2015 COST TRENDS REPORT

Massachusetts Health Policy Commission

Topics to be covered

2015 Cost Trends Report

1. Spending trends in Massachusetts and the United States
   - Estimated 13% growth in drug spending in MA in 2014
   - Substantial growth in top drug classes, in addition to high spending for Hepatitis C drugs
2. Policy considerations for discussion

Pharmaceutical spending rising in both the US and MA

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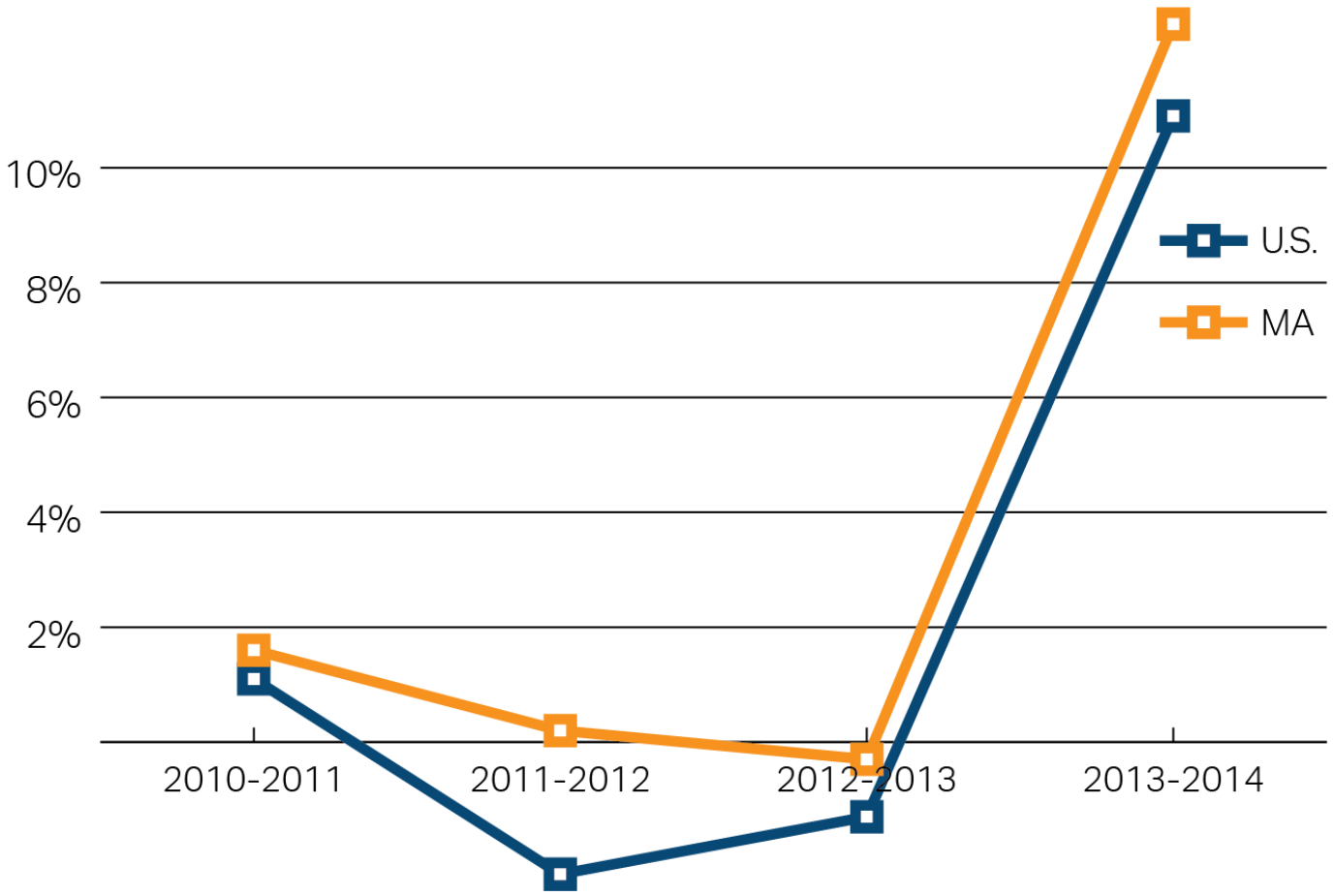
Commercial payers' per-enrollee annual growth rate for prescription drug spending, 2010 - 2014



Source: CMS National Health Expenditures (US commercial), CHIA data (MA commercial).

