Prescription Drug Affordability: Challenges and Innovation in New Hampshire

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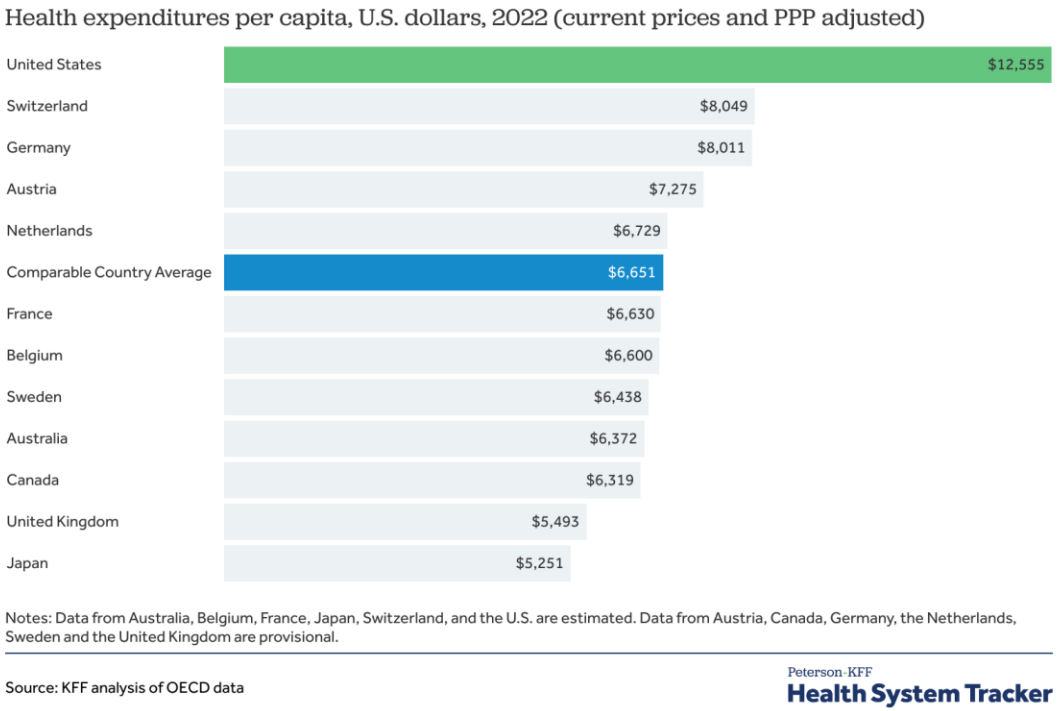
Houston: We Have a Spending Problem



The U.S. spends far more than other countries on health care yet has worse health outcomes.

Relative to other countries, the U.S. has:

Lower than average life expectancy.	Worse population health.	Fewer people with coverage and access to care.

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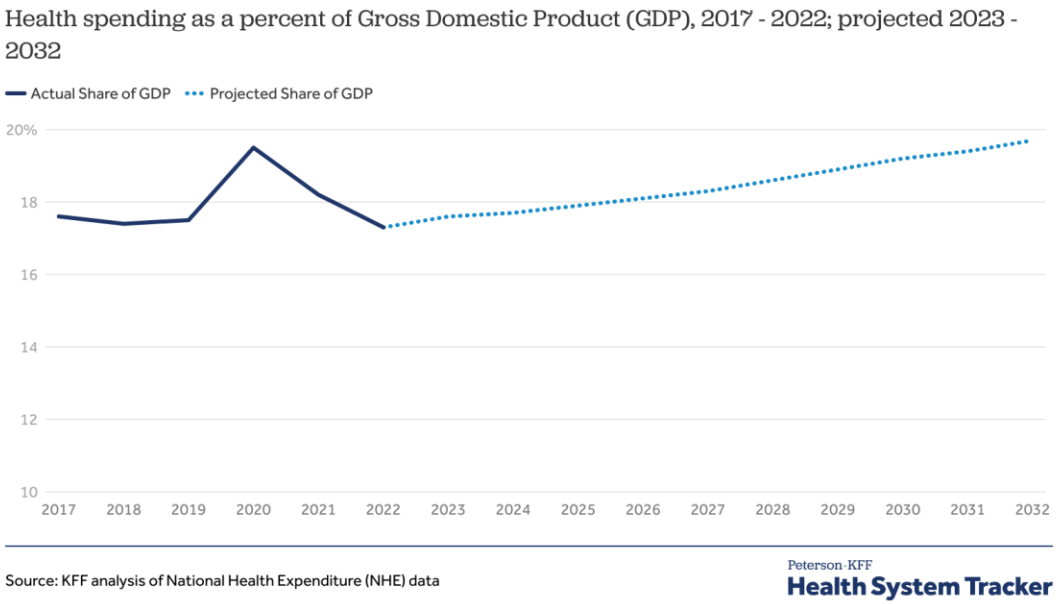
The Problem is Growing



