Issue: AZ Prescription Drug Pricing

Prescription Drug Pricing

The Problem of US Drug Costs

Americans pay the highest drug prices in the world. A quarter of adults in the United States report difficulty in affording their drugs. Three in 10 report that in 2018, they did not take full doses as prescribed because of the drug's cost. Three in 10 of those skipping medications say their conditions have deteriorated—about 8% of the public overall.[1] According to a report from the International Federation of Health Plans, in 2017 a two-syringe package of Humira®, an anti-inflammatory used to treat arthritis, psoriasis, and Crohn's disease, cost $4,481 in the US, compared with $856 in Britain, $1,227 in Switzerland, and $738 in South Africa.[2]

In fact, the price of drugs in the U.S. has risen at three times the rate of inflation between 2007 and 2018.[3] The price of a year's supply of Humira in the U.S. rose from about $19,000 in 2012, to more than $38,000 by 2018.[4] Twenty-three of the nearly 100 prescription drugs that launched in 2018 had a list price over $30,000 per year.[5] The cost of insulin doubled between 2012 and 2016.[6]

In 2019, Arizona PIRG Education Fund surveyed the cash prices of 12 common drugs, calling over 250 pharmacies in 11 states.[7] They found that patients could save between $102-$5,400 a year by shopping around. Additionally, they found that "large chain pharmacies tend to have higher prices than small chain or independent pharmacies. Eight of the 12 drugs in the survey had higher median prices of 8.8 percent to 840 percent at large chains compared to small or independent pharmacies."

Per capita spending for prescription drugs increased from $90 in 1960, peaked in 2014, declined to $1,025 in 2017 and is projected to increase from 2019 onward.

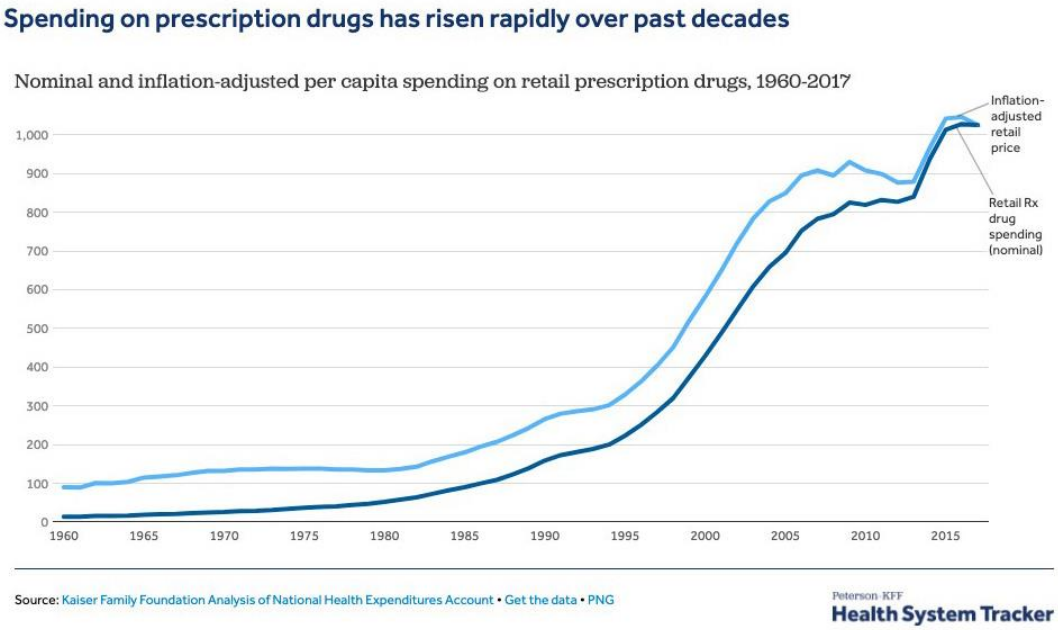

Figure 1 – Spending on Prescription Drugs[8]

Impact

- **High drug prices have the greatest impact** on people with high-deductible insurance plans and those whose co-payments are based on a percentage of the price of a prescription.

- **They also create the worst consequences for the most vulnerable**, including individuals who are uninsured. Nearly 1 in 3 U.S. adults has not taken full doses of a prescribed medicine because of cost. Nearly one in three consumers spend less on groceries in order to pay for their medications, and one-third of Americans have forgone filling prescriptions altogether because of high costs. [9,10]

- **And for Americans who need the most expensive—or the most—medications, the costs are devastating.** Most insurance plans separate covered medications into "formulary tiers": Tier 1 for generic drugs with the lowest cost-sharing or co-payments; Tiers 4 or 5 for specialty drugs for rare diseases or high-priced drugs. Individuals with rare diseases and chronic disorders are typically in the highest tier of the formulary and are often required to pay a percentage of the list price of the drug rather than a set price.

