



State Drug Price Transparency and Price Gouging Laws:

Why They May Raise Health care
Costs

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March 2018

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INTRODUCTION

In October 2017, Governor Jerry Brown of California signed a “drug price transparency bill,” requiring pharma and biotech companies to give advance notification of significant price increases and provide specific justifications. Brown hailed the bill as a big step toward holding down spending on health care. “Californians have a right to know why their medical costs are out of control,” said Brown.

Many other states are finding the pharma industry to be a tempting target, especially with all the media attention given to a small number of high-profile price hikes. In Maryland, a new “price-gouging” law restricts generic and off-patent medicines from “excessive and not justified” price increases. Nevada has tackled the cost of diabetes medicines such as insulin, requiring drug makers that have raised list prices by a significant amount to release data about the costs of making and marketing the drugs. Other states like New York, New Hampshire, and Maine are considering legislation that would take various approaches to controlling drug pricing as a solution to rising health care costs.

But a new study by the Progressive Policy Institute suggests that state-level drug price laws potentially harm competition and boost drug costs, while doing very little to slow down the overall growth of health care costs. First, we describe the range of state-level drug price laws – both the ones that have been enacted and the ones that are under consideration.

Second, we discuss how the passage of widely differing state-level drug pricing laws will be counterproductive and could actually boost health care costs. Conflicting state rules will raise costs for drug makers. Smaller companies and generic companies with low margins will be especially hard hit, potentially reducing competition. And the state rules will move the drug industry more toward a utility model, which will encourage inefficiency.

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Third, we show how these laws will be ineffective in achieving their purported goal – lowering the rate of health care cost increases. PPI analysis shows that prescription drugs make a relatively minor contribution to rising health care costs. Nationally, drug costs account for only 12 percent of the rise in personal health care spending between 2011 and 2016. Out of that total, we estimate that brand drugs accounted for only 9 percent of the rise in personal health care spending over this period, and generics only 3 percent. Note that this increase in spending is a combination of increase in usage, increase in population, and price trends. For example, the average price of generics has declined sharply since 2011, according to the Express Scripts Prescription Drug Index.¹

Nationally, drug costs account for only 12 percent of the rise in personal health care spending between 2011 and 2016.

Indeed, the steady flow of drugs out of patent protection into generic status has held down the overall increase in drug spending by private insurance companies and public payers such as Medicare. Consumers have especially benefited. According to official figures from the Centers for Medicare and Medicaid Services (CMS), out-of-pocket retail expenditures on prescription drugs in 2016 were virtually identical to where they were in 2011, despite all the news accounts.

Fourth, the obsession of politicians with drug prices is distracting from the real problem: negative or weak productivity growth in hospitals and other health care providers. Negative or weak productivity growth means that health care providers need more workers to take care of the same number of patients, driving up labor costs. Indeed, in California and Maryland – two states that have recently passed drug price laws – rising labor costs are responsible for 50 percent of the increase in health care spending over the past five years. The contribution of drug spending is a quarter of that.

The obsession of politicians with drug prices is distracting from the real problem: negative or weak productivity growth in hospitals and other health care providers.

To put it another way: the increase in health care labor costs from 2014 to 2016 was \$119 billion. That's larger than the *entire* national spending on generics in 2016.

Indeed, we suggest that state lawmakers focus their attention on increasing competition and innovation, both in the brand and generic markets.

STATE DRUG PRICE TRANSPARENCY AND PRICE GOUGING LAWS

Politicians are right to be worried about our health care system. Costs are rising, life expectancies are falling. Pricing for many medical procedures is impossible for normal consumers to understand. In Minnesota, for example, researchers have found that the price charged for a similar knee replacement at different hospitals ranged between \$6,000 and \$47,000.²

Additionally, there have been a few high-profile cases where drug companies are rightfully called out for their pricing behavior. At the same time, some new innovative drugs, such as a cure for hepatitis-C, have temporarily pushed up drug costs in the short run while reducing long-term medical spending.³

However, the data suggest these are isolated problems. Nevertheless, pharma companies make a tempting target for state politicians who want to feel like they are doing something about rising health care costs. The result: Many bills are being proposed around the country purporting to solve the health care problem by regulating drug costs.

One approach – which generally goes under the name of “price transparency” – would force drug companies to provide a justification for price hikes for individual drugs. A second approach – which generally is termed “price gouging” – gives the state government the power to sue drug companies and either force price rollbacks or impose penalties.

Pharma companies make a tempting target for state politicians who want to feel like they are doing something about rising health care costs.

