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BEFORE THE VERMONT GENERAL ASSEMBLY

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Chairwoman Sen. Lyons, and members of the Committee, it is a great honor to be speaking with you today. I am Mariana Socal, MD PhD. I am a physician and an associate scientist at the Department of Health Policy and Management of the Johns Hopkins Bloomberg School of Public Health. I have done extensive research on the coverage and affordability of prescription drugs in the United States. At Johns Hopkins, I also teach a course on US Pharmaceutical Policy. I am speaking today on my own behalf. The opinions expressed herein are my own and do not necessarily reflect the views of Johns Hopkins University. I would like to provide comment on S.98, An Act Relating to Green Mountain Care Board Authority over Prescription Drug Costs.

In this testimony, I will outline how the lack of price transparency for prescription drugs in the United States hurts consumers; how drug prices have increased in the United States disproportionate to what occurs in other countries; and how providing the Green Mountain Care Board authority over prescription drug costs can help increase prescription drug affordability and access for the population of Vermont.

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PART I –THE LACK OF DRUG PRICE TRANSPARENCY HURTS CONSUMERS

The high cost of prescription drugs in the United States is a matter of great clinical and public health concern.[i,ii] About two-thirds of all American adults take prescription drugs daily. This represents more than 131 million individuals.[iii] Unfortunately, more than 1 in every 4 Americans have difficulty affording the prescription drugs they need.[iv] When patients cannot afford their drug, they use lower doses than prescribed, skip doses, or are unable to fill their prescriptions altogether. Often, patients must make hard choices between paying for a drug versus paying for their basic needs such as food or rent.

Prescription drugs can help patients maintain their health and quality of life, can prolong survival, and can also sometimes offer cures. Failing to access a prescription drug when needed is not only harmful to a person's health and quality of life; it can also increase health care costs through the additional services that patients may need to improve their health.

Consider a child with asthma who needs Symbicort, a common inhaler. The cash price of a Symbicort inhaler is about $250 today.[v] This is a high cost for a family, but it pales in comparison to the cost of a visit to the Emergency Department to control an asthma exacerbation. There are also long-term costs that need to be considered. Long-term complications of diabetes, for example, are a particular risk for patients who cannot control their glucose levels appropriately because they cannot afford their drugs. These complications include kidney failure and heart failure, whose care is exponentially higher than the cost of treating diabetes in the first place.

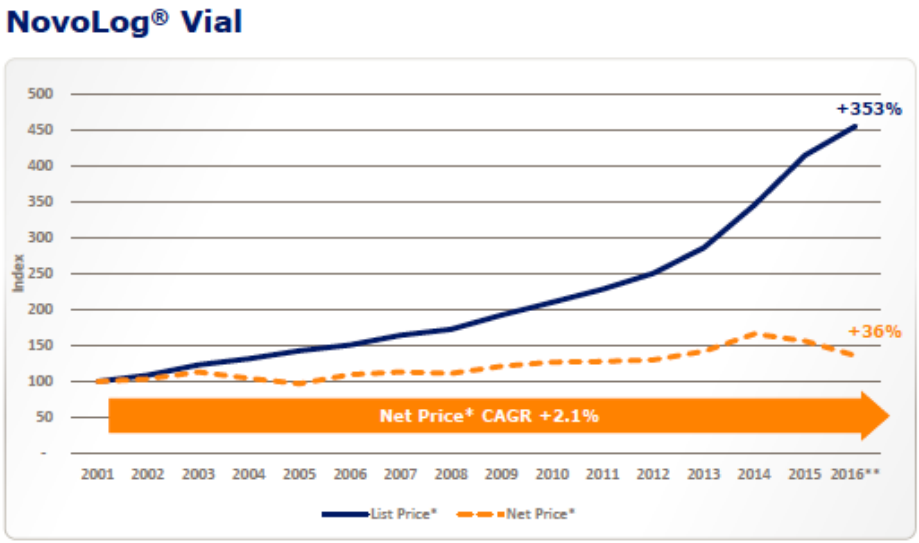
Drug affordability problems, unfortunately, are a very common problem. A recent study that examined insulin affordability found that showed also showed that ***everyone***, from uninsured patients to patients with employer-sponsored private insurance, was similarly likely to report that they couldn't afford their insulin.[iv] **How did we get to a point where even privately insured individuals, who are often assumed to have some of the best health insurance in our country, are having difficulty affording the drugs they need?**

The answer is how drug pricing works in United States, and how the lack of transparency in prices hurts consumers. In the United States, the drug manufacturer sets the price for a drug, which is called the list price. But then, the drug manufacturer cuts deals with health insurers (either directly or through pharmacy benefit managers – PBMs) and provides discounts and rebates in exchange for the insurer covering their drug. The final agree- upon price after rebates and discounts, which is called the net price, is known ***only*** to the manufacturer and to the insurer or PBM. The patients and the public are left in the dark. However, **when patients are required to pay for their drugs, they pay based on the high list price, not the lower net price negotiated by the insurer.** The difference between these two prices can be enormous. Let me provide a concrete example.