Health spending is estimated to outpace growth in the overall economy in **2025** and reach **17.9% of GDP**.

Health spending is projected to account for nearly **one-fifth of the U.S. economy by 2032**.

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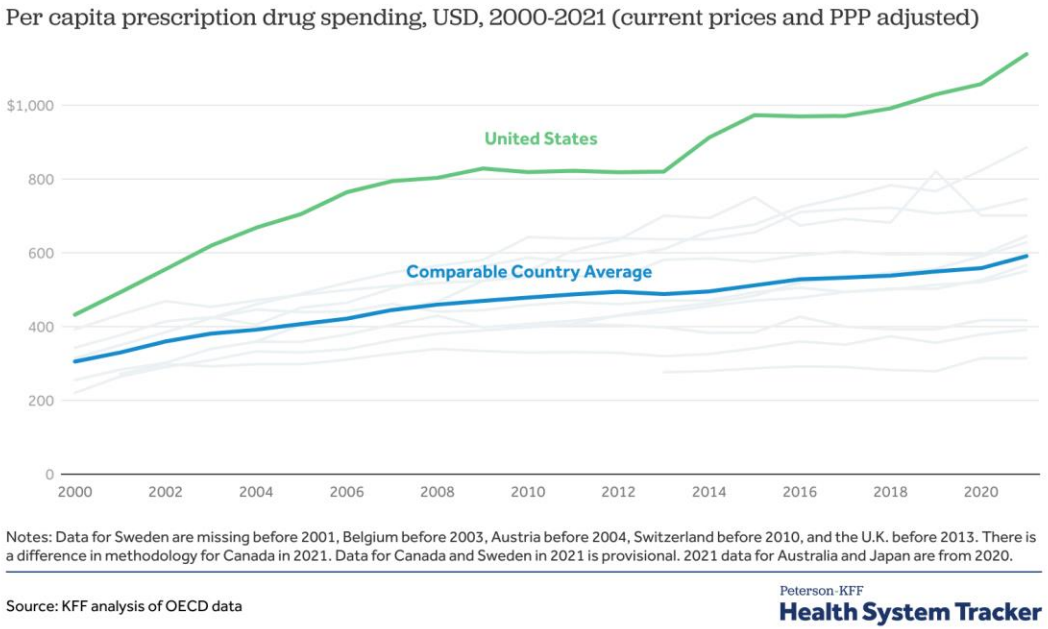
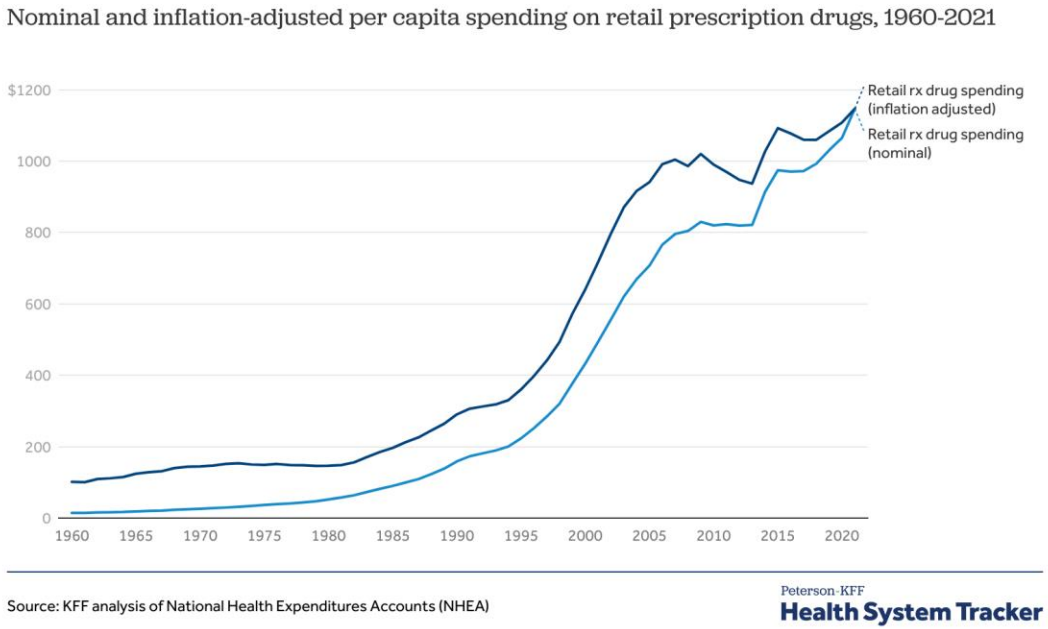
Recent Trends in U.S. Rx Spending

