

Contain Growth in Prescription Drug Prices

Cost Driver Targeted: Drug prices

OVERVIEW

States have sought to constrain prescription drug prices by implementing legislation that would have a direct impact on the reimbursement rates for prescription drugs. Some states have established prescription drug affordability boards (PDABs) to identify higher-priced drugs and to develop and oversee solutions.

[Maryland created](#) the first state prescription drug affordability board in the nation, which employs a phased approach that could eventually establish upper payment limits (UPLs) for drugs across all payers in the state, including in the commercial market. In 2021, [Colorado passed legislation](#) that would enable UPLs to apply to “all purchases of and payer reimbursements for a prescription drug that is dispensed or administered to individuals in the state in person, by mail, or by other means . . .” Legislation creating PDABs is pending or will likely be introduced in the upcoming session in a number of states.

States that wish to implement UPLs without creating the infrastructure of a PDAB can reference prices paid in other countries, where prescription drug prices are much lower. In 2020, the National Academy for State Health Policy (NASHP) developed [model legislation](#) for instituting international reference pricing for public plans, state-regulated plans, and federally regulated (ERISA) plans. Six states (Hawaii, Maine, North Carolina, North Dakota, Oklahoma, and Rhode Island) have proposed legislation based on NASHP’s model. [Massachusetts](#) and [Connecticut](#) proposed but did not succeed in passing legislation that would penalize drug manufacturers with price increases that exceed the consumer price index plus 2 percent each year.

The basic premise of this set of interrelated strategies is to establish or designate an entity to review the prices or price increases of certain drugs and to implement policies to mitigate those high prices or price increases. However, states have chosen to implement these programs in different ways.



KEY STEPS IN DESIGN AND IMPLEMENTATION

Set criteria for which drugs will have their prices reviewed. Defining which drugs' prices will be subject to review and possibly limits is an important initial step. Maryland's law includes drugs that have price increases over a certain threshold, as well as drugs with high wholesale costs. Colorado's law includes criteria for price (\$30,000 per year or per treatment course if less than a year) and price increases (10% per year). Colorado's law also includes provisions for biosimilar and generic drugs that have high prices or price increases. Some proposals include exemptions: for example, Connecticut's proposed legislation exempted drugs deemed to be in short supply.

Determine what action will be taken. The range of remedies applied by states varies. Colorado's Prescription Drug Affordability Review Board can establish UPLs, which apply to all transactions in the state. The board will develop the methodology for establishing those upper payment limits, and for the first three years of the program the strategy is limited to 12 medications. Payments in excess of the UPL are prohibited. Recognizing the analytic work necessary to define and establish a UPL, the NASHP international reference pricing proposal would employ international drug prices as reference prices and prohibit payments in excess of those reference prices. The Massachusetts and Connecticut proposals, and [NASHP model legislation](#) based on these proposals, do not prohibit sales but instead levy civil penalties against manufacturers based on the difference between the sales price and the benchmark price.

Create a governance structure. Many states have established new boards or commissions to carry out this work. Maryland created a Prescription Drug Affordability Board as an independent unit of state government, with appointees by the governor, the Senate president, the speaker, and the attorney general. Colorado similarly created an independent board, appointed by the governor and confirmed by the Senate. NASHP's model legislation sites authority with the superintendent of insurance.

EVIDENCE OF IMPACT

Analyses in multiple states and [at the national level](#) show that pharmaceutical spending is a large and growing component of health care spending in the commercial market. Strategies to lower prices or slow price increases would logically decrease pharmaceutical spending, but the magnitude of the impact would depend on how stringent the limits are, how broadly they are applied, and assumptions about utilization and substitution effects.

Savings estimates developed for a federal proposal (H.R. 3) that would institute reference pricing at the national level suggested [\\$256 billion in reduced costs](#) for employer-sponsored insurance and \$36 billion in reduced premiums and cost sharing in the Affordable Care Act marketplaces over a six-year period.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

The strategy is likely best suited for states that have:

- the political will to take on the pharmaceutical industry
- a strong coalition of payer, provider, business, and consumer organizations
- the willingness to create the analytic capacity to identify high-cost drugs or drugs with significant cost increases
- resources to administer the program.

Addressing prescription drug costs has broad appeal, and proposals have advanced in states with a range of political environments.

EQUITY CONSIDERATIONS

In general, lowering the cost of prescription drugs, particularly those treating conditions such as diabetes that are disproportionately prevalent among communities of color, has the potential to improve the accessibility and affordability of care for people of color and those living in low-income communities. However, proposed laws will need to be evaluated carefully for their health equity impacts to ensure that they do not decrease access to treatments for specific conditions, particularly those that are uncommon or for which there are relatively few treatment options.

States could proactively include provisions that look at equity as part of the criteria when evaluating affordability and setting rates. With all proposals that cap prices or price increases, it will be important to monitor availability of medications to consumers in a state, particularly for uncommon diseases or conditions with few therapeutic options.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Limits on price increases are most readily applicable to drugs that are already on the market and may not be able to restrain high initial prices. Colorado's legislation does include a specific provision applying to drugs that have an initial wholesale acquisition cost of \$30,000 or more. An additional consideration is that states would likely face legal challenges to upper payment limit and reference pricing laws from the drug industry. NASHP's model legislation includes guidance on ways to minimize this risk. Finally, because these initiatives are new, states would likely face implementation issues as they stand up these programs.

RESOURCES

Daniel A. Ollendorf, Patricia G. Synnott, and Peter J. Neumann, *External Reference Pricing: The Drug-Pricing Reform America Needs?* (Commonwealth Fund, May 2021).

National Academy for State Health Policy, "Comparison of State Prescription Drug Affordability Board Bills," NASHP, Mar. 15, 2021.

"NCSL Prescription Drug Policy Resource Center," National Conference of State Legislatures, Jan. 19, 2021.