In 2016, Novo Nordisk, one of the few insulin manufacturers in the United States, published a summary of prices for NovoLog, one of their insulin products (see the Figure below). In 2016 a vial of NovoLog had a $450 list price but the price to insurers was about $150, ***just one third of the list price***. If a patient was required by their insurer to pay a 25% coinsurance for NovoLog,

the patient would be paying $112.50 – and the insurer would pay less than $40 to complete the $150. In this case, the patient is actually paying 75%, or ¾, of the drug's cost. This is a very common situation. **One of my own studies found that, in Medicare Part D, the average coinsurance charged to patients for insulins was about 28% in 2019**.[vi] The NovoNordisk case was unique only because the net prices were publicly displayed by the manufacturer. Aside from this, the high difference between list and net prices is a common feature of the price of many, if not most, high-cost drugs in the United States.

Figure. NOVOLOG's list and net price history as reported by the drug manufacturer in 2016



Source: https://www.novonordisk-us.com/perspectives/our_perspectives.html

The lack of transparency in drug prices not only hurts consumers; it allows health insurers to profit from the payments that patients make out-of-pocket for their drugs. My research found that the list prices of insulin glargine (Lantus) were five times higher than the net prices in 2020. The 2020 list price for insulin glargine was about $28 per 100U and the net price was about $4. At 20% coinsurance, a patient would pay $5.60 out-of-pocket for their insulin, and the

insurer would pay nothing. Because the insurance plan and/or the associated PBMs gets rebates back from the manufacturer and keeps it, both the insurer and the PBM may profit from shifting cost to patients. In this case, the insurer and/or PBM would keep $1.60 per 100U from the patient's out-of-pocket payment, representing a profit of about 40% over the net price ultimately due to the drug manufacturer.

This is a very common situation. **One of my own studies found that, in Medicare Part D, the average coinsurance charged to patients for insulins was about 28% in 2019**.[vii] It is also a problem that is typical of many high-cost drugs, not only insulin. Requiring that patients pay a percentage of the drug's cost (a coinsurance) is the standard for drugs that cost more than $800 per month in the Medicare program. Most insurers cover high-cost drugs similarly.

It is important that we recognize how our current drug pricing structure penalizes consumers. The patient has absolutely no negotiating power in this situation. The patient must pay the percentage defined by the insurer, calculated over the price established by the drug manufacturer, and if they cannot afford it, they must go without their drug. If **a person does not have insurance, or has a high-deductible health plan, the person must pay the full price of their drug.** In the insulin example, the patient would be paying 5 times more than the net cost of their drug, and the manufacturer (or PBM) could keep the difference.

Examining prices of high-cost drugs that challenge patient access and affordability is **critical**. Having an agency with authority to set upper payment limits (UPLs) when manufacturer-set prices create severe barriers to patient access is crucial to add transparency in the pharmaceutical

market, to shield patients from high out-of-pocket drug costs, to protect access and affordability of prescription drugs, and to prevent higher health care costs from the complications caused by the lack of pharmaceutical access. In addition, transparent UPLs could also prevent patients from paying more than their health insurers are liable to ultimately pay for a given drug, preventing health insurers and PBMs from profiting off the payments that patients make for their drugs.

PART II – DRUG PRICES ARE EXTRAORDINARILY HIGH IN THE UNITED STATES AND TEND TO ONLY GO UP OVER TIME, WHEREAS IN OTHER COUNTRIES THEY GO DOWN

Drug prices in the United States are extraordinarily high. My research found that we pay, on average, about 3 to 4 times higher prices than other developed countries such as the United Kingdom, Japan, and Canada, *for the exact same drugs*.[viii] We all know we pay more than other countries for drugs. But the most surprising finding of our study was that the **highest price differentials, i.e., the drugs for which we were paying the most as compared to other countries, were drugs that had been on the US market for a long time.** We estimated that each additional year that a drug was in the US market was associated with a **33% higher price differential when compared to the UK, 25% higher price differential when compared to Canada, and 17% higher when compared to Japan**.

This is because other countries have mechanisms to lower drug prices over time, which we do not have. In the United States, we have what is called a market-based drug pricing model, where manufacturers will charge the prices that the market can bear. Here, we depend on competition to

lower drug prices – the entry of generics or biosimilars which can place pricing pressure on the originator branded drug and lower overall costs. However, many branded drug manufacturers have succeeded in warding off competition in the US for long periods of time. Strategies such as patent thickets, pay-for-delay agreements, product hopping, evergreening, and others have resulted in some very high-cost drugs like Humira to remain in the US market for over 20 years without any competition. A drug that does not have competition has a monopoly in the market, and their manufacturer can charge the price that they want because there are no other alternatives for insurers and PBMs to cover in the formulary and use it in the negotiation with the manufacturer.

