State Policy Actions to Address Prescription Drug Access and Affordability

Economic Affairs Interim Committee
Nov. 12, 2025 | Helena, MT

Agenda

Part 1

- Introduction to NCSL
- Supply chain dynamics
  - R&D costs
  - Health expenditures

Part 2

- State legislative trends and examples
- Questions?

How NCSL Serves State Legislatures

Source: NCSL

The National Conference of State Legislatures (NCSL) is the **bipartisan** organization serving **legislators and legislative staff** in America's 50 states, D.C. and territories.

With a strong belief in the importance of the legislative institution, NCSL knows **when states are strong, our nation is strong**.

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MEETINGS

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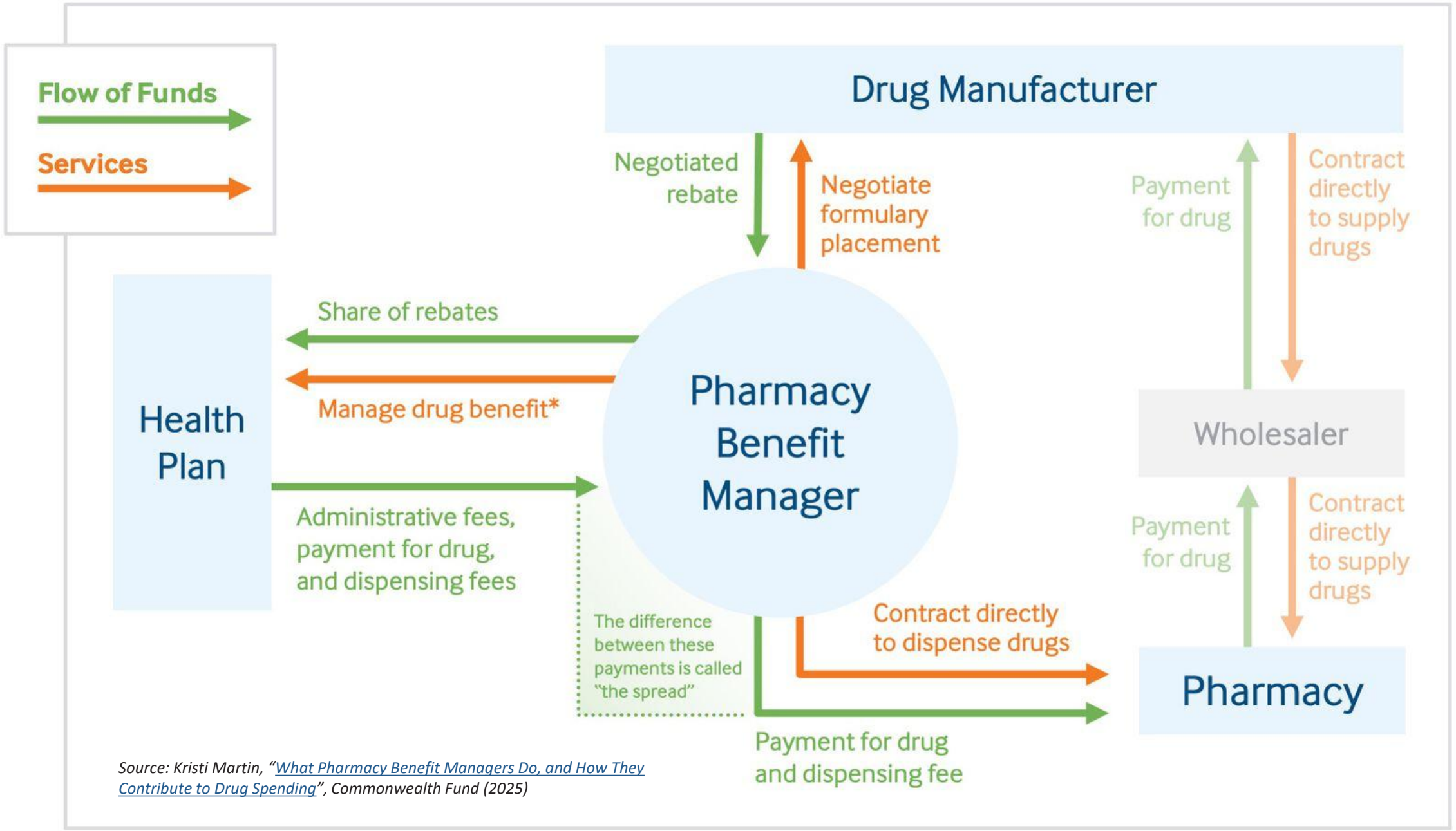
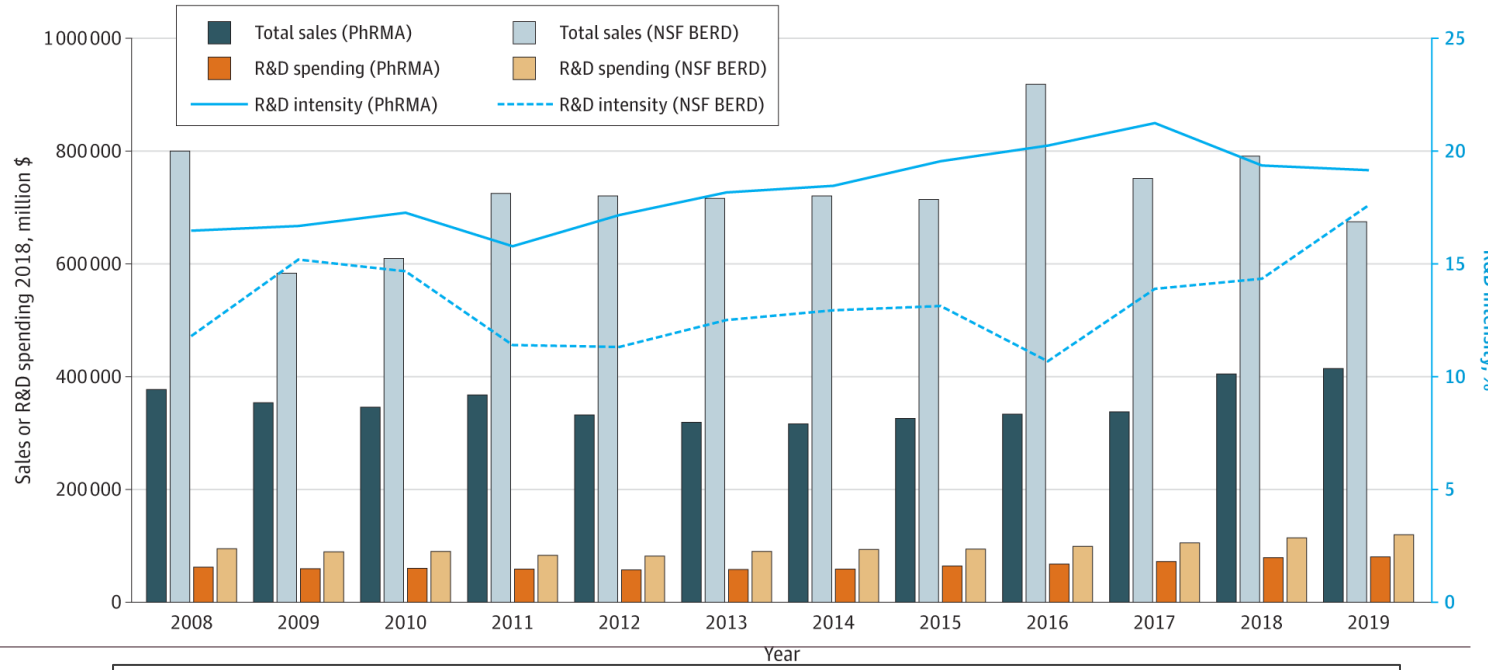


Source: Kristi Martin, "What Pharmacy Benefit Managers Do, and How They Contribute to Drug Spending", Commonwealth Fund (2025)

The Cost of R&D

(Sertkaya, et al., 2024)

- From 2000-2018 mean cost of development (failure +capital) = $879.3 million.
- Ratio of overall R&D spending to sales increased from 11.9% to 17.7%.
- Overall prescription drug sales decreased 15.6%.
    - In contrast, sales by large companies increased 10%. R&D remained stable.