U.S. Per Capita Rx Spending vs. OECD (2000 – 2020)



U.S. Spending on Retail Prescription Drugs (1960 – 2021)



Peterson-KFF Health System Tracker; 2023

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High Drug Prices Have Consequences

61%

of U.S. adults take more than 1 prescription medication

27% take more than 4 prescription medications.

28%

of U.S. adults reported having trouble affording their medications

40% of those with an annual household income of less than $40,000.

31%

of U.S. adults don't take medications as prescribed due to cost.

E.g., skipping refills, cutting pills in half

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Rising Prescription Drug Spending is Squeezing:

1. **Governments (federal and state)**
   - States spend a large portion of their budgets – about 20% - on Medicaid.
   - Spending on major health care programs accounted for more than 25% of all federal spending in 2016.
2. **Businesses**
   - The average premium for employer-sponsored family plans increased 55% between 2007 and 2017, limiting businesses' ability to increase wages.
   - Businesses' health care costs hinder US global competitiveness.
3. **Households**
   - 44% of Americans cannot cover an unexpected $400 expense without borrowing money or selling something.
   - In New Hampshire, the average per-person health care expenditures is $11,793, and family premiums and deductibles account for nearly 50 percent of average wages.
   - 11% of all people in New Hampshire and 26% of Granite Staters who identify as multi-racial reported that they delayed seeking care due to cost concerns.

How Did We Get Here?

1959

Senate hearings on ways to strengthen the drug provisions of the FD&C Act

- 17 births of deformed infants tied to thalidomide in the U.S.

1962

The Kefauver-Harris Amendments of 1962 ("Drug Efficacy Amendment")

- FDA regulatory power to require manufacturers to prove their drugs are not only safe but effective.

1983

Orphan Drug Act (ODA) of 1983

- Encourages drug development for rare diseases by providing additional market exclusivities.

1984

The Hatch-Waxman Act of 1984 ("Drug Price Competition and Patent Term Restoration Act of 1984)

- Sought to maintain adequate incentives for innovation and lower drug prices.

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Where Are We Now?

The Upshot

Nearly 85% of drugs dispensed in the U.S. are generic.

Generic drugs are available in nearly every therapeutic class, many are the standard of care for common diseases.

Prices of generics in the US are lower than in most countries.

The Downside

In 2023, brand-name drugs launched in the U.S. market at prices **35 percent higher** than in 2022.

In 2023, U.S. spending on prescription drugs **increased by $10.4 billion**.

Net prescription drug costs consume **23 percent of health care premiums**.

