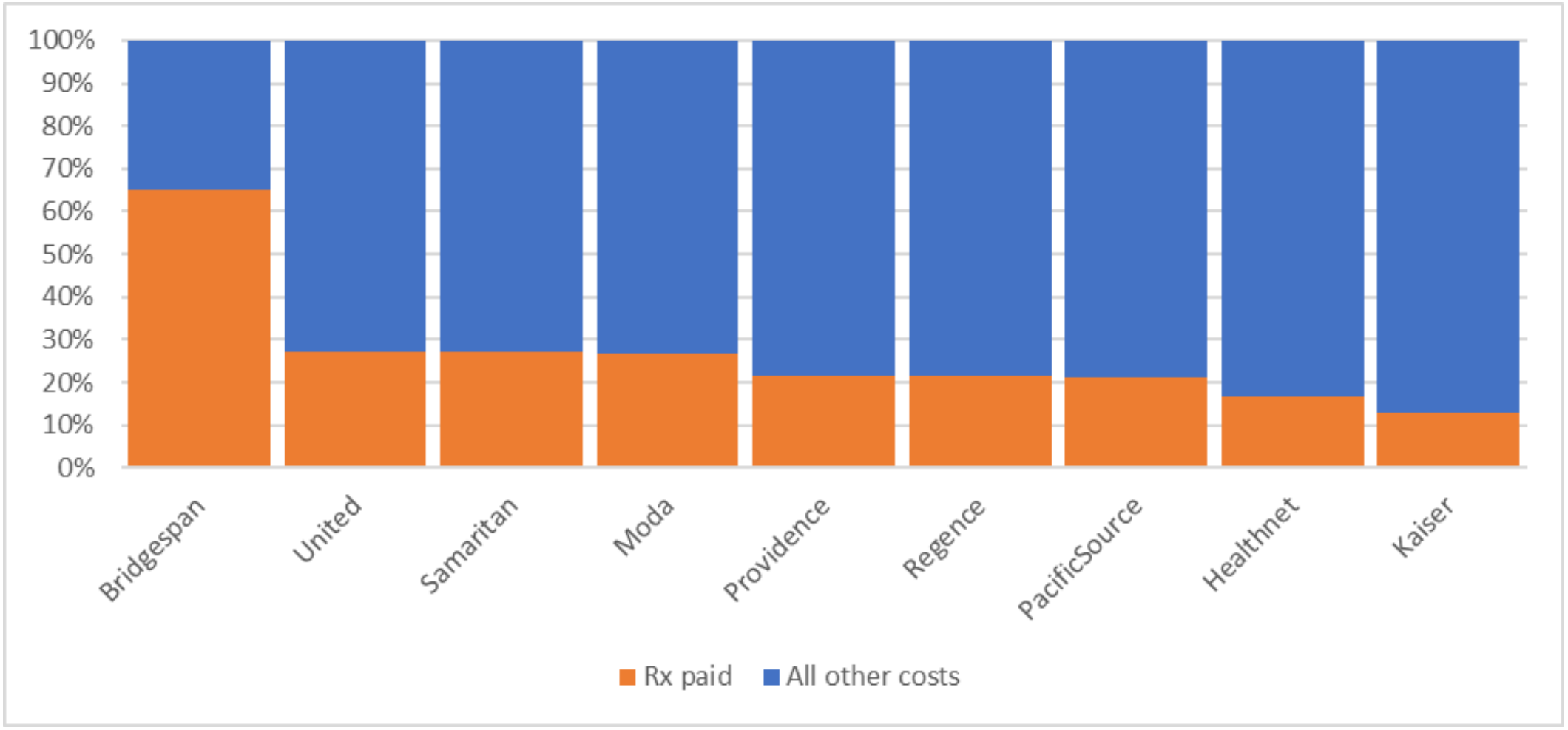


Direct cost averages from annual price increase reports

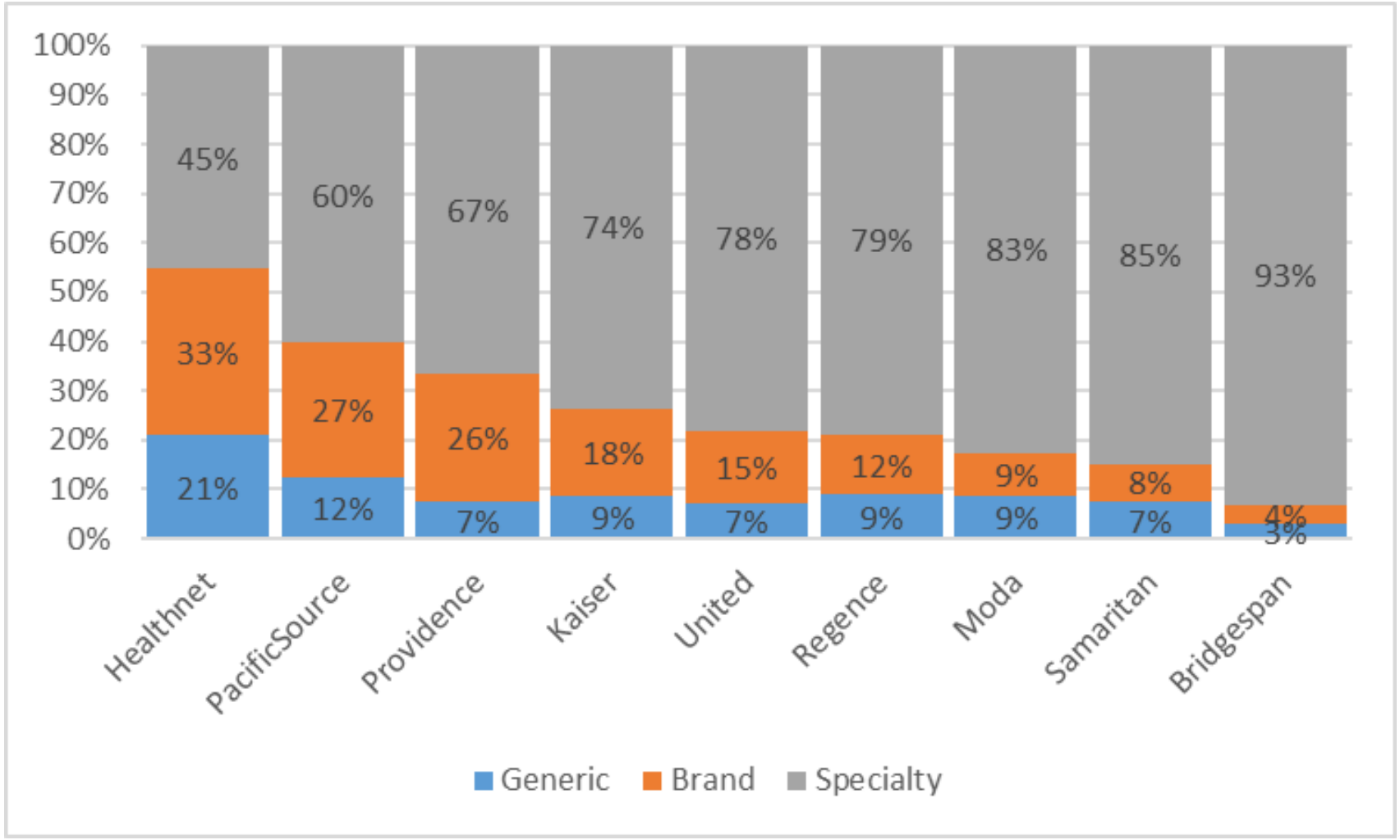




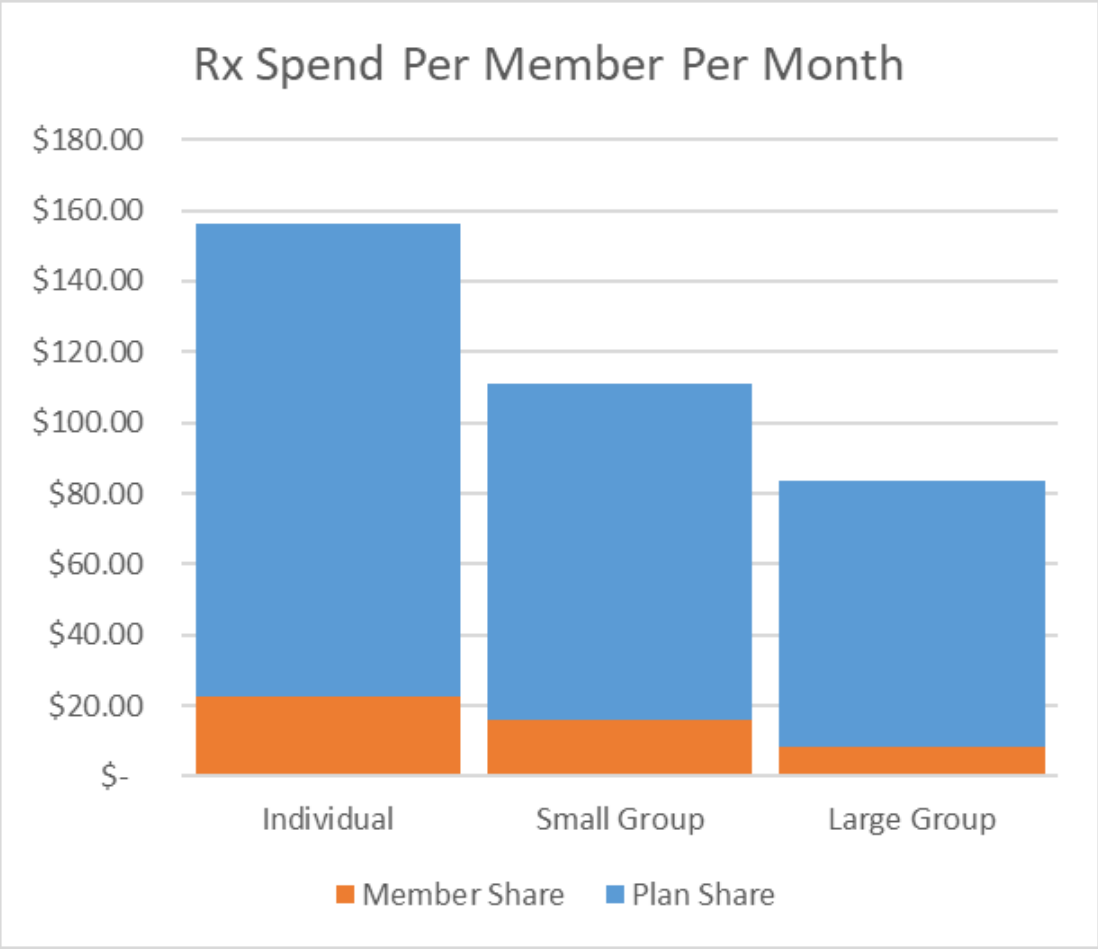
Plan spending on prescription drugs as a percentage of premium