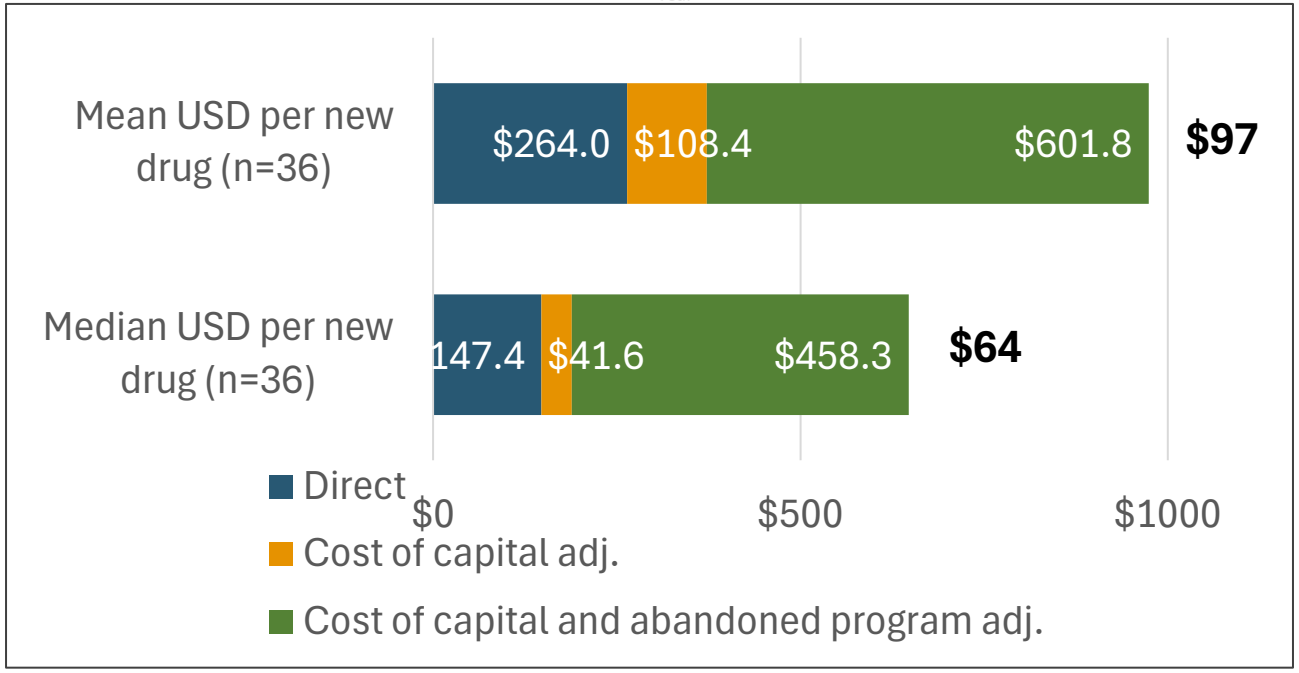


(Mulcahy, 2025)

- In 2019, out of 268 drug developers, 20 firms = 80.8% of R&D activity.

Across 38 new drugs approved:

- Median costs per new approved drug = $708 million.
- Mean costs per new approved drug = $1.31 billion.

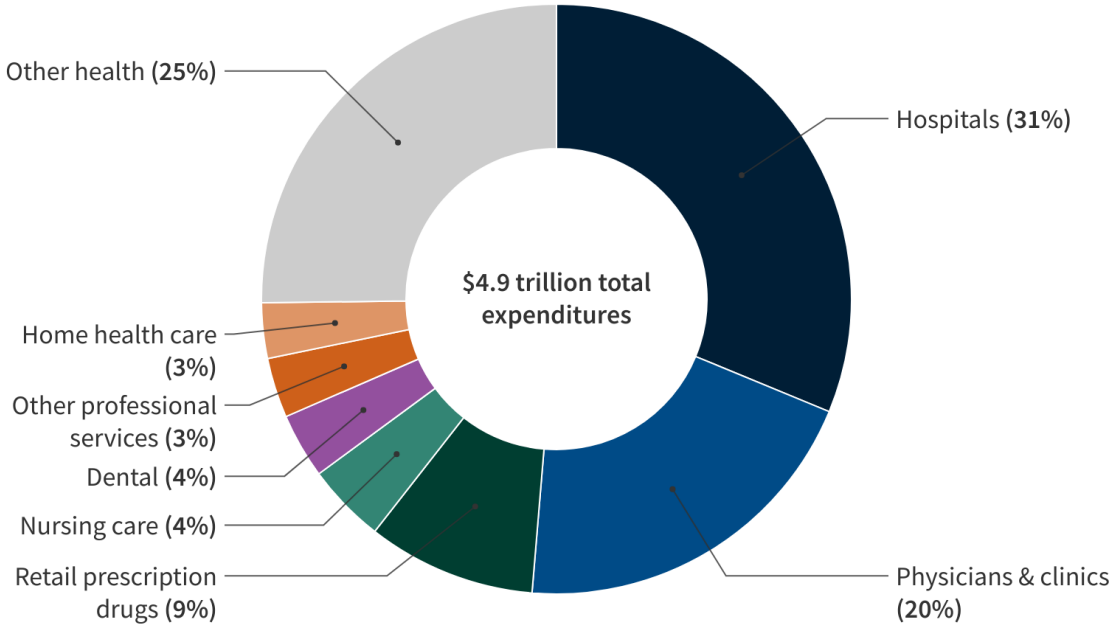


National Health Expenditures

Figure 1

Spending on Hospital Care Totaled $1.5 trillion in 2023, Representing Nearly One Third (31%) of National Health Expenditures in That Year

Distribution of expenditures by type of good or service, 2023



Note: Hospital spending includes expenditures on both inpatient and outpatient services. "Other health" includes spending on durable and non-durable products; residential and personal care; administration; net health insurance; and other state, private, and federal expenditures. "Other professional services" includes spending for services provided by chiropractors; optometrists; physical, occupational, and speech therapists; podiatrists; private-duty nurses; and others. "Nursing care" represents expenditures for nursing care facilities and continuing care retirement communities. Percentages do not sum to 100% due to rounding.

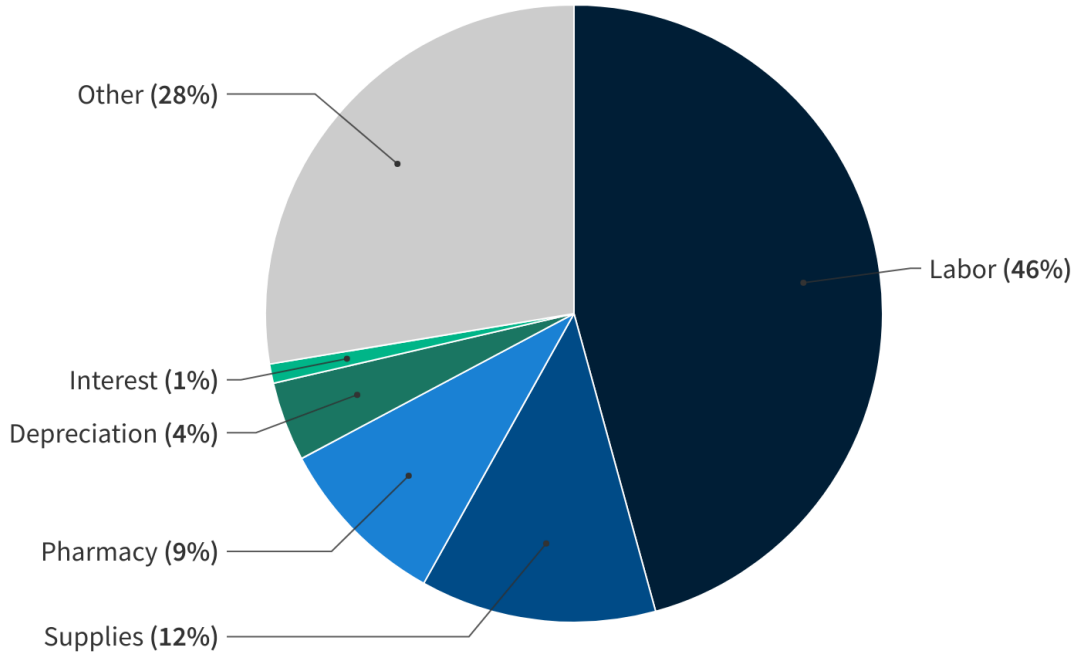
Source: KFF analysis of National Health Expenditure (NHE) data, 2023

KFF

Figure 40

Labor Costs Were the Largest Expense Category for Hospitals in 2023, Followed by Supply and Pharmacy Expenses

Distribution of spending by category, 2023



Note: Analysis of the 2,668 out of 5,112 community hospitals that had data for all expense categories in 2023 and did not have negative expenses listed. Excludes hospitals in U.S. territories. Labor includes both payroll and employee benefit expenses. "Other" may include various types of expenses, including contract labor, facility maintenance, utilities, insurance, marketing, and administration costs.

