Yale SCHOOL OF MANAGEMENT

FIONA M. SCOTT MORTON
Theodore Nierenberg Professor of Economics

PO Box 208200
New Haven CT 06520-8200
T 203 432-5569
F 203 436-9143
fiona.scottmorton@yale.edu
som.yale.edu/scottmorton

courier
165 Whitney Avenue
New Haven CT 06511

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Dear Members of the Commission:

I have read your proposed policy recommendations and I have some comments to relay. I am a professor of economics at the Yale School of Management, where I have taught for 19 years. One of my areas of expertise is pharmaceutical economics and competition in pharmaceutical markets. I previously submitted for your consideration a Brookings paper I wrote last year: https://www.brookings.edu/wp-content/uploads/2017/05/wp30_scottmorton_competitioninpharma1.pdf
I will not address each proposed policy action, but only those where economic analysis indicates a strong benefit or cost.

1) Legislative Priorities

a) Drug Review Board: I suggest you task this board with calculating Quality Adjusted Life Year for each drug. QALY is a commonly used metric outside the United States that gives a measure of the value of the drug. This can then be compared to prices paid in Connecticut.

b) Manufacturers, PBMs, and health insurers disclose funding to patient advocacy groups. EXCELLENT IDEA. These groups are sometimes disguised marketing vehicles for promoting a particular drug rather than neutral nonprofits.

c) Require PBMs to allow audits. GOOD IDEA. What recourse does the customer have if the PBM fails to comply? Could mandatory arbitration be quicker and have lower costs relative to litigation?

d) Require coinsurance and payments under the deductible occur at PBM net negotiated prices rather than list prices. EXCELLENT IDEA. I suggest allowing the transaction to occur at the negotiated price OR BELOW. This would permit a PBM to hide a confidential negotiated price by charging the consumer less.

Other Legislative Recommendations:

b) Require PBMs to exercise fiduciary responsibility: EXCELLENT IDEA. The growing problem economists see in the US PBM industry is misalignment of incentives between the PBM and the client. At his hearing today, the new Secretary of HHS discussed the perverse incentives to raise pharmaceutical list prices. Making the PBM legally obligated to act in the interest of its client would help with this problem.

c) Explore creating a state administered loan program to fund the cost of citizen prescriptions. I think this idea is mistaken for two reasons. First, out of pocket costs of pharmaceuticals can be even better addressed with the policies below. Second, when any program raises the ability of patients to pay, that encourages manufacturers to ***raise*** the cost of the drugs. So this policy will simply cause the state to subsidize high manufacturer prices, which is the opposite of the goal of the rule.

d) Providers must post gifts and compensation from manufacturers. GREAT IDEA

e) Set co-payment and co-insurance maximums per month. THIS IDEA IS EXCELLENT ONLY IF PAIRED WITH f) BELOW. LEVELS COULD BE LOWER IF THE LEGISLATURE IS CONCERNED ABOUT CITIZENS TAKING MULTIPLE MEDICATIONS. It is critical that the out of pocket payment be large enough so that the PBM or insurer can incentivize the patient to switch to a generic or a much cheaper brand. For example, if Brand A costs the PBM $1000 and Brand B costs $300 then the PBM would want to charge a co-pay of $150 for A but perhaps zero for B to make the patient happy to switch. Giving up the co-pay is worth doing to get the patient to save $700. Experts can indicate how large co-pays have to be to change behavior; they might need only to be about $150.

f) Limit manufacturer coupons. To be effective this provision must prohibit ALL manufacturer kickbacks to patients whether in the form of coupons, other payment or forgiveness, and in-kind benefits (e.g. employment, free meals, wrap-around services, etc). Consumers will be protected when these kickbacks are banned because of provision e) above which limits their out of pocket payments to $150. Consumers are therefore better off. Insurers will not want to limit out of pocket payments only (as this will raise premiums). However, they

are better off when out of pocket limits are combined with elimination of kickbacks because then manufacturers cannot pay patients to take particular drug. To take the example above, now it's possible for manufacturer A to give the patient $150 to cover the out of pocket payment and in that way achieve the sale of a $1000 drug when a $300 drug was available. This is on-net profitable for manufacturer A, allows it to avoid competing with drug B on price, and hurts the insurer and consumer (through premiums).

After the reform, the insurer uses out of pocket payments like zero versus $100, step therapy, and other tools to shift patients to the drug that offers better terms. When manufacturers can no long pay kickbacks to insured patients to take their expensive drugs the insurer can bargain with the manufacturer, price competition will kick in again -- and prices will fall. Making the law conditional only in cases when a cheaper drug is available is costly to implement because the state would have to search in real-time across PBM formularies. And this isn't necessary when the patient is protected already (pairing e) with f)).

o) Use the state APCD to analyze drug costs. GREAT IDEA

r) Import from Canada. BAD IDEA. When manufacturers see US states doing this they will simply raise prices to Canadians. Because the US price is higher so the manufacturer will pick some kind of average to charge both types of buyers. This will then cause the Canadian government to be upset and prohibit exports of drugs.

I hope you find these comments to be helpful. Please feel free to contact me with any questions.

Sincerely yours,