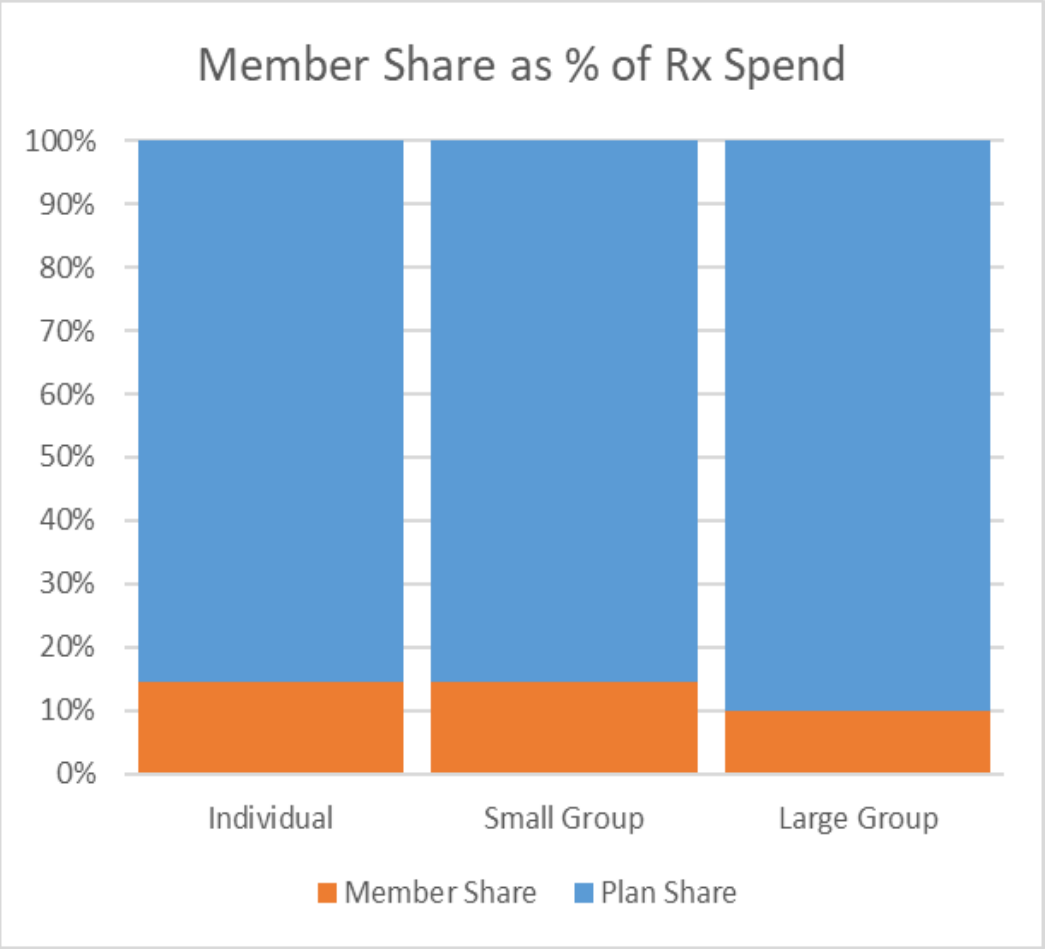


Plan spending on prescription drugs by drug category

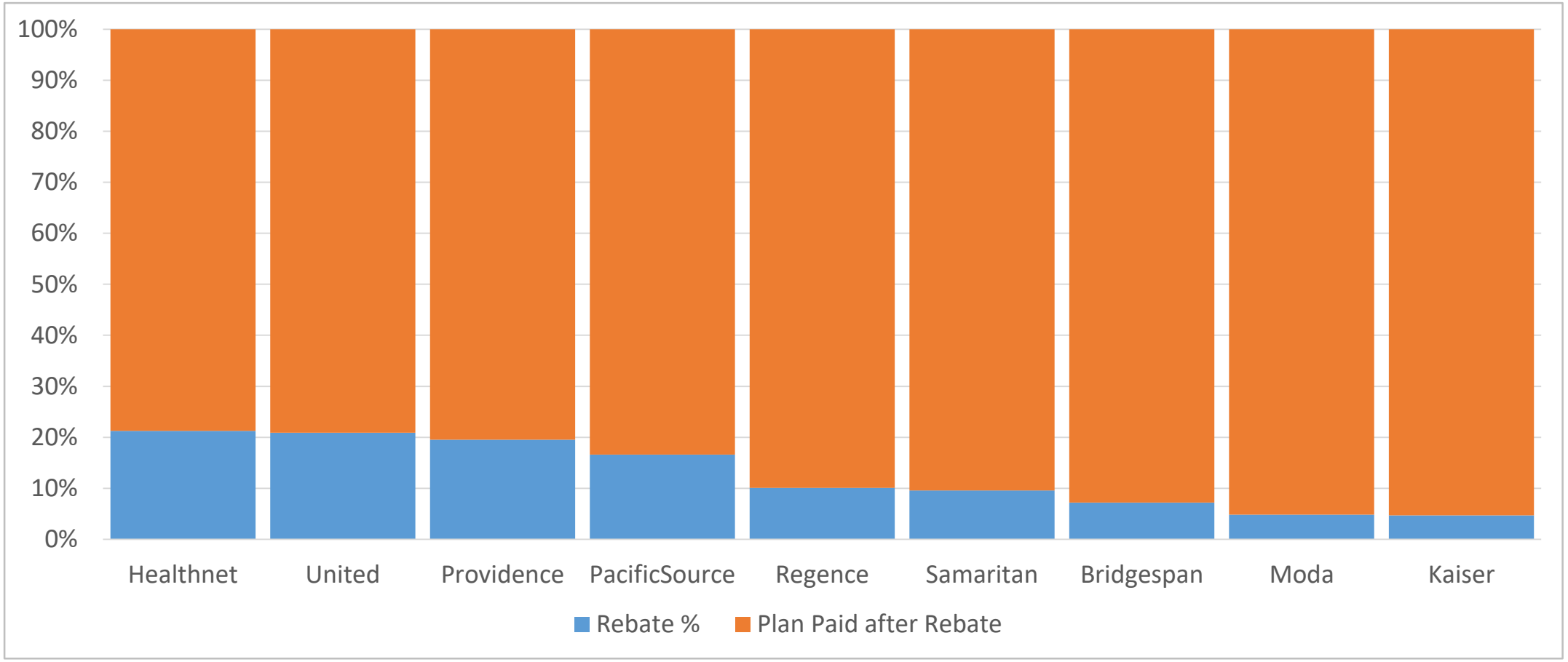


Consumer cost sharing as reported by insurers





Prescription drug rebates as a percentage of total drug spending



Most prescribed prescription drugs

Drug	Class	Prescriptions
COVID-19 (SARS-CoV-2) mRNA Virus Vaccine	Vaccines	537,155
Influenza Virus Vaccine	Vaccines	231,714
Atorvastatin Calcium (Lipitor & generics)	Antihyperlipidemics	194,032
Levothyroxine Sodium	Thyroid agents	191,047
Lisinopril	Antihypertensives	172,584
Bupropion HCl (Welbutrin & generics)	Antidepressants	144,690
Metformin HCl	Antidiabetics	140,073
Amphetamine-Dextroamphetamine (Adderall, Mydayis, & generics)	ADHD/anti-narcolepsy/anti-obesity/anorexiants	130,632
Escitalopram Oxalate (Lexapro & generics)	Antidepressants	117,177
Losartan Potassium	Antihypertensives	112,056

Most costly prescription drugs

Drug	Class	Total Allowed
Humira (Adalimumab)	Analgesics – anti-inflammatory	$76,966,470
Stelara (Ustekinumab)	Dermatologicals	$35,999,195
Enbrel (Etanercept)	Analgesics – anti-inflammatory	$28,675,010
Biktarvy (Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate)	Antivirals	$23,245,660
COVID-19 (SARS-CoV-2) mRNA Virus Vaccine (Includes both Moderna and Pfizer-BioNTech)	Vaccines	$20,679,117
Trikafta (Elexacaftor-Tezacaftor-Ivacaftor)	Respiratory agents	$17,964,545
Cosentyx (Secukinumab)	Dermatologicals	$17,770,873
Keytruda (Pembrolizumab)	Antineoplastics and adjunctive therapies	$16,463,259
Entyvio (Vedolizumab)	Gastrointestinal agents	$14,872,464
Ocrevus (Ocrelizumab)	Psychotherapeutic and neurological agents	$11,115,070

Prescription drugs with increased plan spending

Drug	Class	Year over year increase
COVID-19 (SARS-CoV-2) mRNA Virus Vaccine	Vaccines	$17,866,475
Stelara (Ustekinumab)	Dermatologicals	$7,623,454
Trikafta (Elexacaftor-Tezacaftor-Ivacaftor)	Respiratory agents	$4,906,302
Semaglutide (includes Ozempic, Rybelsus, Wegovy)	Antidiabetics	$3,092,976
Skyrizi (Risankizumab-rzaa)	Dermatologicals	$3,088,360
Keytruda (Pembrolizumab)	Antineoplastics and adjunctive therapies	$3,072,226
Ocrevus (Ocrelizumab)	Psychotherapeutic and neurological agents	$3,046,577
Emtricitabine-Tenofovir Disoproxil Fumarate (includes Truvada)	Antivirals	$2,848,130
Perjeta (Pertuzumab)	Antineoplastics and adjunctive therapies	$2,771,539
Revlimid (Lenalidomide)	Immunomodulators	$2,628,811

Policy recommendations

- Increase transparency of patient assistance programs
  - Require annual reporting on all patient assistance programs
- Expand insurer reports to additional markets
  - Include reporting from all health benefit plan issuers in Oregon instead of just individual and small group
- Require transparency for other supply chain entities (e.g. PBMs)
  - Add aggregated reporting requirements for PBMs
- Consider “upper payment limit” authority for PDAB
  - Explore opportunities for PDAB to set upper payment limits for state and local governments

Policy recommendations continued

- Study feasibility of state generic manufacturing and expanded bulk purchasing
  - Allow state to leverage bulk purchasing power
  - Explore uniform drug lists for all state programs and PBM services
  - Establish centralized office of pharmacy purchasing for coordination and oversight of all state purchasing
- Protect consumer information reported to DPT
  - Exempt a personally identifiable information from public disclosure
- Share Rx data between state agencies working on Rx pricing
  - Require data sharing to allow more collaboration

Questions?

Members of the public:
Use the chat window to sign up to give public testimony.

Program presenters:
Sofia Parra, program coordinator
Numi Rehfield-Griffith, senior policy advisor

First public comment period

Send written testimony to rx.prices@dcbs.oregon.gov

First panel – insulin prices

Presenters:

- Kris Vallecillo, JD, MPP (he/him), policy associate, National Academy for State Health Policy (NASHP)
- Wisam Younis, PharmD (she/her), clinical pharmacist client manager, Regence Blue Cross Blue Shield of Oregon
- Maribeth Guarino, JD (she/her), health care advocate at Oregon Student Public Interest Research Group (OSPIRG)
- Allan Coukell, BSc (pharmacy), senior vice president for public policy, Civica Rx

Presenter:

- Kris Vallecillo, JD, MPP, policy associate, National Academy for State Health Policy (NASHP)

State Action on Insulin Affordability & Access

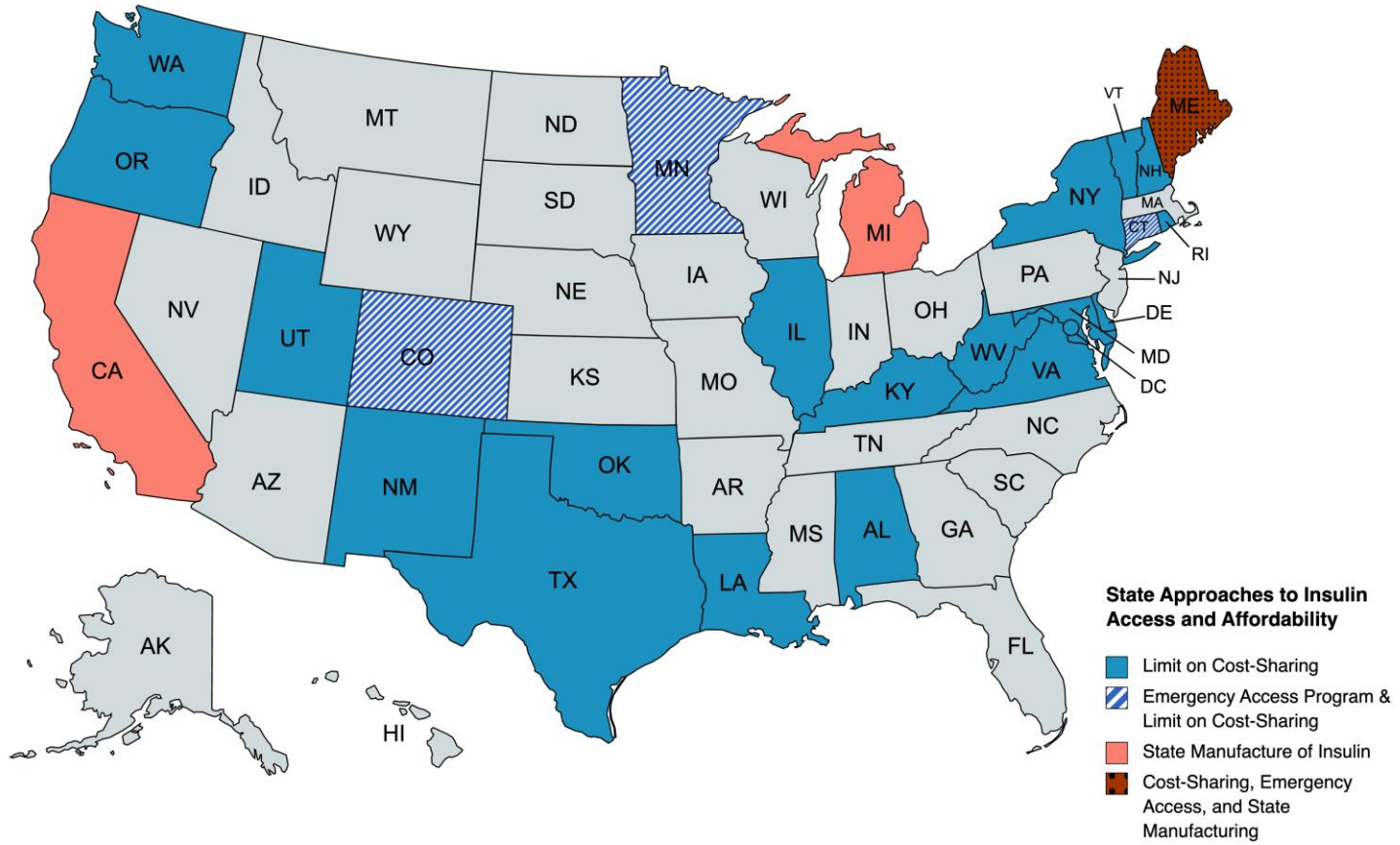
Oregon Annual Prescription Drug Price Transparency Hearing