Source: KFF analysis of AHA Annual Survey data, 2023

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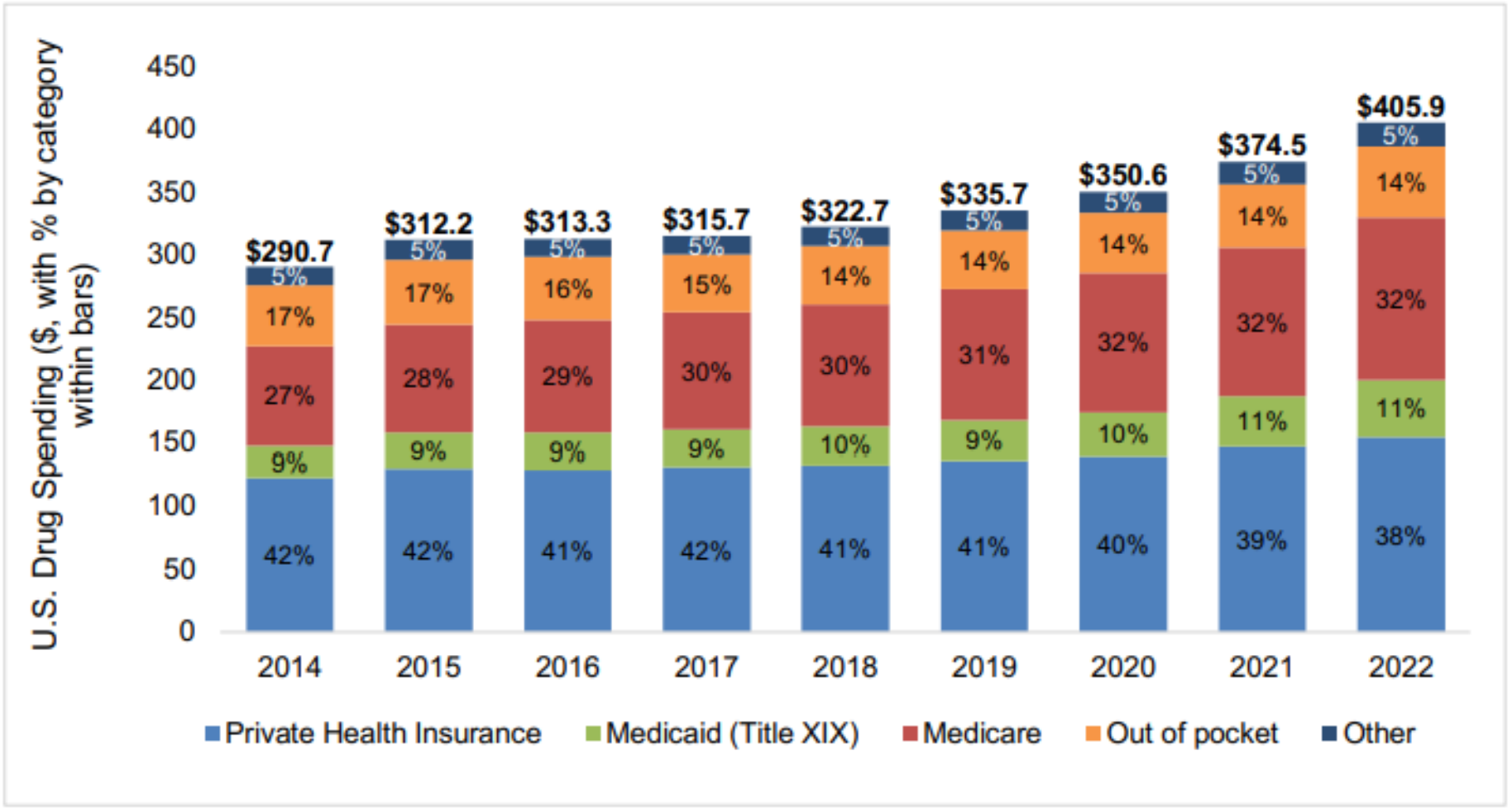
Figure 3.3 National Health Expenditure Estimated Net Drug Spending 2014-2022

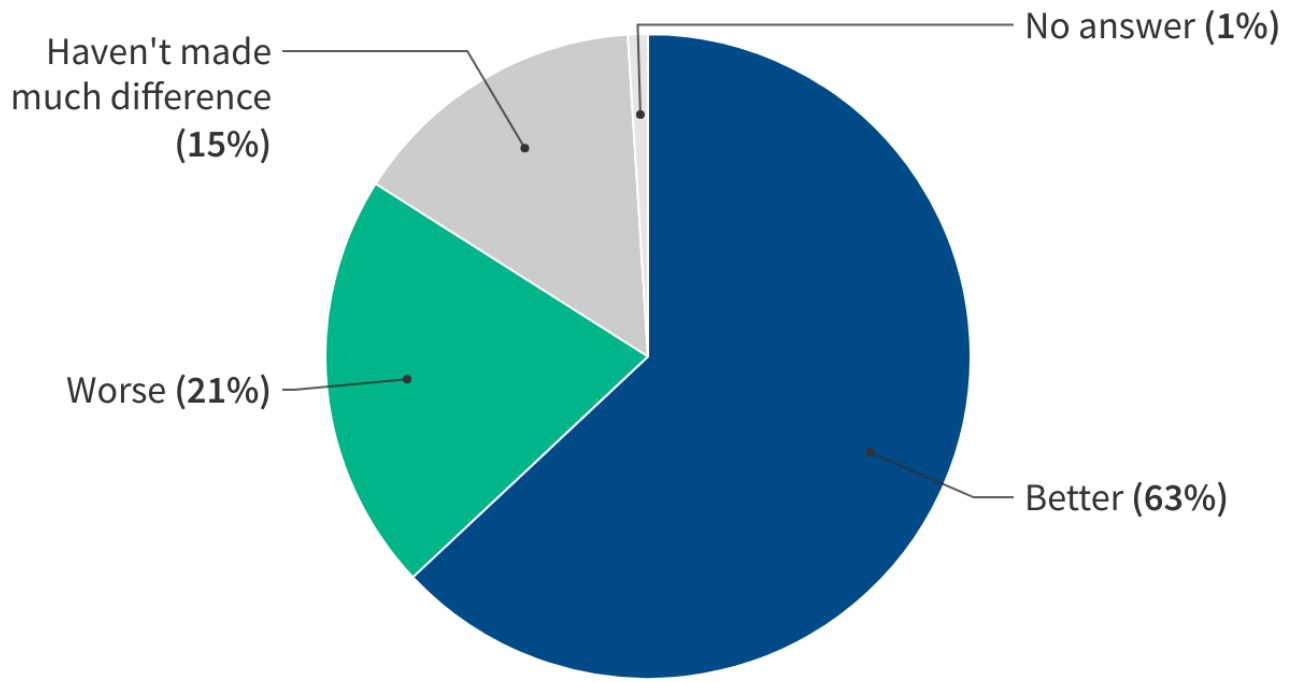


SOURCE: RAND analysis of NHE data.
NOTE: "Other" includes the Children's Health Insurance Program (CHIP) (Title XIX and Title XXI), the Department of Defense, the Department of Veterans Affairs, and other third-party payers and programs. The number at the top of each bar is total spending in billions. Percentages may not add to 100 percent due to rounding.

Figure 2

Six in Ten Say That Prescription Drugs Developed Over the Past 20 Years Have Made the Lives of People in the U.S. Better

Do you think prescription drugs developed over the past 20 years have generally made the lives of people in the U.S....?



Note: See topline for full question wording.

Source: KFF Health Tracking Poll (July 11-19, 2023)

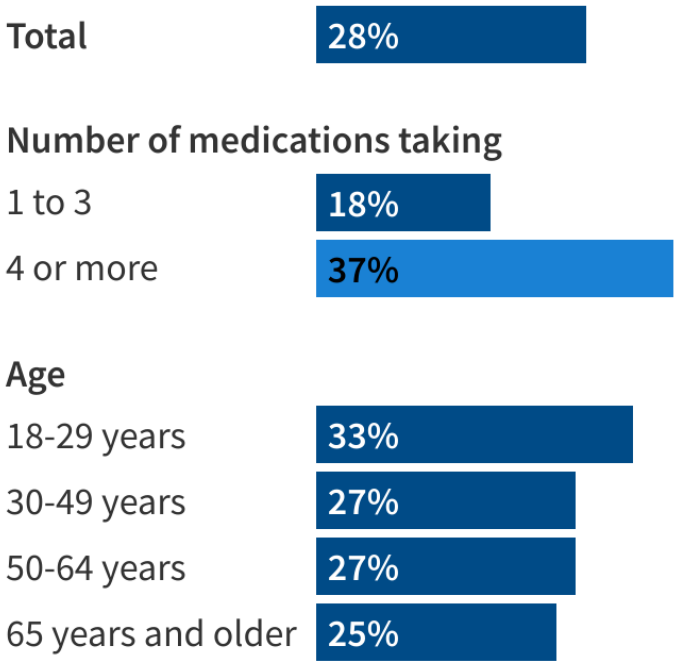
KFF

Public Opinion on Prescription Drugs and Their Prices, KFF, 2024

Consumer Access and Affordability

One Quarter of Adults Have Difficulty Affording Prescription Drugs, Including Larger Shares of Those Who Take More Medications

Percent who say it is **somewhat or very difficult** to afford the cost of their prescription drugs:



Public Opinion on Prescription Drugs and Their Prices, KFF, 2024

KFF 2024 Annual Employer Survey found between 2020-2025:

- Average annual total contributions for family coverage increased from $21,419 to $26,993.
  - Worker contribution increased 23%.
- Average deductible for single coverage is $1,886, an increase of 17% in five years.

Compared to negotiated drug prices (▲4.3%) consumer out-of-pocket spending increased 5.8% annually from 2007-2020 (Mallat et al., 2024).

