



State Strategies To Lower Drug Prices: New Legislative And Medicaid Models



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December 2021

Executive Summary

Building off years of experience taking action on prescription drug prices, states are advancing some of the boldest efforts to date. While earlier strategies such as drug price transparency helped lay the groundwork, newer approaches, such as the prescription drug affordability boards (PDABs) being implemented in Maryland and Colorado, are taking the first steps to curbing drug costs by establishing reimbursement limits for drugs.

In 2020, with the support, guidance, and input of a multidisciplinary state advisory group, the National Academy for State Health Policy (NASHP) released a slate of additional policy models that states are advancing and refining. These models include:

- [Using international reference rates to leverage lower Canadian prices](#);
- [Penalizing drug manufacturers for price increases unsupported by new clinical data](#); and
- [Prohibiting price gouging in generic and off-patent drugs](#).

Some states are also taking creative approaches to combine different elements of these policies to meet their needs. For example, a PDAB might consult international reference rates in setting an upper payment limit or might chose to penalize a manufacturer for unsupported price increases instead of imposing an upper payment limit.

Because Medicaid receives substantial discounts under the Medicaid Drug Rebate Program, NASHP's policy models, such as a PDAB, are likely to achieve their greatest savings outside of Medicaid. State Medicaid programs, however, have been advancing many Medicaid-specific drug pricing strategies with the ability for savings such as [drug spending caps and enhanced negotiations](#) for additional rebates on high-priced drugs, [more active oversight of pharmacy benefit manager \(PBM\) contracts](#), a single preferred drug list across managed care organizations, and [outcomes-based contracts](#).

State Action On Prescription Drug Prices

Unable to wait for federal action, states worked with NASHP to craft a [Call to Action](#) on prescription drug prices in 2016. Since then, states have an impressive record of action advancing a range of legislative and administrative approaches to lower drug prices, including more than [200 laws enacted across 49 states](#) since 2017. The majority of those laws regulate pharmacy benefit managers¹, while others increase transparency surrounding drug prices and rebates or protect consumers from high out-of-pockets costs for lifesaving medications such as insulin. While these laws address important aspects of drug pricing, recently enacted PDAB legislation that includes the ability to set upper payment limits offers the greatest opportunity yet for direct action by states working to bend the cost curve.

Figure 1: State Drug Pricing Laws by Type and Year

	2017	2018	2019	2020	2021	Total	In # of States
Number of States	13	28	37	17	22	49	
Total Laws Enacted	17	45	62	41	47	212	
PBM	7	32	32	20	21	112	46
Transparency	3	4	7	4	7	25	18
Coupons/Cost Sharing	1	0	4	12	9	26	18
Wholesale Importation	0	1	4	2	1	8	6
Affordability Review	1	0	3	0	2	6	6
Study	0	1	5	1	2	9	7
Volume Purchasing	0	0	2	0	1	3	3
Other	5	7	5	2	4	23	18

States continue to face high drug prices, however, including for new drugs like Aduhelm approved under the US Food and Drug Administration’s (FDA’s) accelerated approval pathway with limited evidence of clinical efficacy. States continue to innovate, and in 2021, states introduced some of the boldest legislation on prescription drugs to date based on new NASHP models released in 2020.

Efforts to rein in the high cost of prescription drugs will continue to be a hot topic in state houses in 2022 and beyond.² Looking ahead to policy options for the 2022 state legislative session, this brief explores trending state policies based on NASHP model legislation with the potential to significantly impact drug pricing, including PDABs, international references rates, penalizing manufacturers for unsupported price hikes, prohibiting price gouging in generic drugs, and hybrid approaches that use different components of these model bills in different combinations.

