Part D Has Pricey Generic Drugs Problem With Murky Solutions

A recently published study shines a light on a peculiar quirk of the Medicare Part D benefit structure: For some high-priced specialty medications, seniors might pay less out-of-pocket for brand-name drugs than their generic counterparts.

A leader from one Medicare-focused insurer tells AIS Health that while the issue doesn’t affect a very large swath of members, it’s still worth addressing.

“This kind of nuance that’s happening [with the Part D benefit] is kind of narrow and limited in scope,” says Sharon Jhawar, chief pharmacy officer at California-based SCAN Health Plan, noting that most generic prescriptions filled by seniors are not pricey specialty ones.

“But we know that the specialty pipeline is robust,” and so taking a look at the problem and figuring out solutions “does make sense,” she says.

So what exactly is the problem? A study published in the most recent issue of Health Affairs found that, assuming a 61% discount between brand-name and generic drugs, Part D beneficiaries with prescriptions costing between $22,000 and $80,000 per year would have lower out-of-pocket spending if they use brand-name drugs over a generic.

Maine MCOs Worry Over High Drug Costs Despite New Laws

Maine is “forging new ground” with its recent enactment of a comprehensive prescription drug reform legislative package, the National Academy for State Health Policy says. The Pine Tree State, however, is not alone in its efforts. NASHP reports that 47 states had filed 269 bills to control prescription drug costs as of July 7 — with 46 such laws enacted this year in 29 states.

Maine Gov. Janet Mills, a Democrat, on June 24 signed into law four measures to allow the wholesale importation of prescription medicine (with federal approval), create a prescription drug affordability board, increase drug price transparency and better regulate PBMs — with insurers taking a more active role in PBM oversight.

NASHP, which is based in Maine, says the state has “taken a big step” toward holding the entire supply chain accountable for rising drug prices. Yet the head of the Maine Association of Health Plans (MeAHP) tells AIS Health that the group has reservations about state lawmakers’ efforts.

MeAHP Executive Director Katherine Pelletreau said in comments emailed July 10 that the group “shares the concerns about the rising cost of prescription drugs, but remains concerned these bills avoid addressing the root causes of the problem — the list prices set by manufacturers.”

“These new laws may have unintended consequences for consumers and insurers,” says Pelletreau, whose group has five members — Aetna Inc., Anthem Blue Cross and Blue Shield, Cigna Corp., Community Health Options and Harvard

continued on p. 5
The bill (LD 1272) drug importation program with a wholesale prescription pricing and copays as the price of drugs continues to rise. “While we appreciate the legislature’s intent, the high cost of prescription drugs will likely persist as these bills focused largely on the distribution and health insurance coverage for drugs, rather than the manufacturing and price setting process.”

“Despite efforts to broaden the reach of these bills, left outside the scope is increased transparency into hospital drug costs borne by consumers and insurers, and the list price from manufacturers,” she says. “These new laws are inadequate to address rising drug prices, which may leave many consumers and insurers still on the front lines with increased premiums and copays as the price of drugs continues to rise.”

Specifically, Maine’s package of four bills aims to:

✦ Set up a wholesale prescription drug importation program with approval from HHS. The bill (LD 1272) is modeled after a Vermont law that passed last year (RDB 1/10/19, p. 1) though that program is still to be implemented. The governor’s office notes the Trump administration has indicated its support for similar laws passed in other states, including Florida and Colorado.

Maine’s Dept. of Health and Human Services must seek federal approval for the importation program by no later than May 1, 2020, NASHP notes, describing this bill as “unique in that the program design must consider whether the program can be developed on a multistate basis through collaboration with other states.”

✦ Create a Prescription Drug Affordability Review Board. Under this bill (LD 1449), the board is to set prescription drug spending targets for public entities, including state, municipal, state university, and community college employees and teachers, “based on a 10-year rolling average, accounting for inflation with spending reductions,” the governor’s office says.

The board also is to “provide methods for achieving lower prescription costs through measures such as bulk purchasing, leveraging multi-state purchasing, or negotiating specific rebate amounts.” This is similar to legislation recently passed in Maryland, NASHP notes.