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Interlocking Drivers of High Drug Prices

PATENT ABUSES AND ANTICOMPETITIVE BEHAVIORS

MARKET DISTORTIONS

HIGH LAUNCH PRICES AND UNJUSTIFIED PRICE INCREASES

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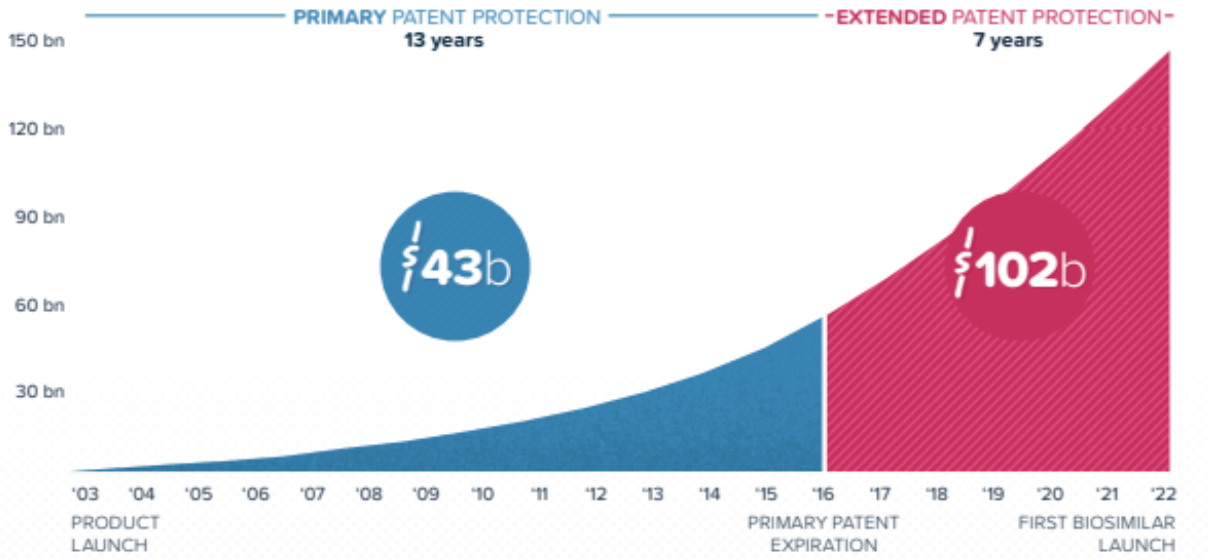

Patent Abuse and Anticompetitive Behavior

- Between 2005 – 2015, ~75% of new drug patents were granted for existing drugs.
- 80 of the 100 best-selling drugs have extended their patent protections at least once, ~ half have done so multiple times.
- Humira (AbbVie)
  - **257** patent applications and 130 granted patents.
  - **39** years of monopoly from granted patents.
  - **90%** patent applications filed after FDA approval.

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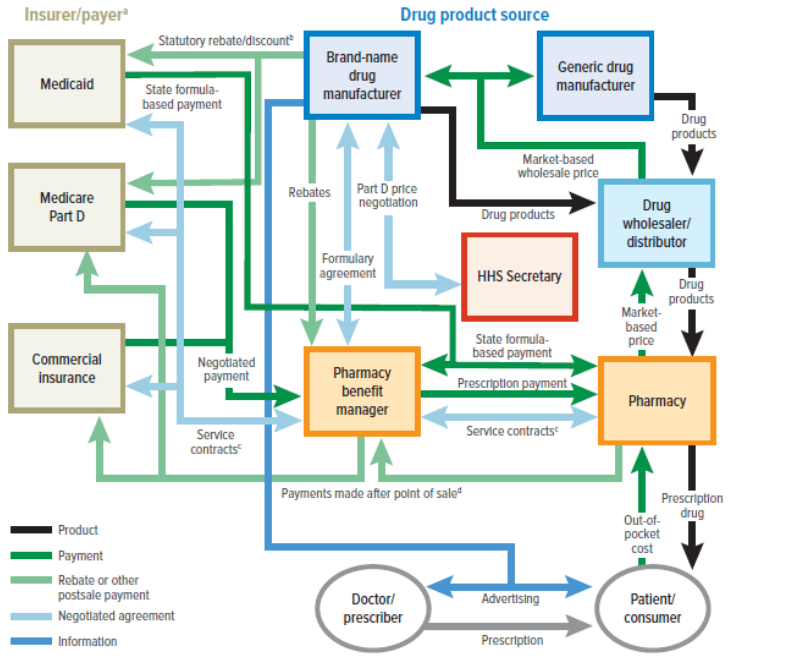
Market Distortions

In the U.S., drugs are not bought by the patients who take them.