Prescription Drug Affordability Boards

NASHP's 2016 recommendations promoted the novel idea of states creating a structure for evaluating drug prices and setting rates based on a "public utility" model. In 2017, NASHP released its initial model legislation to implement prescription drug affordability boards (PDABs). Since then, [a number of states](#) have created PDABs charged with taking an analytical approach to determining which drugs are unaffordable for payers and consumers. PDABs build on the important work that states have done to require drug price transparency from manufacturers and other entities in the drug supply chain. States that already have transparency programs in place are well-positioned to implement PDABs quickly. Because the analysis of affordability is data-intensive, PDABs in states with existing data assets such as all payer claims databases are also at an advantage. States that have not taken these initial steps can require transparency and data reporting from manufacturers, PBMs and carriers to the PDAB or can leverage data and information that might be available from other sources, such as existing Medicaid data warehouses or university-based research institutes.

PDABs, independent by design, are tasked with reviewing drugs with high launch prices or high price increases and determining an appropriate, affordable reimbursement rate for payers within a state. [Maryland was the first](#) in the nation to pass a PDAB in 2019 and has a process to phase in setting upper payment limits, starting with public purchasers. In 2021, [Colorado created a PDAB](#) with broad authority to set upper payment limits across all payers (including Employee Retirement Income Security Act (ERISA) plans that voluntarily opt-in) within the state beginning in 2022.

Typically, PDAB legislation includes defined thresholds to determine which drugs are unaffordable and subject to review. The legislation describes the terms upon which affordability will be determined and provides for rulemaking for the process of determining affordability. PDABs have a level of independence from political influence and strong protections against conflicts of interest. They also have mechanisms for meaningful stakeholder engagement, with some requiring advisory boards representing interested parties.

The approach to PDABs that Maryland and Colorado are implementing, which includes broad ability to set upper payment limits applicable to government, commercial, and ERISA plans (those that chose to opt in), is of particular interest to other states. Of all of the policies states are currently taking action on, this is seen as most likely to bend the rising drug cost curve if applied broadly. It is expected that these PDABs will increase affordability of prescription drugs and achieve meaningful and measurable health cost savings across the payer market. For example, state legislatures, similar to Colorado's, may include a requirement within their PDAB legislation that the savings be measured and directed to reducing health care costs to consumers.

PDAB legislation typically requires the board to conduct its business publicly, and the voice of the consumer is a critical part of public input. As states become more aware of the particular and acute challenges that underserved populations face in accessing affordable medication, states can advance health equity in their consideration of the strategies necessary to drive down the cost of prescription drugs. For example, PDABs can advance equity by bringing diverse voices to the boards and advisory committees, and health equity goals can help guide which drugs are selected for rate setting.³

NASHP Model Policies Impacting Drug Prices

In August 2020, with the guidance from state policymakers and legal experts, NASHP introduced a slate of new model bills designed to take what states had learned in the important work around transparency, importation, and affordability and apply those principles in a more direct and immediate way. Although the mechanics of these bills differ in their operational approach, their policy goals are similar. They are designed to have a direct and immediate impact on prices by either prohibiting or penalizing price increases or requiring prices to be lowered, with minimal demands on state resources. By design, the revenue and/or savings they generate are intended to benefit consumers.

Reducing Prescription Drug Costs Using International Pricing

Compared to citizens of other countries, Americans pay a lot more for prescription drugs, and the rising cost of prescription drugs is a huge driver in the overall annual increase in health care costs that Americans experience routinely.⁴ In the United States, rate setting is the norm for many health care services, including for Medicaid and Medicare. However, when it comes to prescription drugs, the United States has an opaque payment and distribution system that begins with prices set by drug manufacturers.

Referencing a state’s rates to Canadian rates would lead to significant savings for the state and commercial payers. The chart below, using national data, demonstrates the magnitude of the possible savings.