KFF 2023 Health Tracking Poll found:

- 6 in 10 adults take at least one prescription.
  - 1/4 take four or more.
- 3 in 10 adults did not take medicines as prescribed in past 12-months due to cost.
  - 21% did not fill a prescription due to cost.
- 11% of household incomes making $90,000 or more report difficulty affording prescription medicines.

Medicaid and Private Health Plans

Medicaid must cover all FDA approved drugs. Utilization management is used by Medicaid (and commercial health plans) to contain costs.

Substantial variation found in utilization management across Medicaid and ACA plans (Vu et. al., 2025)

(KFF, 2025)

- Drug costs makeup 5-10% of Medicaid budget.
- 3 in 4 adults on Medicaid report one or more chronic conditions. Gross Medicaid spending on prescription drugs increased 62% since 2017.
  - Net spending (after rebates) increased 54% during the same period.
  - Assessing 3 cohorts, PBM rebates matched list prices increases dollar for dollar. (USC-Schaeffer, 2020).

(RAND, 2024) study:

- Deductibles increased annually on average by 5% between 2014-2023 among employer plans and 8% among Marketplace plan.
- In 2014, 28% of ACA plans used coinsurance and 50% used copayments. By 2022, 52% of ACA plans used coinsurance and 19% used copayments.
- From 2014-2022, average spending per enrollee on prescription drugs $1000 per year, but out-of-pocket spending for some groups have been declining.

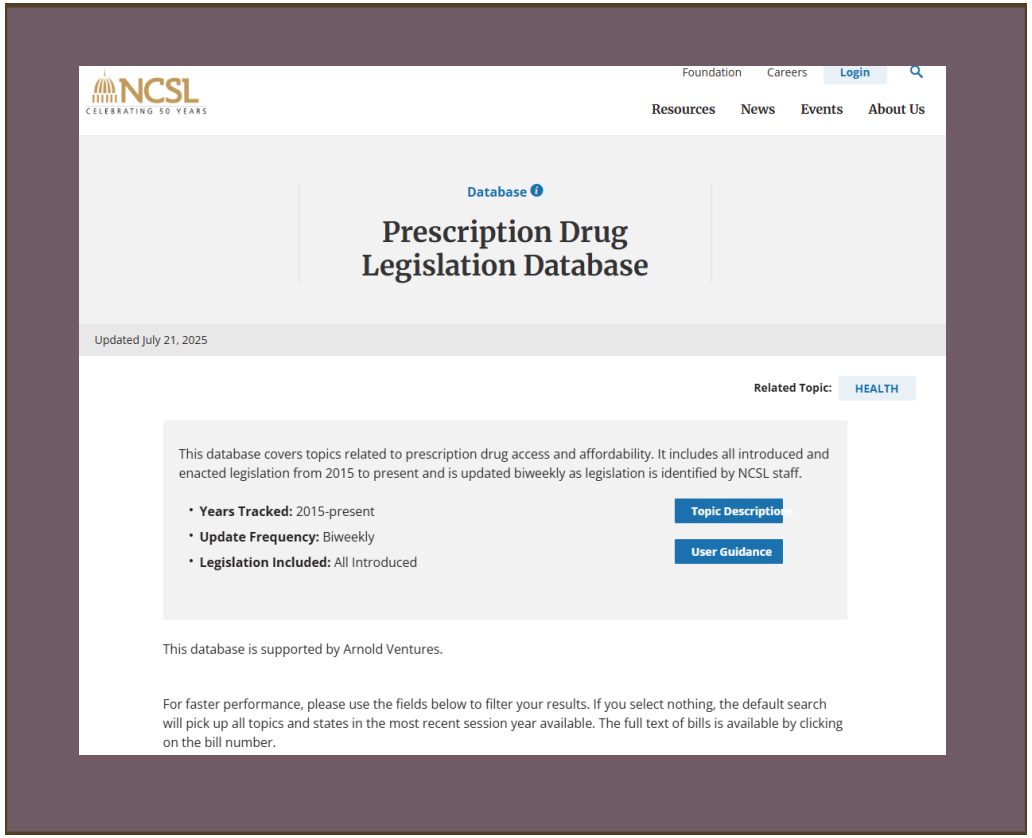
2025 State Prescription Drug Policy Trends

NCSL's Prescription Drug Legislation Database

Over 875 prescription drug policy related bills introduced in all 50 states, D.C. and Puerto Rico.

At least 174 bills enacted in 41 states in 2025.

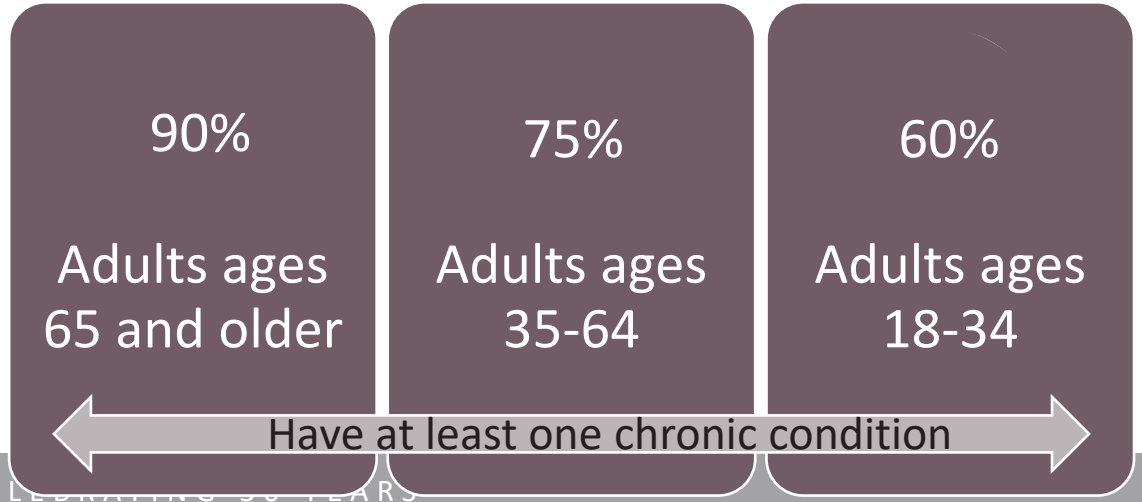
- Pricing
  - Transparency (multiple actors)
  - Importation/Reference Pricing
  - Affordability Boards
- Access and high-cost drugs
  - Copay accumulators
  - Utilization Management
  - Right-to-Try
- Pharmacy Benefit Managers (PBMs)
  - Fiduciary
  - Spread pricing
  - Contracts/rebate structures



Chronic Disease Facts

(CDC, 2024)

- **Chronic diseases like heart disease, cancer and diabetes are the leading causes of death and disability in the U.S.**
  - Leading driver in overall annual health care costs – 90%.
  - 1 in 4 deaths in U.S from heart disease and stroke per year.
  - Annually, 1.8 million Americans have cancer and 600,000 will die.
  - Obesity effects 21% of children and 40% of adults in the US.
  - Alzheimer's effects 7 million Americans – 1 in 9 adults aged 65 and older.



How Copay Accumulators Work

(KFF, 2024)

- Variation among programs (accumulator, maximizer, alternative funding program).

- 34% of companies with 5,000 or more employees have copay accumulator programs in the prescription drug benefit.

- 66% of ACA plans sold in states without limits have copay accumulator programs.

Patients without another treatment option are most affected.

- 19% of prescriptions in 2023 used copay assistance from manufacturers.

Table 1

Amounts Paid For Hypothetical Specialty Medication With and Without a Manufacturer Copay Coupon