December 1, 2022

Kris Vallecillo, Policy Associate

Current Landscape (Nov. 2022)

- Colorado was the first state to enact a cap on cost-sharing for insulin (2019).
- CA included $100 million in its FY23 budget to develop its in-state manufacturing plans.
- Washington established the Insulin Affordability Workgroup (2022) to devise purchasing strategies that reduce the cost and total expenditures on insulin.



Insulin Affordability & Access: State Options

- More than 37 million Americans have diabetes and about 31% take insulin to manage the condition.
- Despite being discovered more than a century ago, insulin prices continue to rise, creating affordability challenges for patients and state/local budgets.
- States have a variety of strategies to improve affordability and ensure access:
  - Caps on cost-sharing requirements
  - Emergency access & safety net programs
  - State-directed or contracted manufacturing of insulin

Insulin Affordability & Access: Limits on Cost-Sharing

- Influence plan design and direct insurers to cap cost-sharing requirements.
- At least 22 states have implemented such a cap, ranging from $100 to $35 per month.
- Provides relief at the point of purchase, where many patients face affordability challenges.
- Additional strategies needed for the uninsured, underinsured, and ERISA beneficiaries, and to address the rise of insulin prices.

Insulin Affordability & Access: Emergency Access & Safety Net Programs

- Provides emergency supply of insulin and offers a stable long-term supply of affordable insulin for uninsured and underinsured patients.
- At least five states have created such a program — CO, CT, ME, MN, & UT
  - Utah's Insulin Savings Program allows consumers to purchase insulin at post-rebate price but does not offer an emergency access component.
- Emergency access:
  - Provide one-time, 30-day supply at a capped copay.
  - Can be needs-based or without application.
  - Manufacturers required to either refund the pharmacy or replace the supply.

Insulin Affordability & Access: Emergency Access & Safety Net Programs

Source: MN Insulin Safety Net Program

- Long-term need:
  - Requires manufacturers to provide insulin to eligible individuals for up to one year.
  - Needs-based and typically requires patients to complete simple application.
  - States can leverage patient assistance programs for those with insurance.
- Manufacturers have challenged these programs as unconstitutional takings.

Insulin Affordability & Access: State Manufacturing of Insulin

- The CalRx initiative empowers the state to develop generic drugs and sell them at low costs, targeting insulin first.
- Other states are exploring the topic.
  - Governor Whitmer (MI) recently signed E.O. for that state to study whether it should adopt a similar program.
  - Maine passed legislation in 2022 to create a commission to assess whether the state has the resources to manufacture its own insulin.
- Direct state investment in manufacturing insulin and other drug products is a novel strategy for states.

Contact Information & Resources

Please feel free to contact either Kris Vallecillo (kvallecillo@nashp.org) or Jennifer Reck (jreck@nashp.org) with any questions.

- NASHP Legislative Tracker
- NASHP Prescription Drug Center's Model Legislation
- The IRA's Health Care Provisions: Opportunities for States

Presenter:

- Wisam Younis, PharmD, clinical pharmacist client manager, Regence Blue Cross Blue Shield of Oregon

Insulin Costs

A payer's perspective

Wisam Younis, PharmD

Clinical Pharmacist Client Manager

Regence BlueCross BlueShield of Oregon

Why are insulin prices still high?

- Insulin is a biologic
- There are no “generics” for insulin, but rather biosimilars (brand drugs)
- Uphill battle for biosimilars:
  - Identifying a pathway for FDA approval
  - Gaining adoption
- Some headway since first biosimilar approval 9 years ago:
  - Established pathway for FDA approval – litigation continues to slow market entry
  - Providers gaining comfort with their use
  - Increased biosimilar innovation, market entry and competition
  - Payers (health plans) adopting biosimilars as preferred products
- Drug manufacturers beginning to moderate list price increases due to public and legislative pressure

How payers address insulin affordability

- Meeting state mandate insulin copay/cost share caps (at a minimum)

- Offering benefit designs that bypass deductibles and/or low copays
  - Plans or employer groups may offer benefit designs that offer certain drugs for chronic conditions (that include certain insulins), enhanced benefits

- Moving to biosimilars when cost is as good or better than innovator products
  - First biosimilar interchangeable insulin available late 2021
  - Requires robust member, provider, manufacturer communication plan to switch insulins

We still have an underlying problem…

- These strategies do not address the cost of insulin to the overall health system
- Employer groups consume a greater burden
- Lower member cost shares lead to increased premiums
- Narrow focus that does not address broader issue of overall drug costs and access
    - Members on insulin have a complicated disease with multiple co-morbidities

Presenter:

- Maribeth Guarino, JD, health care advocate at Oregon Student Public Interest Research Group (OSPIRG)

Prescription Drug Price Transparency Hearing

December 1, 2022
Maribeth Guarino, OSPIRG

Cameron L.

I'm a 24 year old living in Newport, Oregon. When I was 13 I was diagnosed with Type 1 diabetes and it was immediately apparent that this disease not only affects you physically, but also financially. Growing up, the cost of my insulin has caused situations where I've cut out meals or rationed out my remaining store because we didn't have enough money to pay for the next month's worth. Now that I've moved out, I'm already living paycheck to paycheck with a full time 40 hours a week job, and another job I take shifts for on the weekends. And I still can't afford my insulin. I have to rely on my parents to buy it for me. It's terrifying to me knowing I work sometimes 56 hours a week, and still can't afford insulin for myself.

Riley L.

I have 2 sisters that have type 1 diabetes. They both were diagnosed at very young ages. My oldest sister was diagnosed at age 3, so she’s been on insulin for 21 years now. I know that the insulin they are on costs about $4 to make, but were charged $300 for it. Since my family has two people that use it, it only lasts around 2 weeks. Even with insurance, it’s $300 multiple times per month for over 20 years.

Let’s do some math

$300/month x 12 months/year = $3600/year

*Doesn’t account for premiums, other health care needs

Assuming life expectancy is about 75 years and a diagnosis at 13:

$3600/year x 62 years = $223,000 over a lifetime

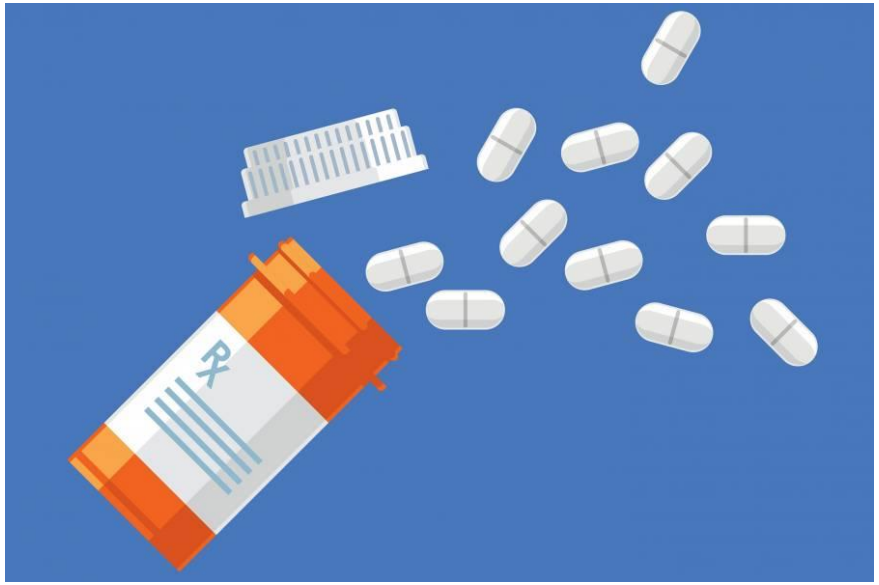
*Doesn’t account for inflation, rising costs

Recent progress

- PDAB, SB 844 (2021) to review affordability of 1 insulin product/year
- HB 2623 (2022) to cap monthly insulin co-pays at $75/month
- Inflation Reduction Act to cap monthly insulin co-pays at $35/month for Medicare

Where do we go from here?

- Empowering entities to lower costs
- Preventing price gouging
- Enforcing reporting and transparency requirements
- Using data responsibly to identify problem areas and solutions



Questions?

Contact:
Maribeth Guarino, Health Care Advocate
mguarino@ospirg.org

Presenter:

- Allan Coukell, BSc (pharmacy), senior vice president for public policy, Civica Rx

Civica Rx: Quality Generic Medicines at Sustainable Prices

Oregon Drug Price Transparency Hearing
Allan Coukell, SVP Public Policy, Civica
01 Dec 2022

CIVICA®

Civica's Mission

Make quality generic medications available and affordable to everyone.