1. First, a doctor usually must write a prescription for the drug.
2. Then, a patient receives the drug (e.g., retail pharmacy), and a claim is submitted to their insurer. The patient will often pay a co-pay or co-insurance for the prescription.
3. The insurer will then reimburse whoever dispensed the drug (e.g., hospital, specialty pharmacy, mail-order pharmacy).

Behind the scenes, other players like Pharmacy Benefit Managers (PBMs) and wholesalers manage the flow of money and product. **As a result, it is very difficult to know exactly what a drug costs for an individual patient.**

Financial, Product, and Information Flows in the U.S. Prescription Drug Market



Data source: Congressional Budget Office.

HHS = Department of Health and Human Services.

a. The figure does not include direct federal purchasers such as the Department of Veterans Affairs, the Department of Defense, the Public Health Service, the Coast Guard, and the Bureau of Prisons.

b. For Medicare Part D, "statutory rebate/discount" includes the Part D inflation rebate and statutory discounts. For Medicaid, it includes the statutory Medicaid rebate, consisting of the basic rebate plus the inflation rebate. (Manufacturers may also pay supplemental rebates.)

c. The relationships between commercial insurers, pharmacy benefit managers (PBMs), and pharmacies are depicted here as contracted arrangements. PBMs are sometimes integrated with the insurer, the pharmacy, or both.

d. Price concessions from pharmacies after the point of sale take the form of periodic payments from pharmacies to the plans or to PBMs.

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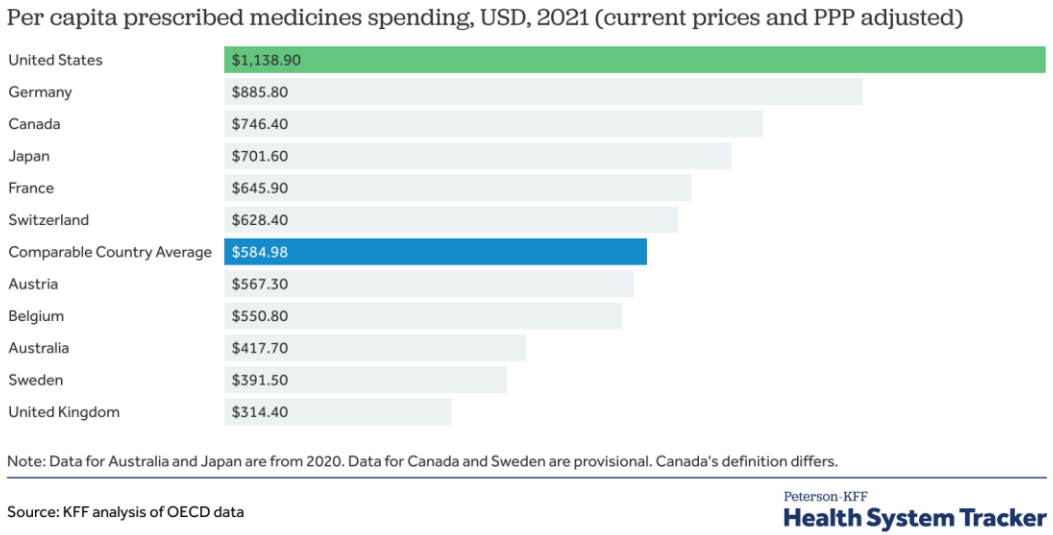
Result: U.S. Spends 2x More on Rx Than Other Countries



The design of the U.S. health care system, particularly when looking at drugs, creates two unique challenges:

1. Unlike systems in other countries, pharmaceutical companies have the power to set their own price through negotiation with thousands of different payers.
2. Consumers and prescribers have almost no way of knowing how much their drugs will cost.

Annual U.S. prescription drug spending ~$500 billion, or **1 in 7 health care dollars**.