Figure 2: Savings from Canadian Reference Rates

Drug Name & Dosage Source: National Average Drug Acquisition Cost (NADAC) data	US Price (NADAC)	Canadian Reference Rate*	Price Difference	Savings off US Prices
Humira syringe (40 mg/0.8 ml) (arthritis, psoriasis, Crohn's)	\$2,706.38	\$541.29	\$2,165.09	80%
1 ml of Enbrel (50 mg/ml syringe) (arthritis, psoriasis, Crohn's)	\$1,353.94	\$272.28	\$1,081.66	80%
1 ml of Stelara (90 mg/1 ml syringe) (arthritis, psoriasis, Crohn's)	\$21,331.28	\$3,267.64	\$18,063.64	85%
1 ml of Victoza (2-pak of 18 mg/3 ml pen)* (diabetes)	\$103.44	\$17.30	\$86.14	83%
Truvada tablet (200 mg/300 mg) (PrEP for HIV)	\$59.71	\$19.78	\$39.93	67%
Xeljanz tablet (5 mg) (rheumatoid arthritis)	\$76.07	\$17.50	\$58.57	77%
Eplcusa tablet (400 mg/100 mg) (hepatitis C)	\$869.05	\$541.32	\$327.73	38%
Zytiga tablet (250 mg) (cancer)	\$87.63	21.47	\$66.16	75%

The model bill directs a state to compile a list of the costliest drugs, defined as price times utilization, using a list from the state employee health insurance plan as the benchmark. This list is then compared to publicly available information from the four most populous Canadian provinces (Ontario, Quebec, British Columbia, and Alberta) and directs that the lowest price becomes the reference rate for payers. The bill applies to state entities (other than Medicaid), commercial payers, and ERISA plans that choose to participate.

This model was introduced in seven states during the 2021 legislative session. In one state where this bill was introduced, the legislature’s fiscal office estimated that referencing to Canadian prices could generate upwards of \$50 million in annual savings for the state employee health plan alone looking at just the top 20 drugs. In another, NASHP worked with the state and was able to determine that applying reference pricing to just the top 23 drugs would save the state employee health plan \$22 million.

The model bill suggests that any savings generated by implementing the reference rates, whether generated by state entities or commercial health plans, be used to reduce consumer health care costs. Lowering the cost of lifesaving drugs such as Humira – which costs \$2,706 a syringe in the US versus \$541 in Canada – will increase affordability and access for people who rely on high-cost drugs.

Pharmacy manufacturers, who continue to make profits in Canada and in other countries with lower prices than the US, will still have the necessary revenue [to invest in research and development](#) while bringing new, innovative drugs to market. The profits that pharmaceutical manufacturers make in the US by charging more to Americans than they do to the citizens of other countries far exceeds their entire global research and development (R&D) budget.⁵ (This does not even account for the billions of direct government support that pharmaceutical R&D receives from the National Institutes of Health.⁶)

Protecting Consumers from Unsupported Price Increases on Prescription Drugs

The dramatic annual increases in the price of prescription drugs are a significant driver in the unsustainable cost of health care for Americans. Sometimes price increases are justified by circumstances such as an increase in the cost of production or a reassessment of the clinical value of the product. In many cases, though, drug companies raise their prices simply because they can and because they know that in a market that does not effectively regulate price, they can increase prices at a rate that far exceeds inflation.

In contrast to transparency laws that provide information but lack teeth, this model bill takes the next step in enabling states to take action against manufacturers that hike prices without justification. The annual report prepared by the Institute for Clinical and Economic Research (ICER) represents a credible, unbiased, well-informed, freely available basis for this action.

Each year, ICER assesses a small number of high-cost drugs that have price increases that exceed the rate of inflation. ICER then conducts a thorough review of available evidence to determine whether there is any clinical evidence to support those sharp price increases. This process is entirely transparent and documented, and manufacturers of the products are invited to participate.⁷ ICER's complete methodology is published and available online.⁸

Once ICER completes its review, it publishes a detailed report documenting the drugs that it has determined have had large price increases without new justifying clinical evidence. In its [most recent report](#), ICER identified seven drugs that accounted for \$1.67 billion in additional US drug spending from unsupported price increases alone.⁹ \$1.4 billion of that was from unsupported price increases on one drug, Humira. From 2017–2020, the ICER reports have identified over \$7 billion in price increases that are not justified with new evidence.¹⁰

The model bill suggests states look to the ICER report as a guide. It puts the manufacturers of a small number of high-priced drugs on notice: If they raise their price above the rate of inflation without new clinical evidence justifying those price increases, they will be penalized. The bill sets the penalty at 80 percent of the revenue from the drug above the base price plus inflation. Manufacturers are required to report each year on the sales volume and pricing per unit so the state can determine the penalty.