"Do what is in the best interest of patients"

Civica Today

Serving in the public interest as a **non-stock, non-profit** 501(c)(4) corporation to address shortages of generic drugs while lowering their cost

Founded by **7 health systems** concerned about generic drug shortages, and **3 philanthropic members** passionate about improving healthcare

Committed to transparency, **a one-price-for all model**, and its membership is open to all

55+ Health Systems Members

>1,400 Hospitals

1/3 of U.S. licensed beds

68 Medicines

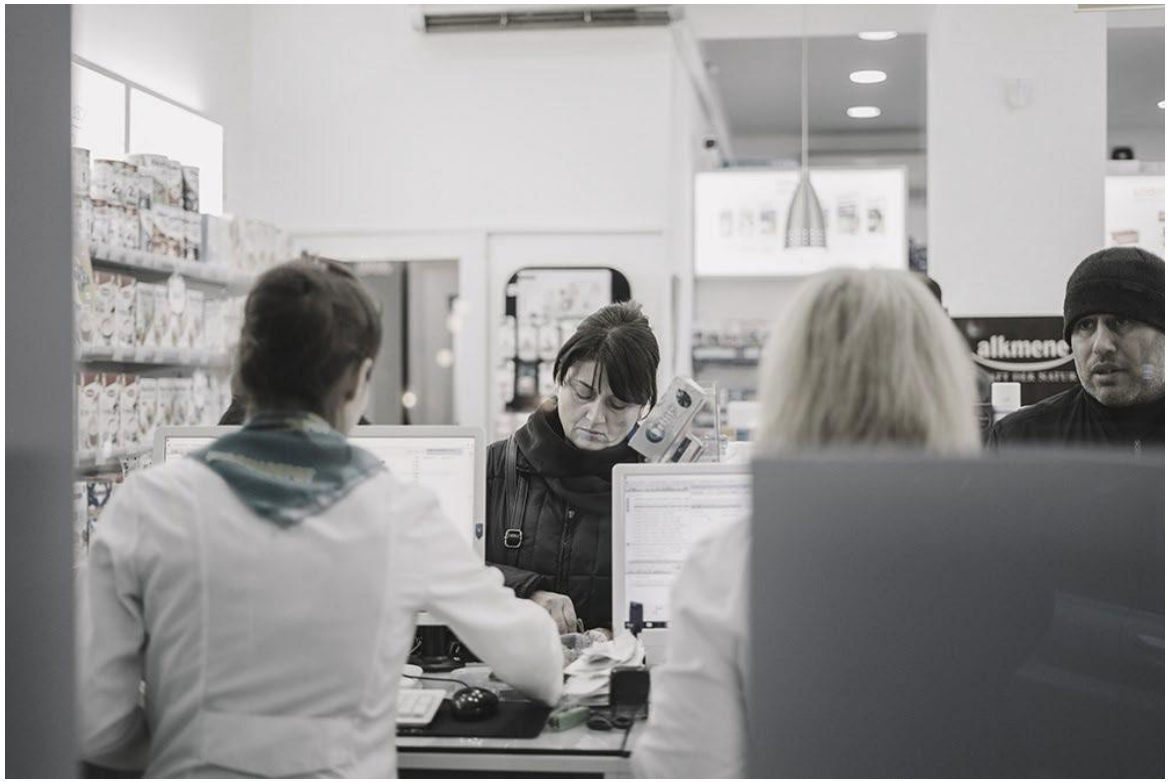
100M Vials for **40M** Patients

Long-term contracts	**Redundant suppliers**	**Strategic stockpiles (Safety Stock)**	**Emphasis on U.S. manufacturing**	**“One price” model**

Expanding the mission: Lowering Costs for High-priced Generics at the Pharmacy Counter

CIVICASCRIPT

With BCBS companies and Anthem, we've created a new entity that is open to other health plans, employers, retailers and other health care innovators who will pass along savings to consumers.



Insulin 1921 - 2021 Celebrating 100 Years

Drs. Frederick Banting and Charles Best*

A discovery of the **life-sustaining liquid** that would transform diabetes from a death sentence into a manageable condition for millions worldwide.*

Heartbreaking Reality

Today, the out-of-pocket cost of Insulin in the U.S. is often $1000 a month.

Some patients are forced to ration, even to the point of death. It's a fact that would "have Banting and Best rolling over in their graves."*

*Healthline.com

Millions of Americans require insulin to manage their diabetes, and some are forced to make painful tradeoffs because of pervasively high costs.

"I began to eat less to make my insulin last longer."*

Sa'ra:, insulin user

25%

OF PATIENTS IN ONE STUDY SKIPPED OR TOOK SMALLER DOSES THAN PRESCRIBED DUE TO HIGH INSULIN COST

"We're told if you don't take care of yourself, you're going to lose your eyesight or lose a kidney…in reality, the biggest fear that we have is not being able to afford insulin, which is the only thing that keeps us alive."*

Gail, person with Type 1 diabetes*

*Insulin's deadly cost: Ultrahigh prices in the U.S. mean many diabetics can't afford the medication they need to survive; *Fortune* Dec. 6, 2021

“Nonprofit Civica goes after insulin prices in a big way, prepping for $30 vials by 2024”

-Endpoints News

- ~$125M development cost
  - Clinical trials
  - Pen delivery device
  - Drug substance partner
  - Capital investments
- Contributions from >25 funders
  - Diabetes organizations
  - Health plans
  - Health systems
  - Foundations
  - Individuals

“ The Civica Insulin Development Project is a tremendous step forward to make insulin accessible for all, regardless of insurance status, and address a national crisis. JDRF is firm in its stance that people with insulin-dependent diabetes should not have to choose between food and shelter or life-saving medicine because of its cost. This project will make a real difference for millions of Americans, including those living with T1D, and we are proud to support it.

Aaron Kowalski, Ph. D., CEO

JDRF

What are we doing?

- Civica will develop, manufacture and distribute insulins at significantly lower prices than insulins currently on the market.
- Civica will produce three interchangeable insulins:
  - glargine (Lantus)
  - lispro (Humalog)
  - aspart (Novalog)
- Each will be available both in vials and prefilled pens, with the first product to market in 2024

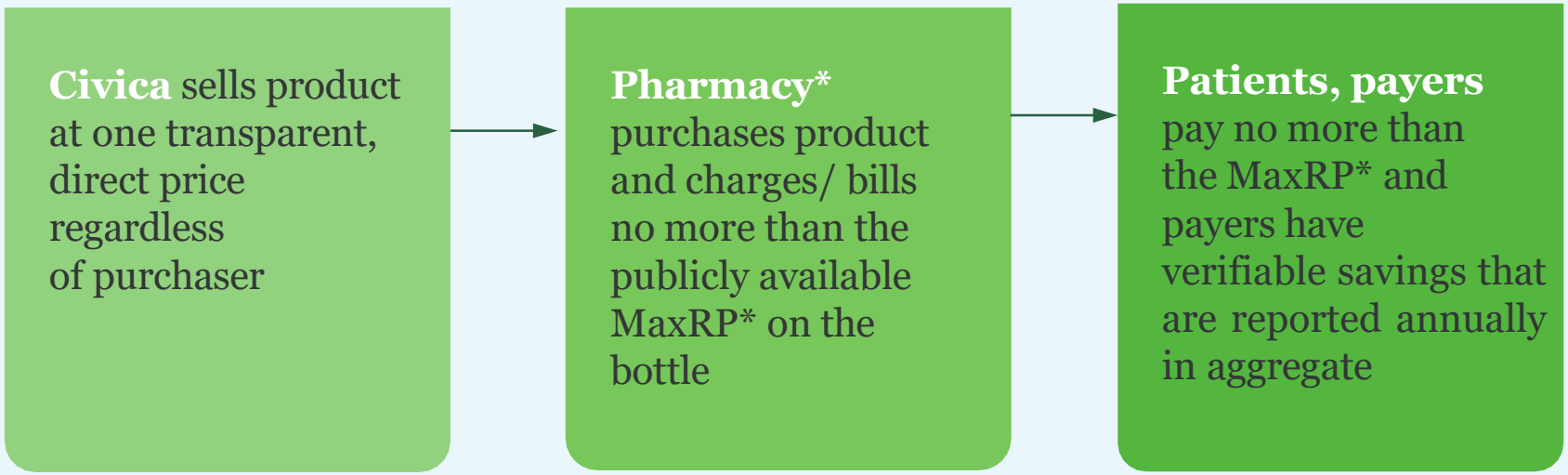
The proof is in the pricing

	ESTIMATED PRICE FOR UNINSURED[4]	CIVICA INSULIN RECOMMENDED PRICE[5]	AVERAGE SAVINGS
 Vial	$329	NO MORE THAN $30	90%
 Box of five pen cartridges	$510	NO MORE THAN $55	90%

1JAMA, Cost-Related Insulin Underuse Among Patients with Diabetes, 2019; CDC NHIS Study, 2020.; 2CDC, 2020 National Diabetes Statistics Report; NCBI, Diabetes in America.; 3Contingent on FDA approval, Civica anticipates that the first insulin (glargine) will be available for purchase as soon as early 2024.; 4Based on Average Wholesale Price of lowest-price reference insulin product.; 5CivicaScript's policy for pharmacies and other distributors who choose to distribute Civica insulins reflects its philosophy that prices to consumers should be fair, reasonable and transparent, and be no more than the public, recommended price.

CivicaScript's transparent, cost-plus distribution path

The Civica model has no rebates or other hidden price concessions in the pharmaceutical distribution channel.



*Available to any pharmacy that will abide by our MaxRP

*MaxRP (maximum retail price) is CivicaScript's maximum recommended price to the consumer and is designed to fulfill the CivicaScript mission to offer low-cost pharmaceuticals to patients.

Relationship to state & federal efforts

- Complementary to state and federal out-of-pocket caps
- Complementary to other Inflation Reduction changes in Medicare
- Opportunity for other states to help transform the insulin market

www.CivicaInsulin.org

Support from Leading Advocates to Reduce Cost of Insulin

Arnold Ventures

Beyond Type 1

BlueCross BlueShield

Gary & Mary West Foundation

Glen Tullman Family Foundation

Intermountain Healthcare

JDRF

Kaiser Permanente

Nomi Health

Peter G. Peterson Foundation

Providence

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Transcarent

Trinity Health

CIVICA®

- Quality
- Supply
- Sustainability

Questions for presenters?

- Kris Vallecillo, JD, MPP, policy associate, National Academy for State Health Policy (NASHP)
- Wisam Younis, PharmD, clinical pharmacist client manager, Regence Blue Cross Blue Shield of Oregon
- Maribeth Guarino, JD, health care advocate at Oregon Student Public Interest Research Group (OSPIRG)
- Allan Coukell, BSc (pharmacy), senior vice president for public policy, Civica Rx

Second panel – supply chain and PBM rebate transparency

Presenters:

- Tonia Sorrell-Neal (she/her), senior director state affairs for Oregon, Taft-Hartley plan employer trustee, Pharmaceutical Care Management Association (PCMA)
- Dharia McGrew, PhD (she/her), director, state policy at PhRMA
- Leah Lindahl (she/her), senior director, state government affairs, Healthcare Distribution Alliance (HDA)
- Kevin Russell, RPh, MBA, BCACP, director, Prescryptive Pharmacy, Redmond Oregon, Central Oregon director – Oregon State Pharmacy Association

Presenter:

- Tonia Sorrell-Neal, senior director state affairs for Oregon, Taft-Hartley plan employer trustee, Pharmaceutical Care Management Association (PCMA)

PBMs and Your Care

This presentation will explain the role of PBMs in healthcare

Tonia Sorrell-Neal

PCMA Sr. Director, State Affairs

Tonia

Healthcare Trustee & PCMA Staff

- 15 years plan decision-maker
- Employer representative
- Always fighting for your choice

LIVES WITH HIGH CHOLESTEROL

access to affordable medications

A Pharmacy Benefit Manager

Leverages pharmacy expertise & scale to lower prescription drug costs.

Promotes competition to counterbalance drug manufacturers' high prices

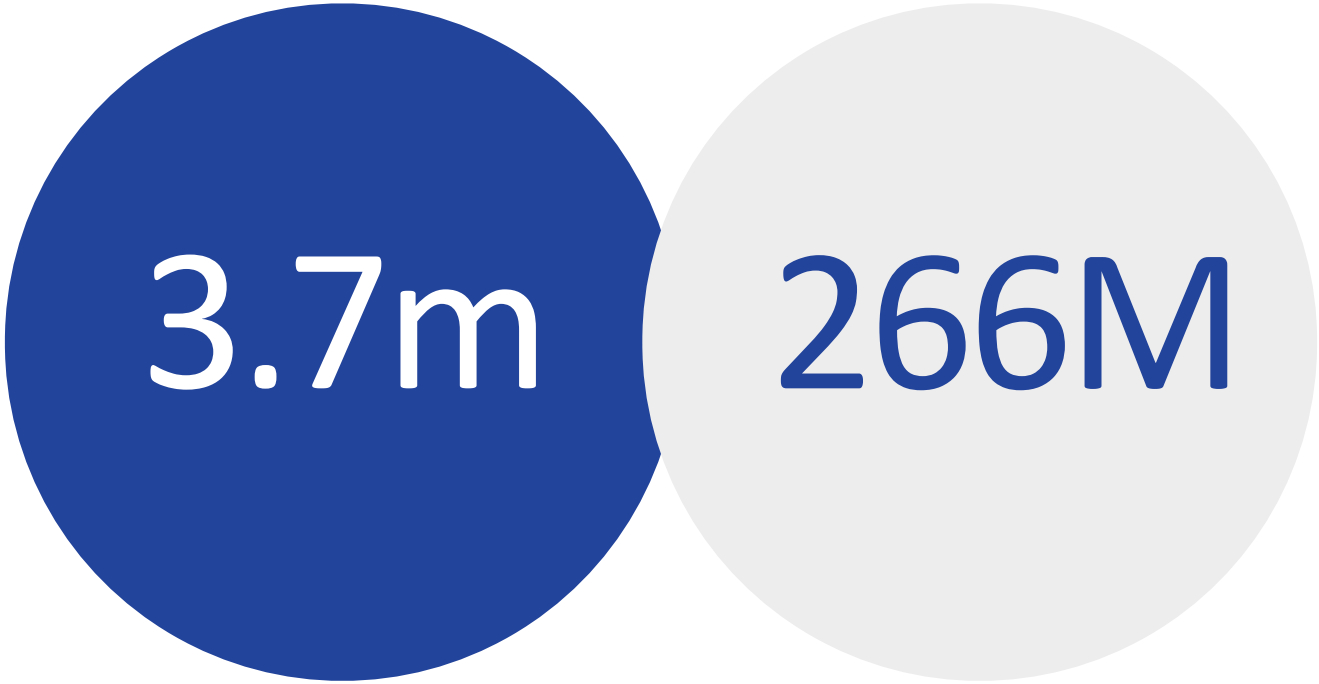
Encourage the use of more affordable prescription drug alternatives, like generics and biosimilars.