The board, with advice from a 12-member advisory council representing public payers, will set drug spending targets and monitor how effectively public payers meet them, NASHP explains. “Of particular interest, the law allows the board to consider expanding the purchasing pool for prescription drugs and allowing carriers who cover small businesses and individuals to buy into a public payer drug benefit plan.” The first report on drug spending targets is due in 2021.

✦ Further expand drug price transparency. The governor’s office says the bill (LD 1162) builds upon legislation that became state law in 2018, seeking to “gather information related to the pricing of drugs all along the supply chain from manufacturers to wholesalers, pharmacy benefit managers and insurance companies.” It adds, “Other bills in this package rely on this data to understand how the costs of development, advertising, and profits affect pricing for the consumer.”

Maine revamped its drug pricing transparency program using NASHP’s recently released model legislation, the association notes. The law requires drug manufacturers to report to the Maine Health Data Organization — which is the state’s all-payer claims data program — when they boost the wholesale acquisition cost (WAC) of brand-name and generic drugs beyond certain thresholds.

“The Maine bill goes beyond other states’ transparency bills because it
requires reporting from each entity in the supply chain about past and projected costs and revenues at the individual drug level,” NASHP says. “A more robust set of data from the entire supply chain will help the state identify which players contribute most to drug price increases.”

✦ Prohibit PBMs from retaining rebates paid by prescription drug-makers, requiring those rebates to be passed along to the consumer or the health plan. The bill (LD1504) “essentially replaces opaque PBM business practices by imposing more transparent, clearly defined fiduciary relationships that include state enforcement and oversight through the health insurance carriers with whom PBMs contract,” NASHP says. Similar to some other states, Maine is requiring PBMs to obtain a license from the superintendent of the Bureau of Insurance, but NASHP says the new law also includes provisions not enacted by any other state. For example, if health insurance carriers use PBMs to manage their prescription drug benefits, the carrier is responsible for monitoring all activities performed by its contracted PBM. Moreover, the new law stipulates that PBMs have a fiduciary duty to their insurance carriers when managing their prescription drug benefits and thus carriers may hold PBMs accountable for their financial dealings.

“To lower costs for consumers, the law requires carriers to use the prescription drug rebates that PBMs negotiate to either lower health plan premiums or to reduce out-of-pocket costs for consumers when they purchase prescription drugs,” NASHP explains. “Without the ability to retain a portion of the rebate, PBMs will now be paid for managing the prescription benefit directly by the carrier. Maine’s law includes provisions that explicitly classify PBM expenses as administrative costs for purposes of calculating a health plan’s anticipated loss ratio. The classification of PBM expenses as administrative rather than as a health benefit encourages carriers to monitor these costs carefully and keep them low.”

Find further information on NASHP’s legislative tracker on states’ efforts to lower pharmaceutical costs at https://bit.ly/2McLRNz. Contact Pelletreau at meahp@maine.rr.com.

by Judy Packer-Tursman

Senators Vow to Keep Fighting For Drug Cost Transparency

After a federal court on July 8 blocked a Trump administration rule — a day before it was set to take effect — requiring pharmaceutical manufacturers to disclose prescription drugs’ list prices in direct-to-consumer (DTC) television ads, HHS brushed aside the legal setback for its high-profile initiative as “disappointing.” The judge indicated that Congress would need to act on the matter, and on July 10 two senators said they intend to plow ahead and do just that.

Under the HHS rule, which was proposed last October (RDB 10/25/18, p. 5) and finalized on May 8, drug manufacturers would have to post the wholesale acquisition cost (WAC) for a typical course of treatment for an acute medication, such as an antibiotic, or for a 30-day supply of medication for a chronic condition, in “a legible textual statement at the end of the ad.” Drugs with list prices under $35 per month are excepted from the posting requirement. The HHS secretary was to keep a public list of drugs advertised in violation of the rule, though there was no enforcement mechanism to ensure companies’ compliance.

In 2018, the Senate passed a bipartisan amendment, introduced by Sen. Chuck Grassley (R-Iowa) and Sen. Dick Durbin (D-Ill.), to the Defense-Labor-HHS-Education appropriations “minibus” package, giving $1 million to HHS to implement the WAC disclosure rule. But the amendment was stripped from the bill during the House-Senate conference process.

