Using Comparative Effectiveness Research to Improve Prescription Drug Affordability

Grace A. Lin, MD, MAS

Professor, UCSF School of Medicine and

Philip R. Lee Institute for Health Policy Studies

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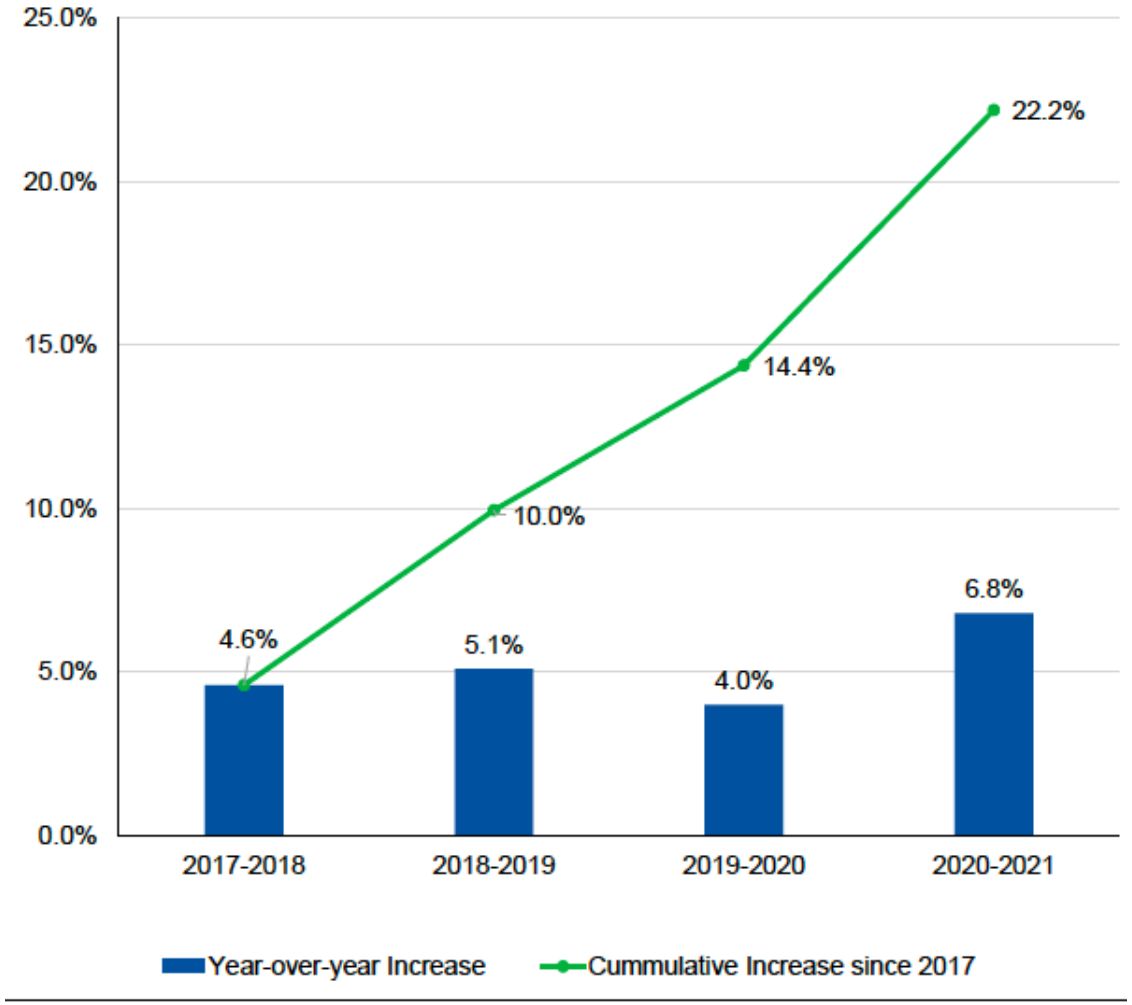
Prescription Drug Spending in the U.S.