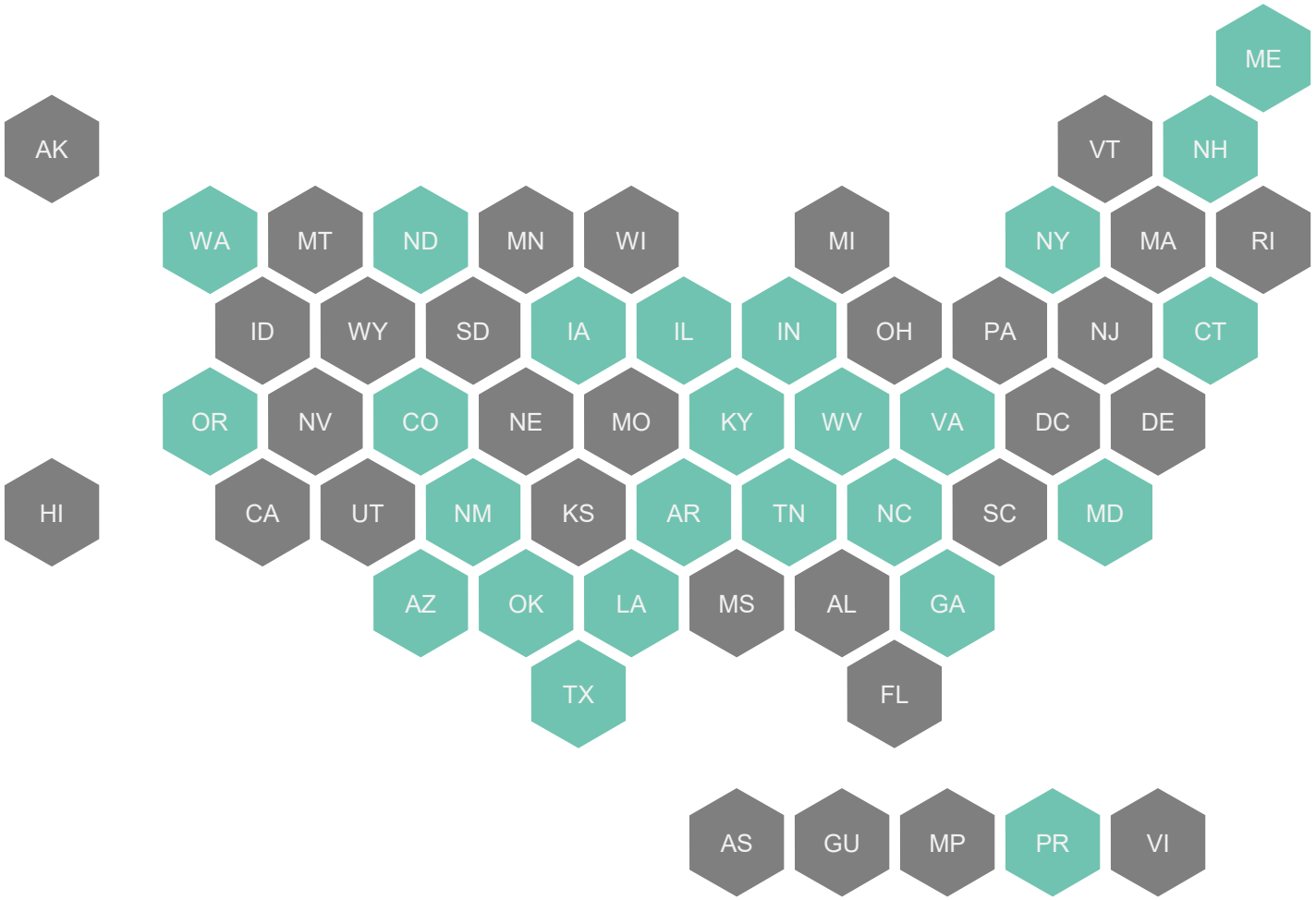
Assumptions: Drug costs $2,000/month and the patient has a $2,000 deductible, 25% coinsurance, and $5,000 out-of-pocket maximum, and when applied, a $6,000/year manufacturer copay coupon

	Jan.	Feb.	Mar.	Apr.	May	Jun.
No Copay Coupon						
Manufacturer copay coupon	$0	$0	$0	$0	$0	$0
Patient cost sharing	$2,000	$500	$500	$500	$500	$500
Health plan/PBM	$0	$1,500	$1,500	$1,500	$1,500	$1,500
With Copay Coupon						
Manufacturer copay coupon	$2,000	$500	$500	$500	$500	$500
Patient cost sharing	$0	$0	$0	$0	$0	$0
Health plan/PBM	$0	$1,500	$1,500	$1,500	$1,500	$1,500

Note: In this example, a 25% coinsurance equates to $500. This example does not account for any cost sharing the enrollee may have paid for any other covered benefits during the year. PBM = pharmacy benefit manager. Amounts do not include the value of any rebates the plan's PBM may receive from the manufacturer or any of that rebate the PBM may pass back to the plan or plan sponsor.

KFF

States Limiting Copay Adjustment Policies



Arizona

(2019) AZ H 2166

Requires that an enrollee's cost-sharing shall include any amount paid by or on behalf of the enrollee for a Rx drug.

Iowa

(2025) S 383

Copay accumulator restriction is part of broader PBM legislation which includes pharmacy network standards, a rebate pass-through requirement.

Maryland

(2025) MD S 773

Copay accumulator paired with gag-clause restrictions.

GLP-1s

Health Outcomes

- Initial findings suggest that after three years GLP-1s increase weight loss but possibly less than some clinical trial results. (Gasoyan, et. al., 2025).
- Significant reduction of cardiovascular events and stroke in people with obesity but without diabetes. (Lincoff, Brown-Frandsen, et. al., 2023).

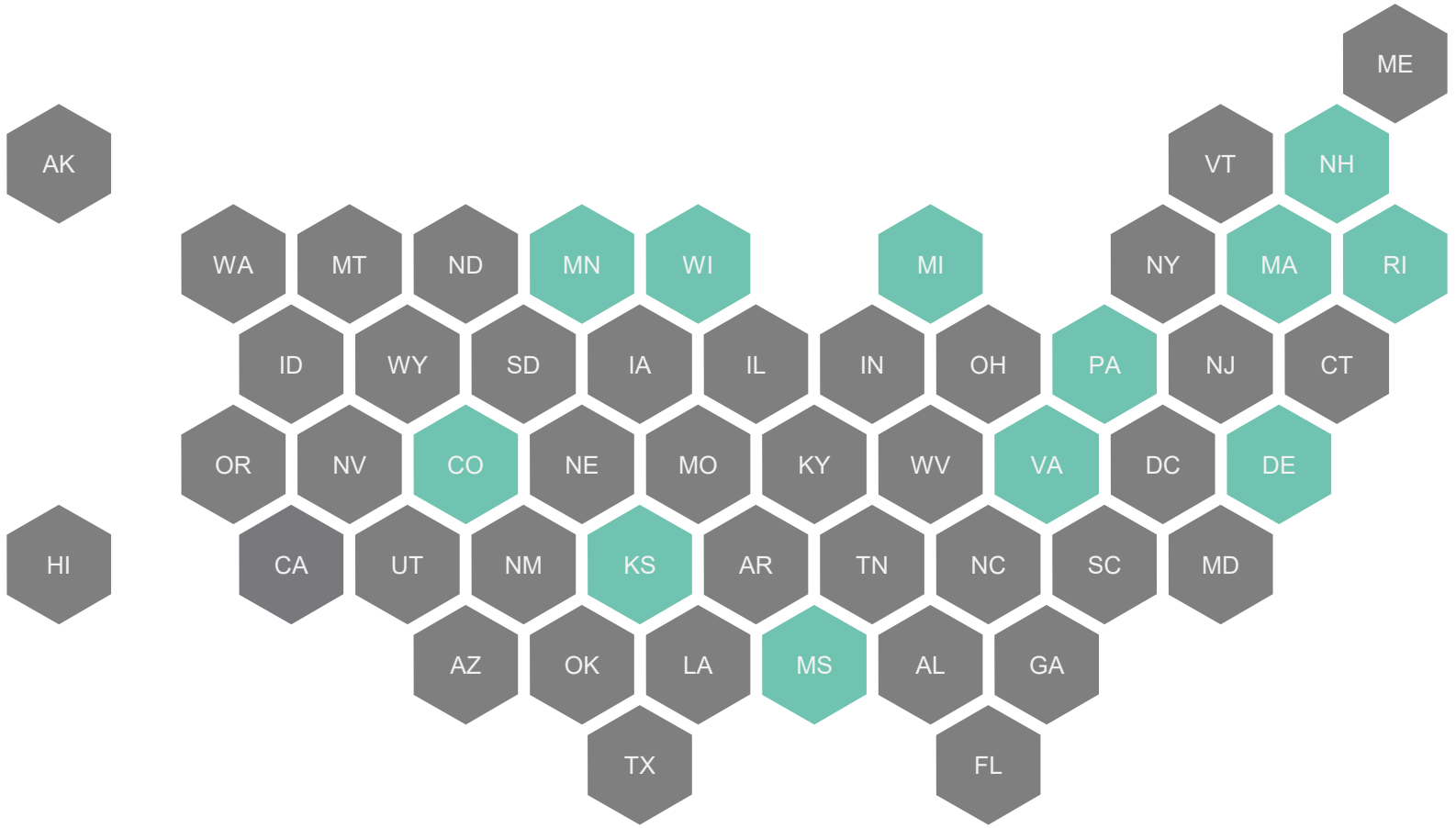
Price (KFF, 2024)

- Average annual list price = $900 - $1300 per 30-day supply.
- Gross spending between 2018-2023 increased by 500%.

