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With Proposal to Cap Drug Price Increases, Massachusetts Once Again Takes Center Stage in the Drug Pricing Debate

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On March 17, **the same day we wrote about proposed legislation in Connecticut to cap drug price increases**, Governor Charlie Baker of Massachusetts included a similar proposal in his proposed budget. Similar to the Connecticut legislation, the Massachusetts bill (**S. 2774**) would penalize manufacturers for increasing the price of any medication above its reference price, adjusted for inflation using the Consumer Price Index, plus 2%. Manufacturers that exceed this threshold would have to pay a penalty equal to 80% of the amount above the excessive price increase threshold – meaning the manufacturer would essentially only collect 20% of the revenue for a drug above the price cap. Like the Connecticut bill, the reference price is based on a drug's Wholesale Acquisition Cost (WAC), which is essentially the list price set by manufacturers for a prescription drug before any negotiations or discounting.

As noted in that prior post, in the absence of any meaningful federal action on drug pricing, states have become the primary forum for legislative action to address high drug prices in the U.S. While most enacted measures to date have focused on regulation of pharmacy benefit managers (PBMs) and increasing transparency, direct measures, such as imposing actual caps on drug price increases, have only recently begun to enter the conversation in the commercial market. (For what it's worth, the Massachusetts bill also contains provisions to impose annual reporting requirements to PBMs related to prices negotiated with payors, payments between PBMs and pharmacies, and manufacturer rebates). Similar price cap bills in Hawaii and Washington that were proposed last year have been reintroduced and carried over to each state's current 2022 legislative sessions, meaning there are now four such bills pending across the U.S.

While the Massachusetts bill is not entirely surprising – Governor Baker introduced a similar proposal last year – there are several reasons why manufacturers and other industry stakeholders are likely paying close attention. For one, Massachusetts is larger and much more influential in terms of state policy than Connecticut, in particular when it comes to health care reform. The Affordable Care Act (2010) was of course heavily modelled after a 2006 health care reform law in Massachusetts, which was itself ushered and ultimately signed by a moderate Republican governor who had success negotiating with a Democratic legislature.

If S. 2774 were to become law, the prospect of corresponding federal legislation being passed would increase significantly. With respect to Medicare drug prices, Congress has already begun to earnestly debate the use of inflation caps. For example, two extremely similar bills – **S. 2543** (2019), which was introduced by Sen. Chuck Grassley (R-IA), and H.R. 3 (**2019**, **2021[1]**), which was introduced by Rep. Frank Pallone Jr. (D-NJ) and which managed to pass the House in 2020 – would have imposed inflation-based rebates on Medicare Parts B and D drugs. And Medicaid has imposed inflation rebates for nearly 30 years, **although a corresponding cap on the total drug rebates manufacturers have to pay has limited the effectiveness of the inflation caps**. Still, the idea of inflation caps for drugs in the commercial market is relatively new ground.

By itself, S. 2774 would be unlikely to have a significant effect on manufacturers – influential or not, Massachusetts is one state, and is not even one of the top 15 in terms of population. Still, as noted above, it could easily serve as a bellwether for other states, and eventually Congress, to begin seriously considering such measures in the commercial market. Cognizant of the risks involved, which many manufacturers will likely argue are existential, the pharmaceutical industry has already begun to **loudly express its opposition to the Massachusetts bill.** The manufacturer industry trade group, Pharmaceutical Manufacturers of America (PhRMA), **reportedly took out a full-page ad in the Boston Globe a couple of weeks ago**, and one would expect that PhRMA and its members are going to throw a considerable amount of resources to undermine the legislation.

As noted in the prior post, despite all the noise in opposition and support for such measures, proposals like the Massachusetts and Connecticut bills will likely have a much more limited impact than either the bill's supporters or detractors would admit. For one, there is the fact that the reference price is tied to WAC, which is literally the list price set by the manufacturers, rather than to say Average Manufacturer Price (AMP), which is the average price by wholesalers for drug to the retail class of trade net of customary prompt pay discounts. The issue is not necessarily that WAC is a useless baseline – **most pharmacies purchase drugs at WAC, negotiated for a purchase discount** (i.e. WAC – 1%). However, using AMP, given it takes into account some (but not all) price concessions would mean the reference price was lower, and some would argue more accurate. Notably, the subtle difference between H.R. 3 (introduced by a Democrat) and S. 2543 (introduced by a Republican) was that the former used AMP as the reference price for Part D drugs while the latter used WAC, which is in many ways emblematic of the fact that WAC appears to be a slightly more conservative and measured approach to price caps. AMP is also the measure used to set rebates in Medicaid, w**hich of course has much lower drug prices than Medicare**.

Still, it's important not to overstate the significant of one measure over another when there is a larger limitation on these price cap proposals. Specifically, capping the increase in baseline prices for drugs, no matter what measure or forum, **will arguably have a limited impact on affordability if the baseline drug prices are already extremely high to begin with**. The fact that it is seen as radical to limit the annual increase in the list price of drugs, given the fact that both the **prices of and spending on drugs is already significantly higher than in other post-industrial countries**, is an indication that the framework of the conversation is still on pharmaceutical manufacturer's terms.

[1] The bill was initial introduced in 2019, but was reintroduced in 2021.

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