

**TASK FORCE ON
HEALTH CARE COVERAGE FOR ALL OF MAINE**

Meeting Agenda

April 2, 2018

1:00 pm to 4:00 pm

Room 220, Cross State Office Building

- ❖ Welcome and Introduction of Chairs and Members
- ❖ Review summary of March 2nd meeting and updated survey results
- ❖ Structure of the Health Insurance Market Study Group Update
- ❖ Cost Containment Study Group Update
- ❖ Public Options Study Group Update
- ❖ Discussion of Next Steps/Plans for Study Groups

Task Force on Health Care Coverage for All of Maine
March 2, 2018
Draft Meeting Summary

Task Force Members Present:

Sen. Rodney Whittemore, Senate Chair; Rep. Heather Sanborn, House Chair; Sen. Brownie Carson; Sen. Geoff Gratwick; Rep. Robert Foley; Rep. Anne Perry; Joel Allumbaugh; Jeff Austin; Mark Hovey; Kris Ossenfort; and Trish Riley.

Task Force Members Absent: Sen. Eric Brakey; Rep. Paul Chace; Dan Kleban; Kevin Lewis; Frank McGinty

Staff: Colleen McCarthy Reid

Welcome and Introductions

The chairs of the task force, Sen. Whittemore and Rep. Sanborn, convened the meeting; members introduced themselves.

Summary of January 22nd Meeting

The task force briefly reviewed and accepted the summary of the January 22nd meeting.

Review of Survey

As a tool to help better understand the areas of agreement and identify possible areas of disagreement among the task force members, Sen. Whittemore and Rep. Sanborn developed a survey. The chairs anticipated that the results of the survey and the expertise of task force members would be used to frame the task force's remaining work.

Staff reviewed the preliminary results of the survey with the task force. Before the meeting, only 7 of the 16 members had responded to the survey. A summary of the survey responses is included with the meeting materials at: <http://legislature.maine.gov/doc/2169>

Members recognized that the survey results were incomplete, but noted that the results may indicate some common ground among the members. Members stressed that responses were needed from all of the members before drawing any conclusions from the survey. The chairs urged the task force members to complete the survey if they hadn't already done so.

Presentations: Options for Potential Reform

The meeting focused on options for potential reform. Presentations were made on the worker's compensation reforms and potential parallels for health care; the Maine Guaranteed Reinsurance Association and potential changes; options for cost containment, including wholesale importation of prescription drugs and rate setting; and options for public models. The presentation materials provided to the task force are posted on the task force's website at: <http://legislature.maine.gov/doc/2169>

❖ Workers' Compensation Reform: Are there Lessons/Parallels?

Michael Bourque, Chief Executive Office, Maine Employers Mutual Insurance Company, spoke to the task force about the potential parallels between the worker's compensation reforms enacted in the early 1990's and the current challenges in health care. Mr. Bourque noted his belief that there are four policy issues that need to be resolved: prevention and a certain amount of personal responsibility for one's health; the cost of health care services; the cost of pharmaceuticals; and affordable access to insurance through a broad pool.

Mr. Bourque pointed out his belief that the success of the workers' compensation reforms in reducing chronic illness and reducing insurance costs was achieved through tough choices, careful management, a managed market and a willingness to compromise. He suggested those same principles could be applied to develop solutions for the health care system.

❖ Reinsurance: Past, Present and Future for Maine Guaranteed Access Reinsurance Association

Christopher Howard, Maine Guaranteed Access Reinsurance Association, presented an overview of the Maine Guaranteed Access Reinsurance Association (MGARA) and how the reinsurance mechanism operated to provide premium relief to the individual health insurance market prior to the Affordable Care Act. MGARA's operations were suspended in 2014 while a federal transitional reinsurance program was in place due to concerns about redundant assessments on Maine insurers. The suspension was to be lifted in January 2018 when the federal program ended, but the Legislature extended the suspension because of uncertainty related to the federal Affordable Care Act and concerns that the federal subsidies created an economic disincentive to reactivate MGARA.

Mr. Howard reported that MGARA has identified a potential solution to address the federal subsidies issues and has been working with the Maine Bureau of Insurance to develop a waiver proposal under Section 1332 of the Affordable Care Act. Under the waiver proposal, Maine may be eligible to receive federal funding equivalent to the cost-savings to the federal government for the positive effect the reinsurance program could have on premium rates and the corresponding reduction in the amount of subsidy that would be required. MGARA has projected that, if a Section 1332 waiver were granted, it could have a positive impact on premium rates of 9% to 14% from 2019 to 2028. More information about the status of the Section 1332 waiver proposal will be known in the coming weeks.