On May 13, Grassley and Durbin introduced legislation to codify and ensure the long-term implementation of HHS’ just-issued final rule.

Then in June, Merck & Co., Eli Lilly & Co., Amgen Inc. and the Association of National Advertisers sued the Trump administration over the rule, making two basic arguments. First, the plaintiffs asserted the rule exceeds HHS’s authority, because Congress neither expressly nor impliedly granted HHS the power under the Social Security Act to regulate drug marketing. Second, they argued the rule involves “compelled speech” that violates the First Amendment.

Court Nixes List-Price Disclosure

On July 8, Judge Amit Mehta of the U.S. District Court for the District of Columbia ruled HHS “lacks the statutory authority under the Social Security Act” to adopt the WAC disclosure rule.

“Neither the Act’s text, structure, nor context evince an intent by Congress to empower HHS to issue a rule that compels drug manufacturers to disclose list prices. The Rule is therefore invalid,” Mehta wrote. “In view of this holding, the court does not reach Plaintiffs’ First Amendment challenge.”

The judge noted that while federal agencies “typically enjoy expansive authority from Congress to formulate rules that have the force of law in areas germane to the statutes that they
implement,” such authority “is not unbounded.”

In his 27-page memorandum opinion, Mehta, who was appointed during the Obama administration, said the court doesn’t question HHS’s motives in adopting the rule, then went on: “Nor does it take any view on the wisdom of requiring drug companies to disclose prices. That policy very well could be an effective tool in halting the rising cost of prescription drugs. But no matter how vexing the problem of spiraling drug costs may be, HHS cannot do more than what Congress has authorized. The responsibility rests with Congress to act in the first instance.”

**Senators Now Seeking New Options**

On July 10, Grassley, who is the Senate Finance Committee’s chair, and Durbin, the Democratic Whip, issued a joint press release. Grassley said he and Durbin plan on renewing their “push to provide a legislative solution to this problem by moving our bipartisan bill introduced earlier this year that would require this type of disclosure by federal law.”

According to the senators, the average American sees nine DTC prescription drug ads each day, and studies show “patients are more likely to ask their doctor for a specific brand-name medication, and doctors are more likely to prescribe one, when they have been marketed directly with drug advertisements.”

AARP voiced its disappointment with the recent court ruling, describing it as “a step backward in the battle against skyrocketing drug prices and providing more information to consumers.”

America’s Health Insurance Plans (AHIP), though it had issued a statement last October commending the Trump administration “for taking such bold action to lower prices for patients,” was more circumspect following the federal court’s decision.

“While we haven’t commented specifically on the litigation, we agree that the DTC rule made sense — and many agree,” AHIP spokesperson Kristine Grow said in an email to AIS Health, citing USA Today’s May 16 editorial in favor of the rule.

Read the court’s decision at https://bit.ly/2SS6qi2. Contact Grow at kgrow@ahip.org.

by Judy Packer-Tursman

**Plans Offer More $0 Copay Drugs to Boost Adherence**

As various players in the health care industry sharpen their focus on disease prevention, some experts say they’re seeing health plans offering more and more “preventive” drugs at no cost to members.

For example, in a June 28 press release, Dean Health Plan said it’s “adding even more preventive drugs to our list of drugs available to [members] for $0.” Additions to the list, which total more than 200, include Advair inhalers (fluticasone propionate and salmeterol) for asthma, the diabetes drug Januvia (sitagliptin), and Alendronate for osteoporosis, says Kevin Engelien, manager of large group product and market research at the Wisconsin-based insurer.

The reason for maintaining such a list — and adding to it — is simple, according to Engelien. “We do this because we feel taking these medications on a regular basis or as prescribed can help avoid more serious health problems or complications,” he says.

Currently, the benefit is available for Dean Health Plan’s large group commercial members, small-group members on pre-Affordable Care Act plans and pre-ACA individual plan members.