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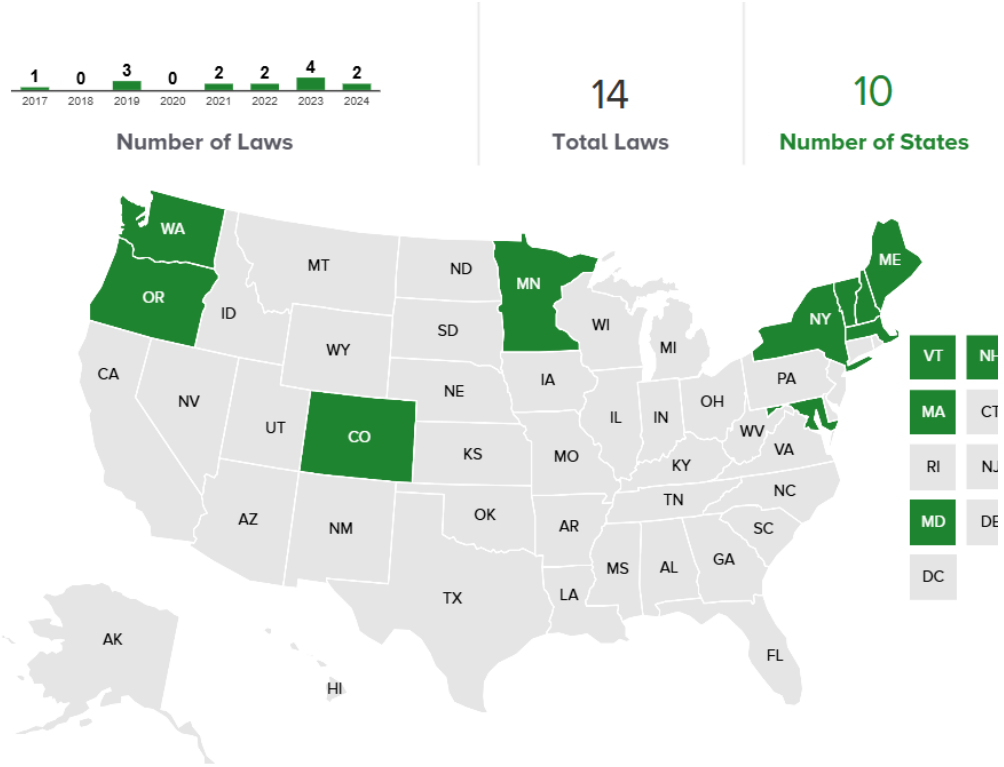
Prescription Drug Affordability Boards (PDABs) and Related State Activity



- New Hampshire became one of the first states to establish a PDAB in 2022.
- Notable State Activity (2017 – 2024):
  - Limits on consumer cost sharing (28 states)
  - PBM licensing, oversight, and regulation (50 states)
  - Transparency (24 states)

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Improving Public Sector Buying Practices

- As health care costs rise, the cost of medications purchased by government programs becomes an important health policy issue.
  - From 2018 – 2021, **the average cost of a brand-name drug increased almost 50 percent** from $430.51 to $631.16 in Medicaid.
- High spending on health care can be damaging to the economy, which may result in payers having to cut benefits or increase cost-sharing.
- Reducing drug costs thus allows the benefits of all health care services to be spread more widely throughout society.

NH PDAB

Mission: *To serve an essential public function by analyzing prescription drug prices in New Hampshire and making recommendations to public payors and the legislature. Our goal is to balance affordability with sustainable spending while ensuring that Granite Staters have access to essential medications.*

Membership	•Five (5) sitting members and five (5) alternates appointed by the Senate President, Speaker of the House, and Governor.
Term	•Five (5) years
Organization	•Independent entity administratively attached to the Department of Health and Human Services.
Leadership	•The Chairman is elected by the Board members by at least 4 of 5 votes and is administered by an Executive Director.

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NH PDAB Stakeholder Advisory Council

Membership	• Twelve (12) member advisory council designated under statute RSA 126-BB:4.
Term	• Three (3) years.
Meetings	• Ad hoc
Leadership	• Nomination of the Stakeholder Advisory Council Chairman must be approved by a majority vote by the Stakeholder Advisory Council.