For example, a California law falls under the price transparency category. It forces pharmaceutical companies to give 60 days’ notice if a drug’s price will increase more than 16 percent over a two-year period. Then they would have to justify why the price increase is necessary.

Other bills around the country are using a similar model. In New York, Assembly Bill 2939, introduced with bipartisan sponsorship, would require prescription drug manufacturers whose drug has a cumulative price increase of three times the consumer price index during a three-month period to file a report with the state.⁴ The report would be required to include research and development costs for the drug, materials and manufacturing costs, and marketing and advertising costs.

In Washington, Senate Bill 5586, also with bipartisan sponsors, would require a prescription drug manufacturer to submit information on the itemized cost for production and sales of a drug if the price increases by 10 percent in 12 months or 25 percent in 36 months.⁵ Additionally, prescription drug manufacturers would be required to submit the covered drug’s pricing history in the United States for the previous five years, the manufacturer’s total profit attributable to the covered drug, and a justification of the price level for a covered drug.

The list goes on. In Maine, Legislative Document 1406 would direct the attorney general to collect information from prescription drug manufacturers if the wholesale acquisition cost of the drug has increased by 15 percent or more over the previous 12 months or by 50 percent or more over the previous five years.⁶ The information required to be disclosed includes the total cost of production and total cost per dose

of the drug, research and development costs, and marketing and advertising costs.

In New Jersey, Assembly Bill 762 would establish the Prescription Drug Review Commission and task the Commission with developing a list of critical prescription drugs for which there is a public interest in understanding the development of pricing for the drugs.⁷ Drug manufacturers would be required to report certain information, including production and total cost per dose of the drug, research and development costs, and marketing and advertising costs.

The clearest example of the second category, price gouging, is the Maryland legislation that recently went into effect. It authorizes the state to bring legal action against companies that raise the price of generic and off-patent drugs by an excessive amount, without defining what that means.

In Oregon, Senate Bill 793 would require manufacturers to provide justification for price increases greater than 3.4 percent for prescription drugs sold in Oregon longer than 36 months.⁸ If the department finds a price increase to be excessive, the legislation requires manufacturers to refund excessive price increases to consumers.

New Hampshire is considering legislation, House Bill 1780, which would try to limit “price gouging” of off-patent or generic drugs, based on a complicated set of criteria.⁹ The state attorney general would be authorized to force refunds of price increases deemed to be excessive, and levy civil penalties.

This is not a full list of states that are considering drug-pricing legislation. But, as we will see in the next several sections, the bills are unlikely to have the impact their sponsors want.

WHY STATE-LEVEL DRUG PRICING LAWS ARE COUNTERPRODUCTIVE

The intention of state drug pricing transparency laws and price gouging laws is to limit drug price increases. However, they may have the counterintuitive effect of raising health care spending and reducing competition. For one, each state law applies a different standard for what counts as an “excessive” price increase. Consider, for example, the difference between the Oregon and Maine proposals. If the Oregon bill were enacted, the transparency rules would be triggered by price increases greater than 3.4 percent for prescription drugs sold in Oregon longer than 36 months. By contrast, the Maine bill would be triggered if the wholesale acquisition cost of the drug has increased by 15 percent or more over the previous 12 months or by 50 percent or more over the previous five years.

Each state law applies a different standard for what counts as an “excessive” price increase.

The result: Pharma companies would have to devote resources to tracking prices and costs, per drug, on a state-by-state basis. Each state is going to have a different set of rules about what information they want, in which form. That will benefit the largest companies, which have the capacity to handle complicated cross-state regulations. Smaller companies would prefer to deal with a single national regulatory system.

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The additional level of regulations is going to translate into higher costs and higher prices. That's especially troubling for generic drug makers, which typically run on thin absolute profit margins, have a broad portfolio of products relative to their size, and face commodity-type markets with large price fluctuations. Some generic drug makers may be forced out of the market by increased regulation, which will lead to less competition, higher prices, and potential drug shortages.

State legislators might be willing to accept these flaws of drug price laws if they could actually slow the rate of health care cost increases. Indeed, the whole movement to regulate drug prices on the state level starts from the assumption that rising drug prices are a major reason health care costs are increasing faster than economic growth.