- **And seniors are at particular risk.** Former Senator Claire McCaskill issued a report in 2018 that stated, "12 out of the 20 most commonly prescribed brand-name drugs for seniors had their prices increased by over 50 percent between 2012 and 2017."[11] Senator McCaskill asked, "Can you imagine if you went to an auto dealership and last year's exact model was being sold at a 20 percent mark-up, and then you went back the next year and it had happened again?"[12]

- **Seniors enrolled in Medicare Part D drug coverage in 2020** must pay the full negotiated price for their drugs until they have spent the deductible amount of $435. Then the Initial Coverage period begins when seniors pay either a co-payment of a set dollar amount or a co-insurance of a percentage of the drug's cost. For 2020, after the senior's payments plus the amount the plan pays for drugs reaches $4,020, then the Coverage Gap ("donut hole") is reached. While in the "donut hole" in 2020, seniors must pay 25% of drug costs until a total of $6,350 in total drug costs is reached, after which the senior leaves the "donut hole" and enters the Catastrophic Phase of coverage. In the Catastrophic phase, seniors make small drug co-payments or co-insurance for the rest of the year.

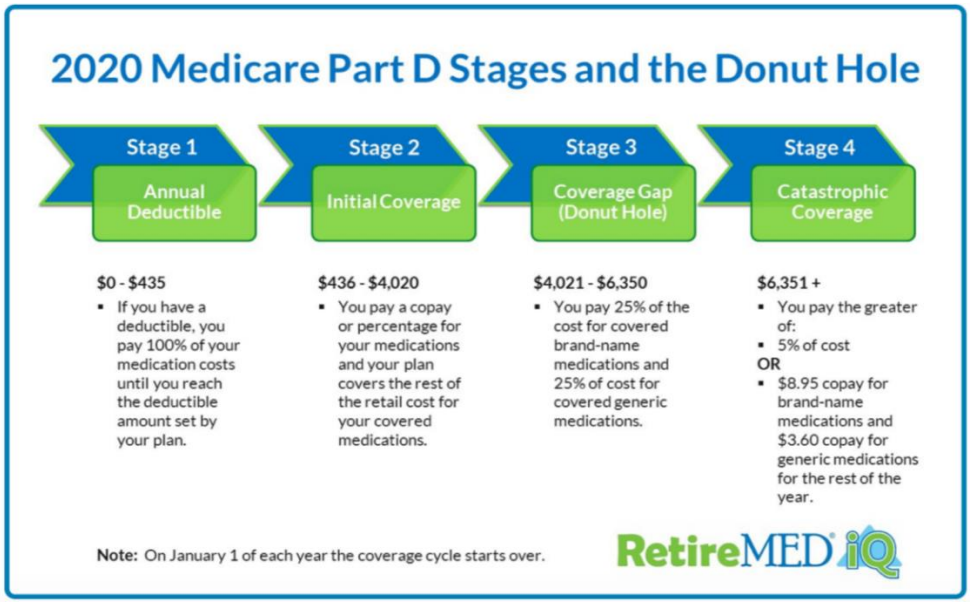

Figure 3 – 2020 Medicare Part D[13]

Why Is This Problem So Hard to Fix?

Lobbying Power

Pharmaceutical companies are some of the most profitable companies in the country.[14] The US patent system, while successful at promoting innovation, confers years of monopoly pricing for a product. Pharma companies have taken advantage of the patent system by making minor changes to a product and then applying for a new patent. For example, a new dosage amount or prescribed dose of 2x/day instead of 3x/day can extend a drug's patent life. In fact, 78% of "new" drug patents are secondary patents on existing drugs, not new drugs.[15]

Because of its wealth, the pharmaceutical industry is one of the most powerful lobbies in Washington and in many state capitals. More lobbying money is spent on health care than any other economic sector—an astounding $297 million in 2019 alone.[16]

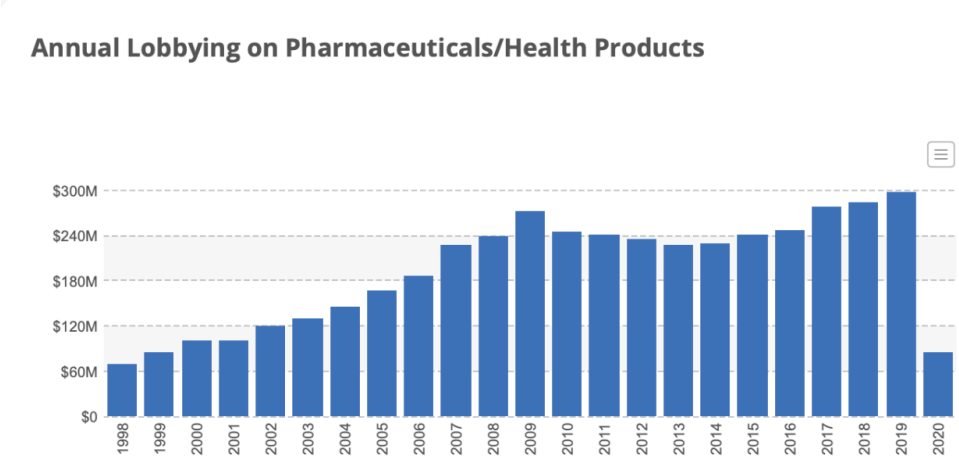

Figure 3 – 2019 Pharma Lobbying Spending *Exceeded $297 Million*[17]

Industry Complexity

The price a patient pays for a prescription drug results from a complex mix of contracts among many players (see Fig. 4 below), each of which adds to a drug's final price, creating multiple layers of profit margins with no accountability.

The **pharmaceutical manufacturer** makes and sends drugs to the **wholesaler** for distribution. The wholesaler buys the drug from the manufacturer based on the manufacturer's Wholesale Acquisition Cost (WAC).