Experts in pharmacy business and insurance

Who we do not work for

pharmacies or drug manufacturers

Who do we work for?



Oregonians

Americans

Who

state of Oregon employees
labor unions
trade associations
teacher’s unions
utility companies
firefighters
retail & restaurant employees
mom and pop in every Oregon community

Ask your health plan sponsor, who your PBM is.

what do we do for all those people

- Improve drug safety
- Negotiate for patient affordability
- Drive innovation & competition
- Create aps and IT solutions to make it easier for patients to get the correct medication
- Support you in hitting your goals.

How

PBMs utilize tools to provide employers choices that help them provide affordable, quality prescription drug coverage for their employees – the patients.

Tools

mail delivery

Making it easy for patients to get their medications through programs like mail delivery and 90-day fills

keeping the conversation on the patient

keeping premiums low, educating on drug options, and pharmacy network options

knowing the patient

Making it easy for patients to know when and how to take the correct medicine

providing pharmacy expertise

PBMs employ specialists in pharmacy, business and insurance including pharmacists.

bulk purchasing

PBMs can bring volume to manufacturers which helps lower the price.

rebates

Keep premiums low as not all drugs have alternatives available.

prescription drug formularies

A customized list of prescription drugs approved by your plan sponsor.

pharmacy & therapeutic Committees

Selecting the right drug for the right diagnosis, at the right time is a key factor in driving efficient, high-quality health care.

The world without PBMs

Without management of prescription drug benefit, 40–50% more in costs.

–Less utilization of generic drugs
–No competition between drug manufacturers
–No quality controls in the pharmacy environment
–No auditing for fraud, waste, and abuse
–No utilization controls to increase adherence
–Paper claims, longer claims processing times

Visante, The Return on Investment (ROI) on PBM Services. (February 2020

Do you have any questions?

Feel free to reach out!

www.pcmanet.org

www.onyoursiderx.com

Tonia Sorrell-Neal

tsorrell-neal@pcmanet.org

Presenter:

- Dharia McGrew, PhD, director, state policy at PhRMA

Prescription Medicine: Costs in Context

Oregon Drug Price Transparency Public Hearing

Dec 1, 2022

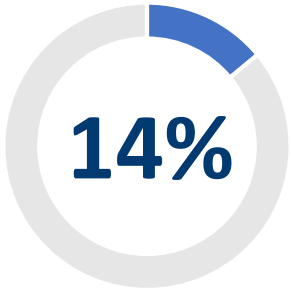
Dharia McGrew, PhD

Director, State Policy

dmcgrew@phrma.org

Spending on Medicines Is a Small and Stable Share of Total Health Care Spending

Prescription medicines account for just

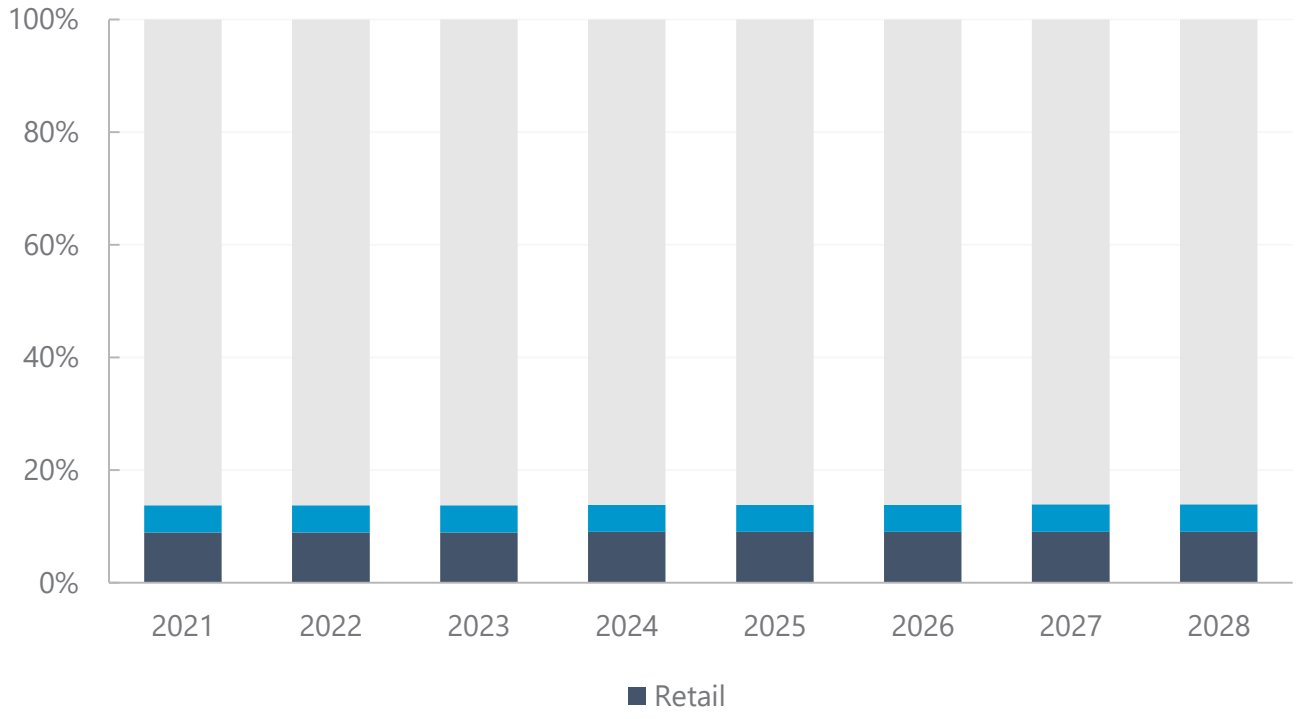


of total health care spending

In 2021, per capita spending on medicines* *declined* by

1%

Projected US Health Care Expenditures Attributable to Retail and Nonretail Prescription Medicines, 2021-2028

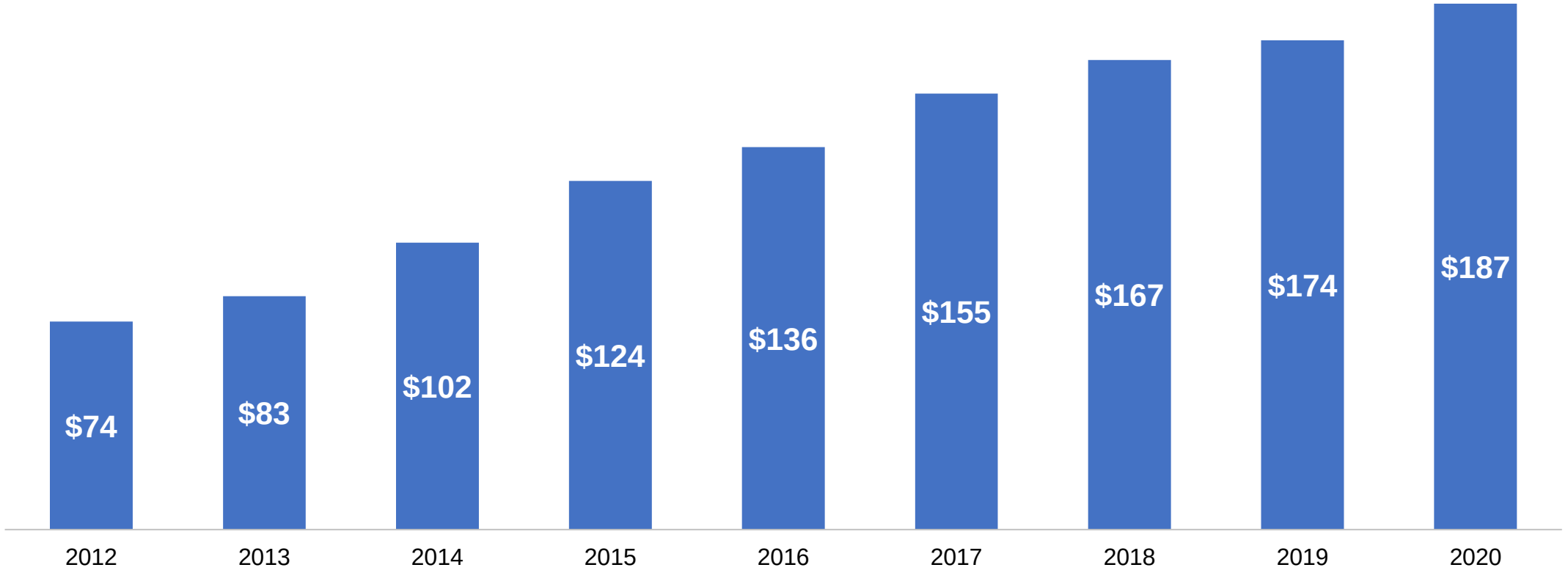


* Excludes spending on COVID-19 vaccines and treatments
Source: Altarum, IQVIA, 2022.

Note: Nonretail prescription medicines are those purchased through physicians' offices, clinics and hospitals and are typically administered to the patient by the provider. Retail prescription medicines are those filled at retail pharmacies or through mail service.

Rebates and Other Manufacturer Price Concessions Have More Than Doubled Since 2012

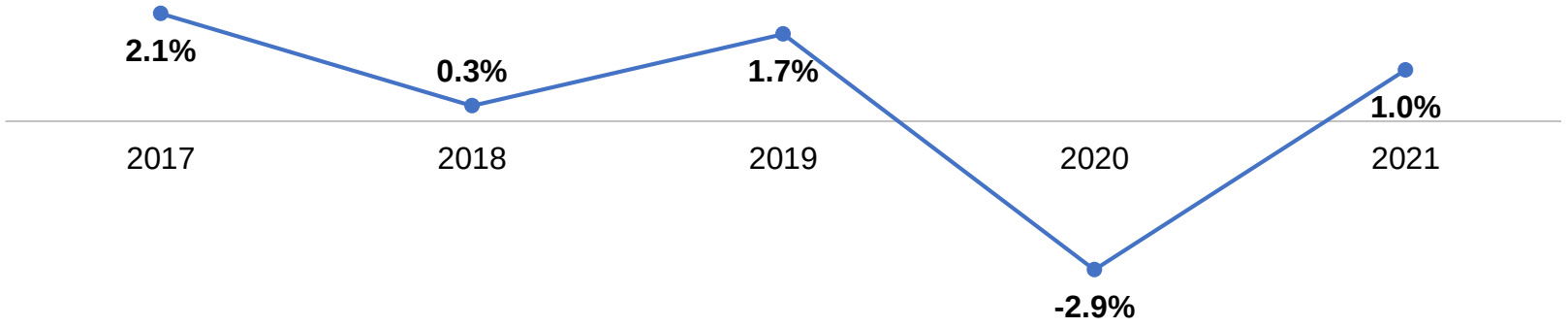
Total Value of Manufacturers' Gross-to-Net Reductions ($B), 2012-2020



Note: Among single-source brand medicines. Price concessions include fees and other manufacturer discounts.
Source: Fein, A. "The 2021 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute. March 2021.

