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Benefits Connection

Containing Drug Costs

Three Real Ways the Rx Drug Market Is Changing Right Now

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Containing Drug Costs

Three Real Ways the Rx Drug Market is Changing Right Now

by Michael S. Grant

I find it heartening that the federal government is tackling prescription drug pricing in the U.S. as a priority. Hopefully, the various bills currently with the House and Senate will come out alive in some form, and the pricing mechanisms for medicines can be improved.

But it can be difficult to identify what strides, if any, have been made towards this goal so far. This is my short list of what I believe have been the most significant efforts made in recent years. Though the fact is that nothing is simple, because even these steps have gotten some push back.

1 *Price Transparency Laws Are Passed at the State Level*

I noted in a previous article that state legislatures (like Maryland, Nevada, Oregon, and Vermont) are doing more to require drug pricing transparency. Of all the states, California has the most comprehensive drug price transparency law to date. California's law requires drug manufacturers to notify state purchasers and health insurers 60 days in advance of a significant drug price increase, their reasons for doing so, and a breakdown of the drug's cost information.

Maryland had gone even farther by passing a law that penalized drug manufacturers for price-gouging generic drugs by fifty percent or more. However, the pharmaceutical industry challenged the law, and in February 2019, the Supreme Court held up a ruling by an appeals court that the law was unconstitutional. So now, other states which had been emboldened to follow Maryland's lead are rethinking their strategies (like Nevada and Illinois). This might mean that to survive, this type of law might need to go through Congress, not through state legislation.

2 *Reduced Drug Pricing Directly to Consumers*

Health insurers and pharmacy benefit managers (PBMs) are responding to the growing demand for cost transparency and cost reduction by providing cost breaks directly to consumers.

For example, Express Scripts, the nation's largest PBM organization, issued a new drug reimbursement list that promises to reduce the reliance on brand rebates. Available as of January 1, 2019, the National Preferred Flex Formulary has lower prices for brand name drugs. With this formulary's set up, the manufacturer reduces drug prices directly for the consumer and doesn't provide drug rebates to the pharmacy benefit manager.

Also starting this year, UnitedHealthcare, the nation's largest health insurer, requires employers who sponsor their plans to pass on the savings they receive for rebated drugs directly to plan members at the point of sale, rather than use the savings to lower plan premiums and costs.

Containing Drug Costs (continued)

With the traditional drug rebate model, a drug manufacturer will often give the pharmacy benefit manager (PBM) a rebate for placing their brand drugs, rather than a competitor's, on any of their formularies. The difference between the original sticker price and the rebated price can be huge. This is known as the gross-to-net bubble.

The problem with this set up is that while the insurer tends to benefit from the vastly negotiated rates, the savings doesn't necessarily trickle down to the consumer. Additionally, the rebate terms are considered trade secrets, so it's impossible to know how much of the final cost is being paid by the consumer.

It will be interesting to see how these new formulary structures will play out in the industry, starting with how receptive health insurers are to include it in their plan designs. If they are well-received, we may see the traditional rebate model continue to loose favor.

3 *Drug Discounts Directly to Consumers*

Drug manufacturers and pharmacies are lowering drug costs or offering discounts directly to the consumer. Many online marketplaces have popped up, like Blink Health, GoodRx, SingleCare, and WellRx, that partner with manufacturers and pharmacies and act as a service vehicle for these deals. In 2016, there were about 500 coupon programs, according to MarketWatch.

However, there has been some push back:

1. Opponents consider this practice a kickback, driving brand use unnecessarily over the generic alternative (by about 60% more according to some accounts).

2. Insurers and pharmacy benefit managers say brand coupons dissuade consumers from using a formulary's preferred generic alternative, threatening the formulary's cost control design.

3. While the consumer who uses a discount card along with their health insurance benefits from additional savings at the point of sale, the insurance company still has to pay its full portion. Ultimately, this cost might be passed back down to the consumer in the form of higher premiums.

While there are real benefits to the consumer for drug discount programs, the industry needs to continue evolving to account for some of these real challenges.

I welcome your thoughts about the items on this list.

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Federal Considerations

COURT TO STRIKE DOWN THE ENTIRE ACA?