The wholesaler sends the drugs to the **pharmacy**, which is reimbursed by **Pharmacy Benefit Managers (PBMs)** such as CVS Health, Express Scripts, and OptumRx, which act as middlemen between pharma companies, **insurance companies** and pharmacies because private insurance companies don't have the time or means to negotiate with every drug company and pharmacy. PBMs also negotiate rebates and determine which drugs insurance companies put onto their formulary thus enabling insurance companies to get the best prices and pharmaceutical companies to get the largest number of their prescriptions into the market. The PBM gets reimbursed by the insurance company, plus a percentage for profit.

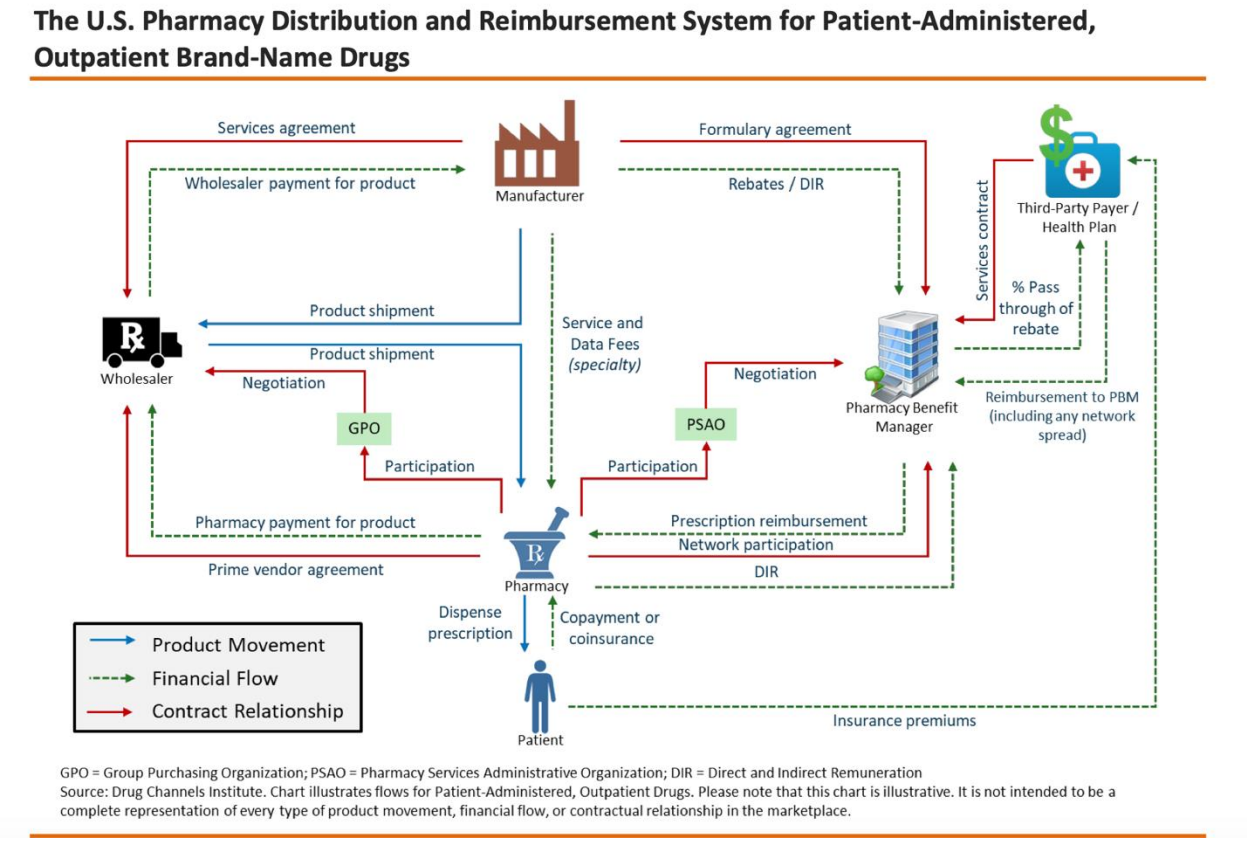

Figure 4 https://drugchannelsinstitute.com/files/2020-PharmacyPBM-DCI-Overview.pdf

Financial Incentives of Key Players

Each player in this "drug distribution food chain" maximizes its profits while responding to a complex, opaque, and secretive structure of financial incentives (including rebates, discounts, and third-party payments), requiring congressional action to change the system.[18]

Pharma Companies

Pharma companies take great financial risk since only five out of every 5,000 drugs in development make it to human trials, and only one out of those five gets to market.[19] This risk is part of the reason that pharmaceutical companies' prices for branded drugs are so much higher than their manufacturing cost: patent protections give companies only a few years of exclusive profit before the drug becomes public and generic.