Drug spending is a pressing issue for cost containment

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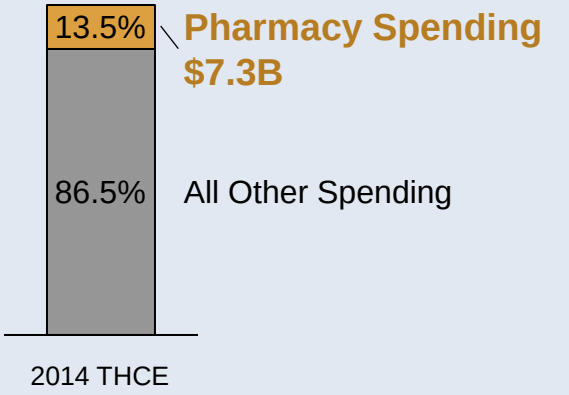
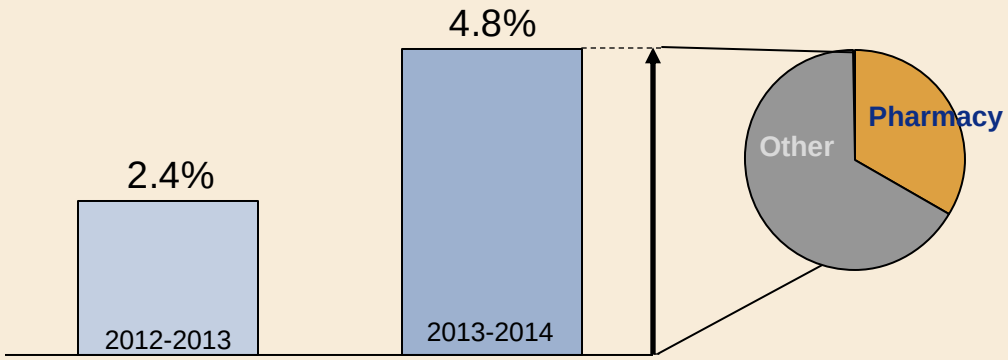
Spending in 2014

In Massachusetts, pharmacy spending grew 13% per capita from 2013 to 2014

Pharmacy Spending accounted for 13.5% of THCE in 2014





Pharmacy Spending accounts for about one-third of 4.8% THCE growth from 2013-2014

Trends in Massachusetts mirror US growth of 12 percent per capita between 2013 and 2014, after a decade of relatively low growth

Drug spending figures do not account for manufacturer rebates, which could affect both level and trend of spending

Source: CHIA data (MA). CMS, National Health Expenditures (US).
Notes: THCE: total health care expenditures.

