

AUGUST 2018

Children, Families, Health, and Human Services Interim Committee
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FINAL REPORT TO THE 66TH MONTANA LEGISLATURE

HOUSE JOINT RESOLUTION 17: PRESCRIPTION DRUG PRICING

CHILDREN, FAMILIES, HEALTH, AND HUMAN SERVICES INTERIM COMMITTEE MEMBERS

Before the close of each legislative session, the House and Senate leadership appoint lawmakers to interim committees. The members of the Children, Families, Health, and Human Services Interim Committee, like most other interim committees, serve one 20-month term. Members who are reelected to the Legislature, subject to overall term limits and if appointed, may serve again on an interim committee. This information is included in order to comply with 2-15-155, MCA.

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This report is a summary of the work of the Children, Families, Health, and Human Services Interim Committee, specific to the Committee’s 2017-2018 House Joint Resolution 17 study as outlined in the Committee’s 2017-18 work plan and House Joint Resolution 17 (2017). To review additional information, including audio minutes, exhibits, and documents presented as part of this study, visit the Children, Families, Health, and Human Services Interim Committee website: <http://leg.mt.gov/cfhhs>. Reports and presentations specific to the study can be found on the [HJR 17 Study page](#).¹

¹ The URL for this page is: <https://leg.mt.gov/committees/interim/cfhhs/committee-topics/hjr-17>.

HJR 17: PRESCRIPTION DRUG PRICING

OVERVIEW

House Joint Resolution 17 asked for a study of prescription drug pricing and its effects on Montanans. The study ranked third in the post-session poll of legislators and was assigned to the Children, Families, Health, and Human Services Interim Committee.

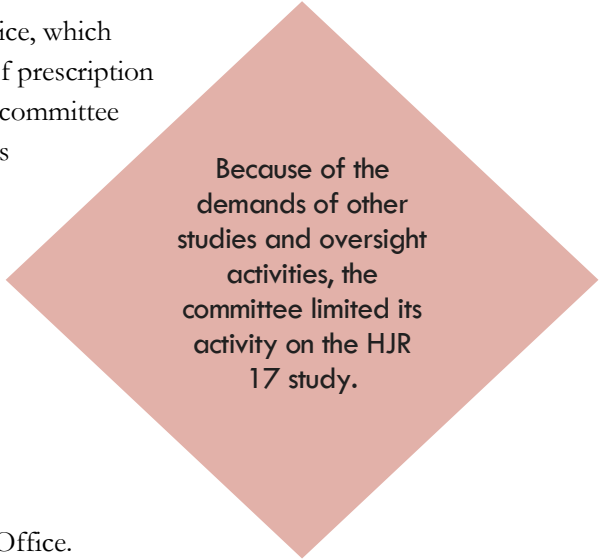
The resolution suggested that the committee review:

- price changes for prescription drugs over the past 10 years, including specific groups or types of drugs as identified by the committee;
- factors related to the price changes;
- the cost of prescription drugs to the Medicaid program, Healthy Montana Kids Plan, and public employee group benefit plans; and
- efforts in other states and in Congress to control the cost of prescription drugs or obtain more information about drug pricing.

At its initial meeting, the committee heard that the State Auditor's Office, which regulates insurers, also planned to devote staff resources to the topic of prescription drug prices. Based on that information and on the level of activity the committee anticipated for its other assigned studies and oversight duties, members decided to limit their involvement with the HJR 17 study to three activities:

- reviewing the cost of prescription drugs to state-funded programs;
- learning about efforts undertaken in other states to control prescription drug prices; and
- hearing about the research undertaken by the State Auditor's Office.

Committee members undertook those activities but did not take further action related to the study. Members decided to focus on their other assigned studies and committee duties, in part because they believed the state could do little, on its own, to lower the costs of prescription drugs.



Because of the demands of other studies and oversight activities, the committee limited its activity on the HJR 17 study.

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COMMITTEE ACTIVITIES

Following is a summary of information the committee received for the HJR 17 study on the topics it selected for review.

Costs to the State

State funds pay for prescription drugs through several different programs.

Medicaid and the Healthy Montana Kids (HMK) Plan use both state and federal dollars to cover health care costs for low-income Montanans. The Department of Corrections pays — largely with state funds — for the medical costs of people who are in the state’s custody because they’ve been convicted of crimes. And the state of Montana and the Montana University System use state funds to help cover the cost of providing health insurance, including prescription drug coverage, for state and University System employees.