The model bill suggests revenues be deposited into a dedicated account to be used by the state to offset consumer drug costs.

Figure 3: Potential Revenue from Penalizing Unsupported Price Increases

Treatment	2019–2020 WAC Increase	2019–2020 Net Price Increase	Increase in US Drug Spending Due to Net Price Change (in Millions)	Potential Revenue from Penalizing Unsupported Price Increases at 80% (in Millions)
Humira® (adalimumab, AbbVie)	7.3%	9.6%	\$1,395	\$1,116
Promacta® (eltromobopag, Novartis)	7.2%	14.1%	\$100	\$80
Tysabri® (natalizumab, Biogen)	7.1%	4.2%	\$44	\$35
Xifaxan® (rifaximin, Bausch Health)	8.4%	3.0%	\$44	\$35
Trokendi XR® (topiramate, Supernus Pharmaceuticals)	8.0%	12.4%	\$36	\$29
Lupron Depot® (leuporelin, AbbVie)	7.5%	5.9%	\$30	\$24
Krystexxa® (pegloticase, Horizon Pharmaceuticals)	7.9%	5.2%	\$19	\$15
TOTAL			\$1.67 billion	\$1.33 billion ¹¹

Prohibiting Price-Gouging for Generic and Off-Patent Prescription Drugs

While the unsupported price increase model described above focuses on a small number of high-cost drugs, including brand name drugs, price increases also have a significant impact in the generic market. For example, Turing Pharmaceuticals raised the price of Daraprim from \$13.50 to \$750 per pill in 2015.¹² This is only one egregious example:¹³

[The model bill](#) would make this type of price gouging illegal. Specifically, generic or off-patent drugs with price increases over 15 percent in a year, or over 40 percent in three years, would be referred to the state attorney general for investigation. If found to have engaged in price-gouging, a company would have to roll back the inflated prices and pay back its profits from price gouging – either directly to consumers when possible or to the state for consumer relief.¹⁴

States Can Combine These Strategies To Meet Their Specific Needs

A state contemplating the implementation of a PDAB or any of these newer model bills may find it effective to consider combining different elements of these bills together and creating a “hybrid” approach. For example, a state moving forward with a PDAB might consider explicitly requiring the board to consider international prices when assessing affordability or developing upper payment limits. A state could likewise incorporate the penalty provisions in the Unsupported Price Increase model bill into a PDAB as an alternative to an upper payment limit or into an anti-price gouging bill as an additional deterrent. These bills are based on similar principles and share similar goals, and a state may choose to borrow design elements from one to enhance another.

Medicaid Strategies

While the strategies discussed above present the opportunity for real savings for the commercial market and some government payers, savings to Medicaid may be limited due to the already low net prices Medicaid programs receive through the Medicaid Drug Rebate Program. Medicaid programs have developed various other notable models to realize additional savings for Medicaid, however, discussed in this section.

Spending Caps and Enhanced Negotiating Authority

In 2017, [New York enacted a law](#) that gave the Medicaid program the authority to negotiate with drug companies for supplemental rebates if drug spending is projected to exceed an annual spending limit. The law targets drugs with utilization in the top percentage of spend and/or price per claim. If the state is unable to reach an agreement with a manufacturer, a drug may be referred to the Drug Utilization Review Board (DURB), which then conducts a value assessment of the product. When conducting a value assessment, the DURB can consider a drug's affordability and net cost to Medicaid, value-based pricing, significant price increases, and/or the proportionality of price to therapeutic benefit. A state plan amendment was not required to implement the spending cap legislation.