Under US patent law, pharma companies hold patents for 20 years.[20] (Drugs for diseases that affect fewer than 200,000 Americans, so called "orphan drugs," are granted additional exclusivity by the FDA.[21,22]) Once a drug goes off-patent, the FDA can approve generic drugs. Generic drugs have the same active ingredients, dosage, and U.S. Food and Drug Administration (FDA) approval.[23] Pharma companies must compete with generic companies, resulting in somewhat lower prices. Many pharma companies resort to hiking the prices of the branded drugs just prior to losing patent protection, allowing generic manufacturers to charge more as well.[24]

Pharmacies

If a patient has no insurance, the price the patient pays for a drug is determined by the pharmacy. In a market that rewards efficiency, small pharmacies struggle, needing to invest in faster software and provide more efficient prescription turn-around to maintain lower prices.[25] Only large companies have the resources to keep up with market pressures. The past two decades have seen the field narrow to three leading national pharmacies: CVS, Rite Aid/Albertsons, and Walgreens.[26] (Fig. 5).

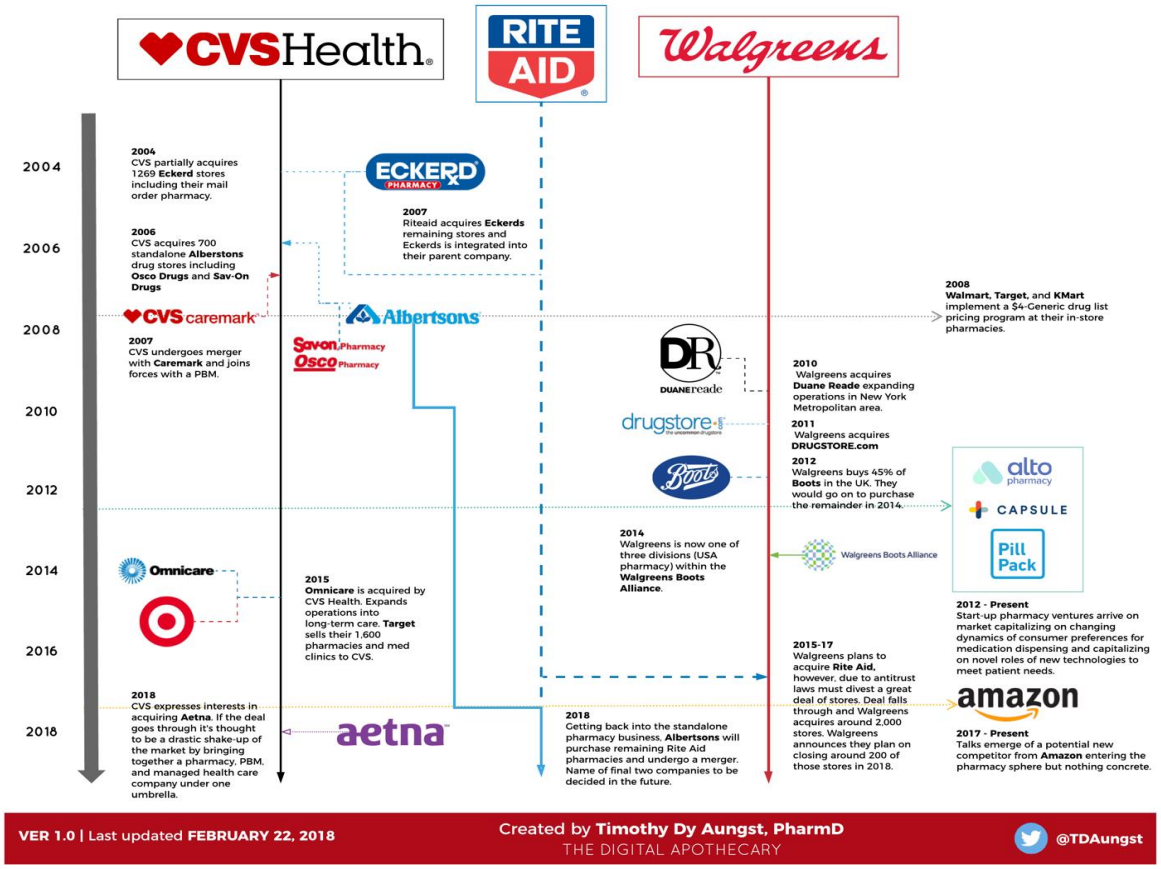

Figure 5 https://www.pharmacytimes.com/contributor/timothy-aungst-pharmd/2018/03/pharmacy-wars-an-era-of-acquisition-mergers-and-losses

Pharmacies and PBMs have also been consolidating. While this vertical integration creates the potential for increased efficiency and the expectation of lower prices as a result of increased negotiating power, as pointed out by the American Antitrust Institute during the 2018 merger between CVS and Aetna, consolidation actually *increases* the power of the remaining businesses to control prices since there are fewer competitors.[27] Thanks to its oversized power in both the pharmacy and PBM industries, CVS now has *more* control over formularies and pricing negotiations, eliminating the competition that would ordinarily reduce prices for patients.

Insurance Companies

If a patient is insured, the patient's price is determined by the insurance company, which must cover multiple layers of other entities' profit margins. These costs are passed along to consumers through higher insurance rates and copayments. In 2018, in Arizona, 99 percent of the individual healthcare market was controlled by only three insurance companies, a strong indicator that the market might benefit from more oversight.[28]

Insurance companies also agree to purchase a certain number of prescriptions from manufacturers, but manufacturers agree to "buy back" ("rebate") unsold prescriptions for a percentage of the original price. These rebates provide incentives for insurance companies to encourage doctors to prescribe more of a sometimes-expensive branded drug in order to limit their exposure to buybacks.

