January 2016

MASSACHUSETTS HEALTH POLICY COMMISSION
2015 COST TRENDS REPORT

Prescription Drug Spending

Key Findings

Drug spending increased in 2014:

- **After more than a decade of overall low pharmaceutical spending growth rates, dramatic jumps in spending occurred in 2014 for both Massachusetts and the U.S.** With trends in Massachusetts largely mirroring national trends, drug spending has become an increasing concern for payers, providers—especially those engaging in new risk-based payment models —and patients facing out-of-pocket costs for medications.

- **In 2014, prescription drug spending in Massachusetts grew 13.4 percent per capita (14.1 percent total) over 2013 levels.** In the U.S. overall, prescription drug spending grew by an estimated 11.6 percent per capita (12.5 percent total) in 2014. THCE grew 4.8 percent in 2014, exceeding the 3.6 percent target benchmark set by the HPC. CHIA estimated that the growth in drug spending accounted for approximately one-third of THCE growth (1.6 percentage points).

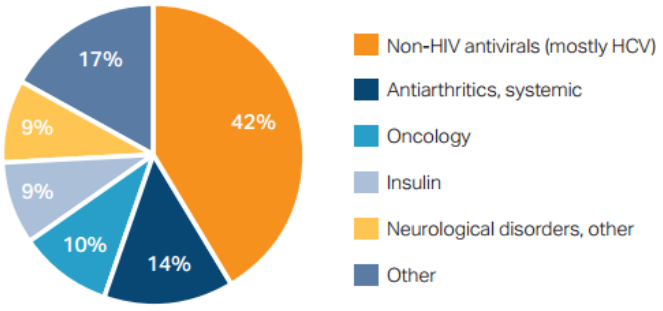
Key factors driving drug spending in 2014:

- **Three main factors drove the high growth in drug spending in 2014: the entry of new high-cost drugs, price growth for existing drugs, and a low level of patent expirations.[1] New, effective, but very high-cost drugs for the Hepatitis C virus (HCV) were a particular driver of drug spending growth.**

- In 2014, 42 percent of total drug spending growth was due to growth in antivirals (mostly HCV drugs), with spending growth in antiarthritics, oncology, insulin, and neurological disorder therapies also representing particularly high contributions (based on data from drug data vendor IMS that includes spending for both pharmacy and non-pharmacy drugs).

- **Many top drug classes have had double-digit spending increases each year, before accounting for rebates.** For oncology drugs, spending in Massachusetts before rebates grew 12.3 percent from 2013 to 2014, to almost $700 million in 2014. However, net of rebates and discounts, prices for branded drugs on the market for at least two years grew 5.5 percent from 2013 to 2014, less than the net 6.8 percent growth rate from 2012 to 2013. **Collecting and incorporating drug-rebate information is crucial for accuracy in tracking drug spending.**

Exhibit 4.4: Top therapy classes by contribution to 2014 drug spending growth in Massachusetts



Note: Spending includes drugs provided in both pharmacy (prescription) and non-pharmacy (hospital and physician office) settings. IMS estimates are not directly comparable to Center for Health Information and Analysis methodology; top contributions may represent upper bound estimates.
Source: IMS Health Incorporated.

[1] IMS. Medicine use and shifting costs of healthcare: A review of the use of medicines in the United States in 2014. IMS Institute for Healthcare Informatics 2015.

Affordability concerns:

- The prices of high-cost drugs impact affordability for patients accessing high cost products**. Cost-sharing for a specialty-tier drug under Medicare Part D is usually between 25 and 33 percent of the drug's negotiated price.** In 2013, 23 percent of commercial plans had a specialty tier of cost-sharing. All plans sold on ACA exchanges have specialty tiers, with the average bronze plan offering 34 percent cost-sharing for these drugs.