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2024 NH PDAB Spending Analysis

- **Objective**: Provide a retrospective analysis of outpatient retail prescription drug spending across four (4) New Hampshire public employee health plans.
- **Key Metrics**:
  - Costliest Drugs
  - Most Utilized Drugs
  - Year-over-Year Cost Growth

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Top 25 Costliest Drugs (2023)

- **Total Gross Spending**: $127.5 million
- **Top 5 Costliest Drugs**:
  - Humira ($21.9 million)
  - Stelara ($13.6 million)
  - Ozempic ($10.1 million)
  - Eliquis ($8.1 million)
  - Dupixent ($6.9 million)
- **Insights**:
  - The average total cost per patient per year was $58,343.
  - Spending on these drugs represented 21% of total prescription drug spending ($289 million).
  - Ozempic ranked the highest in aggregate patient out-of-pocket spending, totaling $258,066.
  - Trikafta ranked the highest cost per person per year ($260,413), average cost per script ($26,807), average patient cost ($2,761), and cost per dose day ($879.77).

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Top 25 Most Utilized Drugs (2023)

- **Total Spending**: $6.5 million
- **Top 5 Most Utilized Drugs**:
  - Atorvastatin calcium ($0.66 million)
  - Lisinopril ($0.17 million)
  - Levothyroxine Sodium ($0.50 million)
  - Amlodipine Besylate (> $100,000)
  - Metoprolol Succinate ER ($0.43 million)
- **Insights**:
  - Spending on the Top 25 utilized outpatient retail prescription drugs represented 2.2% of total gross spending.
  - Primarily low-cost generic drugs treating chronic conditions like hypertension and diabetes.
  - Spending on these drugs was less than total gross spending on Dupixent.

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Top 25 Year-Over-Year Cost Growth (2022 – 2023)

- **Total Increase**: $37 million
- **Key Drugs**:
  - Mounjaro (726% increase)
  - Ozempic (94% increase)
  - Wegovy (538% increase)
  - Stelara (27% increase)
  - Humira Pen (17% increase)
- **Insights**:
  - Spending on semaglutide (Ozempic, Wegovy) and tirzepatide (Mounjaro) had a combined increase of $13.5 million, or 37% of the total increase, despite low rates of utilization (although increasing).
  - Skyrizi had the greatest year-over-year cost growth, increasing 3,923%.

By the Numbers

44%	Top 25 costliest prescription drugs contributed 44% of total gross spending.
$60.6 million	Spending on the Top 5 costliest drugs totaled $60.6 million.
2.2%	Top 25 utilized prescription drugs contributed 2.2% of total gross spending.
> 30%	Spending on three anti-obesity drugs contributed to more than a third of increased spending.

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Key Trends and Insights

The Top 25 costliest and YoY growth categories reveal that spending is concentrated on **single-source brand-name** and **high-cost specialty drugs** that face little or no competition.

The Top 25 costliest prescription drugs reflect a **significantly higher average cost per script** than the most utilized prescription drugs.

Spending on Ozempic, Wegovy, and Mounjaro contributed to **more than a third** of increased year-over-year spending growth.

Enbrel remains one of the **costliest** and **highest spend prescription drug**; this, in part, reflects the financial burden shouldered by taxpayers when firms delay generic or biosimilar entry through legal or other means.

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Inflation Reduction Act of 2022

1. Annual out-of-pocket cap for seniors under Medicare Part D.
2. Annual Medicare negotiation (“Maximum Fair Prices” or MFPs) by the Centers for Medicare and Medicaid Services (CMS) for certain high-cost, single source drugs without competition.
3. Penalties on single-source drugs and biologics covered under Medicare Part B and D whose price rise faster than inflation.