❖ Options for Cost containment

State Options for Prescription Drug Pricing. Ellen Schneider, National Academy for State Health Policy, briefed the task force on a number of policy options for states to address prescription drug costs. Ms. Schneider particularly focused on the creation of a state-administered wholesale drug importation program to purchase drugs from Canada. This policy option was developed through NASHP and can be operated on a large or small scale. The importation program can be modified in several different ways in terms of who the program is made available to or the number of drugs included in the program. Data shows that the price of drugs in the US is twice as much as brand name drugs in Canada. Through an importation program, Ms. Schneider explained that a state can control profit margin and make sure savings are passed to payers and consumers.

Ms. Schneider noted that legislation is required to authorize a state to administer the program and to contract with Canadian suppliers. Model legislation has been developed and was recently introduced in Utah.

State Options for Price Controls. Staff provided an overview of Maryland's rate setting program. Currently, Maryland operates the nation's only all-payer hospital rate regulation system. The Maryland Legislature first authorized the Health Services Cost Review Commission (HSCRC), to set hospital rates

for all payers in 1974. In order to ensure that the system applied to government payers like Medicare and Medicaid, Maryland negotiated and was granted a waiver of federal law that required Medicare and Medicaid to begin paying hospitals on the basis of HSCRC-approved rates in 1977. Under the waiver, all third party purchasers—insurance carriers, Medicare, Medicaid, uninsured individuals and others-- pay the same rate.

In 2014, Maryland received approval from the Centers for Medicare & Medicaid Services (CMS) for a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services with the goal of reducing costs and improving patient health. Under the revamped waiver, all of Maryland's hospitals operate under fixed global budgets (they are provided a set amount of revenue per year and must care for all of their patients within that limit).

❖ Options for a Public Model

At the invitation of Sen. Gratwick, Tom Sterne, M.D and Dean Felton outlined a proposal for a new public option. The proposal they described is a hybrid public-private model developed to revamp the provider reimbursement system through a state-sponsored Trust. They proposed using an innovative tax and operating structure to support a transition from fee for service to a "net cost" of service model. The model would be designed to be State sponsored, ERISA exempt, qualified under ACA and Medicaid waivers, and structured to receive and administrate all Maine healthcare revenues.

Under this proposed cost reimbursement model, the "Trust" will include the following functions:

1. Single source centralized provider reimbursement claims process;
2. Acting as a central purchasing agent for providers for all supplies and pharmaceuticals;
3. Assuming responsibility for quality assurance standards, compliance and for dispute resolutions on all matters among the trust, providers, insurers and the residents of Maine;
4. Negotiating net reimbursement costs with all provider services, aggregate caps for participating hospitals and setting the trust budgets and claim attachment points for insurer in the reimbursement structures;
5. Overseeing the phased-in expansion of services into area service gaps throughout the state in conjunction with our private partners as determined by need in terms of location and services;
6. Maintaining data and data security to HIPAA standards;
7. Supporting academic research, especially health promotion and healthcare wellness delivery on issues such as addiction, smoking, nutrition, weight loss, chronic disease, etc.; and
8. Recognizing the personal financial stress of deductibles and co-pays on residents, the model seeks to minimize this burden via financing programs for deductibles, deductible buy-backs from federal subsidies, and the use of annual caps on out-of-pocket payments.

Dr. Sterne and Mr. Felton proposed that the task force work toward developing a business plan to move through the Section 1332 ACA waiver process and the complementary 1115 waiver process with these innovations in mind.

Public Comment

The task force accepted public comment on the charge to the task force and the health care topics under discussion. Fifteen people provided comments. Copies of the written testimony submitted to the task force are posted on the task force website at:

<http://legislature.maine.gov/doc/2171>

Task Force Discussion: Next Steps

After listening to the presentations and public comment, the task force briefly discussed their next steps. Rep. Sanborn reported that the Legislative Council has authorized 4 additional meetings for the task force before November 1, 2018. Given the additional time, Rep. Sanborn suggested that the task force break into smaller groups to facilitate further discussion and the development of potential recommendations in several areas.

The task force agreed and decided to form 3 study groups organized around the following topics: Controlling Costs; the Structure of the Health Insurance Market; and Public Options.

The chairs asked members to express whether they had any preferences for a study group by email; they will consider preferences and name the members of the study groups as soon as possible. It is anticipated that the study groups will have the chance to meet once or twice before the next full task force meeting and will have additional time to meet after the Legislature adjourns.

Fourth Meeting

The fourth meeting will be held on April 2, 2018 at 1:00 pm.

The meeting adjourned at 4:00 pm.

Task Force on Health Care Coverage for All of Maine

Survey Questions—13 respondents

Note from the chairs: We have developed this survey as a tool to help us better understand the areas of agreement and identify possible areas of disagreement among the task force members. We hope to use the results of the survey and the expertise of our task force members to frame our remaining work.