A drug's price should be at its highest when the drug first enters the market. That's when a drug is protected by a patent and has the monopoly, i.e., competitors may not be approved or sold in the country. The monopoly period allows manufacturers to recoup their investments in the drug before other manufacturers enter the same market. There is, therefore, no rationale for raising prices year after year -- especially for drugs that already completed their original monopoly period and have already had the chance to recoup their investment, and especially when there have been no changes to the product that may have required additional R&D funding and no major events whose cost needs to be offset, such as a natural disaster disrupting manufacturing in ways that would require repairs and new investments.

Drugs have succeeded in continually increasing their prices in the United States year after year, often faster than inflation, while in other countries they only lower their prices over time, mainly because there are not allowed to. In January of 2021, a record number of 832 drugs raised their

prices in the United States. 99% of these drugs were branded, and most of them had also increased their price for at least the last 2 years. Unfortunately, this pattern has remained the same in all recent years. Between 2022 and 2023, in just one year, more than 4,200 prescription drugs increased prices in the United States. Price increases were on average about 15%.[ix]

The Inflation Reduction Act of 2022 established a penalty for manufacturers that raise their drug prices faster than the rate of inflation. It has been estimated that in Medicare Part B alone (the part of the program that covers physician-administered drugs) the savings from inflation penalties would amount to about $1 billion per year.

Increasing list prices is harmful to consumers even if net prices to insurers stay the same. Based on how coinsurance and deductible payments are calculated, high list prices are always detrimental to consumers, even if net drug prices to insurers are lower. Having an agency with authority to set UPLs when manufacturer-set prices, including those that are fast increasing, can significantly challenge payors and patients' ability to pay for drugs is *critical* to protect drug access and affordability for everyone in Vermont.

PART III – HOW AUTHORITY OVER DRUG COSTS COULD EXPAND ACCESS AND AFFORDABILIT IN VERMONT

Authority over drug costs is important to correct core problems that are part of the US pharmaceutical market. First, it will bring transparency to the market. When the UPL for a drug is known, patients will know what is the maximum that their plan can pay for the drug. Transparency will help cost-sharing like coinsurance or deductibles be calculated over the UPL instead of the higher list price. Plans will also benefit from transparency, especially small plans that did not have sufficient negotiation power to obtain lower prices from manufacturers and large plans that may not know how well their PBM is negotiating on their behalf. The new Medicare Drug Negotiation program will contribute to expanding drug price transparency because it will also make public what is the maximum fair price of a drug.

In the US pharmaceutical market there is no incentive for price transparency. In **the current model, all participants in the US pharmaceutical market (pharmacies, distributors, PBMs, etc.) can profit off the price of the drugs that they cover or sell. This incentivizes drug manufacturers to keep prices high**, since cheaper drugs tend to offer fewer opportunities for profits for supply chain participants as compared to more expensive drugs. A UPL would help bring transparency to the supply chain, correcting the distorted incentive to keep prices high, and helping bring down drug prices. Upper payment limits are, by definition, the upper bound of what can be paid for a drug. Therefore, plans and other supply chain participants can always negotiate lower prices than the UPL; they simply cannot pay more than the UPL.

Right now, more than 10 states have passed laws that allow for drug affordability review.[x] Prescription Drug Affordability Review Boards in Colorado, Maryland, Minnesota, and Washington state have authority to set up UPLs. UPLs in Colorado, Minnesota, and Washington

apply to all consumers in the state (excluding enrollees in self-funded plans that elect not to participate) while UPLs in Maryland apply to state employees only. Prescription Drug Affordability Review Boards in Maine and New Hampshire have the authority to "determine spending targets for specific drugs and can recommend policies to meet the targets." [xi] Lastly, states like New York and Massachusetts have models to enhance Medicaid's capacity to negotiate with manufacturers for supplemental rebate agreements. Affordability boards also differ with respect to the specific drugs that they target. Overall, the following aspects are typically part of determining a drug's affordability:

- The drug's list price (usually wholesale acquisition cost – WAC)
- Levels of discounts and rebates provided by manufacturers to health plans, pharmacy benefit managers, and pharmacies, for the drug;
- The drug's net price after all rebates and discounts;
- The average patient copay for the drug and the average cost to those un or underinsured.

Vermont should continue to lead the way in making health care in general, and particularly prescription drugs, accessible and affordable to all its residents. It should act to protect patients who live with chronic conditions and need prescription drugs to survive. **Drug affordability review with UPL-setting is an important step, which should be followed by policies to prohibit patients from paying more out0of-pocket than the total cost of their drug.** Ensuring that all persons in Vermont can access and afford life saving drugs will provide a foundation that can be built on to make sure that high quality, affordable prescription drugs can be accessible to those that need it most.

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