Comparison of list prices, Big Four prices, and Medicare negotiated drug prices per 30-day supply, U.S. dollars, 2024

Drug Name	Clinical use(s)	List price, 2024	Big Four price, 2024	Medicare negotiated price, 2026
Eliquis	*Blood thinner*	$594	$402	$249
Jardiance	*Diabetes, Heart failure*	$611	$434	$204
Xarelto	*Blood thinner*	$542	$392	$206
Farxiga	*Diabetes, Heart failure*	$582	$420	$182
Januvia	*Diabetes*	$547	$392	$117
Entresto	*Heart failure*	$668	$478	$314
Enbrel	*Psoriasis, Rheumatoid arthritis*	$7,402	$4,775	$2,335
Imbruvica	*Blood cancers*	$17,018	$10,669	$10,619
Stelara	*Crohn's disease, Psoriasis*	$26,517	$9,472	$4,490
NovoLog/Fiasp	*Diabetes*	$140	$138	$134

Note: List prices are as of January 2024 and were collected from the Texas State Department of Health Services' Prescription Drug Price Disclosure Program. "Big Four" prices were collected from the VA National Acquisition Center website. All drug prices correspond to the NDC-11 codes shown in the Appendix and are calculated for a 30-day supply as described in the Methods. The list price for NovoLog was significantly reduced by Novo Nordisk, Inc after NovoLog was selected for price negotiation.

Source: KFF analysis of VA National Acquisition Center, Centers for Medicare and Medicaid Services (CMS), and the Texas Prescription Drug Price Disclosure Program

Peterson-KFF Health System Tracker

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NH PDAB MFPs Spending Analysis

New Hampshire PDAB Estimated Savings at Negotiated Maximum Fair Prices Relative to Estimated Plan Negotiations

For price year calendar 2023, dollar amounts in millions

Drug Name	Year Approved	Gross Drug Spending, 2023	Estimated Manufacturer Rebates	Estimated Net Spending, 2023	IRA Price Ceiling Category	MFP Discount off List Price	Estimated Net Spending at MFP, 2023	Spending at MFP vs. Spending at Estimated Net Prices, 2023
Eliquis	2012	$8,058.00	0.45	$4,431.90	Short Monopoly	0.56	$3,545.52	-$886.38
Jardiance	2014	$5,514.50	0.63	$2,040.37	Short Monopoly	0.66	$1,874.93	-$165.44
Xarelto	2011	$2,495.40	0.53	$1,172.84	Short Monopoly	0.62	$948.25	-$224.59
Januvia	2006	$2,096.60	0.7	$628.98	Long Monopoly	0.79	$440.29	-$188.69
Farxiga	2014	$1,649.90	0.68	$527.97	Short Monopoly	0.68	$527.97	$0.00
Entresto	2015	$1,050.00	0.27	$766.50	Short Monopoly	0.53	$493.50	-$273.00
Enbrel	1998	$1,667.70	0.51	$817.17	Long Monopoly	0.67	$550.34	-$266.83
Imbruvica	2013	$2,215.40	0.11	$1,971.71	Short Monopoly	0.38	$1,373.55	-$598.16
Stelara	2007	$13,604.60	0.41	$8,026.71	Long Monopoly	0.66	$4,625.56	-$3,401.15
Novolog/Fiasp	2000	$696.00	0.76	$167.04	Long Monopoly	0.76	$167.04	$0.00
Total		**$39,047.80**		**$20,551.18**			**$14,546.95**	**-$6,004.24**

Estimated Savings for New Hampshire Public Payors (excluding Medicaid) Relative to Plan Negotiations. This analysis relied on methods and rebate estimates from "Interpreting the First Round of Maximum Fair Prices Negotiated by Medicare for Drugs" (Hernandez, 2024) and gross spending for four (4) New Hampshire public payors using CHIS data.

- The PDAB analyzed spending among four (4) New Hampshire public payors (excluding Medicaid) on those drugs selected by CMS for price negotiations, known as "Maximum Fair Prices" (MFPs).
- The analysis relied on the work of Hernandez et. al, which estimated manufacturer rebates using SSR Health and is the closest proxy to estimate net spending by drug since the PDAB does not have access to rebate information.
- In 2023, if the MFPs were in effect and applied to New Hampshire public payers (excluding Medicaid), the MFPs would've resulted in an estimated **$6 million** in net savings compared to current performance.

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Implications

- **Challenges**
  - Increasing utilization among branded anti-obesity therapies fueling spending growth year-over-year.
  - Patent abuses and extended market exclusivities lock in artificially high prices and many of the drugs that benefit from these tactics are the costliest to the state.
  - Spending driven by single-source brand-name and high-cost specialty drugs.
- Policy interventions are needed to ensure fair pricing and sustainable access to medications.

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Thank You!

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