Pharmacy Benefit Managers (PBMs)

PBMs have come under scrutiny for a practice called **"spread pricing".** When a patient buys a drug from a pharmacy, the pharmacy receives reimbursement from the PBM. This reimbursement is slightly higher than the price the patient paid so the pharmacy can make a reasonable profit. The PBM then seeks reimbursement from insurance companies for that drug. PBMs take the difference as profit.[29]

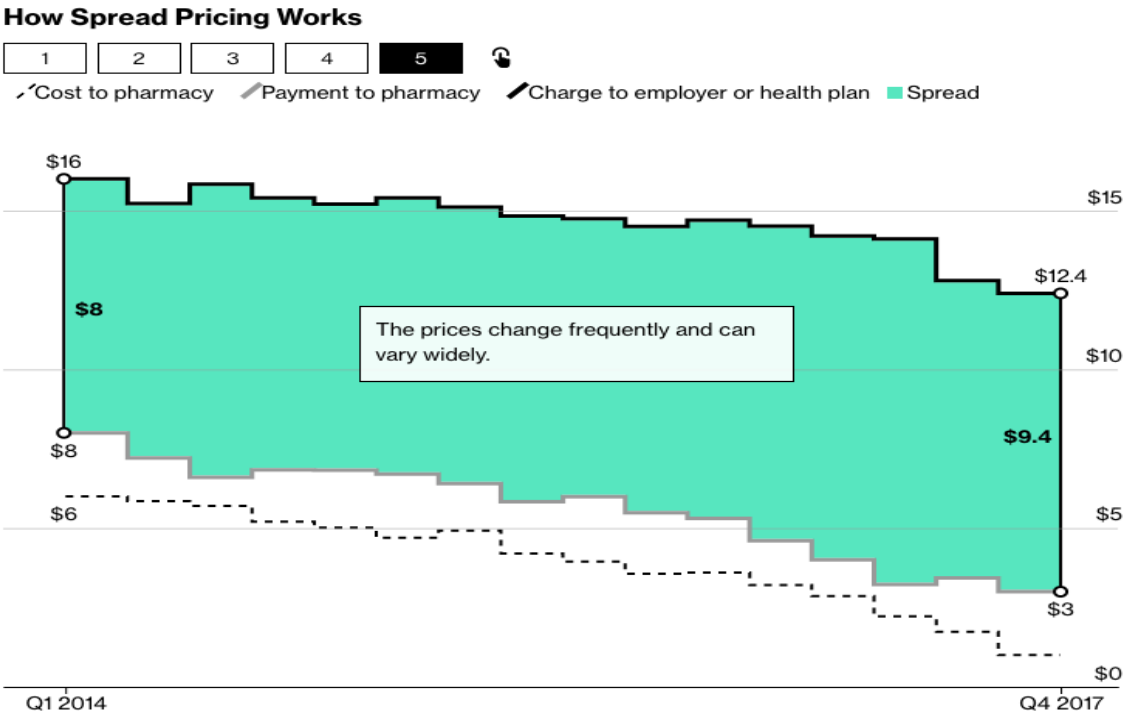

Figure 6 https://www.bloomberg.com/graphics/2018-drug-spread-pricing/

The problem occurs when the PBM asks for a significantly higher reimbursement than it paid the pharmacy. See Figure 6 for an example. Suppose that, in 2014, a patient paid $8 for a prescription, but the insurance company was charged $16, resulting in a "spread" (or profit to the PBM) of $8. By 2017, this spread grew to $9.40. (At the Bloomberg website, this is illustrated interactively in five steps.)

Because insurance companies negotiate fixed-cost copays with PBMs, PBMs can increase the cost of drugs to obtain larger commissions. This enables insurance companies and drug makers to charge even higher prices, ultimately leaving patients and taxpayers to foot the bill.[30]

It is easy to see that direct negotiations between pharmacies and drug manufacturers could save a lot of money.[31] When West Virginia cut PBMs out of its state Medicaid program, it achieved an estimated $30 million savings in the first year alone; by the end of the year, the change had actually saved the state $54.4 million.[32]

PBMs claim that the choice to utilize spread pricing is up to their pharmacy and insurance company customers, as an alternative to administrative fees. PBMs also claim that reports such as the Bloomberg article cited above are cherry-picking examples: that PBMs make money for some drugs but lose money on others. But PBMs do not have to disclose spread pricing fees or other practices.

An additional issue surrounding PBMs involves **Medicare Part D**, which helps cover the cost of prescription drugs. With the launch of Medicare Part D in 2006 and more recently the ACA's closing of the "Donut Hole", Medicare has become a major payer for prescription drugs, jumping from 2% to 30% from 2005 to 2017.[33]

The federal government should have significant power in pricing negotiations with pharmaceutical companies. However, in 2006, the industry aggressively lobbied to prevent Medicare from negotiating directly with manufacturers; consequently, Medicare is required by law to use PBMs and is prevented from negotiating directly with drug companies.[34] This represents a huge loss for Medicare, which could have saved an estimated $14.4 billion in 2016 for its costliest 50 oral drugs by negotiating directly with drug companies.[35,36] By 2017, Medicare could have saved another $4.4 billion of the $7.3 billion it spent just on insulin, had it been able to use the prices negotiated by the Veterans' Administration.[37]

What Solutions Have Been Proposed?

