

Date: March 23, 2018	POLICY ANALYSIS PREPARED FOR THE BOARD OF DIRECTORS	 OF NORTHERN LARIMER COUNTY
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HB18-1284: DISCLOSURE OF PRESCRIPTION COSTS AT PHARMACIES

Concerning the cost of prescription drugs purchased at a pharmacy.

Details

Bill Sponsors:	House – <i>Buckner (D) and Wilson (R)</i> Senate – <i>Martinez Humenik (R) and Kefalas (D)</i>
Committee:	House Health, Insurance, & Environment
Bill History:	3/8/2018- Introduced in House- Assigned to Health, Insurance, & Environment
Next Action:	3/29/2018- Hearing in House Committee on Health, Insurance, & Environment

Bill Summary

This bill prohibits insurance carriers and pharmacy benefit managers (PBMs) from prohibiting a pharmacy or pharmacist from providing a covered individual with information regarding the amount they will have to pay or the clinical efficacy of affordable alternative drugs. The bill also prohibits carriers and PBMs from requiring the pharmacy to charge a copayment that exceeds the total charges that are submitted by the pharmacy. Finally, the bill requires the Commissioner of Insurance to take action against the carrier or PBM when it has been determined that they have not complied with these requirements.

Issue Summary

Prescriptions in Colorado

There are approximately 10.8 medications dispensed per year per person in Colorado, of those 8.7 are generic medications.¹ In 2017, more than 45.9 million prescription drugs were filled at pharmacies in Colorado, resulting in \$6.28 billion of retail sales.² According to the Colorado Health Institute’s (CHI) 2017 Colorado Health Access Survey, 10.7 percent of Coloradans cite the cost of prescription drugs as reason for not filling the medicines they are prescribed.³ In the 2016 Community Health Survey conducted by the Health District of Northern Larimer County, it was found that 9 percent of residents within the Health District had been unable to have a prescription filled because they could not afford it during the preceding 2 years. This rate is much higher among those who reported being uninsured (28%). Another study by CHI found that in 2015 the median out-of-pocket expenditures on prescription drugs was \$149 per year.⁴

Prescription Drug Coverage

A health insurance carrier or pharmacy benefit manager (PBM) creates a formulary for specific health plans to detail a list of covered drugs. A formulary is a list of drugs developed by a committee within the carrier or PBM utilizing evidence-based medicine and the judgment of experts. When creating this list the decision-making committee considers and reviews clinical literature, information from the Food and Drug Administration (FDA), current therapeutic use, economic data, and provider recommendations.⁵ The primary

¹ Center for Improving Value in Health Care (n.d.) *Utilization*. Retrieved from <http://www.civhc.org/get-data/interactive-data/statewide-metrics/utilization/>

² Henry J Kaiser Family Foundation (2018). *Health Costs & Budgets Indicators*, Retrieved from <https://www.kff.org/state-category/health-costs-budgets/prescription-drugs/>

³ Colorado Health Institute (2017). *Colorado’s New Normal: Findings from the 2017 Colorado Health Access Survey*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20CHAS%20DESIGN%20FINAL%20for%20Web.pdf

⁴ Colorado Health Institute (2016). *Sticker Shock: Prescription Drug Affordability in Colorado*. Retrieved from <https://www.coloradohealthinstitute.org/research/sticker-shock-prescription-drug-affordability-colorado>

⁵ Academy of Managed Care Pharmacy (Nov.2009). *Formulary Management*. Retrieved from <http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=9298>

purpose of a formulary is to encourage patients to access the most effective and affordable medications available. Frequently, this formulary is combined with a system of tiers to create incentive-based formularies.⁶ The tier correlates to the level of coverage that will be provided.

Typically, the most cost-effective or least expensive drugs are assigned to a preferred tier and have the lowest cost-sharing requirements for the patient.⁶ How the tiers are structured and whether non-preferred drugs are included in the tiers depends on the plan and the carrier. The first tier tends to be generics and possibly some select brand names, which are the least expensive drugs covered by a plan.⁷ Within the second tier are what are known as preferred drugs, or brand name drugs that have been chosen by the committee for the formulary, and tend to be a little more expensive than tier one drugs.⁸ The third tier, which may or may not be included in a plan’s formulary, are the non-preferred drugs.⁸ Finally, the final tier typically includes most specialty drugs and are the most expensive.⁸ In 2017, an annual study of employer health benefit plans delineates the average cost sharing for covered individuals that had tiers in their pharmacy benefit formulary.⁸ The below chart demonstrates both the average copay and coinsurance for these covered workers.⁸

Prescription Drug Overpayments

When a commercially insured individual’s copayments exceed the total cost of the drug to their insurer/PBM it is a prescription drug overpayment, known as a “clawback.”⁹ Pharmacists tend to report that the insurer

Among Covered Workers With Prescription Drug Coverage, Average Copayments and Coinsurance, 2017