Many similar factors drive drug spending in MA as in the US overall

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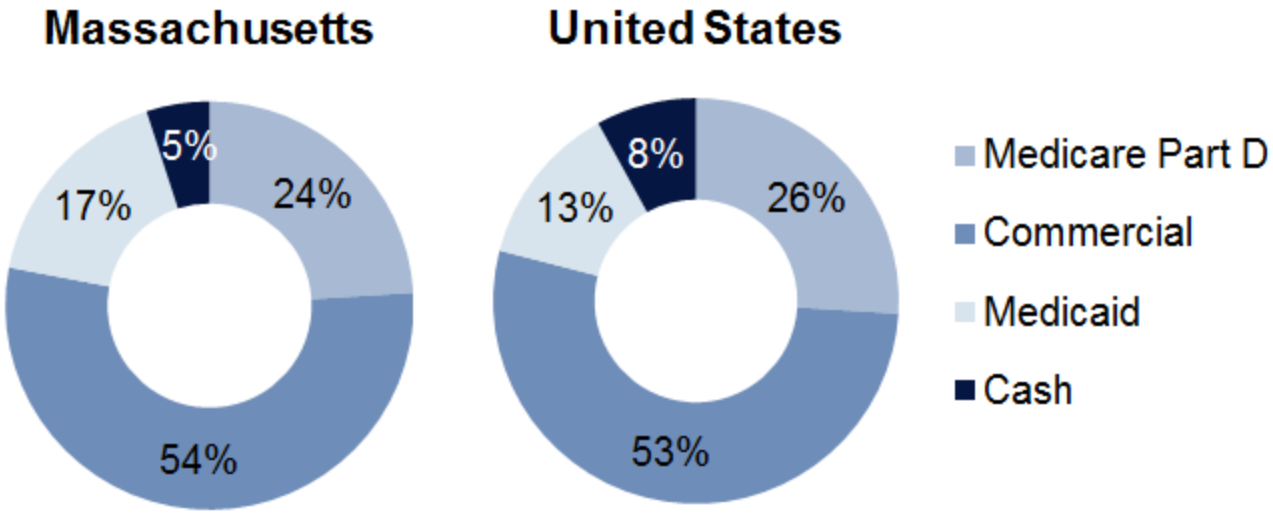

- National nature of drug prices
  - Drug prices for commercial insurers largely determined by negotiations between a national pharmacy benefit management company (PBM) and drug manufacturers
  - Private payers can also negotiate independently with drug manufacturers for additional rebates
  - State Medicaid agencies may negotiate individually with manufacturers or join multi-state consortiums
- Similar payer distribution for prescription drugs

Source: Data from IMS Health Incorporated.
Notes: THCE: total health care expenditures.

Drivers of national pharmaceutical spending increase in 2014

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1. **New high-cost drugs**
   Sofosbuvir (Sovaldi) and other HCV drugs entered the market late 2013 and early 2014 at extremely high prices: $84k for 12-week treatment with Sofosbuvir

2. **High drug price increases**
   While price increases for brand drugs have greatest impact on total spending, increases for some generics also impact spending and access

3. **Low rate of patent expirations**

Stakeholder Impact

- Most commercial payers had financial losses due to HCV drugs
  - Sofosbuvir came to market earlier than payers expected due to FDA fast track approval
- Payers worried about meeting the health care cost growth benchmark
- Providers worried about APM budgets
- Consumers may face high cost-sharing and higher premiums