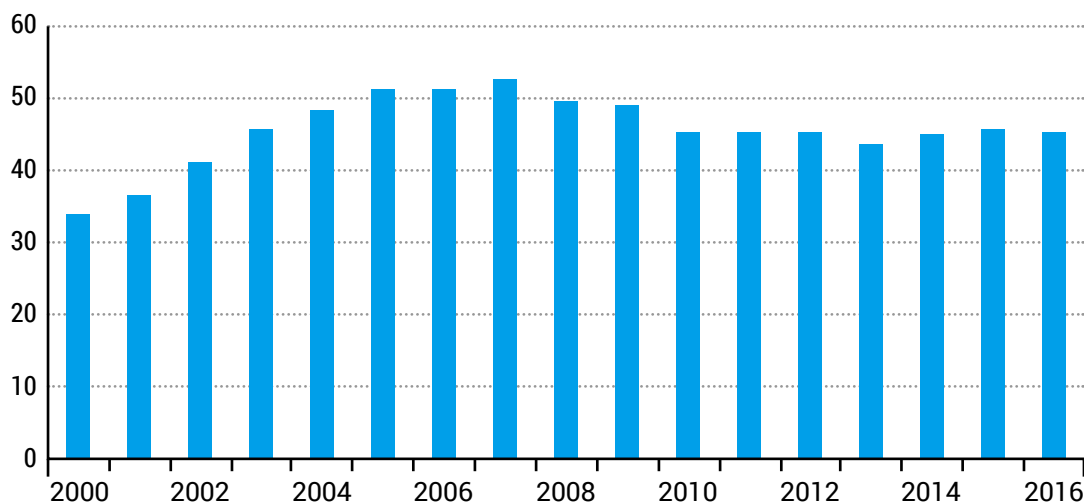
However, the data show that the cost of prescription medicines, both brands and generics, is a relatively small share of total health care costs. In 2016, the total amount spent on prescription drugs, net of rebates and

discounts, was \$323 billion.¹⁰ That seems like a large number, but, compared to the nation's total personal health care bill of \$2.8 trillion, the spending on prescription medicines is relatively small. Overall, net spending on prescription medicines amounts to 11.4 percent of personal health care spending, down from 11.9 percent in 2000. This includes the amount spent by all payers and providers, including Medicare, Medicaid and private insurance companies, as well as the amounts spent by consumers out of pocket.

The cost of prescription medicines, both brands and generics, is a relatively small share of total health care costs.

Moreover, sensationalist stories of sick individuals who have big out-of-pocket costs are the exception rather than the rule. Retail out-of-pocket spending for consumers has been flat, according to government numbers. (Figure 1). Consumers have benefited from the rising number of generics, which may cost pennies to buy.

FIGURE 1: Out-of-Pocket Consumer Spending on Prescription Drugs (billions of \$)



Data: CMS

Moreover, total spending on prescription drugs – including private health insurance companies, Medicare and Medicaid – is responsible for a relatively small share of rising health care costs in recent years. We analyzed two measures of drug spending over the five-year period from 2011 to 2016 – retail outlet sales of prescription drugs, as published by Centers for Medicare and Medicaid, and spending on prescription drugs, net of rebates and discounts, as published by IQVIA Institute for Human Data Science.¹¹

By both measures, the cost of prescription drugs rose by roughly \$70 billion between 2011 and 2016. By comparison, all other personal health care spending rose by \$490 billion over the same period. In other words, drug spending accounted for only 12 percent of the increase in health care costs in the 2011 to 2016 period, despite all the news reports.

How does this break down between branded and generics? By our estimates, brand drugs were responsible for only 9 percent of the increase in health care costs between 2011 and 2016, while generics were responsible for only 3 percent of the increase in health care costs over that period.¹² Note that this increase in spending is a combination of increase in usage, increase in population, and price trends. For example, while the volume of generic utilization rose significantly, that was mainly offset by the fact that the average price of generics has declined sharply between 2011 and 2016, according to the Express Scripts Prescription Drug Index.¹³ More recently, generics prices have been plunging.¹⁴

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STATE-LEVEL ANALYSIS

In this context, there is literally no support for the notion that drug spending – whether it's brand drugs or generics – is an important driver of health care costs on a national scale. And the same is true on the state level as well.

For the purposes of this study, we analyzed the health care spending patterns of three states: California, Maryland, and New Hampshire. California has passed a drug price transparency law, Maryland has passed a price gouging law, and New Hampshire is considering a price gouging law.

According to our estimates, prescription drugs accounted for only 15 percent of the increase in personal health care spending in California from 2011 to 2016. (Table 1). This includes both private and public health care spending, such as Medicare, Medicaid, and the VA system. Brands accounted for 11 percent of the increase, and generics 4 percent of the increase. These PPI estimates are based on state-level CMS data for 2011 to 2014, combined with extrapolations from national data.¹⁵

For Maryland, the prescription drug share of the increase in health care spending was only 16 percent. That breaks down to 12 percent for brands and only 4 percent for generics.