Net Prices for Brand Medicines Have Stayed Nearly Flat For The Past Five Years

Average Net Price Growth for Brand Medicines, 2017-2021



On average, a brand medicine's net price is

49%

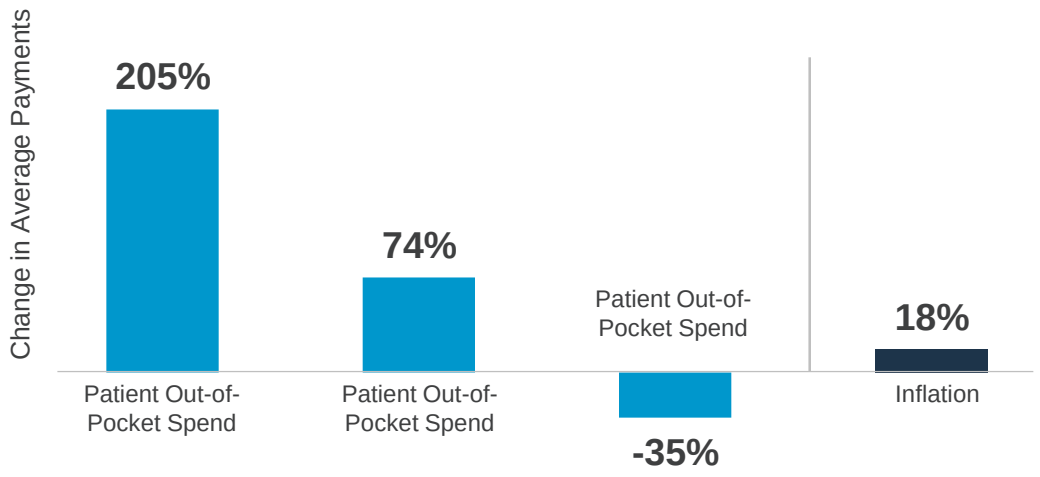
lower than its list price.

Source: IQVIA, 2022.

Patient Cost Sharing is Increasingly Tied to List Prices through Coinsurance and Deductibles

Patient Spending Rises as Plans Use More Deductibles and Coinsurance

Change Among Large Employer Health Plans, 2007-2017

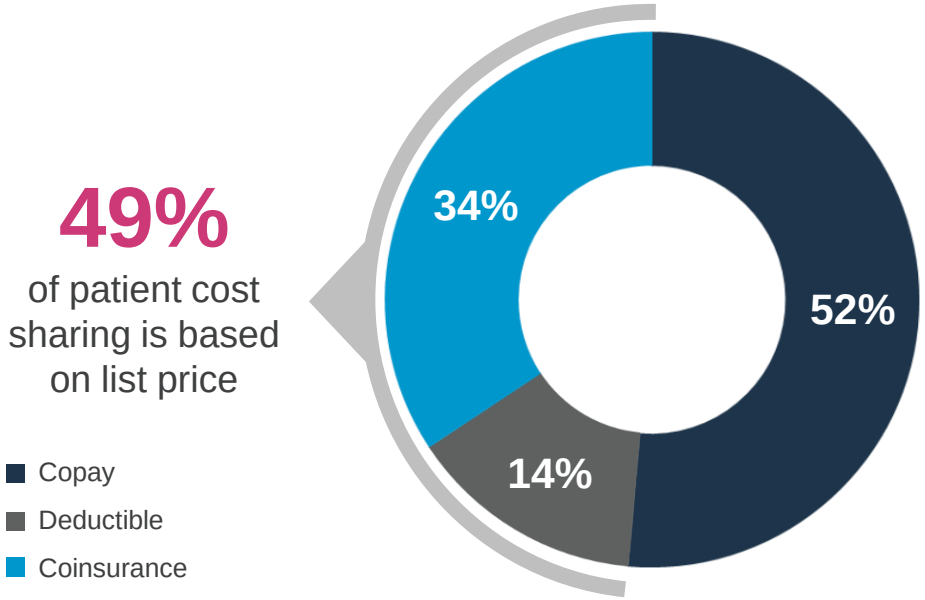


Source: Peterson Center on Healthcare and Kaiser Family Foundation. Tracking the rise in premium contributions and cost-sharing for families with large employer coverage. August 2019.

More Than Half of Commercially Insured Patients' Cost Sharing For Brand Medicines is Based on the Undiscounted List Price

49%

of patient cost sharing is based on list price



Source: IQVIA Institute for Human Data Science. Medicine spending and affordability in the United States. August 2020.

Vertical Consolidation in PBM Market

1. Cigna partners with providers via its Cigna Collaborative Care program. However, Cigna does not directly own healthcare providers.
2. AllianceRx Walgreens Prime is jointly owned by Prime Therapeutics and Walgreens Boots Alliance.
3. Since 2020, Prime sources formulary rebates via Ascent Health Services. In 2021, Humana began sourcing formulary rebates via Ascent Health Services for its commercial plans.

Source: Drug Channels Institute research; Companies are listed alphabetically by insurer name.

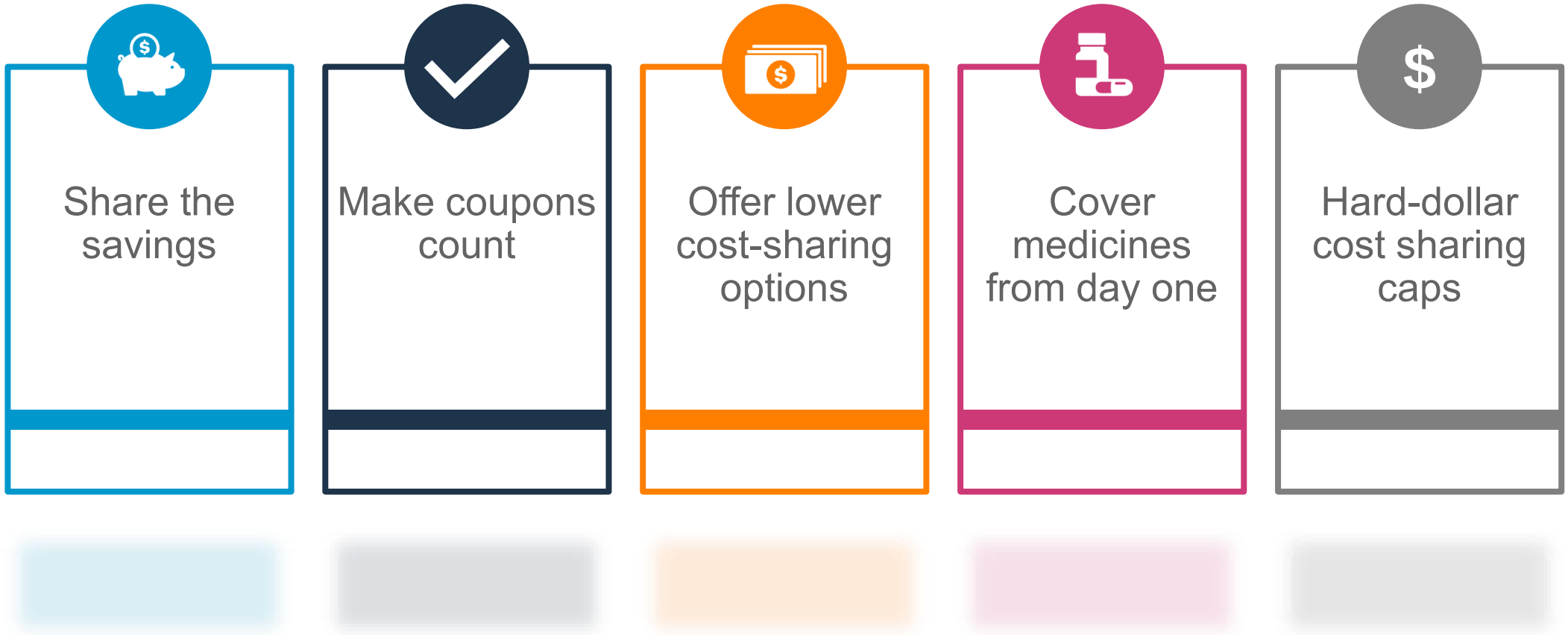
This chart appears as Exhibit 210 in *The 2021 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*. Available at http://drugch.nl/pharmacy

DRUG CHANNELS INSTITUTE

March 2021

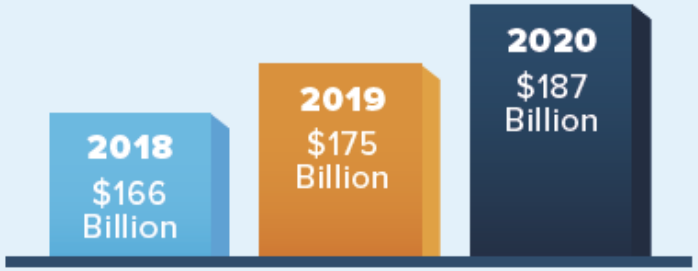
PhRMA RESEARCH • PROGRESS • HOPE

Policies That Help *Patients Pay Less*



Sharing Negotiated Discounts Could Save Some Patients Almost $1000 Annually and May Only Increase Member Premiums About 0.6 Percent.

Negotiation between biopharmaceutical companies and pharmacy benefit managers/health insurers results in significant rebates.



Legislation to require insurers and pharmacy benefit managers to share negotiated discounts and rebates at the pharmacy counter could save some patients **$900+ annually**.

Sharing all of the negotiated rebates with patients may increase member premiums **0.6 percent or less**.

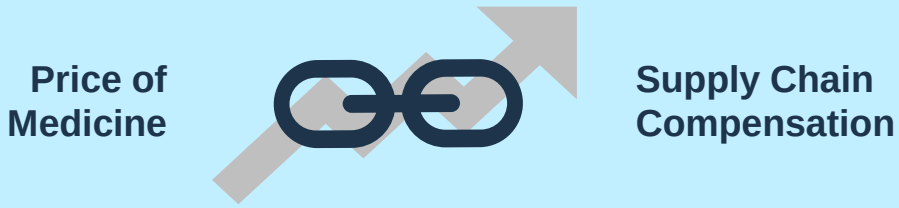
Source: Milliman. Measuring the Impact of Point-of-Sale Rebates on the Commercial Health Insurance Market. July 2021. https://www.milliman.com/-/media/milliman/pdfs/2021-articles/7-6-21-measuring-the-impact-of-point-of-sale-rebates.ashx

“Delinking” Supply Chain Compensation From the Price of Medicines Would Better Align Incentives in the System

Rather than receiving compensation based on the price of a medicine, supply chain entities should receive a flat fee based on the services they provide.

Today: Current System

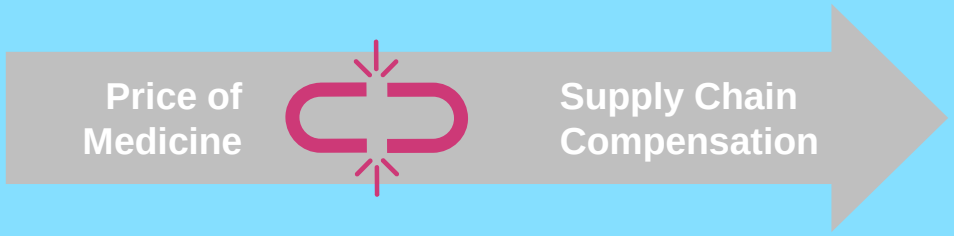
Compensation for supply chain entities is often tied to the price of a medicine.



When the price of a medicine goes up, supply chain payments go up.

Tomorrow: With “Delinking” Reforms

Supply chain members receive flat fees based on the services they provide.



No relationship between supply chain compensation and the price of a medicine.