In an unexpected and somewhat surprising move, the Administration sent a letter to the Fifth Circuit Court of Appeals in late March, taking the position that the entire ACA should be invalidated because the individual mandate penalty has been set to $0.

By way of background, late last year a judge in the U.S. District Court for the Northern District of Texas ruled that when the Tax Cut and Jobs Act of 2017 reduced the Affordable Care Act's individual mandate to $0, it rendered the entire ACA unconstitutional. A coalition of 16 state attorneys general and the Administration appealed that ruling on the grounds that, beyond the individual mandate, the rest of the ACA was severable and should be upheld.

The Administration's recent position letter to the Court is a departure from that prior posture, aligning it with the 20 state Republican attorneys general and the two individual plaintiffs challenging the law. The Administration's decision not to defend the ACA—and to effectively side with the plaintiffs against the ACA—is rare.

Generally, the Department of Justice defends federal laws if reasonable arguments can be made in their defense. This change in position could lead to additional litigation by states seeking courts to declare that the ACA is constitutional and enforceable—at least one state has already done so, but a federal judge concluded that the case was premature. We will continue to track the litigation and timely report developments.

PORTIONS OF ASSOCIATION HEALTH PLAN RULE VACATED

In late March, a judge with the US District Court vacated significant portions of the Trump Administration's Association Health Plan (AHP) rule, holding that the rule stretched the definition of "employer" beyond what was contemplated by ERISA, and was, therefore, unlawful.

The court noted that the rule provided no meaningful limit on what associations needed to demonstrate in order to qualify as employers under ERISA, and failed to show why geographic proximity was connected to any commonality of interest among employers.

The District Court's ruling isn't likely to affect a large number of employers, as growth in AHPs following the AHP rule had been fairly limited. Employers that relied on the rule to form AHPs or to become participating members in AHPs should consult with carriers, underwriters, and legal counsel on next steps.

The case is likely to end up on appeal, possibly to the U.S. Supreme Court. We will continue to track the progress of the litigation and keep you apprised of developments.

State Considerations

MASSACHUSETTS

Paid Family and Medical Leave—Updated Draft Regulations

The Massachusetts Department of Paid Family and Medical Leave (the Department) published its updated draft regulations of the MA Paid Family and Medical Leave (PFML).

Below are new key provisions:

- Employees will not accrue additional benefits, such as vacation, sick leave and PTO while on PFML.
- Employees may have the option to choose accrued paid leave provided by their employer or apply for PFML for a particular leave. If an employee uses the employer-provided leave, that leave will run concurrently with the PFML leave period. The employee cannot be paid with PFML benefits for such a period.
- Employers can require those returning from medical leave to provide a fitness for duty certification from their provider stating they can return to work. The employer must have a policy that is applied uniformly or require similarly situated employees to provide the same certification for such leave.
- The PFML weekly benefit will not be reduced by wage replacement received through STD unless the total amount received would exceed the covered worker's average weekly wage.
- The definitions of PFML have been expanded to provide additional clarity on each term. There is also coverage guidance for employers that have self-employed workers and contractors. The calculation is based on whether more than 50% of its MA workforce are self-employed 1099-MISC contractors based on each pay period of the previous calendar year.

A public comment and hearing period will commence in May. The Department anticipates final regulations to be released in advance of the July 1st deadline.

Important Dates

April 29, 2019:

Online applications for private plans made available through MassTaxConnect.

July 1, 2019:

- Payroll deductions to cover worker contributions from employees' wages start.
- Employers must post a mandated workplace poster.
- Employers must distribute written notice of the PFML to all MA W-2 employees and to new hires within 30 days. In turn, the employers must receive employees' written statement acknowledging receipt of this notice.

October 2019:

Employers will be required to file quarterly reports through MassTaxConnect.

October 31, 2019:

Employers will begin to remit quarterly contributions to the Trust Fund through MassTaxConnect for the July-September quarter.

January 1, 2021:

PFML benefits will be available for bonding with a child, managing family affairs when a family member is on active duty, and for serious personal health conditions.

July 1, 2021:

PFML benefits will be available for the care of a family member with a serious health condition.

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