Even if the cost of drugs were held completely flat, the vast majority of the health care cost problem would still remain.

In other words, despite all the rhetoric in California and Maryland, drug costs account for a relatively small share of rising health care costs in these states. Even if the cost of drugs were held completely flat, the vast majority of the health care cost problem would still remain.

The role of drug prices in driving health care costs is slightly larger in New Hampshire, since prescription drugs account for 20 percent of the increase in health care spending. Nevertheless, the situation is qualitatively similar to California and Maryland.

It should be noted that the consensus assumption line in New Hampshire was that Skyrocketing prescription drug prices are the major driver of increased health-care costs

in New Hampshire, according to data for 2015 presented by the state Insurance Department at its annual meeting.¹⁶

However, the actuaries used by the New Hampshire State never broke out the impact of rising labor costs on health care costs and premiums. As we will see in the next section, they missed the single biggest driver of health care costs.

TABLE 1. California, Maryland, and New Hampshire: Factors Driving Health care Costs, 2011-2016

Share of total increase in personal health care spending	CALIFORNIA	MARYLAND	NEW HAMPSHIRE
Health care labor costs	52%	50%	42%
Prescription drug spending (branded)	11%	12%	15%
Prescription drug spending (generic)	4%	4%	5%

Data: CMS, BEA, BLS, PPI estimates

THE ROLE OF FALLING PRODUCTIVITY AND OUT-OF-CONTROL LABOR COSTS

While state legislators are focusing on pharmaceutical prices, they are not paying enough attention to the real cause of soaring medical costs: negative or weak productivity growth in hospitals and other health care providers. While there are many ways to measure productivity in health care, they all have the same fundamental characteristic: When productivity growth is low, health care providers have to hire “too many” workers, which drives up labor costs.

PPI analyzed compensation for the health care workforce for California, Maryland, and New Hampshire using data from the Bureau of Labor Statistics and the Bureau of Economic Analysis. We found that, in the first two states, rising labor costs accounted for more than half of the increase in health care spending from 2011-2016 (Table 1). That’s more than triple the impact of drug spending. In New Hampshire, the impact of higher labor costs is more than double the impact of drug spending.

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hiring workers much faster than the population is growing, even after adjusting for aging (Table 2).

Hospitals and other health care providers are hiring workers much faster than the population is growing, even after adjusting for aging.

Why are labor costs rising so fast? Basically, hospitals and other health care providers are

TABLE 2. Health care Hiring Is Out of Control: Percentage Increase, 2011-2016

	CALIFORNIA	MARYLAND
Health care workers	14.3%	11.5%
Age-weighted population*	8.8%	7.2%
Population	4.2%	3.0%

*Age groups are weighted by relative health care

spending Data: BLS, CMS, Census, PPI

For example, in California, the population increased by 4.2 percent between 2011 and 2016, and the age-weighted population grew by 8.8 percent. But total private and public health care employment jumped by 14.3 percent over the same period. Similarly, in Maryland, health care employment rose much faster than the age-weighted population.

One way to interpret these numbers is that the health care systems in California and Maryland required more and more workers to deal with the same number of patients, even after adjusting for aging. Even as the state legislators focused on drug pricing, the real problem was that the productivity of the health care system in these states was falling.

CONCLUSION

There's little evidence that state-level drug price transparency laws and price gouging will have a significant effect holding down health costs. Conflicting state-level regulations will have the effect of raising costs and reducing competition. That's not good.

State legislators need to look at drug spending in context. While the numbers for drug spending seem large, they are quite a bit smaller than the spending on labor costs. So a state government that really wants to make an impact on health care costs must encourage investment in new information and biological technology that allows more to be done with the same number of workers.

On the federal level, the key is to encourage more competition in both the brand and generic markets. That means increasing the pace of new drug approval and increasing the pace at which brands move into the generic market.

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The Progressive Policy Institute is a catalyst for policy innovation and political reform based in Washington, D.C. Its mission is to create radically pragmatic ideas for moving America beyond ideological and partisan deadlock.

Founded in 1989, PPI started as the intellectual home of the New Democrats and earned a reputation as President Bill Clinton's "idea mill." Many of its mold-breaking ideas have been translated into public policy and law and have influenced international efforts to modernize progressive politics.

Today, PPI is developing fresh proposals for stimulating U.S. economic innovation and growth; equipping all Americans with the skills and assets that social mobility in the knowledge economy requires; modernizing an overly bureaucratic and centralized public sector; and defending liberal democracy in a dangerous world.

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