Connecticut & U.S. Health Care Cost Drivers
Session II (Solutions and Policies)

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NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

About NASHP

- A national, nonpartisan organization committed to developing and advancing state health policy innovations and solutions to improve the health and well-being of all people.
- NASHP provides a unique forum for the productive exchange of strategies across state government, including the executive and legislative branches.
- To accomplish our mission, we:

- **Advance** innovation in developing new policies and programs
- **Surface** and support implementation and spread of best practices
- **Ensure** availability of info, data, tools
- **Encourage** sustainable cross sector solutions by strengthening partnerships
- **Elevate** the state perspective

State Policy Tools to Address High Prescription Drug Costs

Policy Approach	Tools	Commercial Market?
1. Transparency	• Reporting by drug manufacturers, wholesalers, PBMs, and health plans on prescription drug prices, spending and rebates*	✔
2. Active state purchasing	• Wholesale Canadian Importation (requires FDA approval)* • Stronger PBM contracting* • Pooled Purchasing (e.g. ArrayRx) • Direct negotiation for high-cost drugs (Medicaid) • Outcomes-based contracting (Medicaid)	✔ ✔
3. Limit Price Increases	• Prohibiting Price Gouging* • Penalizing Unsupported Price Increases (UPIs)*	✔ ✔
4. Set Upper Payment Limits	• Prescription Drug Affordability Boards (PDABs)* • International Reference Rates* • Medicare Reference Rates*	✔ ✔ ✔

Regulating PBMs

- Goal = Increase Oversight and Protect Consumers
  - Banning Gag Clauses
  - Licensure/Registration (>30 states)
  - Limiting Patient Cost Sharing
  - Transparency

- Ensure Adequate Pharmacy Reimbursement
- Assign Fiduciary Responsibility
- Improve State Contracts - Medicaid Carveouts and Reverse Auctions
- The Impact of ***Rutledge***

- NASHP Resources: Model Bill and Q&A

Referenced Based Prices: International Reference Rates Model

Why:

- Other countries pay a fraction of what Americans pay for prescription drugs
- Rate setting is a common approach in the health care sector – one that can be extended to setting rates for prescription drugs
- International prices offer a fair, easy-to-implement approach to rate setting

Implementation Structure

- State Employee Health Plan identifies 250 costliest drugs
- Insurance Commissioner crosswalks to Canadian prices Payers cannot pay more than that limit for drug
- Canadian price becomes upper payment limit for all payers (except Medicaid)
- ERISA: Self funded plans may participate voluntarily
- Protects local pharmacies

Examples of Canadian Rates

Drug Name & Dosage	US Price (NADAC)	Canadian Reference Rate*	Price Difference	Savings off US Prices
Humira syringe (40 mg/0.8 ml) (arthritis, psoriasis, Crohn's)	$2,706.38	$541.29	$2,165.09	80%
1 ml of Enbrel (50 mg/ml syringe) (arthritis, psoriasis, Crohn's)	$1,353.94	$272.28	$1,081.66	80%
1 ml of Stelara (90 mg/1 ml syringe) (arthritis, psoriasis, Crohn's)	$21,331.28	$3,267.64	$18,063.64	85%
1 ml of Victoza (2-pak of 18 mg/3 ml pen)* (diabetes)	$103.44	$17.30	$86.14	83%
Truvada tablet (200 mg/300 mg) (PrEP for HIV)	$59.71	$19.78	$39.93	67%
Xeljanz tablet (5 mg) (rheumatoid arthritis)	$76.07	$17.50	$58.57	77%
Eplcusa tablet (400 mg/100 mg) (hepatitis C)	$869.05	$541.32	$327.73	38%
Zytiga tablet (250 mg) (cancer)	$87.63	21.47	$66.16	75%
	Average discount based on 8 top selling drugs in 2018			**73%**