For ACA-compliant plans, the law requires that a set list of preventive drugs and services must be available to members at no cost, such as oral contraceptives and certain statins. The list must include all those medications and services given an “A” or “B” rating by the U.S. Preventive Services Task Force (USPSTF), meaning there is a good chance the net benefit is anywhere from moderate to substantial.

The ACA-mandated spate of preventive drugs is a “fine list,” Engelien tells AIS Health, but Dean Health Plan sees a “market demand” to offer a more comprehensive list of drugs at a $0 copay.

To decide what goes on that list, Dean Health Plan works with its PBM, Navitus Health Solutions, in a “no less than monthly” process of reviewing the utilization and effectiveness of drugs, as well as any changing mandates, Engelien says. (For example, USPSTF recently gave an “A” rating for pre-exposure prophylaxis, or PrEP, for patients who are at high risk of acquiring HIV, meaning ACA-compliant plans must cover it at no cost.)

**Larger Lists Becoming More Common**

As part of the formulary review process, “there’s a peer review that’s done, which is you look left and you look right at what other carriers are doing, and sometimes that’s either brought to you from an employer where they were previously, or just the PBM in some cases can do that, because PBMs do work with multiple carriers,” Engelien says.

In general, Dean Health Plan is seeing more comprehensive lists of $0 copay preventive drugs from other carriers, particularly large national ones,
he says. So the Wisconsin plan “tried to find what we thought was a comfort-able place” with its own list based on not only what competitors are doing, but also how it interprets the definition of preventive and what drugs it deter-mines will truly drive better outcomes for patients, according to Engelien.

> I think the driving force, to the plans that I consult to, is more in trying to make sure that people with chronic conditions get the treatment necessary.

It’s not just smaller regional in-surers like Dean Health Plan that are making more drugs available to mem-bers at no cost.

“I do think there is a trend in non-grandfathered self-insured clients offering preventive drug lists, and also kind of widening their preventive drug lists,” says Stephen Wolff, a pharmacy consultant in Milliman’s Chicago office.

**Chronic Conditions Are a ‘Driving Force’**

While Wolff says self-insured plans “love to benchmark their benefits against each other” to stay competitive, he doesn’t necessarily see them benchmarking $0 copay preventive drug lists.

Rather, he attributes the expansion of those lists to the rise of high-deduct-ible health plans in the employer-spon-sored insurance market.

“I think the driving force, to the plans that I consult to, is more in trying to make sure that people with chronic conditions get the treatment necessary,” he says. “So even if you have a deduct-ible, you can get first-dollar coverage on diabetes meds, for example.”

“That way, members will continue to use these drugs even when they have a deductible and hopefully save the plans money in the long run.”

Some large PBMs offer “off-the-shelf recommendations” for preventive drug lists, but often larger employers tap firms like Milliman to customize their lists, according to Wolff. For such clients, the reasoning goes that they “want to really be thoughtful” with their drug spend in order to help people with chronic illnesses keep taking medications that are going to lower the total cost of care, he adds.

**Defining ‘Preventive’ Can Be a Pain Point**

However, the fact that different health plans define preventive drugs differently — and thus have variable lists of $0 copay medications — can sometimes be a “pain point” for con-sumers, Engelien points out.

“There can be disruption on the coverage side when there’s not con-sistency,” he says. “So you’re on… what we define as kind of an expanded preventive drug list at $0 cost to you with one carrier and then your employer moves to another carrier, and now you’re paying $800 out-of-pocket a month [for a medication].”

That issue aside, Dean Health Plan’s goal is simply to put together a list of $0 copay preventive drugs that it feels best serves members, according to Engelien.

“So you balance what you have to be responsible for on the mandated side to what you think is going to be right for the most effective outcomes,” he says. “And then there’s obviously the financial piece of it too, and you need to manage that as well.”


**Costly Generics Plague Part D continued from p. 1**

“That’s really frustrating for con-sumers because you may actually not be in a plan that allows you to switch to a branded drug” if it’s cheaper than the generic, says Stacie Dusetzina, one of the study authors and an associate professor at Vanderbilt University.

“The other practical thing is, that would a terrible thing for us to be trying to get people to do because generally we want to encourage people to use generic drugs because they’re the best deal for us as a society,” she says. “So we want to make sure that the message is loud and clear to people that if you take the generic it should cost you less money than the brand, not more money.”