Since New York's law went into effect in 2018 through 2021, the state Medicaid program has negotiated over 50 new supplemental rebate contracts with manufacturers, which have generated over \$500 million in new supplemental rebates. The DURB used value-based pricing benchmarks from ICER to guide the state department of health on target supplemental rebates for two drugs and used domestic reference pricing for a third drug that had two biosimilars on the market.

In 2019, the state expanded this effort by enacting a law that authorizes the department of health to identify and negotiate enhanced rebates for newly launched high-cost drugs or drugs with significant price increases over a 12-month period. This gives the DURB the ability to review drugs that pose an affordability challenge even before the drug pierces the spending cap.

Massachusetts has a program similar to New York's that enables enhanced negotiating authority within its Medicaid program. If an agreement cannot be reached and the drug exceeds certain price thresholds, the drug can be referred to the Massachusetts Health Policy Commission (HPC) for review. As of September 1, 2021, this approach has been successful in reaching agreements on supplemental rebate contracts with 14 manufacturers on 46 drugs with a total annual value of \$159 million without the need for HPC review. Both New York and Massachusetts have been successful in achieving additional rebates and reducing spending growth without limiting access to high-cost drugs, in part because they already have the necessary infrastructure in place to conduct affordability reviews.

Stronger Contracting with Pharmacy Benefit Managers

Over the past five years, lawmakers have frequently targeted pharmacy benefit managers (PBMs) as one of the entities in the drug supply chain contributing to higher costs. PBMs were originally intended to help keep costs down by negotiating lower prices and rebates on behalf of insurers. Now some states are concerned that PBMs have become profit centers for commercial payers and large pharmacy chains¹⁵ and are contributing to higher costs paid by consumers at the pharmacy counter. There is also concern that PBM practices have contributed to the closure of local independent pharmacies.¹⁶ As PBMs have become more significant players in the prescription drug payment and distribution system, the lack of transparency with respect to their business practices has become more concerning to state policymakers.

States have enacted [more than 100 laws](#) to address the PBM practices that contribute to these costs since 2017. Most of these laws affect PBMs that contract with state-regulated commercial health plans, but PBM-related strategies are also important for state purchasers such as Medicaid.

Following reports out of [Ohio](#) and [Kentucky](#) that revealed PBMs were making large profits from “spread pricing¹⁷,” many state Medicaid programs have sought to strengthen their contracts with PBMs. In 2018, Ohio Medicaid required the state’s five managed care plans to transition to a pass-through pricing model with their contracted PBMs. Under a pass-through model, a PBM is required to pass all rebates and discounts it negotiates with a manufacturer to the health plan; the PBM cannot retain any of the difference between what the PBM pays the pharmacy for a drug claim and what it collects from the health plan.

As major purchasers of drugs, states can leverage their buying power by demanding favorable terms with PBMs. [NAHSP’s model contract terms](#) enable states to restrict PBM compensation to an administrative-fee-only model, eliminate spread pricing, require 100 percent pass-through of rebates, and provide robust transparency for monitoring and enforcement. Achieving advantageous contract terms with a PBM during the procurement process may supplement or provide an alternative to direct regulation of PBMs outside of legislative activity.

Ohio has since transitioned from transparent pass-through contracts with multiple PBMs to the use of a [single state-contracted PBM](#) across all managed care providers. The switch to a single PBM is estimated to save up to \$200 million per year. West Virginia and [New York](#) have similarly carved the pharmacy benefit out of Medicaid managed care organizations and into the fee-for-service program, where drug reimbursement is based on the ingredient cost of a drug plus a professional dispensing fee. This reimbursement methodology limits spread pricing because PBMs operating under Medicaid fee-for-service programs must abide by federal and state rules regarding drug reimbursement, whereas PBMs acting on behalf of Medicaid managed care organizations can negotiate individual prices with pharmacies, which may or may not be transparent to the state.¹⁸ The carve-out [saved West Virginia \\$54 million](#) in the first year; New York’s carve-out will be implemented in 2023. [Louisiana has also enacted a law](#) that allows its department of health to assume direct responsibility for Medicaid pharmacy.