Access (KFF, 2024)

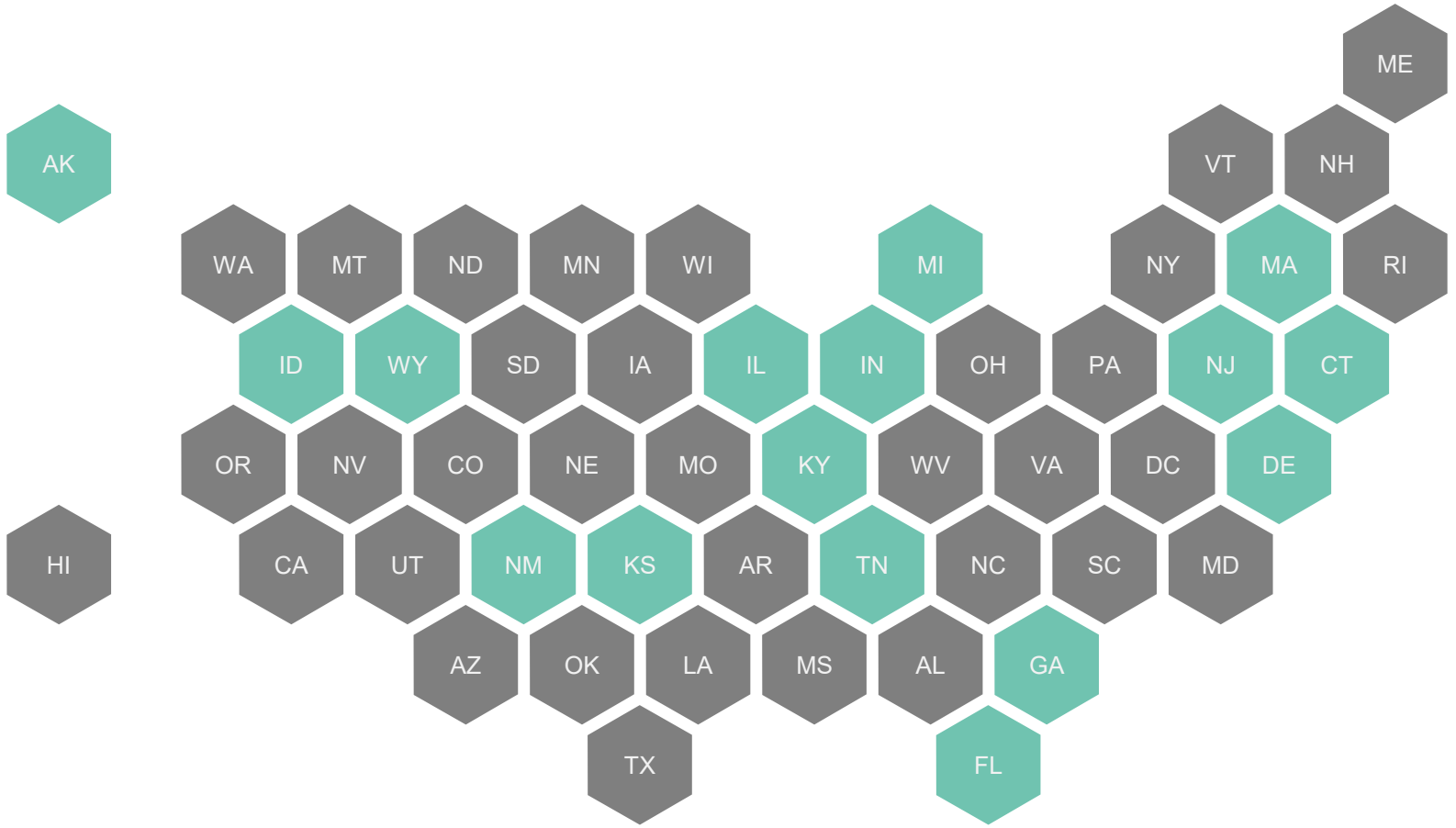
- 12% of survey respondents said they took a GLP-1 for any reason.
- 4 in 10 participants said they took a GLP-1 to lose weight.
- Utilization between 2018-2023 increased by 400%.
- New indications being studied, and in late-stage clinical trials for SUD, Alzheimer's.

Medicaid Coverage of Obesity Medication



Provides coverage as of October 2025

State Employee Health Plan Coverage of Obesity Medication



Provides coverage as of October 2025

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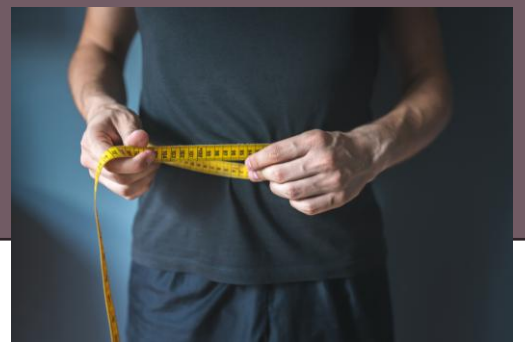
2025 State Legislative Examples - Weight-Loss Drugs



Connecticut	Colorado	Florida	Washington
Allows the state to petition the federal HHS to authorize generic, lower cost forms of GLP-1 drugs to treat obesity or diabetes. If approved, the state may explore contracts with generic manufacturers of GLP-1s for use in the state Medicaid program. The state may also enter a consortium seeking the same contracts.	Requires state-regulated health plans to offer plan members the option to purchase coverage for FDA-approved GLP-1 drugs to treat obesity.	Pilot program that allows 2,800 participants within the state employee health plan to receive GLP-1 medication, only responsible for cost-sharing. Report annually to legislature results.	Specifies that the state shall not add coverage of prescription drugs for weight loss without a specific appropriation from the legislature.
CT H 7192	CO S 48	FL S 2500	WA S 5167

State-Level Prescription Drug Price Transparency

Manufacturers

- Price launches on brand drugs
- Price increases
- Pricing considerations and aggregate cost information

Insurers (13 states)

May apply to generic, grand or specialty drugs, or all:

- Most frequently prescribed drugs.
- Most costly drugs by plan spend
- Drugs that contribute the most to plan spend.
- Impact of drug costs on premiums.

Pharmacy Benefit Managers (PBMs) (23 states)

Aggregate amounts of all rebates including:

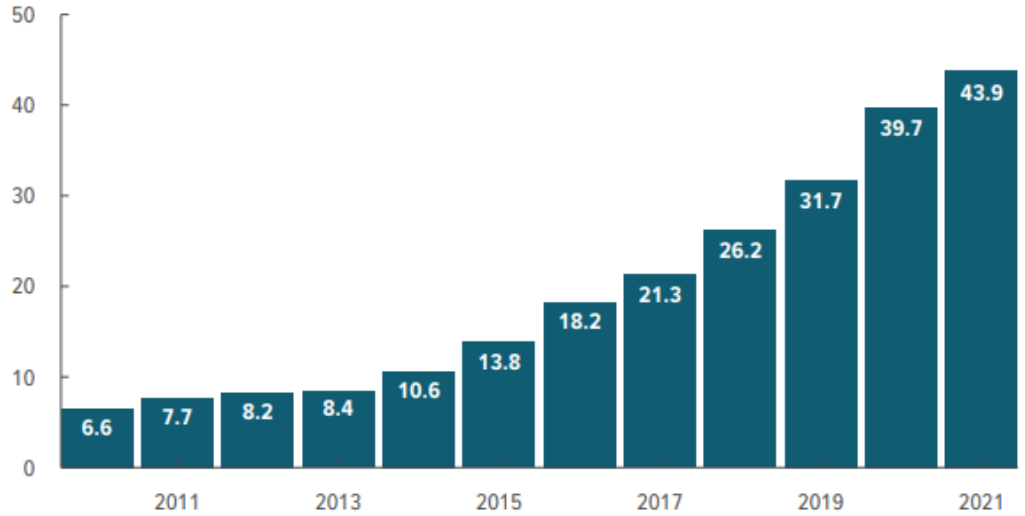
- Rebates received
- Rebates distributed to insurers
- Rebates distributed at point of sale to reduce enrollee's cost-sharing.
- Reimbursements paid to manufacturers

340B (The Basics)

- Outpatient drug purchases increased to $66.3 billion in 2023, increasing 23% from 2022(HRSA, 2023) .
- 54% of overall national drug spending is for specialty, even though they makeup a fraction of the utilization.
- 36% of prescription drugs purchased through 340B are for specialty.
- Care settings are shifting from inpatient to outpatient as seen in federal outpatient payment systems (16.3% in 2015 to 27.4% in 2022).

Figure 1.

Spending on Drugs Purchased Through the 340B Program, 2010 to 2021

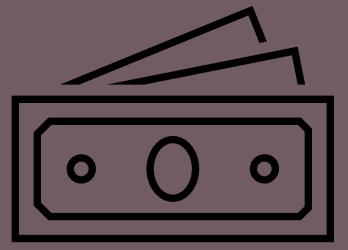


Data source: Congressional Budget Office, using data from the Health Resources and Services Administration. See www.cbo.gov/publication/60661#data.

Amounts are adjusted for inflation using the gross domestic product price index and are expressed in 2021 dollars.

Spending refers to the dollar amount that participating facilities spent on discounted drugs purchased through the 340B program, as reported by the Prime Vendor Program. Approximately 10 percent of 340B facilities do not participate in the Prime Vendor Program.

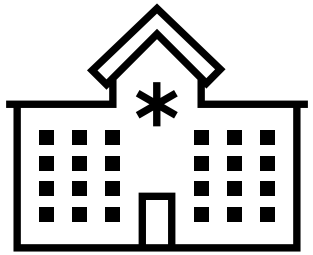
Average annual growth in spending reflects the compound annual growth rate.



State Legislative Trends on 340B Policy

Bills passed in 22 states to:

- Require to provide drugs to covered entities/contract pharmacies at 340B prices.
- Prohibit manufacturers from requiring claims-level data before administering reimbursements.
- Oversight of 340B entities and transparency reporting requirements.
- Define covered entities.
- Prohibit discriminatory practices against contract pharmacies.