Federal

- The U.S. Government sued Mylan for overcharging for the EpiPen® for emergency treatment of serious allergic reactions. From 2007 to 2016, Mylan raised the list price of the EpiPen from just under $100 to more than $600.[38] (The generic version sells for around $400.[39]) The suit was settled in August 2017 for $465 million, which was only one third of the $1.2 billion Mylan overcharged for EpiPen.[40]

- In October 2018, the U.S. Congress passed *The Patient Right to Know Drug Prices Act* and *Know the Lowest Price Act*. These bills outlawed PBM "gag clauses," which prohibit pharmacies from telling patients that a cheaper drug is available.[41]

- On May 8, 2019, the Department of Health and Human Services announced a new rule that requires pharmaceutical companies to show the price of prescription drugs in television advertisements. On June 14, 2019, three pharma companies and a trade group sued, arguing that the rule is illegal because it violates the companies' First Amendment rights.[42] The rule would have taken effect July 9th but on July 8th, a federal judge ruled that disclosure of list prices in TV ads could not be enforced.[43]

- Taxpayer-funded research by the National Institute of Health contributed more than $100 billion to develop 210 new drugs approved between 2010 and 2016.[44] The Protect American Investment in Drugs (We PAID) Act of 2019, introduced in the U.S. Senate and currently in committee, would ensure that prices of drugs developed using federally funded research (such as NIH or CDC grants) are set at reasonable levels.

States

Despite much talk about helping those in need, the federal government has done relatively little, presenting an opportunity for state legislatures to seize the initiative.

However, because the companies involved in setting prices are almost all national—if not global—making state-level improvements is difficult. States also have little impact on the cost of drugs, since rebates are negotiated at the federal level. States also have no control over their share of Medicare Part D, also mandated by the federal government. Still, state legislatures are becoming increasingly active in their efforts to curb prescription drug costs. In 2019 alone, 33 states enacted 51 laws to help control drug prices.[45]

In early May 2019, 44 states filed a lawsuit against drug companies Teva, Pfizer, Novartis, and Mylan, alleging they conspired to inflate the prices of generic drugs by as much as 1,000 percent. The scheme affected the prices of more than 100 generic drugs, according to the complaint.[46]

The National Academy for State Health Policy (NASHP) has created an interactive map showing every state bill introduced related to drug pricing, as well as their contents and fate. This list is available at https://nashp.org/rx-legislative-tracker/ The National Conference of State Legislators has published an overview of recent approaches and innovations in state law at https://www.ncsl.org/research/health/rx-costs.aspx.

Areas of focus include:[47]

- Establishing drug cost review boards/commissions for information gathering and possible rate setting
- Requiring drug price transparency
- Prohibiting price-gouging
- Regulating pharmacy benefit managers
- Implementing state wholesale drug importation from Canada

Drug Cost Review Boards

Maryland passed the country's first drug cost review board in 2019, perhaps a model for other states. HB 768 creates a Prescription Drug Affordability Board with the authority to evaluate expensive drugs and recommend appropriate methods for addressing these costs, including setting upper limits on what Marylanders would pay for these drugs.[48] Beginning in 2022, the Board can also begin to set upper payment limits for prescription drugs purchased by state, county, and local governments. In December of 2023, the Board will recommend whether the General Assembly should pass legislation to expand upper payment limits for all purchases of prescription drugs.

In 2019 **Maine** enacted a law that established a state agency to review drug costs and act against price increases exceeding a certain threshold. The board will set annual spending targets for drugs purchased by the state and local governments in 2021.[49]

NASHP has written model legislation for drug affordability review: https://nashp.org/wp-content/uploads/2018/08/NASHP-RX-Rate-Setting-Model-Act.pdf

Transparency

Mandating transparency by itself does little to control prices. But disclosure of drugs' wholesale costs at the pharmaceutical company level has been legislated in several states. This is unlikely to be successful because wholesale costs are only one factor in setting the final price a patient pays for a drug.[50] While publicly traded drug companies must disclose their Research and Development (R&D) costs, focusing exclusively on drug companies ignores the real transaction prices at each stage of the pharmaceutical distribution chain. Attempts to pass legislation requiring pricing transparency on the part of pharma companies have also been opposed by the powerful pharma lobby.

A **California** price transparency law (SB 17), enacted in October 2017, applies to all drugs (brand-name and generic) with a wholesale acquisition cost of at least $40. When the price of these drugs increases more than 16 percent in the prior 12 months or 32 percent in the preceding 24 months, manufacturers must report a variety of data about their business operations and costs to justify the price increases. The law is being challenged by industry.

NASHP has written model legislation for drug transparency: https://nashp.org/wp-content/uploads/2019/04/Comprehensive-Transparency-Model-Legislation-final-4_22_2019.pdf

Prohibiting Price Gouging/Limiting Out-of-Pocket Costs

In 2017, **Maryland** passed the country's first anti-price-gouging law (SB 631) that prohibited makers of essential drugs from raising prices to "unconscionable" levels.[51] The law applied to all off-patent and generic drugs on the World Health Organization's list of "essential medicines," which are considered to be the minimum pharmaceutical treatments needed for a basic health care system. An "unconscionable" price increase was defined as a price hike not justified by changes in production and for which consumers had no meaningful treatment alternative.