1. Do you agree that all Maine residents should be required to have health care coverage?

YES	NO
9	4

Comments:

- Yes or self- insured with no charity care
- Affordable access

2. Do you agree that there should be a limit to what an individual pays for health care coverage based on a certain amount or percentage of income?*

YES	NO
9	2

**Does not equal 13 total responses as two respondents did not answer yes or no*

Comment from Respondents who did not answer yes or no:

- I'm not opposed to helping those of limited means but a percentage of income is not the right measure in isolation; and
- To some degree, but not entirely

3. Do you agree that all health plans should be required to provide a certain level of minimum benefits? Please explain.

YES	NO
11	2

Comments:

- Yes, otherwise revert back to sale of junk policies that are at best misleading
- Yes, so that the insured can be assured of basic health care from caregivers in our medical care delivery system
- Yes and those should be adequate to assure comprehensive coverage - it may be something less than the current EHB but should not be "bare bones"
- Yes, especially preventative care. There should be a baseline of coverage with the ability to add coverages that individuals may opt for.
- No- there needs to be more flexibility for plans to innovate and individuals to purchase the coverage they want/need

- Yes. All health plans should cover women's health, mental health, preventative care, diagnostic testing, treatment of chronic illness etc.
- Affordable...20 year old needs a physical ...50-99\$/month premium
- Basic health care plans only.
- Yes, this needs to happen regarding prevention that ensures that health care usage is less and at lower cost level then giving the opportunity to control the cost of healthcare.
- No, customers should have the power decide what they want and what they don't.

4. Do you agree that the affordability of health care coverage needs to be addressed? If so, what steps would you recommend?

YES	NO
13	0

Comments:

- Starting with pharmacy costs and government ability to negotiate prices
- Offer a single payer, publicly sponsored and funded system (funded by payroll taxes, and income taxes on others w/ ability to pay)
- Cost containment, public option.
- Costs are largely driven by the underlying cost of care and the inefficiency of the system. Initiatives like global budgets and rate-setting like MD, MA and VT show promise
- We need to control cost of care, more competitive and control costs of drugs
- Reduce RX, Hospital, Provider, Insurer, Brokers overheads, costs, and profits by aligning with Medicare reimbursements, providing pricing transparency, and quality metrics.
- Yes- that requires addressing the underlying cost of care. That requires an honest analysis of the structure and cost of the current delivery system, ongoing cost transparency, opportunity for service providers to enter and innovate in the market, and freedom for consumers to choose care providers and options.
- Yes. I believe that ultimately prices will have to be regulated in order to deal with health care inflation.
- Low premiums will bring in younger members that don't draw many services
- Need to continue addressing overall cost. Right to shop and primary care providers new law is already showing some positive results in addressing cost of care.
- This needs to happen at many different levels. Regulations regarding pricing of pharmaceuticals and durable medical and other supplies. Regulating pricing of hospital and provider care and this may be related to the need for a different approach to regulating and funding healthcare.
- Allow individuals to purchase insurance across state lines and to pool bargaining power through non-employment based organizations.

5. Do you agree that access to health care coverage needs to be addressed? If so, what steps would you recommend?

YES	NO
12	1

Comments:

- Improved bandwidth for effective telehealth; greater investment in repayment programs for rural clinicians (akin to NHSC); greater availability of urgent care
- A Medicare for all or single payer system (paid for by taxes) should be an option--with a second (higher) tier of care available for those willing to pay--as exists for "private pay" consumers in other countries.
- Affordability
- Medicaid expansion must be completed; state could develop a robust reinsurance to make individual coverage more affordable
- Access to care is important but in a rural state very difficult. I think more telemedicine needs to be made more accessible but the smaller hospitals will not be able to provide all services to all patients some more critical care will need to be centralized
- I do not see an issue with access. The issue is cost
- All Mainers should have access to affordable health care coverage that does not requirement to spend more than a certain percentage of their household income on out of pocket costs or premiums
- Like car insurance, reward "good drivers". Allow large private insurers to include members on large client plans
- PL 90
- This needs to be multifaceted. One possibility is to get Medicaid and Medicare meet in the middle, with public supplemental coverage for people in a certain income range
- Price is the biggest barrier to access. Stop mandating what plans must include so that people can buy only what they need. Establish more price competition by allowing people to purchase plans across state lines. Promote HSAs and high-deductible plans.

6. Do you agree that administrative costs in the current health care system need to be addressed? If so, what steps would you recommend?