Components of drug spending growth in the US

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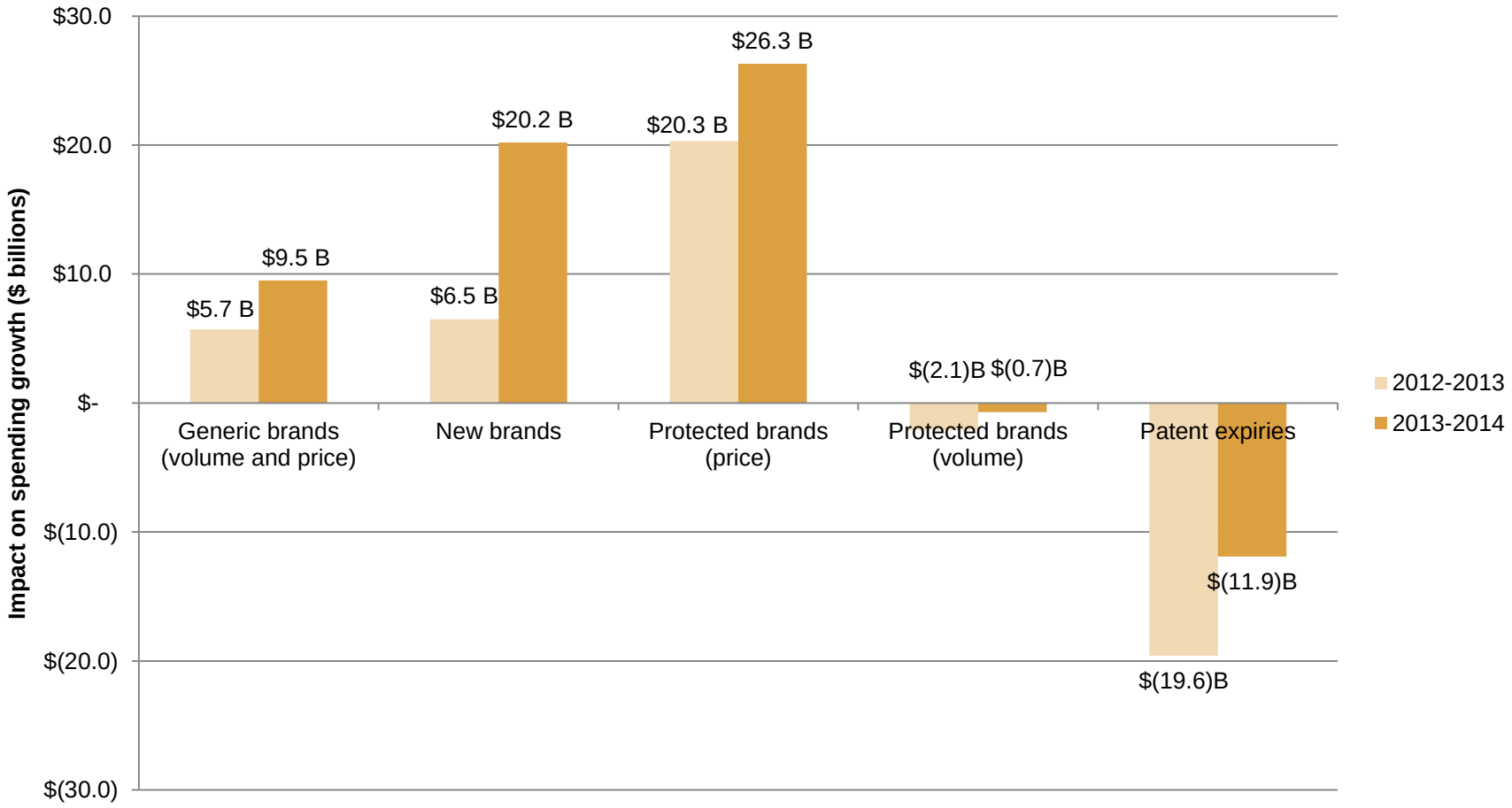
Estimates of US spending growth for pharmacy and non-pharmacy drugs:
+$10.8B to $330.5B in 2013, +$43.4B to $373.9B in 2014



Source: IMS, "Medicines Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014," April 2015.

In MA, HCV drugs drove drug spending growth in 2014, but other top contributing therapy classes have had sustained high growth rates

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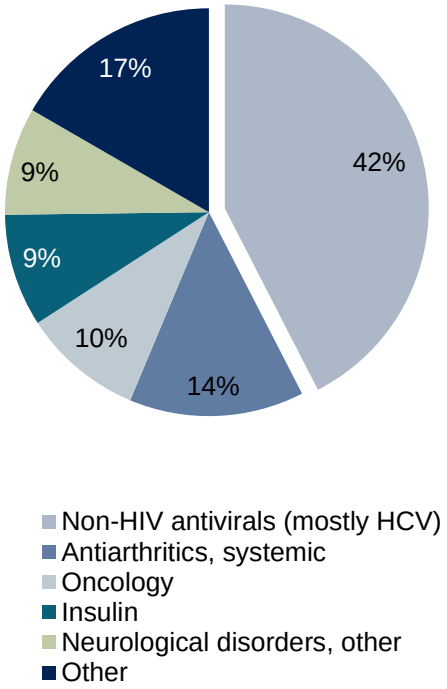
Top therapy classes by contribution to drug spending growth in Massachusetts (dollars in millions)