The law allowed Maryland's Medicaid agency to inform the Attorney General about drugs that cost at least $80 and had a wholesale cost increase of 50 percent or more in 12 months. If the Attorney General did not find an adequate explanation for the price increase, the matter could be referred to the state court, which could then decide whether penalties should be imposed on the manufacturer.

Maryland's law was challenged by the generic drug industry and nullified in April 2018 when an Appeals Court held it was unconstitutional because it regulated commerce beyond Maryland's borders. After that decision, no state has successfully passed an anti-price gouging bill. On February 18, 2019, the law died when the Supreme Court formally declined to hear the appeal from the state's Democratic Attorney General.[52]

In 2018 Democratic State Senator Troy Singleton, **New Jersey**, introduced SB 977, which prohibits excessive charges for drugs developed by publicly funded research. It died in committee.[53]

In 2018 **California** passed SB 1021 to limit out-of-pocket costs for plans regulated by certain state departments. Copayments for a covered prescription drug for an individual prescription for a supply of up to 30 days are capped at $250. The bill prevents the cost of a drug copayment from exceeding the retail price. It also limits formularies to four tiers and has provisions to keep insurance companies from routinely placing specialty drugs on their highest pricing tiers.[54]

California also passed AB 265 (in 2017) to prevent any drug company from providing discounts on the branded drug if the patient's insurance company also covers a lower-priced generic equivalent, since the reduced-price branded drug will still probably be more expensive than the generic.[55]

Nevada passed AB 381 in 2017, which limits the ability of an insurance company to move a drug from a lower-priced tier to a higher-priced tier.[56]

Colorado passed the first bill in the country to cap the price of insulin co-pays.[57] The bill, signed on May 22, 2019, placed a cap on co-pays of $100 per month regardless of how much insulin a patient uses. The insurance company will cover whatever exceeds $100. In 2020, Illinois follow with a similar bill and New Mexico passed a bill to cap co-pays at $25 per prescription.[58]

NASHP has also written model legislation for drug affordability review: https://nashp.org/wp-content/uploads/2017/07/Prescription-Drugs-Rate-Setting_Model-Legislation.pdf

Regulating Pharmacy Benefit Managers (PBMs)

Twenty-one states passed 32 bills regulating PBMs in 2018.[59] Each state's bills have some or all of the following approaches:

- Requiring PBMs be licensed by or registered with the state
- Requiring PBMs to report certain cost information about rebates or pricing methodology
- Barring PBMs from collecting copayments that are more than the total charges submitted by a pharmacy
- Requiring a PBM to establish a threshold for patients' cost-sharing expenses for a drug

The National Academy for State Health Policy (NASHP) has written two model legislation/bills for regulating PBMs:
Model A: https://nashp.org/wp-content/uploads/2019/02/Updated-MODEL-A-PBM-legislation-1_31_2019.pdf
Model B: https://nashp.org/wp-content/uploads/2019/02/NASHP-PBM-Model-Act-B-022019.pdf

Drug Importation from Canada

In the absence of federal action on drug importation, several states have approved legislation legalizing importation of prescription drugs from Canada, should the federal government allow importation.

Vermont became the first state to approve legislation (S.175) to import low-cost drugs from Canada on May 16, 2018.[60] The bill creates an importation program to purchase high-cost drugs through authorized wholesalers in Canada and make them available to Vermonters through an existing supply chain that includes local pharmacies.

Colorado also joined the ranks of states approving drug importation from Canada when the Governor signed legislation similar to Vermont's in May 2019.[61]

In June 2019, **Florida's** Governor signed a bill that allows the state to import prescription drugs from Canada, if federal authorities give their approval.[62] The governor cites direct support from President Donald Trump.[63]

NASHP has written model legislation regarding the importation option: https://nashp.org/wp-content/uploads/2019/03/Wholesale-Importation-Act-FINAL-3_25_2019.pdf

Industry Consolidation Oversight

Little can be done at the state level about national pharmacy/PBM mergers other than filing complaints with the federal Department of Justice.

States can provide increased oversight into mergers done within the state, with attention paid to how they will affect patients' costs and competition in the market. **California**, for example, passed AB 595 in 2018, instituting stronger oversight for health care mergers in a state where five insurers cover 90 percent of the market.[64]

Purchasing Consortiums

California's Executive Order N-01-19 of January 7, 2019, directs the state's Medicaid system and all state agencies to negotiate and purchase prescription drugs collaboratively. Currently, California's Medicaid enrollees participate through a number of individual managed care plans that negotiate

independently. The state will create a single list of preferred drugs targeted for price negotiation. To implement the changes, the state has contracted with Magellan Medicaid Administration. The program will go live by Jan. 1, 2021. Private purchasers and other government agencies will eventually be able to participate. California expects other states to join in its program.[65,66]

New Mexico: Gov. Lujan Grisham, in April 2019, signed SB 131 into law to allow the state to consolidate public purchasers, including various state agencies and Medicaid, to leverage their buying power to lower drug costs. The Interagency Pharmacy Purchasing Council is also identifying ways to use public purchasing to benefit individuals in the private sector and partnering with other multi-state purchasing collaboratives. Additional plans are to explore a common formulary for all state agencies, a single purchasing agreement and a common agreement for all PBMs.[67]

National Purchasing Consortiums

All 50 states participate in the Minnesota Multistate Contracting Alliance for Pharmacy program (MMCAP) through which states contract with a purchasing organization to negotiate Medicaid supplemental rebates on their behalf.[68] MMCAP shares savings through competitive bidding and aggressively negotiated contracts that adhere to State of Minnesota procurement regulations. This volume aggregation results in deep cost savings on pharmaceuticals. Savings are estimated to be about 24% for branded drugs and 65% for generics.[69]

Patient Assistance Programs (PAPs)

PAPs are programs sponsored by pharma companies that provide financial assistance or free drugs to low income people to augment any existing prescription drug coverage.[70] The assistance the enrollee receives is not counted towards the beneficiary's Part D out-of-pocket costs.