**Researchers Pinpoint Two Causes**

The way Dusetzina and her col-leagues explain it in their study, there are two primary reasons why some brand-name drugs cost Part D benefi-ciaries less than their generic counter-parts. One is the fact that there’s less competition from generics and biosimilars in the specialty-drugs market, and thus smaller price differences between generics/biosimilars and their corre-sponding brand-name drugs.

Then there’s the Affordable Care Act’s effort to close the Part D “doughnut hole,” or the phase of the benefit after patients have met their deductible when they’re responsible for 100% of the cost of their medications. Since 2012, patients who use brand-name drugs have received a manufacturer dis-count that counts toward their out-of-pocket spending while in the doughnut hole — which means those taking brand drugs reach the catastrophic phase, when they’re responsible for just 5% of their drugs’ cost, faster than people taking generic drugs.
The Bipartisan Budget Act (BBA) of 2018 fixed the issue for biosimilars—ensuring beneficiaries would not pay more for biosimilars than for their brand-name counterparts—but not for generic drugs.

For example, even after the passage of the BBA, the generic version of specialty multiple sclerosis drug Copaxone (glatiramer acetate) cost Part D beneficiaries $1,072 more annually in out-of-pocket spending than the brand-name version of the drug, the study found (see chart below). For the cancer drug Gleevec (imatinib) the generic cost $911 more annually, and for another cancer drug, Nilandron (nilutamide), the difference is $869.

That quirk of the Part D benefit means plan sponsors have to carefully consider the role of any rebates they’ve negotiated with drug manufacturers when they decide whether to put a brand-name specialty drug, the generic version or both on their formularies.

SCAN Health Plan, for example, opted to cover both the brand and generic version of Copaxone, as the manufacturer discount for the brand helps lower members’ out-of-pocket costs while in the coverage gap, Jhawar says. For Gleevec and Nilandron, SCAN covers only the generic versions, “as the

For Medicare Part D Beneficiaries, Generics May Not Always Be Cheaper

by Jinghong Chen

Medicare beneficiaries who use generic specialty medications may pay more out-of-pocket than those using the brand-name version of those drugs, according to a new study published in Health Affairs. Manufacturer discounts in the Medicare Part D coverage gap, which count toward beneficiaries’ out-of-pocket spending, allow those using brand-name drugs to reach the catastrophic coverage phase with lower actual out-of-pocket spending. The study found that despite lower median point-of-sale prices for specialty generic drugs, patients with prescriptions costing between $22,000 and $80,000 per year would save money if they use brand-name drugs. The graphics below show the annual out-of-pocket savings associated with generic drugs and the median-point-of-sale price differences of brand-name drugs and their generic counterparts.

### Annual Out-of-Pocket Savings on Generic and Biosimilar vs. Brand-Name Drugs in Medicare Part D After Passage of the Bipartisan Budget Act of 2018

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Median Point-of-Sale Price (1Q 2018)</th>
<th>% of Part D Plans Covering the Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>Brand-Name Drug</td>
<td>Generic or Biosimilar</td>
</tr>
<tr>
<td>Copaxone</td>
<td>$7,152</td>
<td>$4,670</td>
</tr>
<tr>
<td>Gleevec</td>
<td>$7,665</td>
<td>$5,045</td>
</tr>
<tr>
<td>Nilandron</td>
<td>$8,054</td>
<td>$10,604</td>
</tr>
<tr>
<td>Copaxone</td>
<td>$1,175</td>
<td>$967</td>
</tr>
<tr>
<td>Gleevec</td>
<td>$3,277</td>
<td>$2,807</td>
</tr>
<tr>
<td>Remicade Inflecta</td>
<td>$267</td>
<td>$16</td>
</tr>
<tr>
<td>Neupogen</td>
<td>$924</td>
<td>$383</td>
</tr>
<tr>
<td>Lantas Basaglar</td>
<td>$350</td>
<td>$908</td>
</tr>
<tr>
<td>Ability Artipirazole</td>
<td>$377</td>
<td>$777</td>
</tr>
<tr>
<td>Invega Paliperdone</td>
<td>$1,130</td>
<td>$459</td>
</tr>
<tr>
<td>Abilify Crestor</td>
<td>$924</td>
<td>$383</td>
</tr>
<tr>
<td>Crestor Rosuvastatin</td>
<td>$267</td>
<td>$16</td>
</tr>
</tbody>
</table>