New Jersey, Maryland, New Hampshire, Louisiana, Minnesota, and Colorado have opted to use [reverse auctions](#) to procure pharmacy benefit services for their state employee health plans. This approach is designed to achieve savings by encouraging PBMs to be more competitive on pricing in their bidding for contracts. New Jersey, which was the first state to implement a reverse auction, reports \$2 billion in savings over five years without cutting drug benefits for its State Health Benefits Program and School Employees’ Benefits Program enrollees.

Single Preferred Drug Lists

In lieu of carving out pharmacy benefits from managed care, states can also create a single preferred drug list (PDL) across Medicaid managed care organizations. Single PDLs create administrative ease for patients and providers because members do not need to change medications if they change health plans. Single PDLs can also increase transparency around rebates and maximize rebates by managing to the lowest net cost for the state rather than the lowest net cost to managed care plans, which are constrained by Medicaid best price and cannot negotiate additional supplemental rebates. In Washington, an analysis showed that if the state Medicaid program had maintained the 2019 managed care plan reimbursement rates, the state's health care authority would have spent between \$3 and \$6 million more than they did in 2020 under the single PDL. Massachusetts also requires Medicaid managed care organizations to use a unified PDL that identifies the therapeutic classes for which preferred products have been designated.

Outcomes-Based Contracting

Nine states have state plan amendments (SPAs) that enable outcomes-based contracts with drug manufacturers based on a specific drug and agreed-upon outcomes. Outcomes-based contracts allow states to collect supplemental rebates based on a drug's performance. These contracts can be time and labor intensive, so states should structure them in a way that ensures a return on investment. One way to do that is to target the highest priced drugs. However, in some cases, the manufacturers of these drugs, especially single-source drugs, may not be willing to enter such contracts. Manufacturers may also be concerned about triggering Medicaid best price through an outcomes-based contract in which a costly drug could be made available at very low cost or no cost if it fails to perform as promised against outcomes measures. A recently finalized federal rule would allow manufacturers to report multiple best prices to avoid this scenario.¹⁹

Accelerated Approval

[State Medicaid programs have expressed concerns](#) about paying high prices to cover drugs the FDA approves under the accelerated approval program for which clinical outcomes have not yet been verified through confirmatory studies.[1] Though the accelerated approval program may be beneficial for rapidly getting drugs to those who need them, Medicaid programs are required to cover those drugs before confirmatory trials, often subject to delays, affirm their clinical benefits. Though accelerated approval drugs represent less than 1 percent of use by Medicaid beneficiaries, annual net spending on those drugs represents 9 percent of spending on all drugs covered by Medicaid.[2] The Medicaid and CHIP Payment and Access Commission [recommended in a June 2021 report](#) to Congress that drug manufacturers pay higher rebates to Medicaid programs until a drug's clinical benefit is proven and the FDA grants full approval. Outcomes-based contracting represents an additional tool states can use for accelerated approval drugs if manufacturers of accelerated approval drugs are willing to enter into such contracts.