What has Arizona Done to Fix the Problem? Key AZ Legislation

- With the legislative session shortened due to COVID-19, there were no prescription drug bills passed during the 2020 session.[71] Since the legislature was adjourned *sine die*, it is unclear which bills will be re-introduced in future sessions.

- In the 2019 session, HB 2285 (titled: Pharmacy Benefit Manager; prime sponsor: Senator Regina Cobb), was passed. The bill is intended to provide transparency in pricing by pharmacy benefit managers. Additionally, plan sponsors and PBMs may not prohibit in-network pharmacies from dispensing 90-day prescription fills if the pharmacy agrees to the reimbursement rate and the plan allows it.[72]

- In the 2019 session, HB 2166 (titled: Insurance; cost sharing; calculation; prime sponsor: Senator Nancy Barto), was passed. This measure requires a health care insurer to include any cost sharing amount paid by either the enrollee or another person on behalf of the enrollee when calculating an enrollee's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance or other applicable cost sharing requirements.[73]

- In the 2018 session, HB 2202 (titled: Pharmacy benefits managers; pharmacies; practices; prime sponsor: Representative Regina Cobb), died in committee. The bill would have prohibited pharmacy benefit managers (PBM) from receiving payments for more than what the pharmacist receives. Additionally, the PBM could not prevent the pharmacist from telling the patient what the cost of the drug would be if they bought it outside of their plan, and the pharmacist must sell the drug to the patient if they do not want to buy it through their plan.

Also, the PBM cannot prevent the pharmacist from selling a 90 day supply if allowed by state law.[74]

- In the 2018 session, HB2107 (titled: Pharmacies; practices; pharmacy benefits managers; prime sponsor: Representative Maria Syms), was passed. The bill prohibits a PBM or other entities that administer prescription drug benefits from prohibiting or penalizing a pharmacy or a pharmacist from informing a patient of a lower cost alternative. In addition to preventing "gag clauses," it prohibits mandatory "claw backs," where insured patients pay more in copays than pharmacies receive in reimbursements.[75]

Bills Introduced and not passed in 2020

- SB1413 and SB1601 (titled: Insulin drugs, cost sharing limit; sponsored by Senators David Farnsworth and Rebecca Rios), would have placed an upper limit of $100 that a subscriber must pay for a one month supply of insulin. Both bills remained in committee when the Senate adjourned *sine die*.[76,77]
- SB1387 (titled: Prescription drugs; upper payment limit; sponsored by Senator Juan Mendez), would have established a Prescription Drug Affordability Board to protect residents from the high cost of prescription drugs. The bill never made it off the floor when the Senate adjourned *sine die*.[78]

Conclusion

The causes for increases in prescription drug prices are complicated, as is solving this problem, because of the complex web of agreements between the multiple players involved, their lobbying power, and the lack of transparency in the pricing process. There is no single scapegoat for the skyrocketing prices of medications—there is plenty of blame to spread around.

In the meantime, anything that legislators and legislative candidates can do to understand the complexities and opportunities for improvement at the state level can only increase the likelihood of helping to solve the problem of runaway drug prices.

[1]https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/
[2] https://healthcostinstitute.org/in-the-news/international-comparisons-of-health-care-prices-2017-ifhp-survey
[3] https://www.upi.com/Health_News/2020/03/04/US-drug-prices-rose-three-times-faster-than-inflation-in-a-decade/3221583293777/
[4] https://www.nytimes.com/2018/01/06/business/humira-drug-prices.html
[5] https://www.goodrx.com/blog/prescription-drugs-approved-in-2018-list-prices-over-30k-per-year/
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[8] https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/
[9] https://familiesusa.org/wp-content/uploads/2019/05/SILC_The-Problem-with-Rx-Drug-Pricing_Fact-Sheet_05172019.pdf

[10] https://www.goodrx.com/blog/health-insurance-aside-americans-still-struggle-to-pay-for-their-medications/
[11] https://www.hsgac.senate.gov/imo/media/doc/Manufactured%20Crisis%20-%20How%20Devastating%20Drug%20Price%20Increases%20Are%20Harming%20America's%20Seniors%20-%20Report.pdf
[12] https://www.hsgac.senate.gov/media/minority-media/breaking-brand-name-drugs-increasing-at-10x-cost-of-inflation-mccaskill-report-finds
[13] https://www.retiremediq.com/blog/part-d-donut-hole/
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[15]https://pharma.nridigital.com/pharma_nov19/from_evergreening_to_thicketing_exploring_manipulation_of_the_pharma_patent_sys
[16] https://www.opensecrets.org/lobby/indusclient.php?id=H04&year=2018
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