NOTE: Traditional generics are small-molecule drugs that are chemically equivalent to the brand-name version. Biosimilars are “generic” versions of biologic products. Specialty generics are high-price products used to treat rare or complex diseases. Plans may elect to cover the brand-name drug only; the generic or biosimilar only, or both products, so the percentages of Part D plans covering the product might not sum to 100.


Contact sales@aishealth.com if you’d like to review our rates for group subscriptions.
prices for these provide the best savings for the member,” she adds.

In general, SCAN takes beneficiaries' out-of-pocket expenses into account when making drug-coverage decisions, Jhawar says. “What that does do, though, is it causes a convoluted message out there,” she adds. “Because people don’t know necessarily that’s the lens through which an insurer has made that decision, and some may say on the surface, ‘oh, why don’t they cover the generic,’ when in actuality they’re making decisions in the best interest of their beneficiaries because in Part D there are these nuances in the way the benefit’s structured.”

The way Kelly Brantley, a managing director at Avalere, sees it, “there’s a sort of misaligned set of incentives within Part D that absolutely allows Part D plans to push for greater and greater rebates off of brand drugs, and they have done so.”

But the system was designed that way for a reason, because extracting greater drug rebates helps plans keep premiums low — which CMS has pushed them to do, she says. “You can’t have a flat premium and rising drug prices and have nothing else going on behind the scenes.”

MedPAC Proposes New Part D Structure

In a June 2019 report to Congress, the Medicare Payment Advisory Commission (MedPAC) suggests that the Part D benefit should be changed so that manufacturers of brand-name drugs have to provide a discount in the catastrophic phase of coverage, rather than in the doughnut hole. That change would be coupled with a hard overall out-of-pocket spending cap for Part D beneficiaries, and plan sponsors would be responsible for a larger share of catastrophic benefits.

Jhawar says SCAN has supported MedPAC’s proposal, as it “begins to better align incentives among all stakeholders — so government, the plan, the manufacturers.”

But Dusetzina says it would be even better to “be really looking hard at the benefit overall and maybe not trying to work within the current framework, but actually create a new design.” As an example, she points to a proposal by the American Action Forum that would more fundamentally restructure the Part D benefit.

Further ‘Patches’ Could Cause Issues

Another proposed solution, the study says, is to extend the coverage-gap discounts for brand-name drugs and biosimilars to generic drugs as well. Dusetzina, though, is wary of that idea.

“One of the reasons we have some of these issues is because we’ve patched the [Part D] benefit over time — we closed the doughnut hole because we realized that’s a problem; we made a fix to biosimilars because we realized that this was a problem,” she says. “We could keep patching it, but I think that this next fix for generics actually is a little bit more complicated because of the need to have those prices be as low as possible to get formulary placement.”

In fact, new Part D “patches” may already be in the works. Axios reported on July 10 that Senate Finance Committee Chairman Chuck Grassley (R-Iowa) and ranking member Ron Wyden (D-Ore.) have been negotiating a drug price package that would cap seniors’ out-of-pocket costs in Part D and restructure how the catastrophic phase is financed to place more responsibility on drug manufacturers. But an amendment proposed by Wyden, which would limit the ability of manufacturers to raise Part D drug prices faster than inflation, is becoming a sticking point with Republicans, according to The Hill.

Whatever lawmakers decide upon, Brantley points out that well-intentioned policy changes don’t always turn out as planned.

“Part D is so complicated, it’s hard to know what sort of fixes drive other quote-unquote problems,” she says. “There will be another entirely new set of incentives under whatever Part D policy change scenario you develop.”