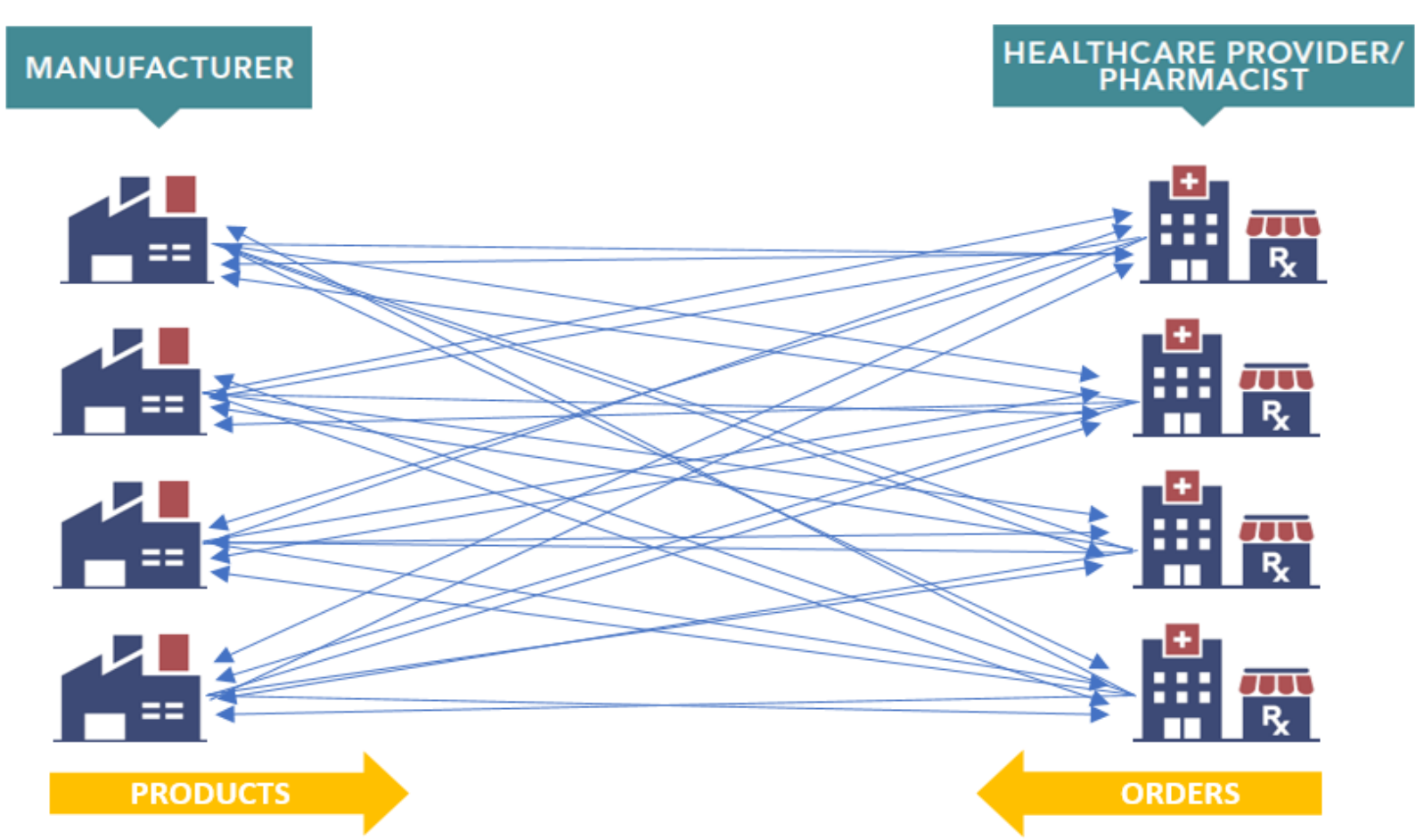
Presenter:

- Leah Lindahl, senior director, state government affairs, Healthcare Distribution Alliance (HDA)

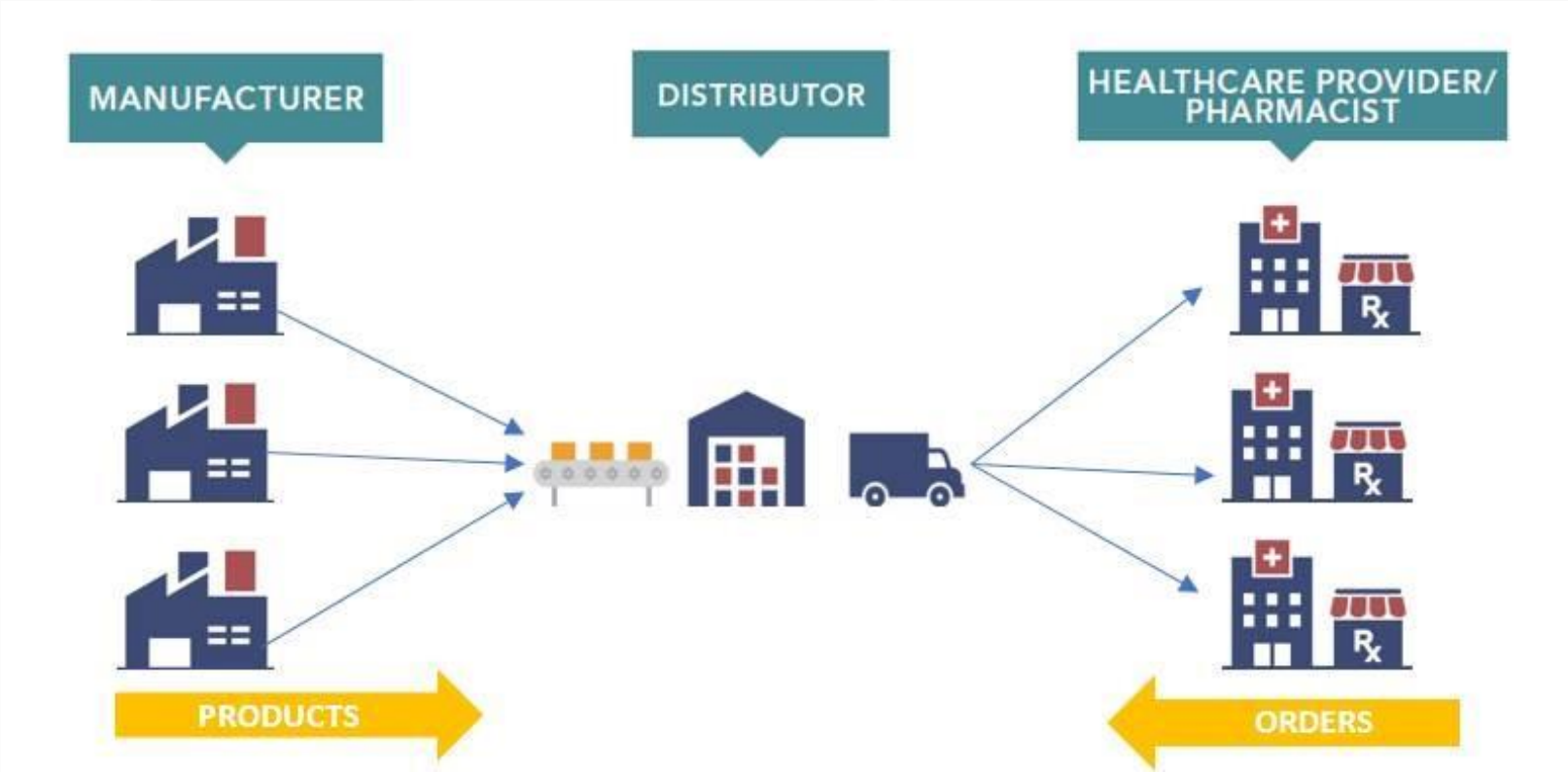
THE ROLE OF A WHOLESALE DISTRIBUTOR

Leah Lindahl
Senior Director, State Government Affairs
Healthcare Distribution Alliance
LLindahl@hda.org

Supply Chain Without Pharmaceutical Distributors

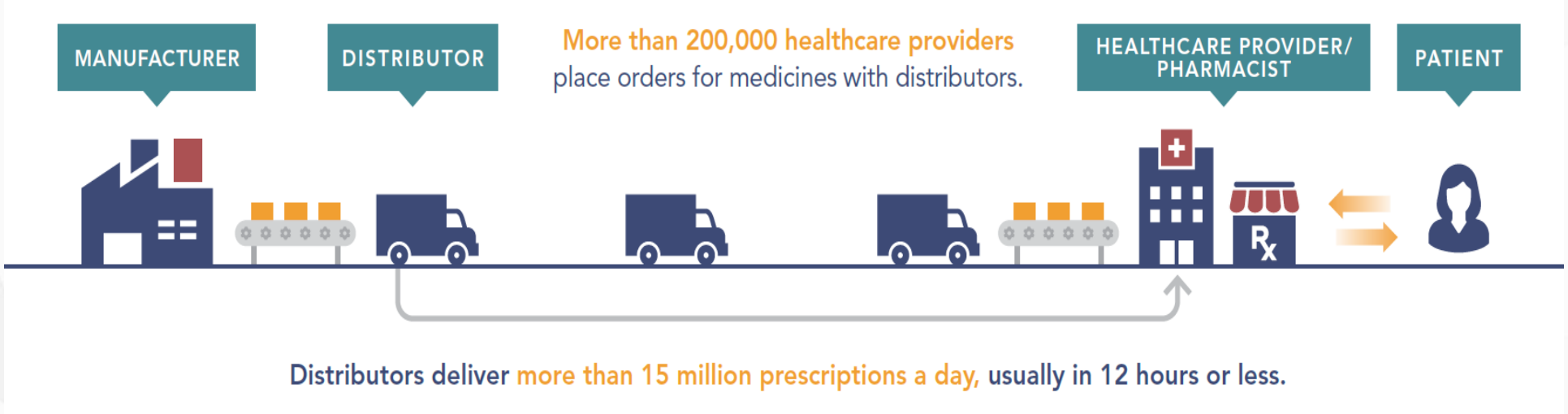


Supply Chain With Pharmaceutical Distributors



Pharmaceutical Distributors:

A vital link in the healthcare supply chain

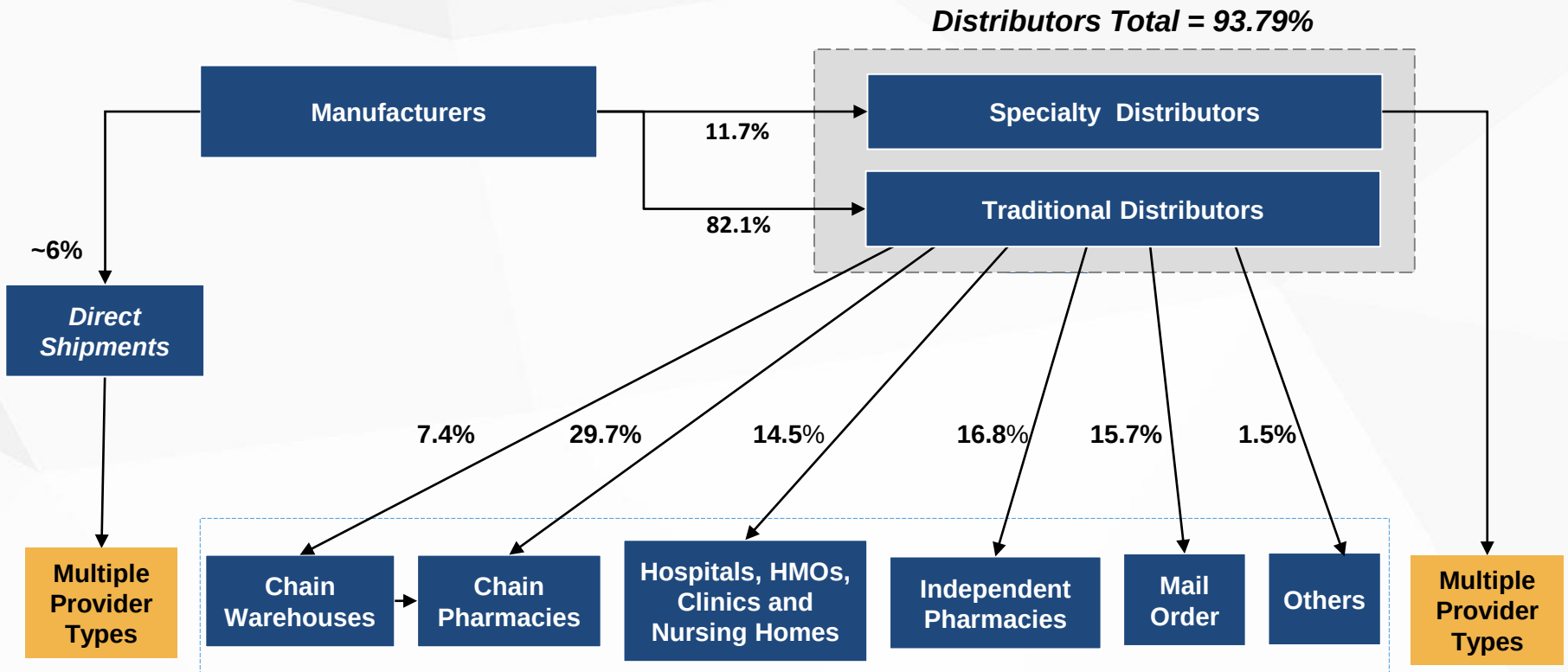


DISTRIBUTORS ARE LOGISTICS EXPERTS.