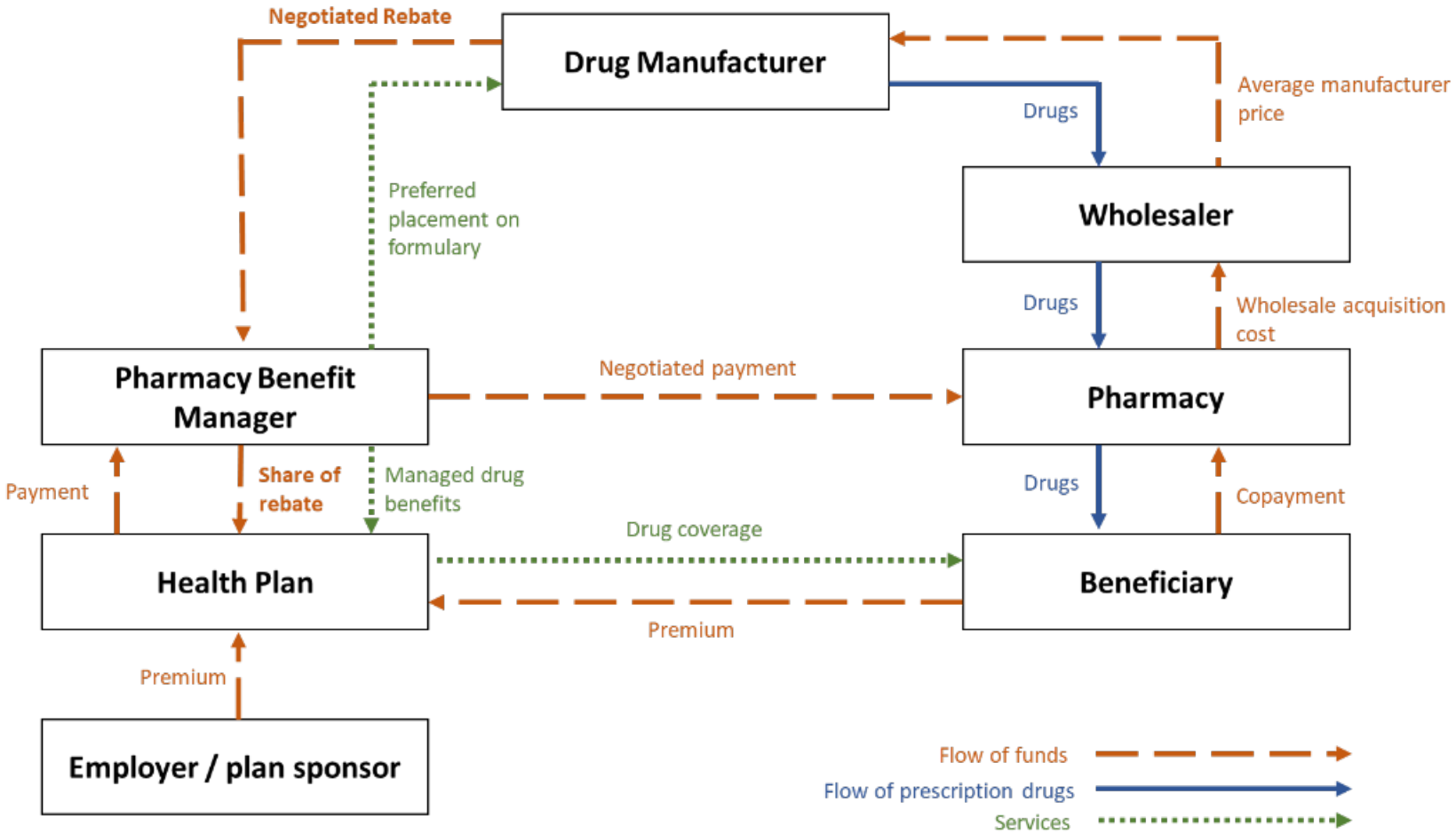
- Spending on prescription drugs $335 billion in 2018 (Congressional Budget Office)
- Average price of prescription brand name drug increased by 50-100% between 2008-2018
  - More specialty drugs, higher launch prices
  - Growth of prices of drugs already on the market
- Out-of-pocket spending for prescription drugs is high
  - 25% of people under age 65 report “difficulty” affording prescription drugs