Furthermore, “policymakers keep making rules in this vision of maybe a static drug world, but every day there’s new innovations, and I don’t know how we create policy that is more flexible in terms of what drugs are out there,” Brantley says. “But it’s only going to become more complex and more diverse and more different, so we need to come up with policy that flexes to account for that kind of innovation.”


by Leslie Small
News Briefs

✧ The Trump administration has withdrawn its controversial proposal to remove the safe harbor for drug manufacturer rebates to Medicare Part D plans and PBMs, a White House spokesperson confirmed to various media outlets on July 11. As first reported by Axios, the proposal was killed after facing resistance from White House domestic policy chief Joe Grogan “and other fiscal hawks on grounds that it was too expensive — costing the government nearly $180 billion over a decade,” Politico reported. “Based on careful analysis and thorough consideration, the president has decided to withdraw the rebate rule,” spokesperson Judd Deere said in a statement to Politico and others. HHS issued its own statement, citing ongoing efforts to lower prescription drug prices. Leerink analyst Ana Gupte told investors her firm expects Cigna Corp., CVS Health Corp. and UnitedHealth Group stocks to rally on the news. “We see this as positive for PBMs directly on margin sustainability in Medicare, and in the future on any potential spillover of the elimination of the safe harbor provision of rebates into the Commercial book,” she said. Read the Axios article at https://bit.ly/2XGO9gY and Politico article at https://politico.com/2XGl8NN.

✧ In a July 2 note to clients, Bernstein analysts characterized payers’ early coverage decisions on Zolgensma, Novartis’ $2.1 million gene therapy for spinal muscular atrophy, as “surprisingly restricted,” Fierce-Pharma reported. The analysts said the restriction is due to payers unexpectedly balking at Zolgensma’s price point. However, a Novartis spokesperson countered that Bernstein’s take does not paint “an accurate picture of the reimbursement situation or decisions that are occurring on the ground.” Read more at https://bit.ly/2L5MDON.

✧ The state of Illinois recently distributed $4.7 million to more than 70 independent pharmacies under the Critical Access Pharmacy program, most of them located “downstate” outside the Chicago area. The State Journal-Register reported on July 2. The program aims to help small, independent pharmacies facing financial problems under the state’s Medicaid managed care program. “If we didn’t get those (state) funds, we’d be out of business,” one independent pharmacist told the news outlet. Read the article at https://bit.ly/32iYn5X.

✧ Patient-specific drug cost comparisons for prescriptions are now available to nearly 800 providers at California health system Providence St. Joseph Health under a collaboration with Blue Shield of California and the tool’s developer, Gemini Health LLC. In the first two months since the program’s expansion from a pilot, the initiative is expected to deliver $100,000 in annualized savings in Blue Shield of California patients’ out-of-pocket costs based upon switching from existing medications to lower cost dose-matched, clinically equivalent alternatives, the companies said. Find more information at https://bit.ly/2LtHnT.

✧ Retail prices for 97 specialty prescription drugs widely used by older Americans, including Medicare beneficiaries, increased by an average of 7% between 2016 and 2017. That’s well above the rate of inflation, though lower than year-over-year specialty drug price hikes in the prior decade, AARP notes in its recently released report. The average annual cost for a single specialty medication used to treat a chronic condition was almost $79,000 in 2017, AARP says. Read the report at https://bit.ly/322sMFg.

✧ Amid a shortage of Mylan NV’s EpiPen caused by manufacturing delays, Novartis AG said July 9 that it would make its generic Symjepi epinephrine shots immediately available in local pharmacies across the U.S., Reuters reported. The article notes that demand for the devices, which treat severe allergic reactions, is typically high in the summer as families look to renew prescriptions before sending children to summer camp or to prepare for the new school year. Visit https://reut.rs/2LduvTI for more information.

✧ The HHS proposed rule on implementing the International Pricing Index model for Medicare Part B drugs is under review by the Office of Management and Budget. The proposal (83 Fed. Reg. 54546, Oct. 20, 2018) was unveiled in an Advanced Notice of Proposed Rulemaking (ANPRM) last fall. The ANPRM, among other things, proposes that CMS reimburse Part B drugs based on drug pricing data from not only the U.S. but also 16 other developed countries as opposed to based on their average sales price plus 6%. Visit https://bit.ly/2XfveoA.