Endnotes

- [1] For a complete review of state PBM regulation, see “[Legislative Approaches to Curbing Drug Costs Targeted at PBMs: 2017-2021.](#)”
- [2] On July 1, 2021, the National Conference of State Legislatures released a report highlighting recommendations developed by a bipartisan group of lawmakers from across the United States. www.ncsl.org/Portals/1/Documents/Health/NCSL-Prescription-Drug-Policy_36550.pdf
- [3] Colorado’s PDAB statute indicates: “To the extent possible, the Board shall appoint council members who have experience serving underserved community and reflect the diversity of the state with regard to race, ethnicity, immigration status, income, wealth, disability, age, gender identity, and geography.”
- [4] https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/U.S.%20vs.%20International%20Prescription%20Drug%20Prices_0.pdf
- [5] www.healthaffairs.org/doi/10.1377/hblog20170307.059036/full
- [6] www.ineteconomics.org/research/research-papers/government-as-the-first-investor-in-biopharmaceutical-innovation-evidence-from-new-drug-approvals-2010-2019
- [7] ICER’s process also allows interested parties, such as states, to nominate drugs for review. For ICER’s most recent report, several states, in an effort coordinated by NASHP, nominated Enbrel, which ICER determined was the No. 1 drug last year contributing the most to excess spending due to an unsupported price increase.
- [8] https://icer.org/wp-content/uploads/2020/10/UPI_Revised_Protocol_20200715.pdf
- [9] ICER published an interim report on unsupported price increases occurring in 2020 on December 6, 2021, noting forthcoming corrections to appear in the final version of the report.
- [10] During the 2021 legislative session, opponents to this bill, including PhRMA and PhRMA-funded advocacy groups, objected to this bill based on the utilization by ICER of comparative effectiveness research using quality adjusted life years (QALYs). However, the ICER report that this bill utilizes to identify over-priced drugs does not use QALYs in any way, and the methodology that the bill uses to assess penalties does not rely on QALYs or any other comparative effectiveness analysis.
- [11] States can make a rough estimate of their potential revenue by adjusting the amounts listed in this column by their percentage of the US population. NASHP can help states wishing to refine their estimates further.
- [12] www.nytimes.com/2015/09/21/business/a-huge-overnight-increase-in-a-drugs-price-raises-protests.html
- [13] There are a number of examples of spikes in the prices of generic drugs: In January 2019, Fluoxetine, a generic version of the antidepressant Prozac, jumped from \$9 per bottle to \$69, an increase of \$60 or 667 percent. In February 2019, Guanfacine, a generic treatment for high blood pressure and attention deficit hyperactivity disorder, jumped from \$29 to \$87 per bottle, an increase of \$58 or 204 percent. And, in April 2019, Azacitidine, a generic version of the chemotherapy drug Vidaza, jumped from \$105 to \$210 per vial, an increase of \$105 or 100 percent.
- [14] A previous price-gouging bill enacted in Maryland was struck down by the Fourth Circuit. When NASHP created the model act, it worked with a team of legal experts, including a former Maryland assistant attorney general who worked on the original case, to address the specific points of law raised by the court. To that end, this bill includes language making it clear that it applies to in-state transactions only to avoid violations of the dormant commerce clause. It also requires drug wholesalers to maintain a registered agent in-state. It is also designed to be very specific in scope to avoid any challenge based on vagueness. It is designed to apply only to generic and off-brand drugs to avoid any possible argument that the limit on price increases infringes the owner of any patents.
- [15] OptumRx (United Health Group) ExpressScripts (Cigna), and CVS Caremark (Aetna) control about 80 percent of the PBM business in the United States. www.fiercehealthcare.com/payer/two-new-pbm-launches-aim-to-bring-greater-transparency-to-market

Endnotes

[16] <https://khn.org/news/article/last-drugstore-how-rural-communities-lose-independent-pharmacies/view/republish>

[17] “Spread pricing” refers to the practice in which a PBM pays a pharmacy at a lower rate and bills the health plan it serves at a higher rate for the same prescription, retaining the difference, or “spread,” as profit.

[18] www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicaid-prescription-drugs

[19] www.federalregister.gov/documents/2020/12/31/2020-28567/medicaid-program-establishing-minimum-standards-in-medicaid-state-drug-utilization-review-dur-and

[20] <https://medicaiddirectors.org/wp-content/uploads/2021/04/NAMD-MACPAC-Rx-recommendation-letter-of-support.pdf>

[21] <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2784982>

For more information on strategies to lower drug prices, please see [NASHP’s toolkit](#) or contact Jennifer Reck at jreck@nashp.org.

Acknowledgements

The National Academy for State Health Policy's Center for State Rx Drug Pricing is supported by Arnold Ventures.