	Average Copay	Average Coinsurance
Plans With Three or More Tiers		
First Tier	\$11	17%
Second Tier	\$33	25%
Third Tier	\$59	38%
Fourth Tier	\$110	28%
Plans With Two Tiers		
First Tier	\$11	NSD
Second Tier	\$30	29%
Plans With the Same Cost-Sharing For All Covered Drugs		
First Tier	\$11	19%

NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs.
NSD: Not Sufficient Data

or PBM keeps the overpayment, not the pharmacy itself. A recent study analyzed the general scope of these overpayments, which is difficult to concretely do with the data that is publicly available on prescription drug prices.¹⁰ The study found that brand name drugs had a higher mean overpayment than generics, yet fewer brand name drug claims involved an overpayment than generics.¹⁰ The following chart depicts the overarching results from this study.¹⁰

⁶ Goldman, D.P., Joyce, G.F., and Zheng, Y. (July 2007). Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health. *JAMA*; 298(1). doi: 10.1001/jama.298.1.61

⁷ National Council on Aging (n.d.) *Medicare Part D Copay Tiers*. Retrieved from <https://www.mymedicarematters.org/resource-library/infographics/part-d-copay-tiers/>

⁸ The Kaiser Family Foundation & Health Research and Educational Trust (2017). *Employer Health Benefits: 2017 Annual Survey*, Retrieved from <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017>

⁹ Van Nuys, K., Joyce, G., Ribero, R., and Goldman, D.P. (March 2018). Overpaying for Prescription Drugs: The Copay Clawback Phenomenon. *USC Leonard D. Schaeffer Center for Health Policy & Economics*. Retrieved from http://healthpolicy.usc.edu/documents/2018.03_Overpaying%20for%20Prescription%20Drugs_White%20Paper_v.1.pdf

Table 1: Frequency and Average Size of Overpayments, 2013

	Number of Claims	Number of Claims with Overpayment	Percentage of Claims Involving Overpayment (95% CI)	Mean Overpayment (SD)
All Drugs	9,539,846	2,188,578	22.94% (22.91, 22.97)	\$7.69 (8.59)
Generic	7,295,525	2,055,024	28.17% (28.14, 28.20)	\$7.32 (7.43)
Brand	2,244,321	133,554	5.95% (5.92, 5.98)	\$13.46 (18.01)

Source: Optum Clinformatics™ Data Mart pharmacy claims, January-June 2013, and CMS NARP reimbursements from the same period. Confidence intervals are binomial.

The study also found that the top 20 drugs with the highest rates of overpayments ranged from 49.31 percent of claims with overpayments to 60.49 percent.¹⁰ These drugs treat an assortment of conditions including insomnia, high cholesterol, pain, and coughs.¹⁰

Carrier/PBM Contracting

Pharmacy benefit managers (PBMs) must negotiate contracts with both pharmacies and insurance plan sponsors. A PBM contract with the pharmacy sets reimbursement rates for dispensing medications, along with other provisions. If a carrier does not utilize a PBM in its pharmacy benefit scheme, then it contracts with pharmacies in the same manner a PBM does. Some contracts reportedly restrict pharmacists from proactively telling a patient that a drug could cost less if they pay the cash price, rather than the cost dictated by their health plan. This restriction is known as a “gag clause.” A survey by the National Community Pharmacists Association found that within the past month 38.8 percent of pharmacists reported a gag clause preventing them from providing other options to patients between 10 and 50 times.¹⁰ Much of the information regarding gag clauses comes anecdotally, this includes from media sources like the New York Times.¹¹

Other Legislation

There are seven states (Connecticut, Georgia, Maine, Mississippi, North Carolina, North Dakota, and Virginia) that have enacted laws that prohibit “gag clauses” in contracts with pharmacies.¹² Five states (Arkansas, Georgia, Louisiana, Maryland, and North Dakota) have passed legislation targeting overpayments.¹⁰ The Pharmaceutical Care Management Association, which represents PBMs, has filed a lawsuit against the state of North Dakota for its legislation, which targets both of these issues, but goes further than other states and includes language regarding pay-for-performance provisions.¹³

At the federal level, two bills have been recently introduced by a group of bipartisan Senators that target pharmacy gag clauses.¹⁴ The *Patient Right to Know Drug Prices Act* would prohibit PBMs from enacting gag clauses in contracts with pharmacies for marketplace and employer health plans.¹⁵ The other piece of

¹⁰National Community Pharmacists Association (2016). *Survey of Community Pharmacies*. Retrieved from http://www.ncpa.co/pdf/dir_fee_pharmacy_survey_june_2016.pdf

¹¹ Pear, R. (Feb 24, 2018). *Why Your Pharmacist Can't Tell You That \$20 Prescription Could Cost Only \$8*. Retrieved from <https://www.nytimes.com/2018/02/24/us/politics/pharmacy-benefit-managers-gag-clauses.html?auth=login-email>