Referenced Based Prices: Leveraging the IRA

- **The recently enacted Inflation Reduction Act (IRA) presents another source of reference-based pricing for states**
- **How Many Drugs and When:** HHS will negotiate for top 10 Part D drugs, with prices effective 2026, eventually reaching top 20 drugs across Parts B and D in 2029
- **Which Drugs:** Single-source drugs that (1) are at least 7 years (small molecule) or 11 years (biologic) beyond approval; **and** (2) account for at least $200 million spend across Parts B and D
- **Exceptions:** Drugs marketed as generic/biosimilar (or biologics with reference biosimilar pending entrance within 2 years), orphan drugs targeting single approved disease, and plasma products
- **Maximum Fair Price (MFP):** Range from 75% to 40% of non-federal AMP; the longer a drug has been on the market, the lower the MFP

Medicare Drug Price Negotiations

Process:

- HHS compiles list of drugs that meet the criteria
- From those drugs, HHS selects the first 10 drugs off the list in order of highest to lowest spending (not discretionary)
- HHS requests information from manufacturers of drug on list
- HHS reviews information and offers a Maximum Fair Price
- Manufacturers can accept or propose a counter-offer
- HHS publishes final and binding Maximum Fair Price which is binding
- Strong penalties for lack of compliance/ no judicial review

- NASHP Resources:
  - Model law, blog and Q&A

Policy Tools

What do you want to address?

Lack of Transparency

- All payer claims databases
- Enhanced hospital financial reporting
- NASHP's Hospital Cost Tool

Consolidation

- Pre-transaction review and approval of proposed transactions
- Banning anticompetitive contract terms between providers and physicians

Rising Spending

- Health care cost growth benchmarks
- Health insurance rate review – affordability standards

High Prices

- Reference-based pricing state employee health plans
- Limit outpatient facility fees
- Public option
- Establish maximum payment limits for out-of-network services
- All-payer model, global budgets

https://www.nashp.org/policy/health-system-costs/model-legislation-and-resources/

Bar Anti-competitive Health Plan Contract Terms

- Prohibit anticompetitive health plan contracting terms (all-or-nothing contracts, anti-tiering or anti-steering, most-favored nations, or gaga clauses). Provisions unenforceable, constitute unfair trade practice
- State example: Nevada (AB 47 2021), bars all-or-nothing contracting, anti-tiering or anti-steering provisions, exclusive contracts between insurers and providers
- NASHP Resources:
  - Model law and policy brief to prohibit anticompetitive health plan contracting

Health Insurance Rate Review – Affordability Standards

- Use health insurance rate review authority to implement health care affordability standards
  - Modeled after Rhode Island policy that uses premium rate review to cap growth of commercial plans reimbursement to hospitals i.e., CPI (consumer price index) +1%
  - Intent is to emphasize investment in primary care, integration of behavioral health (BH), utilization of alternative payment models, structural provider contracting requirements that limit cost growth and encourage quality improvement, and alignment of quality measures.
- NASHP Toolkit, including model law and regulations

Limit Out of Network Hospital Payment Rates

- Limit out-of-network rates for inpatient & outpatient hospital services to the lesser of (a) a state's median in-network commercial rate; or (b) [X]% of the Medicare rate for the same service in the geographic area.
  - Goes beyond surprise balance bills to a broader range of services
- Why? Empirical models suggest OON rate limits can reduce in-network negotiated rates, encourage in-network participation, and reduce spending by leveling the bargaining dynamic between payers and dominant providers.
- State example: In 2017, Oregon limited rates for most hospitals participating in its public employee plan at 185% of Medicare for OON, 200% for INN
- NASHP resource: Model law, webinar, and detailed Q&A

Thank you!

Resources with support from Arnold Ventures:
NASHP's Rx Drug Pricing Resources: https://www.nashp.org/policy/drug-pricing-center/
NASHP's Health System Costs Resources: https://www.nashp.org/policy/health-system-costs/

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