Distributors provide a one-stop-shop for dispensing locations to acquire product from any licensed manufacturer. Wholesale distributors do not **manufacture**, **prescribe** or promote medicines or **impact patients benefit design or out of pocket costs**.

Distribution to Points-of-Care

Ranging from large chains to small, independent pharmacies



Ensuring Safe, Reliable Delivery of Medicine Across the Country

Safety

Distributors continuously monitor, protect and enhance the security of the pharmaceutical supply chain to ensure medicines are safely stored and efficiently delivered.

Technology

Distributors go to great lengths to deliver a wide range of medicines where and when they are needed — regardless of the circumstances.

Efficiency

Every day, distributors deliver millions of prescription medicines and healthcare products to hundreds of thousands of providers across the country.

Due to these efficiencies, distributors provide between $33–$53 billion in cost savings to the U.S. healthcare economy each year.

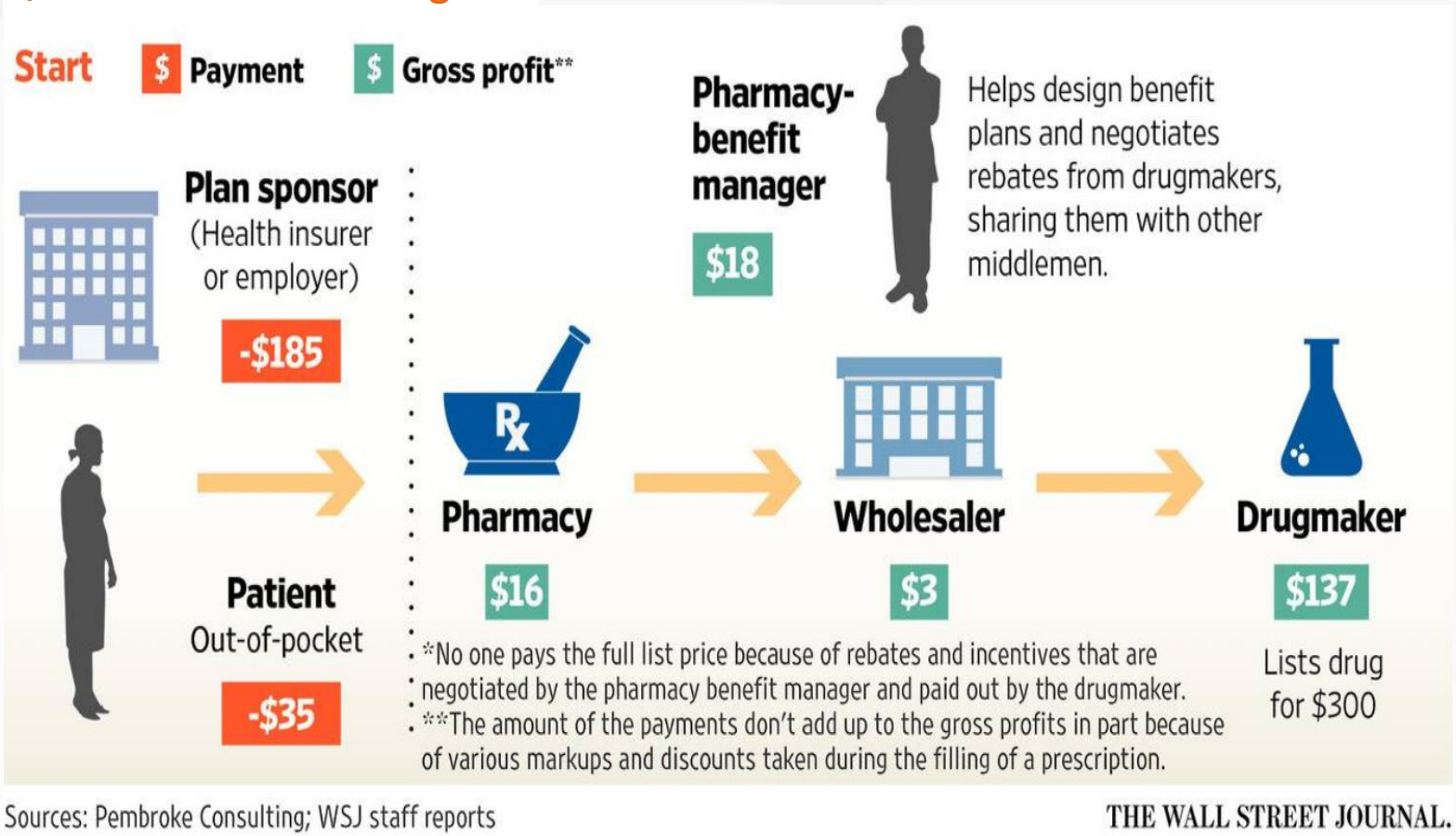
Wholesale Distributors & Pricing

- Pharmaceutical wholesale distributors primarily utilize a **fee-for-service model**.
  - Purchase from manufacturers based on the Wholesale Acquisition Cost ("WAC"), a publicly available figure set by the manufacturer.
  - Charge manufacturers bonafide service fee based on federal law, these fees are NOT passed on to subsequent customer.
  - Typically sell branded drugs based on WAC or often WAC – a %.
  - May purchase generic drugs at the list price but can use market power to negotiate discounted prices on generic drugs.
- High value, high volume but very low margin industry. Consistently maintaining a profit margin of **less than one percent** of the cost of brand medicines.

Wholesale distributors do not have any insight into pricing of dispensable units, or the prices that consumers pay based on what it costs them to fill their specific prescriptions. Distributors are not a part of any negotiations on the "pay side" of the supply chain, rather this is the role of health insurers and pharmacy benefit managers (PBMs). Wholesale distributors do not have data on a per pill or per dose basis seen at the pharmacy cash register.

Supply Chain Profits Example

$300 Brand Name Drug



Sources: Pembroke Consulting; WSJ staff reports

THE WALL STREET JOURNAL.

HDA
Healthcare Distribution Alliance
PATIENTS MOVE US.

LEARN MORE

www.healthdelivered.org

Presenter:

- Kevin Russell, RPh, MBA, BCACP, director, Prescryptive Pharmacy, Redmond Oregon, Central Oregon director – Oregon State Pharmacy Association

The Drug Supply Chain of Independent Pharmacies and the Affects on Price and Access

Kevin Russell R.Ph, MBA, BCACP
Director of Pharmacy, Prescryptive Pharmacy in Redmond, OR
Central Oregon Director, Oregon State Pharmacy Association
Kevinr@prescryptive.com

How Independent Pharmacies Buy Drugs

Major Wholesaler (3)
Brand + generics

Buying Group Contract

95% of $

- Brand drug cost is essentially same for all pharmacies between wholesalers and buying groups
- Must buy 90% of generics from program
- Must maintain high generic/brand $ ratio- hurt by PBMs mandating brands.

5% of $

Secondary Wholesalers
Discounted generics

- Discounted price with high variation and availability. A few deep discounts available.
- Purchasing limited to <10% due to major wholesaler contract.
- Discounted biosimilars often unrealized as PBMs mandate other brands.
- PBMs often use these prices to set MAC payments to pharmacies

Takeaways

- Independent pharmacies pay essentially the same price for 95% of drugs purchased and are purchasing at lowest price possible to them.
- Buying at better discounts is prevented by wholesaler contracts and PBM mandated brands.

Brand Name Drug (example)

PBM

Pharmacy cost = $400
Pharmacy bills PBM U&C = $480

PBM returns contracted rate of $404 and to charge patient 20% coinsurance for benefit.

$323.20

$2

PBM charges pharmacy $2 in fees (range $0.50-$20.20)

PBM pays net of $119.20 for $400 drug and then bills payor for ???

Pharmacy makes $2

$80.80 benefit cost to patient

$202

PBM gets 50% rebate from manufacturer

Manufacturer

Takeaways

- The patient is not sharing in rebate savings so is paying 40% of drug bill instead of 20% benefit
- Business and labor costs for pharmacy are $10-15 per Rx so the pharmacy is losing money

PBM = Pharmacy Benefit Manager
U&C = Usual and Customary price that a pharmacy charges all customers for a drug.

Generic Drug (example)

Pharmacy cost = $10
Pharmacy bills U&C of $80

PBM

PBM returns MAC rate of $8 and to charge patient $8 as less than benefit copay of $10. $0

PBM net makes $2 and bills payor for ???

$2

PBM charges pharmacy $2 in fees (range $0-$20.20)

Pharmacy loses $4

$8.00 cost to patient

Takeaways

- The patient is getting a great deal buying below cost.
- The PBM will make money from pharmacy and payor.
- PBM MAC rate is based on prices pharmacy cannot access.
- Pharmacy is losing significant money. Should they refuse to fill and deny patient access to their medication?

Normally no rebates on generics but there are for biosimilars

Manufacturer

MAC = Maximum Allowable Cost and is determined by PBMs for individual generic drugs

How do pharmacies stay in business?

See recently published report: *Understanding Pharmacy Reimbursement Trends in Oregon*.
Available at oregonpharmacy.org

- 75% of all payments for pharmacy claims are below the business cost to dispense
- 44% of Oregon CCO Medicaid payments are below the pharmacy acquisition cost of drugs
- Currently pharmacies are only paid a margin of -2% to 2% for brand name drugs
- However, 1-2% of pharmacy claims (mostly generics) are very profitable and subsidize other losses.
- Pharmacies may refuse to dispense prescriptions with large losses

This system forces pharmacies to charge much higher U&C (cash) prices to be able to capture the 1-2% of very profitable payments (see $80 price in previous example). It also creates access problems for patients when their drug is paid at rates so low pharmacies won't fill it.

This system is unequitable, unstable, and is causing care at pharmacies in Oregon to collapse. Pharmacy businesses will not open to provide needed access to care in the face of negative margins and uncertainty.

What are solutions to lower drug prices for patients and maintain access to drugs and services at local pharmacies?

1) Legislatively require pharmacies be paid by third parties on a drug cost + dispensing fee basis. This creates equity across all prescriptions and removes incentives for pharmacies to charge high prices or to refuse to fill prescriptions. This will stabilize community pharmacies, improve service, and eliminate pharmacy deserts.
2) Require drug rebates to be shared with patients at the point of sale.
3) Examine the wholesaler market and how it prevents pharmacies from buying drugs at lower costs.

Your local pharmacists care, let them provide care.

Questions for presenters?

- Tonia Sorrell-Neal, senior director state affairs for Oregon, Taft-Hartley plan employer trustee, Pharmaceutical Care Management Association (PCMA)
- Dharia McGrew, PhD, director, state policy at PhRMA
- Leah Lindahl, senior director, state government affairs, Healthcare Distribution Alliance (HDA)
- Kevin Russell, RPh, MBA, BCACP, director, Prescryptive Pharmacy, Redmond Oregon, Central Oregon director – Oregon State Pharmacy Association

Second public comment period

Send written testimony to rx.prices@dcbs.oregon.gov

Thank you for attending

Send written comments to rx.prices@dcbs.oregon.gov

DFR | Division of Financial Regulation

Department of Consumer and Business Services