Prescription Drug Costs are Rising in California

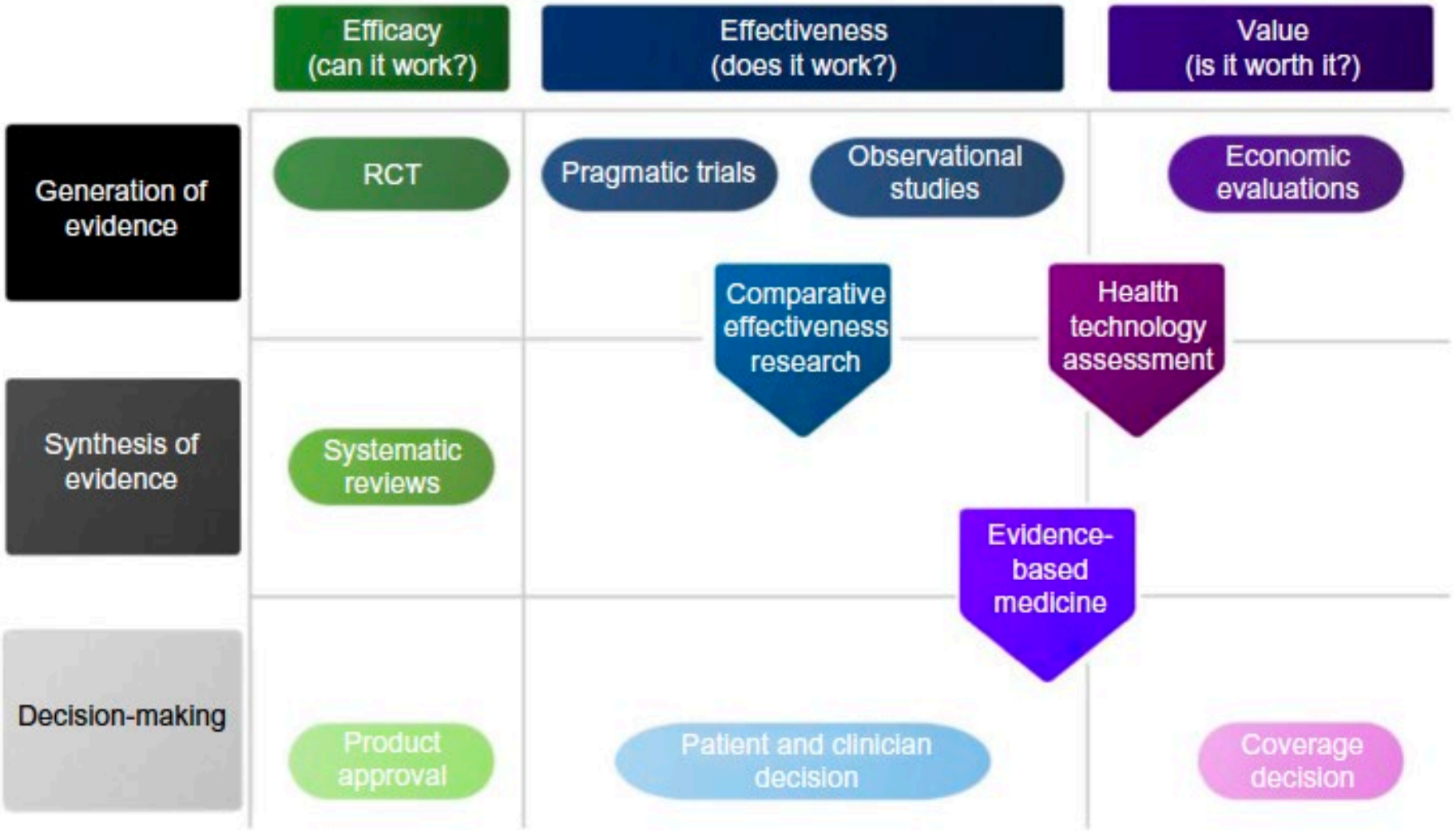


CA Department of Managed Healthcare 2021 Prescription Drug Transparency Report

Why Do Prescription Drugs Cost so Much?



What is Comparative Effectiveness Research (CER)?



Ijzerman et al. Comparative Effectiveness Research 2015:5 67

Institute for Clinical and Economic Review (ICER)

- **Independent, nonprofit** research institute founded in 2006
- **Mission:** To move the US toward a future health care system that provides fair pricing, fair access, and future innovation