- **While patient liability is limited through ACA out-of-pocket maximums, these limits still represent a substantial financial burden for many patients. Furthermore, drug costs ultimately impact all consumers through the inclusion of these costs in insurance premiums.**

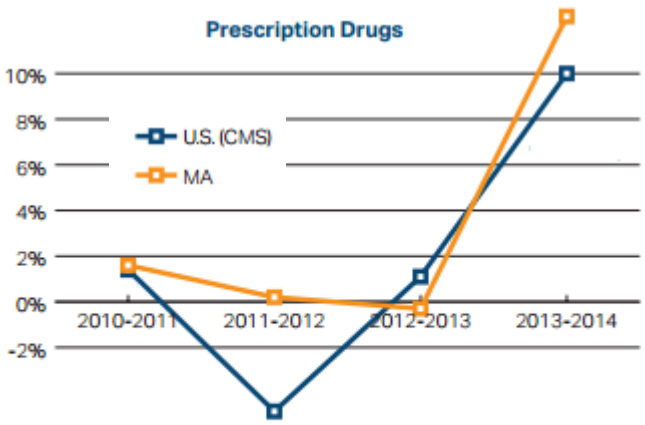
Expectations for future drug spending:

- **While 2014 had unique factors for spending, many trends strongly suggest that large increases in drug spending will continue, in the absence of policy changes.**

- **Expensive and complex products—specialty and biologic drugs— have been gaining in their share of all drug spending.** Spending on specialty drugs, which typically cost more than $6,000 a year, grew from 26 percent to 34 percent of Massachusetts' drug sales between 2010 and 2014. While increases in prices and spending on new products have long been offset by expiring patents, the complex market for biologics is unlikely to exactly mirror traditional levels of substitution with lower-cost generic products.

- **CMS estimates annual high single digit spending growth over the next decade.** In fact, data from the first three quarters of 2015 show drug spending increases of more than 8 percent in the U.S. relative to the same time period in 2014.

Exhibit 2.6: Annual growth in commercial spending per enrollee, by spending category, 2010 – 2014



Source: Centers for Medicare and Medicaid Services; Center for Health Information and Analysis

HPC Recommendations

Rebate data, pricing transparency and public accountability:

- The Legislature should require increased transparency in drug pricing and manufacturer rebates.
  - Collecting and incorporating drug-rebate information is crucial for accuracy in tracking drug spending. Collection strategies should consider the confidentiality of net pricing agreements in their design.
  - CHIA may be able to leverage existing authority to collect drug-rebate information.
  - The Legislature should add pharmaceutical and medical device manufacturers to the list of mandatory market participant witnesses at the HPC's Annual Health Care Cost Trends Hearing.

Value-based price benchmarks and risk-based contracting:

- All payers should pursue the use of value-based benchmarks when negotiating prices and consider opportunities for the use of risk-based contracting with manufacturers.

- The price benchmark begins with calculating a sustainable price that reflects the long-term comparative clinical and cost-effectiveness of the drug; the benchmark price also reflects the potential budget impact, including any expected off sets in decreased medical spending over a five year time horizon as a result of the drug's use.
- Some payers have considered value in coverage through developing risk-based contracting with drug manufacturers, such as price-volume or performance-based models.

Group purchasing and joint negotiation:

- Public and commercial payers and purchasers should consider a range of opportunities for group purchasing and joint negotiation.
  - While MassHealth has demonstrated the ability to negotiate high rebates, other states have different models, and it is important for the Commonwealth to continue to review best practices and identify opportunities to maximize value in spending. Other models include achieving additional rebates on top of those rebates required by law or negotiated through PBMs, or aiming to extend discounts to all state payers.

Advocacy for federal level changes:

- Massachusetts state and federal lawmakers should advocate for legislation to allow Medicare to negotiate prescription drug prices.

Protocols and guidelines for efficient utilization of drugs:

- Stakeholders should work together to develop and use treatment protocols and guidelines that make appropriate use of lower-cost drugs when available and to achieve consensus on appropriate use when new high cost drugs enter the market.