Representatives of those agencies told the committee in September 2017 that:

- drug costs have been rising more rapidly than other medical costs and make up a large portion of the expenses for the state-funded programs;
- the highest-cost drugs to each program typically involve brand-name or specialty drugs prescribed to treat chronic, ongoing medical conditions;
- the top-prescribed drugs usually are generic drugs and make up a much lower percentage of total costs, even though more prescriptions are written for those drugs than for the high-cost drugs;
- state agencies are taking steps to manage both the overall costs of prescription drugs, through means such as cooperative purchasing agreements or rebates, and to manage the duration or amount of opioids prescribed under the plan.

Action in Other States

A number of states have taken action since 2015 to make drug prices more transparent or to control the price of drugs. However, not all of those actions have succeeded.

- The Maryland Legislature in 2017 passed a bill allowing the state attorney general to investigate potential price-gouging for generic drugs and to seek fines or a reversal of the price hike when a company violated the law. However, a federal appeals court struck down the law in April 2018 as an unconstitutional regulation of interstate commerce.
- New York legislators in 2017 put a cap on prescription drug spending for the Medicaid program and gave the state health commissioner the authority to ask manufacturers of high-cost drugs to provide

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additional discounts if spending exceeds the cap. If manufacturers don't agree to higher rebates, the state could require that patients receive approval for purchasing the drug.

- Nevada legislators in 2017 approved a bill to improve price transparency and marketing practices related to drugs for treating diabetes.
- Ohio voters in 2017 considered, but rejected, a ballot measure that would have prevented the state from paying a net price for any prescription drug that was greater than the lowest price that the U.S. Department of Veterans Affairs pays for the same drug.
- The Vermont Legislature in 2016 required the state to identify up to 15 drugs on which it spends “significant health care dollars” and for which the wholesale acquisition price went up by 50% or more in the past 5 years or 15% or more the last 12 months. Makers of those drugs must provide the attorney general with information that justifies the increase; the attorney general may file suit against drugmakers who fail to provide the information.
- Washington lawmakers in 2015 created a task force on the out-of-pocket costs of prescription drugs. The task force members agreed not to try to reach consensus on any recommendations but developed a variety of options for consideration.

In addition to those state-level activities, the National Academy for State Health Policy has identified options for state action on drug prices and has developed model legislation for some of the ideas. In 2018, Vermont passed a NASHP bill to allow the state to reimport drugs from Canada. Before the state can do so, however, it must receive federal approval of its reimportation program.

State Auditor Review

The State Auditor's Office began looking at prescription drug pricing shortly after the 2017 legislative session ended, including whether the state could take action to reduce prices or improve price transparency.

In January 2018, representatives from the office presented an overview of their work to the committee. Among other things, they discussed:

- the complexities of the prescription drug distribution and pricing system, which involves not just the drug manufacturers that make the drugs and the pharmacies that dispense them but also wholesalers, pharmacy benefit managers, health insurers, third-party administrators, and employer-funded health plans;
- factors that go into drug pricing, including research and development costs, advertising, and manufacturer rebates and coupons;

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- the use of “clawbacks,” in which a third party — typically a pharmacy benefit manager — keeps the difference between the amount a consumer is required to pay under the consumer’s insurance plan and the actual cost of the drug when the required copayment is higher than the drug’s cost; and
- the use of “spread pricing,” when a third party handling a drug submits a bill to an insurer that is higher than the amount the third party paid to the pharmacy for the drug and then keeps the difference between the two payments.

The office also reported that it was reviewing its authority to regulate insurers and pharmacy benefit managers, including its ability to request documents and contracts to evaluate pricing practices and identify potential solutions for reducing drug prices. In addition, the office was reviewing actions and legislation in other states to see if Montana might be able to take steps to promote transparency in pricing and better regulate and oversee the parties involved in the pricing and sale of prescription drugs.

CONCLUSION

The committee decided against devoting a significant amount of its time to the HJR 17 study for many reasons. The scope of the topic is broad and could have taken time away from the committee’s other assigned studies. Impending budget cuts for the Department of Public Health and Human Services warranted close monitoring to determine the impacts of the reductions. The federal government generally regulates the manufacturing and sale of prescription drugs, making it difficult for states to take significant steps to bring down prices on their own. Finally, the State Auditor’s Office was reviewing the topic, as well.

The committee made the following findings and recommendations at the conclusion of the study.

- Prescription drug costs have grown at a faster rate than most other medical costs.
- Montana state agencies that administer health care programs for low-income or incarcerated Montanans and that operate health insurance plans for state employees are closely monitoring the costs of prescription drugs and making efforts to reduce the impact those costs have on state-funded programs.
- State agencies should continue to review the options available to them for reducing drug prices and should propose legislation to curb costs or make costs more transparent to Montanans.