Contribution to drug spending growth in 2014



		2010	2011	2012	2013	2014	2013 - 2014
1	**Non-HIV Antivirals (mostly Hepatitis C)**						**Difference**
	Growth		37.7%	20.9%	-10.1%	352.3%	
	Spending	$64.4	$88.7	$107.2	$96.4	$436.0	$339.6
2	**Antiarthritics, Systemic**						
	Growth		15.6%	19.7%	23.5%	28.4%	
	Spending	$228.4	$264.1	$316.2	$390.6	$501.5	$110.9
3	**Oncology**						
	Growth		2.8%	11.2%	7.2%	12.3%	
	Spending	$506.1	$520.3	$578.5	$620.0	$696.4	$76.4
4	**Insulin**						
	Growth		15.0%	29.1%	33.7%	19.8%	
	Spending	$182.0	$209.3	$270.3	$361.4	$432.9	$71.5
5	**Neurological Disorders, Other**						
	Growth		40.2%	24.2%	27.0%	39.9%	
	Spending	$77.3	$108.4	$134.6	$171.0	$239.3	$68.3

Overall, many top drug classes have substantial annual spending growth, although total spending in earlier years was offset by decreases in other drug classes, due to factors including generic entry

Source: Data from IMS Health Incorporated.

Note: Spending includes drugs provided in both pharmacy (prescription) and non-pharmacy (e.g. hospital and physician office) settings. IMS estimates are not directly comparable to CHIA methodology; top contributions may represent upper bound estimates.

Many trends point towards ongoing increases in drug spending, as pharmaceutical innovation continues

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National Health Expenditures estimates annual high single digit spending growth for drugs in the US over the next decade.

Drug Pricing

Sofosbuvir and other new HCV drugs have very high prices (like “orphan drugs”), but a wider market than the typical orphan drug. This pricing trend will likely continue in new products.

New costly cholesterol drugs. PCSK9 inhibitors treat high cholesterol at a cost of ~$14k per patient per year.

- The FDA approved the first two products in summer 2015: alirocumab (Praluent) and evolocumab (Repatha)
- Approved for patients with high cholesterol resistant to traditional therapies, but off-label prescribing may capture additional populations

Specialty Drugs

Spending on specialty drugs has grown from 26% to 34% of MA pharmaceutical sales from 2010 to 2014. Such drugs are typically costly, >$6,000 per year.

In MA, spending for specialty products grew by 67% between 2010 and 2014 compared with 16% growth for traditional products.

Biologics

Biologics are an area of innovation and growth, typically within specialty drugs. They are not amenable to typical generic competition; FDA regulations are still in flux.

- In MA, spending on biologics grew by 56% between 2010 and 2014

Source: Data from IMS Health Incorporated.

Public polling indicates strong support for possible solutions

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86%

Favor requiring drug companies to release information to the public on how they set drug pricing[+]

84%

Favor the Medicare program negotiating with drug companies to lower the prices of prescription drugs for seniors*

[+]Kaiser Family Foundation Health Tracking Poll (conducted August 6-11, 2015)

* *STAT*/Harvard T.F. Chan School of Public Health Poll, November 2015.

Select efforts to slow price growth

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Value-based benchmarks	• Third party quantifies the value of a drug, accounting for the therapy's expected clinical benefit, medical savings, and price • Institute for Clinical and Economic Review (ICER) calculates value-based benchmark price for selected new drugs; plans to evaluate 15-20 drugs over the next two years • Value can be used in price negotiations and potentially benefit design
Risk-based contracting	• Payers contract with manufacturers to pay less / more depending on whether drug produces expected outcomes • Harvard Pilgrim Health Care developed a performance-based rebate model for PCSK9 evolocumab (Repatha)

Group purchasing	• Payers pool purchasing power to improve leverage with manufacturers
	• Numerous models for Medicaid programs and other participants:
	  • Northwest Prescription Drug Consortium: open to all OR and WA residents
	  • Minnesota Multi-State Contracting Alliance for Pharmacy: includes 47 states and several cities (MA, CT, IL do not participate)

Source: "Harvard Pilgrim strikes 'pay-for-performance' deal for cholesterol drug." Boston Globe, November 08, 2015.

