Potential Policy Options to Reduce Prescription Drug and Other Costs

The Health Policy Commission's 2018 *Cost Trends* Report [1] discusses several options for reducing prescription drug costs. Of the options discussed, the legislature recently passed into law legislation that enhances the ability of MassHealth to negotiate directly with drug manufacturers for additional supplemental rebates. In addition, the following proposals discussed in HPC's 2018 report could result in real savings for the Commonwealth.

1. ***Addressing Hospital Mark-up of Medicines and Variation of Drug Costs Across Hospital Settings***

    a. *Hospitals should be paid on the services they provide, not the value of the drug they administer; hospitals should pass on negotiated savings to patients and should not mark up drugs and pocket the reimbursement margin.* HPC highlighted in its 2018 report that there is substantial variation in billing for chemotherapy across hospitals in the state. Prices for medicines at the highest-priced hospital were often more than double that of the lowest-priced hospital – for the exact same medicine.

    b. *Insurance design should encourage medicines to be dispensed in the least costly setting, as medically appropriate.* Physician-administered chemotherapy medicines are an example of how the shift from physician's offices to hospitals contributes to higher spending. From 2004 to 2014, chemotherapy infusions in hospital outpatient departments increased dramatically – from 6% to 46% for commercial patients and from 16% to 46% for Medicare patients. Drug spending was more than twice as high in the hospital setting.[2] Had this change in site of service not occurred, spending would have been 7.5% and 5.8% lower for Medicare and commercial infused chemotherapy patients, respectively.[3]

        - Hospital outpatient departments are often paid twice as much by commercial payors as physician offices for administering the same medicines to patients with cancer or autoimmune disorders.[4]
        - Concentration of hospitals in a market reduces quality for some procedures. In contrast, hospital competition improves quality.[5]

2. ***Reducing Low Value Care***

    a. *The Commonwealth should work to reduce instances of low value care*. For example, health services that are proven to provide little or no benefit to a patient are a major driver of inefficiency and an untapped opportunity to save money. The Health Policy Commission noted in its 2018 report that it has studied low value care. In the cross section

[1] https://www.mass.gov/files/documents/2019/02/20/2018%20Cost%20Trends%20Report.pdf.

[2] Winn A et al. Spending by Commercial Insurers on Chemotherapy Based on Site of Care, 2004-2014. JAMA Oncology. February 22, 2018

[3] Fitch, Kathryn, et. al. Cost Drivers of Cancer Care: A Retrospective Analysis of Medicare and Commercially Insured Population Claim Data 2004-2014. Milliman. 2016.

[4] Medical Pharmacy Trend Report: 2016 Seventh Edition. Magellan RX Management. 2017.

[5] Martin Gaynor and Robert Town. The impact of hospital consolidation-Update. Robert Wood Johnson Foundation. 2012.

of commercial claims studied, nearly 800,000 low value services were identified, accounting for nearly $80 million in health care spending.

3. Sharing Pharmacy Benefit Manager (PBM) Savings with Patients

a. HPC's report references an Ohio state audit of its Medicaid program that identified a large difference or "spread" between the prices PBMs charged managed care organizations (MCOs) for generic drugs and the amount the PBMs paid the pharmacies that dispensed the drugs. PBMs kept the difference as profit, accounting for 31% of the $662.7 million paid by MCOs on generic drugs.[6] PBMs should not profit from drug reimbursement but instead should be paid fair market value for the services they provide (e.g., formulary development, claims processing).

b. Research shows that on average, 40% of the list price of medicines is given as rebates or discounts to insurance companies, the government, pharmacy benefit managers and other entities in the supply chain.[7] These rebates and discounts exceeded $166 billion in 2018 alone and are growing every year.[8] HPC also notes the example of UnitedHealthcare's March 2018 announcement that it would share the drug rebates it receives with certain customers as one method for lowering patient out of pocket costs. Manufacturer rebates should be shared with patients when they purchase their medicine.

4. Utilizing Value-Based Agreements (Value-Based Contracting) in MassHealth.

a. States are permitted to enter into voluntary, value-based agreements for Medicaid lives (e.g., the HPC report notes Oklahoma Medicaid value-based agreements). Value-based arrangements can improve patient outcomes, reduce medical costs, and reduce the cost of medicines. These arrangements can improve patient access to medicines while supporting better health outcomes and reducing hospitalizations and other medical costs. Value-based contracting arrangements function best when tailored carefully to address the medication involved and the patients and disease conditions they seek to treat. Value-based agreements for Medicaid patients should be voluntary given a statutory minimum rebate is already in place.

b. Voluntary, value-based agreements could include:

1. Outcomes based arrangements, which tie costs or discounts to patient outcomes;

[6] Office of Ohio Auditor David Yost. Auditor of State Report: Ohio's Medicaid managed care pharmacy services. Aug. 16, 2018. *Available at* https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.

[7] The Pharmaceutical Supply Chain. Berkley Research Group. 2017. *Available at* https://www.thinkbrg.com/media/publication/863_863_Vandervelde_PhRMA-January-2017_WEB-FINAL.pdf.

[8] https://www.drugchannels.net/2019/04/the-gross-to-net-bubble-reached-record.html.

2. Conditional treatment continuation arrangements, which typically are conditioned on meeting short-term treatment goals;

3. Indication-based pricing arrangements, where the net price varies based on the indication for treatment;

4. Regimen-based pricing arrangements, where the net price of a medicine decreases when a patient must take additional medication to make the treatment more effective; and

5. Expenditure cap arrangements, which limit the cost of medicine per patient to a negotiated threshold.

5. Social Determinants of Health.

a. Social determinants of health (SDH) can negatively affect access to health care services, outcomes and can lead to increased costs. HPC reports that evidence demonstrates that addressing health related social needs (e.g., housing, nutrition) improves health outcomes, reduces health disparities, and lowers avoidable health care utilization. HPC correctly advises that policymakers and market participants should advance efforts to address SDH policies designed to reduce systemic health inequities.