- Develop **publicly available value assessment reports** on medical tests, treatments, and delivery system innovations
- Use *comparative effectiveness and cost-effectiveness analyses* to suggest **value-based price benchmarks**
- Convene regional **independent appraisal committees** for public hearings on each report – with all stakeholder groups participating

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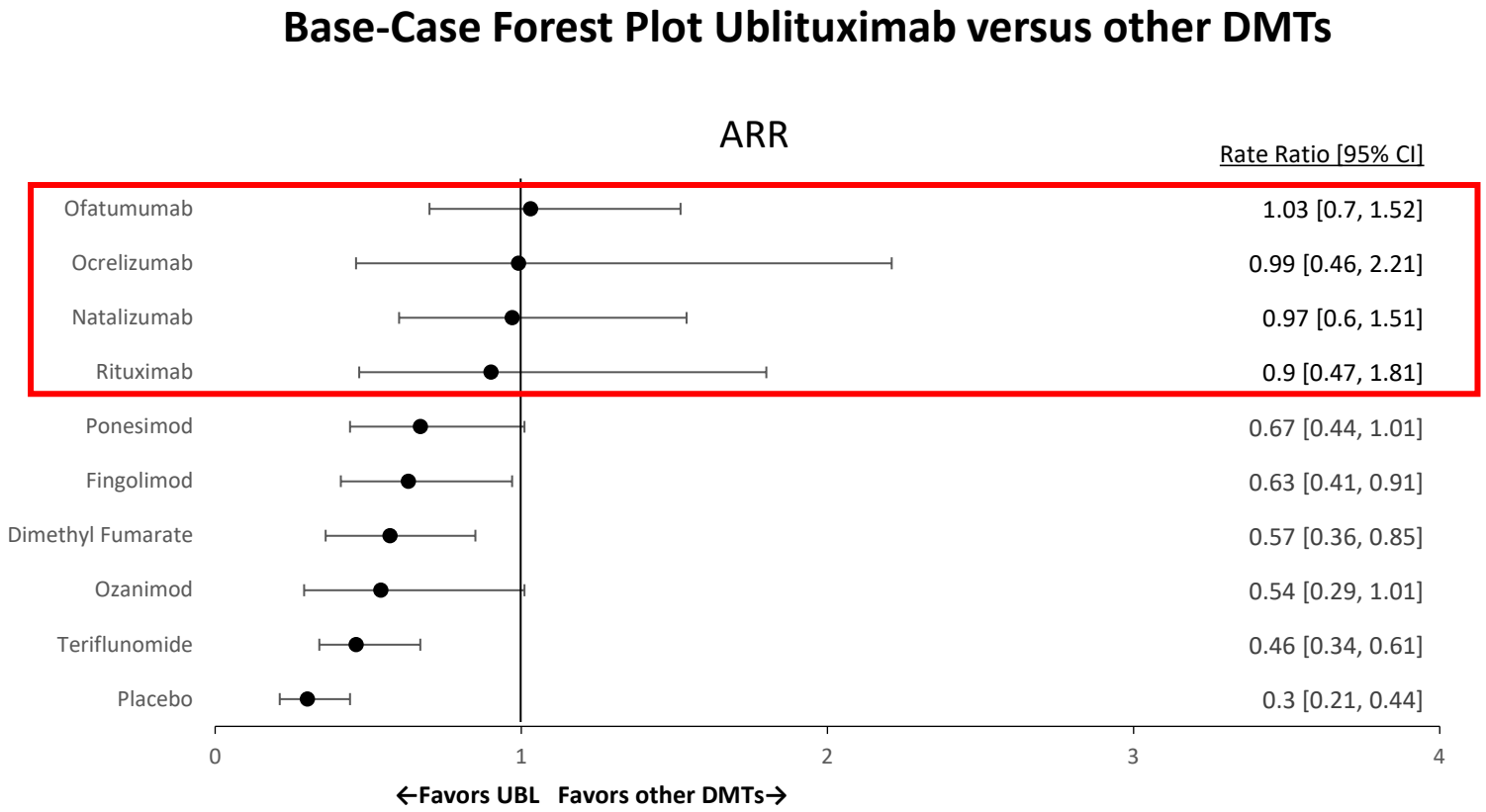
Comparative Effectiveness of Multiple Sclerosis (MS) Therapies



