The Collective

The Oklahoma Business Collective on Health

At the intersection of business and health

New events have been posted on our website: DrivingHealthValue.org

A recent study published in* HealthAffairs Scholar *explores:

What drug characteristics explain the wide range of manufacturer rebates?

Prescription drug list prices, often cited in policy discussions, do not account for rebates negotiated between manufacturers and payers.

This study identified 161 drugs found in SSR Health and SPEC as of December, 2023, and finds that rebates vary substantially across drugs. (These companies track brand drug pricing, do data analytics, and measure standards and performance). Biosimilar and brand name (originator) drugs have the highest, most variable rebates, while rebates for cancer treatments and orphan drugs are lower and vary less. Drugs that face more competition from alternative options within the same therapeutic class, are self- administered, or received Food and Drug Administration (FDA) approval in the past have higher rebates.

Conclusion: The findings indicate that rebates are sizeable and vary along several dimensions, many relating to market competition, which complicates policy discussions around drug pricing. [The publication is a bit techy, but interesting. Click the top orange button below to read it].

WHAT DOES THIS MEAN FOR EMPLOYERS? Consider your plan parameters.

1. What are you really paying for drugs in your plan?
2. What measures are in place to ensure accountability for promised rebate dollars?
3. Are your partners pushing brand name drugs and minimizing or eliminating generic, biosimilar or biologic options? What's best for YOUR plan?
4. How do brand name drugs in your formulary impact rebate amounts? Do they produce the highest rebates? Are there alternatives that cost less in the long run?
5. Can you carve out your drug plan if you choose to?

6. Have you been denied rebates where you thought they were owed?

Drug Pricing Explained: The Forces that Shape Prescription Medication Costs

Source: NORC at the University of Chicago

To understand the complex market and regulatory forces that influence drug pricing, NORC partnered with Arnold Ventures to examine five pharmaceutical products, tracing the steps of each drug's development, commercialization, and sale to patients.

Leveraging years of research, policy, and pricing expertise, NORC's Health Care Strategy (HCS) team examined the prescription drug landscape, seeking to identify medications that were top-of-mind for Americans due to pre-existing media attention directed to high price or access issues. HCS also identified medications with compelling supply chain dynamics that impact consumer price and access but are often unknown to the general public. With drugs identified, HCS researched the complete story of each drug—including research and development, patenting, launch, market share, regulation, distribution, and rebates—and produced five research papers that illuminate the factors impacting patient price and access.

This information is shared through playbooks. Each treatment's playbook tells a story about how decisions and actions by key supply chain players impact pricing. Many factors determine the cost of prescription drugs. Pharmaceutical companies play a major role, as do government programs, providers, private insurers, and pharmacy benefit managers. [Read more by clicking the second orange button below.]

HealthAffairs Scholar: Drug Characteristics/Mfg. Rebates

NORC: Drug Pricing Explained - 5 Supply Chain Playbook Links

More on Drug Pricing from Harvard Health

News You Can Use

2025 Trends in Drug Benefit Design

Pharmaceutical Strategy Group (PSG) is sharing the results of its extensive research on the latest trends in drug benefit design.

Plan sponsors face complex decisions and challenges as they build and implement their drug benefit. PSG's **2025 Trends in Drug Benefit Design Report** [download by clicking on the orange button just below this section] provides a view into how plans work to achieve access and affordability for members while controlling their pharmacy spend.

The report contains valuable insights from benefits leaders representing plans nationwide.

Key Findings

- **PBM Unbundling Gains Traction:** Most payers believe unbundled PBM arrangements could deliver substantial value, with especially high

awareness among health plans.

- **Payers Divided on Coverage of GLP-1s for Obesity:** While almost all payers cover GLP-1s for diabetes, just 2 in 5 cover GLP-1s for obesity, and nearly half who don't currently cover these drugs for obesity wouldn't do so at any price.
- **Alternative PBM Pricing Models in Spotlight:** As established PBMs and newcomers offer additional options, 1 in 3 payers are using or evaluating PMPM guarantees, while 1 in 4 are using or evaluating cost-plus models.
- **Cost Sharing Likely to Increase:** The most common pharmacy benefit cost sharing changes under consideration involve increasing member copays/coinsurance or raising deductibles.
- **Employers Increasing Benefits Investment:** Despite cost pressures, half of employers anticipate increasing their benefits investment in the next 1-2 years.

Download the 2025 Trends in Drug Benefit Design Report

Medical Minute

Breast cancer screening - Prescriptive authority bill survives despite governor vetoes

Oklahoma HB 1389 passed with overwhelming bipartisan support expanding insurance coverage for breast cancer imaging and advanced diagnostic tests —but Governor Kevin Stitt vetoed the legislation. The goal was to promote early detection, resulting in less expensive and more effective treatments.

In his veto message, Gov. Stitt argued it would create new costs when mammograms are already covered, and providers could order more tests if needed. On May 29, lawmakers overrode the veto, and 28 female lawmakers signed a letter to Stitt expressing "profound disappointment" in his veto.

New Law - Mammography Screening

All health benefit plans shall include the coverage specified for a low-dose mammography screening for the presence of occult breast cancer and a diagnostic and supplemental examination for breast cancer. Such coverage shall not:

1. Be subject to the policy deductible, co-payments and co-insurance limits of the plan; or
2. Require that a female undergo a mammography screening at a specified time as a condition of payment.

Any female 35-39 years of age is entitled pursuant to the provisions of this section to coverage for a low-dose mammography screening once every five years. Any female 40 years of age or older is entitled pursuant to the provisions

of this section to coverage for an annual low-dose mammography screening.

Click below to review definitions and details of HB 1389.

Oklahoma's New Mammography Law: HB 1389

Educating Employers

How Prior Authorizations Work (or Don't Work)

Dr Eric Bricker provides the basics in less than 7 minutes.

Who Sets Prior Authorization Rules in the First Place??

Learn How the Same Milliman Care Guidelines (MCG Care Guidelines)
Are Used by the 8 Largest Insurance Carriers and
1900 Hospitals, and Affect 200+ Million Americans.

Health Insurance Carriers outsource Prior Authorization to vendors who use the MCG Care Guidelines as the clinical basis for their decisions. These Prior Authorization Vendors approve or deny coverage for services based on guidelines from Hearst Health (which is owned by privately held Hearst, a global diversified information, services and media company).

Approving and denying health insurance coverage for medical care in America is a complex web of relationships with MCG care guidelines at its center.

Fixing Prior Authorizations (PAs)

More than 40 of the nation's largest health plans have signed an agreement to limit and simplify prior authorization and commit to six specific reforms.

Payers say Prior Authorizations shield patients from low-value and inappropriate care but also recognize the frustration that patients and providers feel when provider-recommended care is delayed or denied.

The most noteworthy commitment is the push toward real-time authorizations using FHIR APIs (a standard for secure data exchange). If this is truly realized, it would cut down on delays and reduce friction for both providers and patients. [Source: *HealthLeaders]*

CMS to Test New Prior Authorization Process in Six States... Oklahoma is one of them.

Update on Prior Authorization Carrier Commitments

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