Hawaii

(2025) H 712 Summary: Prohibits drug manufacturers from denying, restricting, or prohibiting the acquisition, shipping, or delivery of a 340B drug to pharmacies contracted with 340B covered entities. Authorizes the 340B covered entity and Attorney General to bring a civil action for enforcement. Specifies a 4-year limitations period for bringing an action. Requires each covered entity to report certain information annually to the Department of Health.

Oklahoma

(2025) H 2048 Summary: Creates the 340B Nondiscrimination Act. Prohibits certain actions related to reimbursement of certain entities, makes certain provisions inapplicable when Medicaid provides reimbursement for covered drugs. Prohibits certain actions by a manufacturer or distributor related to certain entities. Establishes contract requirement. Authorizes the Insurance Department to establish rules and regulations.

State Legislative Examples - 340B Transparency

MINNESOTA

2023 H 4755

Each 340B covered entity as defined by federal law, must report to the commissioner of health the following information for the previous calendar year:

- The aggregated acquisition cost for prescription drugs obtained under the 340B program.
- Data must also be reported at the national drug code level for the 50 most frequently dispensed.

INDIANA

2025 S 118

A 340B covered entity shall report the following information and transactions to the state for the previous calendar year:

- The number and percentage of low income patients of the 340B covered entity that were served by a sliding fee scale for a prescription drug dispensed or administered under the 340B program.

A covered entity that fails to provide the information required will pay a fine of $1,000 a day it is past due.

IDAHO

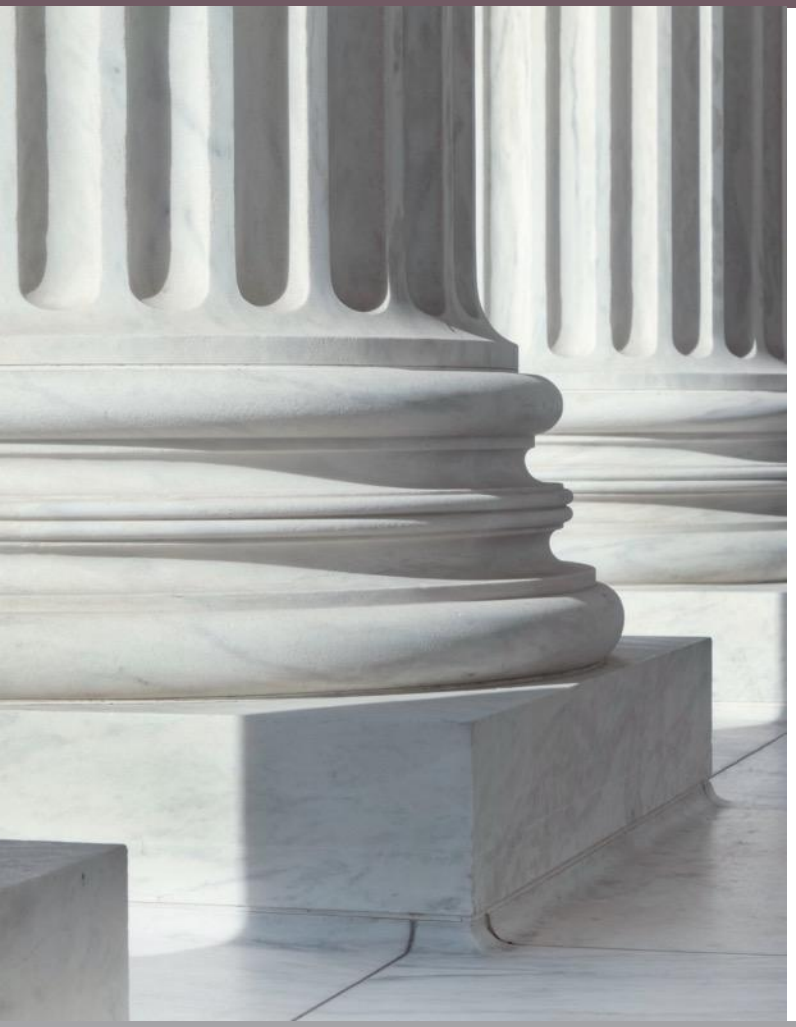
2025 H 136

A 340B covered entity shall report the information and transactions for the previous calendar year:

- The aggregate acquisition cost for all prescription drugs obtained under the 340B program and administered or dispensed to patients.
- The aggregate payment made to pharmacies under contract to dispense drugs obtained under the 340B program.
- How the covered entity uses any savings from participating in the 340B program.

Trends in State Pharmacy Benefit Manager (PBM) Reform

NCSL is tracking around 288 introduced bills across 44 states and territories.



Approximately 1/3 of state Rx legislative activity addresses PBM business practices.

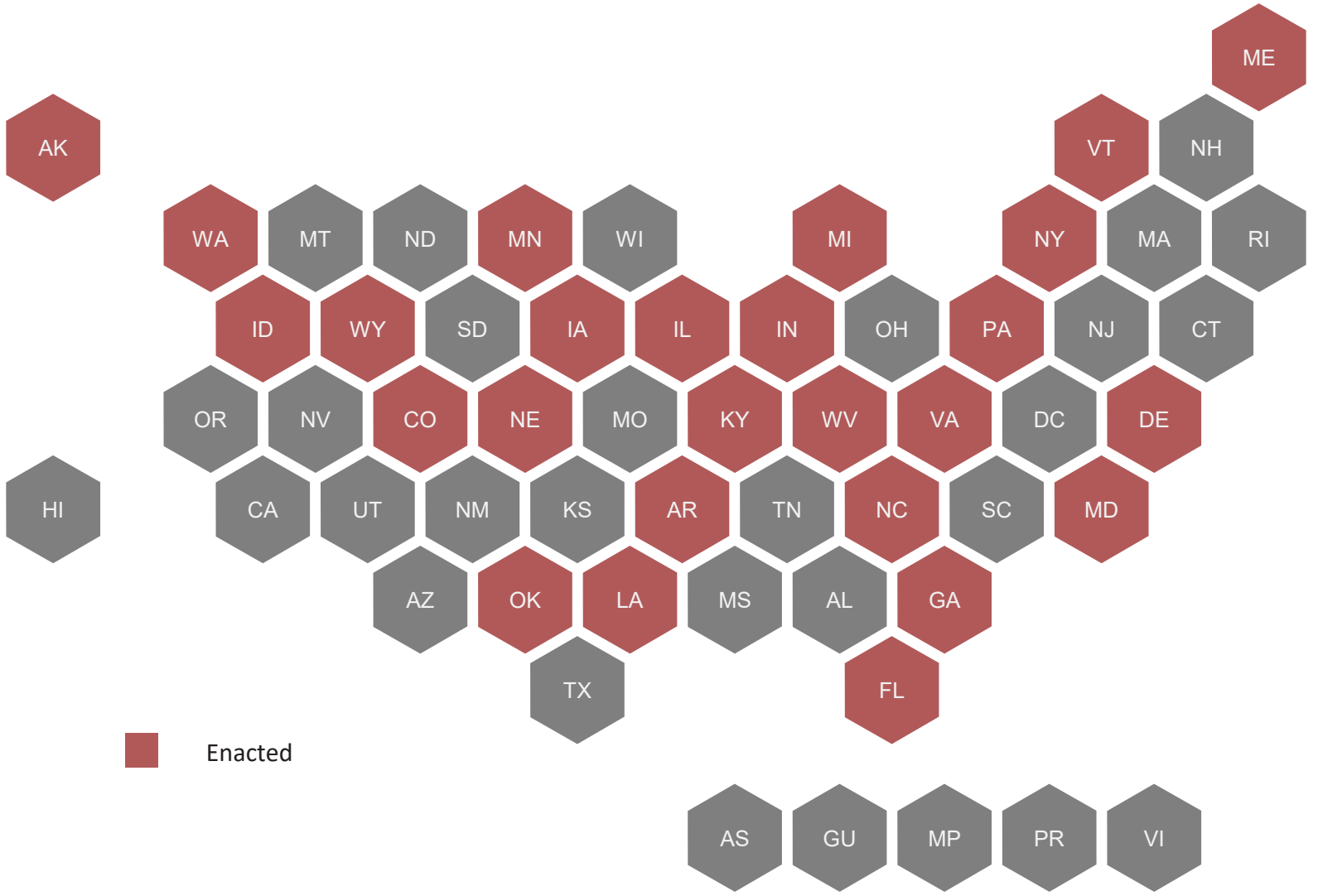
Early trends were:

- Oversight and enforcement
- Licensure and registration

In 2025, 69 bills were enacted in 30 states re: PBM reform. Trends now are:

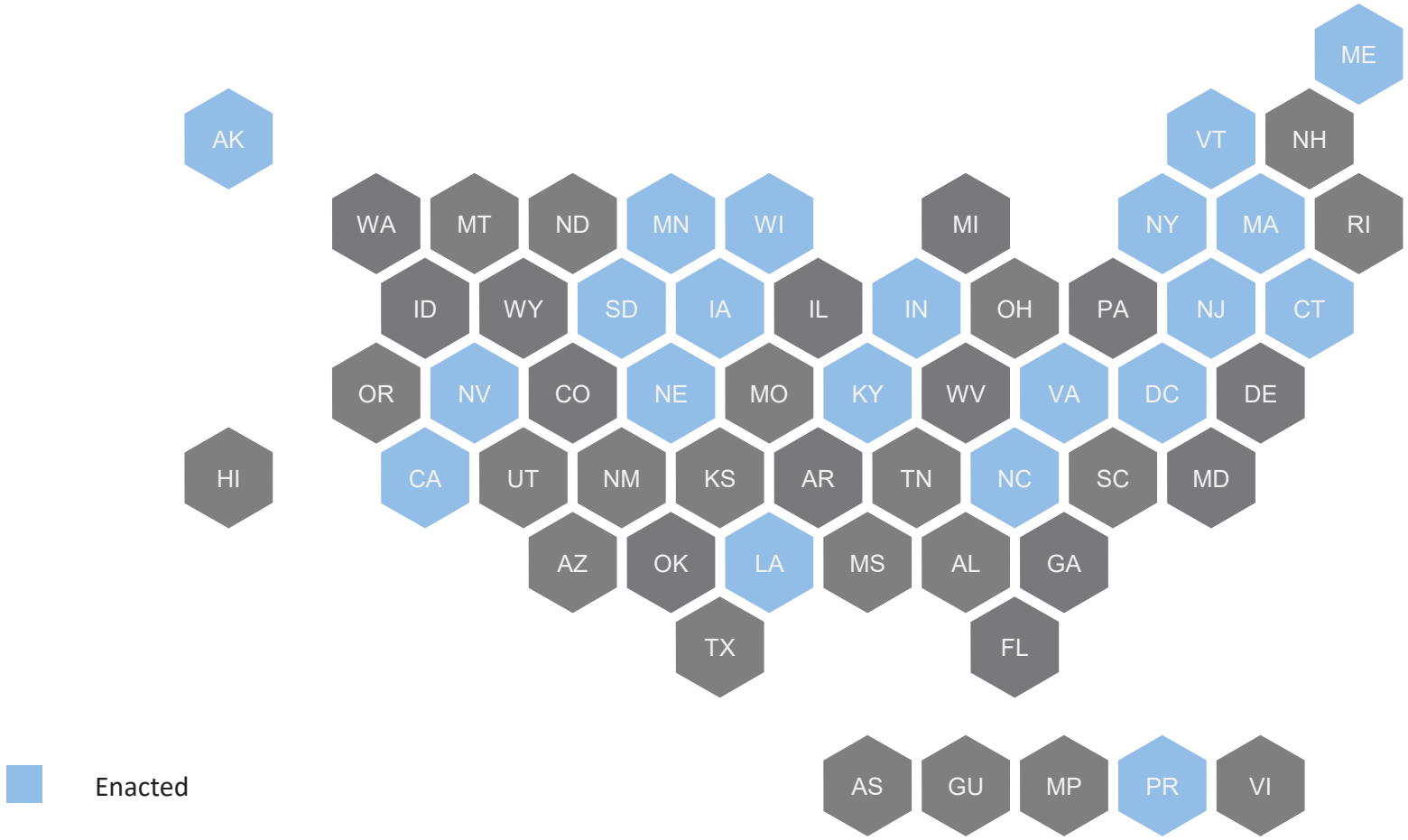
- Contract re-negotiations to include:
  - Fiduciary requirements
  - Rebate sharing or pass-through
- Pharmacy protections
  - Reimbursement
  - Network adequacy

State Limitations on Spread Pricing by Pharmacy Benefit Managers (PBMs)



Updated July 2025

States with PBM Fiduciary Requirements



PBM State Initiatives

Pass-through Pricing

14 states:

- Alabama
- Arkansas
- Colorado
- Georgia
- Idaho
- Indiana
- Iowa
- Louisiana
- New Hampshire
- New Jersey
- Pennsylvania
- Utah
- Virginia
- West Virginia

Single PBM

4 states:

- Kentucky
- Louisiana
- Mississippi
- Nevada

FFS Carve-Out

8 states:

- California
- Missouri
- New York
- North Dakota
- Ohio
- Tennessee
- Wisconsin
- West Virginia

Reverse Auction

8 states:

- Colorado
- Delaware
- Louisiana
- Maryland
- Minnesota
- New Jersey
- Ohio
- New York (pending)

Source: Annual Medicaid Budget Survey 2024-2025, KFF (2024) and NCSL's Prescription Drug Legislation Database.

State Examples – PBM Reforms

Rebate Pass-Through

Alabama AL S 252

PBMs would be further required to pass through 100% of rebates received from drug manufacturers to the health benefit plans for which they provide services.

Single PBM

Nevada NV S 389

Requires the DHHS to select and contract with a state PBM to manage pharmacy benefits for Medicaid and certain other health benefit plans.

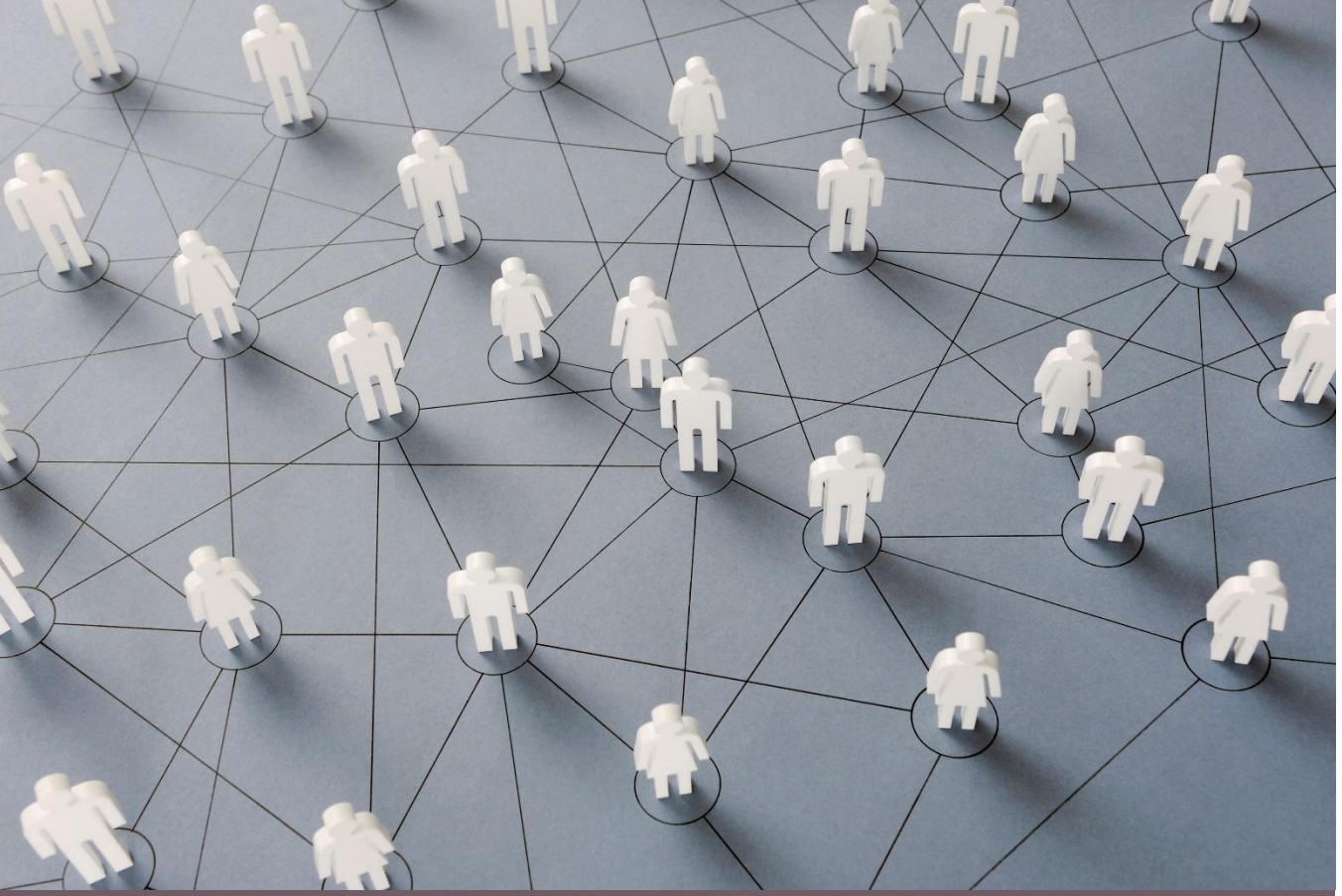
Virginia VA H 2610

The state will select and contract with a PBM to administer all pharmacy benefits for Medicaid recipients, including those enrolled in a managed care organization.

Reverse Auction

Delaware DE S 134

Allows the use of reverse auctions in the procurement of professional services for or related to pharmaceuticals or PBM services.



Colleen Becker

Program Manager, Health

Reach out anytime!

EMAIL	colleen.becker@ncsl.org
PHONE	720.713.0298
WEB	www.ncsl.org