Policy considerations for discussion

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- Implications for HPC's policy recommendations and work in 2016
- How should drugs and other high-cost innovations be considered in evaluation of state performance on spending and the benchmark?
- Should the state require additional research, transparency, and / or reporting on drug pricing (including the ability for the state to cap prices)?
- What are other opportunities at the state level to support innovation and value yet contain costs?

Top 20 drug classes by spending

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	2010	2011	2012	2013	2014
1. Oncology					
Growth		2.8%	11.2%	7.2%	12.3%
Spending	$506.1	$520.3	$578.5	$620.0	$696.4
2. Antiarthritics, Systemic					
Growth		15.6%	19.7%	23.5%	28.4%
Spending	$228.4	$264.1	$316.2	$390.6	$501.5
3. Non-HIV Antivirals (mostly HCV)					
Growth		37.7%	20.9%	-10.1%	352.3%
Spending	$64.4	$88.7	$107.2	$96.4	$436.0
4. Insulin					
Growth		15.0%	29.1%	33.7%	19.8%
Spending	$182.0	$209.3	$270.3	$361.4	$432.9
5. Antipsychotics					
Growth		13.5%	-28.4%	-15.6%	3.8%
Spending	$499.7	$567.1	$405.9	$342.5	$355.4
6. HIV Antivirals					
Growth		12.5%	18.0%	9.9%	5.1%
Spending	$227.0	$255.4	$301.4	$331.1	$348.0
7. Inhaled Steroids					
Growth		8.2%	10.8%	12.1%	0.7%
Spending	$256.8	$277.8	$307.9	$345.1	$347.5
8. Immunomodulators					
Growth		9.5%	21.4%	20.5%	30.8%
Spending	$128.9	$141.1	$171.3	$206.4	$269.9
9. GI Anti-Inflammatory					
Growth		12.6%	62.5%	11.6%	-23.2%
Spending	$164.4	$185.1	$300.7	$335.6	$257.6
10. Analeptics					
Growth		16.9%	17.4%	2.1%	-1.9%
Spending	$177.1	$207.1	$243.1	$248.1	$243.4

	2010	2011	2012	2013	2014
11. Neurological Disorders, Other					
Growth		40.2%	24.2%	27.0%	39.9%
Spending	$77.3	$108.4	$134.6	$171.0	$239.3
12. Cholesterol Reducers					
Growth		8.8%	-22.9%	-14.0%	-1.1%
Spending	$312.6	$340.1	$262.2	$225.5	$223.1
13. Bronchodilators					
Growth		12.5%	17.1%	0.8%	-6.3%
Spending	$166.5	$187.3	$219.3	$221.1	$207.2
14. Anticoagulants					
Growth		-5.0%	-17.5%	-20.1%	3.8%
Spending	$274.4	$260.8	$215.2	$172.0	$178.5
15. Analgesic Narcotics					
Growth		4.5%	8.8%	8.1%	2.9%
Spending	$133.0	$139.0	$151.2	$163.4	$168.2
16. Specific Antagonists					
Growth		26.2%	27.8%	7.3%	4.8%
Spending	$88.2	$111.3	$142.2	$152.6	$160.0
17. Antidepressants					
Growth		-7.6%	-13.0%	8.0%	-27.1%
Spending	$249.0	$230.0	$200.2	$216.3	$157.6
18. Hematinics					
Growth		-15.5%	-12.3%	-2.8%	-1.7%
Spending	$216.2	$182.6	$160.1	$155.6	$153.0
19. Non-Insulin Diabetes					
Growth		0.4%	-5.7%	-4.3%	16.9%
Spending	$141.4	$142.0	$133.9	$128.2	$149.9
20. Seizure Disorders					
Growth		4.2%	-2.3%	18.0%	9.5%
Spending	$113.2	$118.0	$115.3	$136.0	$148.9

Source: Data from IMS Health Incorporated.