¹² National Conference of State Legislatures (March 14, 2018). *Prohibiting PBM “Gag Clauses” that Restrict Pharmacists from Disclosing Price Options Recent State Legislation 2017-2018*. Retrieved from http://www.ncsl.org/Portals/1/Documents/Health/Pharmacist_Gag_clauses-2018_14523.pdf

¹³ Pharmaceutical Care Management Association (July 12, 2017). *PCMA Challenges North Dakota Health Mandates that Undermine Patient Safety, Increase Prescription Drug Costs*. Retrieved from <https://www.prnewswire.com/news-releases/pcma-challenges-north-dakota-health-mandates-that-undermine-patient-safety-increase-prescription-drug-costs-300487045.html>

¹⁴ Office of Senator Susan Collins. (March 15, 2018). *Senator Collins, McCaskill, Stabenow Lead Bipartisan Group of Senators in Introducing Legislation to Prohibit “Gag Clauses” that Cause Consumers to Pay Higher Prices for Prescription Drugs*. Retrieved from <https://www.collins.senate.gov/newsroom/senators-collins-mccaskill-stabenow-lead-bipartisan-group-senators-introducing-legislation>

Date: March 23, 2018	POLICY ANALYSIS HB18-1284	Page 4
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legislation, *Know the Lowest Price Act*, provides the same requirement for Medicare Advantage and Medicare Part D health plans.¹⁵ The Pharmaceutical Care Management Association has released a statement on the legislation stating that they “support the patient always paying the lowest cost at the pharmacy counter, whether it’s the cash price or the copay.”¹⁵ The largest PBM in the country, CVS Health, also applauded the introduction of these bills.¹⁶

This Legislation

This bill is titled the “Patient Drug Cost Savings Act.” The General Assembly declares that consumers have the right to know about the options to reduce the amount of money they pay for prescription drugs at pharmacies. It declares that this bill will save consumers money by allowing pharmacists to provide information regarding the cost of prescription drugs.

The bill prohibits carriers and pharmacy benefit managers that have contracts with pharmacies or pharmacists from prohibiting them from providing a covered person information about the cost-sharing for the drug and that of another, more affordable drug. The other drug that the pharmacist provides information on to the individual must be therapeutically equivalent. A carrier or PBM cannot penalize a pharmacy or pharmacist from disclosing this information or selling the patient a more affordable alternative. A carrier or PBM cannot require a pharmacy to charge and collect a copayment that exceeds the total charges submitted by the network pharmacy. If a carrier has not complied with these requirements the Commissioner of Insurance will institute a corrective action plan for the carrier or use their enforcement powers to obtain compliance. Finally, the bill clarifies if any of these requirements conflict with federal rules or laws, then the federal law or rule supersedes the bill.

Reasons to Support

Overpayments, or “clawbacks,” may directly increase a patient’s out-of-pocket costs. With over 2 million claims with overpayments in 2013, at an average of \$7.69, American consumers overpaid more than 16 million dollars that year. Evidence shows that increased cost-sharing is associated with decreased pharmaceutical use and adherence.⁷ The magnitude of the effect of higher prices for patients at the point of sale may be especially great on vulnerable patients and those that are chronically ill. Creating a dual-pronged approach to target the gag clauses and the overpayments will allow patients to not be kept in the dark about when they may be overpaying. The elimination of the gag clauses will also allow pharmacists to ensure that an individual is receiving the most appropriate and affordable medication. The legislation also lessens the interference in the pharmacist-client relationship by the insurer or PBM. Consumers need accurate information at their pharmacy so they can get their drugs at the most affordable price. Furthermore, without the clawbacks, this could slightly decrease the price of drugs for all consumers at the point-of-sale.

Supporters

- Colorado Cross-Disability Coalition

Reasons to Oppose

With many in the PBM industry stating that gag clauses are not a norm for contracting with pharmacies, the problem may be more anecdotal than actual. However, the 38 percent of pharmacists that reported gag clauses may dispute this assertion.

¹⁵ Pharmaceutical Care Management Association (March 15, 2018). *PCMA Responds to “Patient Right to Know Drug Prices Act” and “Know the Lowest Price Act”*. Retrieved from <https://www.pcmanet.org/pcma-responds-to-patient-right-to-know-drug-prices-act/>

¹⁶ CVS Health (March 15, 2018). *CVS Health Applauds New Legislation to Better Inform Pharmacy Choices*. Retrieved from <https://cvshhealth.com/newsroom/press-releases/cvs-health-applauds-new-legislation-better-inform-pharmacy-choices>

Date: March 23, 2018	POLICY ANALYSIS HB18-1284	Page 5
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Opponents

- No opposition has been made public at this time

Other Considerations

If an individual opts for paying for the drug at the cash price rather than through their insurance, the money spent will not count towards their maximum costs for that plan year. Therefore, it may take people longer to reach that out-of-pocket maximum if they keep paying the cash price at the pharmacy. This could lead to people actually paying more for their drugs in the long-term, as it takes longer to reach the point when their insurance plan no longer requires cost-sharing.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.