ARR: annualized relapse rate, CI: credible interval, DMT: disease-modifying therapy, PBO: placebo

Monoclonal Antibodies are highlighted with a blue box.

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Health-Benefit Price Benchmarks for MS therapies

Intervention	Annual WAC	Annual Price at $100,000 Threshold	Annual Price at $150,000 Threshold	Discount from WAC to Reach Threshold Prices
Ublituximab	$59,000	$16,500	$34,900	41%-72%
Natalizumab	$102,128			66%-84%
Ofatumumab	$89,760			61%-82%
Ocrelizumab	$71,187			51%-77%
Rituximab*	$4000-9000			----

WAC: wholesale acquisition cost; *rituximab was not directly modeled but this is an estimate of pricing

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Potential Policy Applications of CER – Payers/State

- Use CER to **negotiate drug prices** to ensure prices are aligned with patient benefit
  - Establish benchmarks for price negotiation and negotiation of supplemental rebates
  - Important for Medi-Cal with shift to Medi-Cal Rx

- Use CER in **formulary decisions** and to **build value-based formularies**
  - Medi-Cal could use CER to inform which drugs are included on the preferred drug list
  - Private payers, CalPERS could use CER for formulary tiering decisions, exclusionary formularies, waste-free formularies

- Use CER to **establish a maximum price** for any payer for specific drug
  - Could be done via state Prescription Drug Affordability Board
  - Could focus on launch prices and drugs with price growth to keep prices affordable

Summary

- CER provides objective information about the clinical benefits of interventions compared to one another
- Can also provide “fair price” – health benefit price benchmark
- Results of CER can be used as tool to help bring downward pressure on prescription drug prices and spending by:
  - Establishing price targets for negotiation
  - Driving formulary decisions towards more cost-effective drugs
  - Influencing value-based formularies
  - Establishing maximum prices that payers in the state could pay

Thank you

Grace Lin, MD, MAS

grace.lin@ucsf.edu

Background - California

- SB-17: CA drug price transparency law
  - Drugmakers: report specialty drug list prices at launch, list price hikes >16% on drugs that cost $40+/month
  - Payers: Report top 25 drugs most frequently prescribed, highest spending by list price, highest spending growth
  - No net price requirements; impossible to know if spending increases are due to net price increases or more utilization
- Medi-Cal Rx
  - Move from formularies run by individual MCOs to single FFS formulary