YES	NO
12	1

Comments:

- Improvements in wider availability of clinical information (within parameters of HIPAA protections)

- The administrative overhead costs of private, for profit health insurance should only be kept for "private pay" higher level health care--immediate access to surgery when desired but not medically necessary, private hospital rooms, etc.
- But it is- like fraud and abuse- is an easy target and not the largest cost driver. We already limit insurer costs via MLR and need to look at the complexity of the system as an admin cost driver, e.g. separate billing processes could be standardized
- Administrative costs for both providers and carriers. Right now carriers are limited to 15% administrative costs I would suggest that we look at similar limitation on the provider side as well as the facility costs. A billion dollar expansion will make health in Maine less affordable and less accessible to most Mainers
- There are simpler models like DPC in terms of administrative costs, but we need to be careful thinking about reducing admin costs with regulations as they often contribute to admin costs in the first place.
- Administrative costs are far too high and the complexity of the current system is unnecessary.
- Audit...healthcare providers bill "all they can get" on the claim. Unnecessary tests or not honestly completed services i.e. billing for a manipulation after only a five minute discussion
- One form to fit all claims would be a good start. PCP law does away with all the insurance paper work hassle.
- The best way to deal with this is to un-complicate the oversight and quality and funding systems in order to decrease the administrative requirements.
- Give purchasing power to patients instead of government and insurance companies so that the structure of the healthcare system is built to serve patients, not government and insurance company bureaucracy.

7. Do you agree that the cost and pricing of health care services need to be addressed? If so, what steps would you recommend?

YES	NO
12	1

Comments:

- Yes, true transparency of what hospital charge for services
- But not sure. One step: cost-free medial education for those willing to enter a public health service--whether generalist or specialist.
- Price comparison shopping with incentives
- Meaningful and complete transparency is needed in addition to connecting the buyers and sellers more directly.
- I think that ultimately prices for health care services will have to be set. The market has failed to keep prices low enough for us to afford.
- Reduce overbilling and needless services through audit, patient review of their claims to assess accuracy
- Encourage consumer participation...Right to shop is a great start and already working. Importing Pharma drugs that are clean will save Americans a lot and force the US Pharma's to compete. Competition works every time.

- Repeal the certificate of need law so more providers can enter the market. Support healthcare savings accounts so we can put purchasing power in the hands of patients to drive price competition between providers.

8. Do you agree that the cost and pricing of prescription drugs need to be addressed? If so, what steps would you recommend?

YES	NO
13	0

Comments:

- Greater alternatives (competition) to break up market power of certain single source Rx; widescale application of 340B drug pricing
- Allow negotiation by all consumers at all levels. Also, study and employ strategies used in England, Canada and other countries where prices are much lower.
- Collective bargaining and purchasing
- A fast growing but still small part of spend. Rate-setting of high cost drugs; transparency of PBMS and alternatives to same- too many hands in the supply chain adds to cost
- Price transparency as well as quicker introduction of generic drugs to the market place
- Increased FDA, SEC, and DOJ oversight and penalties.
- Again transparency is the first step. We also need more distribution options such as dispensing through the doctor's office and clinic/office settings for infusions. We need patients to have incentives to seek lower cost options and delivery settings
- I think Rx re-importation from Canada is a good place to start
- Reduce pathways to competition with manufacturers; patent extensions and exclusivity deals foster drug monopolies
- There should be some regulation that requires a cost analysis and range of profit
- Streamline the FDA approval process so it doesn't cost billions and take 10 years to bring a new drug to market

9. Do you have any ideas for other state-level policy changes to improve the current health care system? Incremental or short-term improvements?

Comments:

- Restrict short term limited duration insurance to 3 months;
- Ensure association health plans pay for the externalities associated with creaming the best risk out of the individual market;
- Combine MHDO and HIN into a quasi public-private entity that isn't hemmed in by its type of financing
- Link health maintenance and preventative measures with providing lower cost insurance. Real prevention--smoking cessation, weight loss and control (managing the obesity epidemic), nutrition and exercise programs for both healthy and at-risk people. Run a pilot for a study, and see what savings can be achieved.
- Public option
- Medicaid expansion

- Require all insurance sold in individual market to be in one risk pool
- Require all health care purchased with public dollars to jointly purchase and negotiate prices;
- Develop a public option or buy in to the aforementioned public payers plan
- I don't believe state level policy will be enough. It needs to be federal universal coverage
- Repeal of certificate of need laws or remove barriers to entry for new providers. Continued steps to improve transparency of pricing.
- I believe we'll have to do something to address health care pricing -- something like the Maryland model or other global budgeting solution
- Bring Private health insurers in the room and say we are going to take this away from you bit by bit with policy if you don't come back with a plan that works for all age levels at reasonable premiums
- Activate PL 90
- No, not without the kind of deliberation that this task force is doing.
- Give all state employees the option to switch their current healthcare plan for an HSA paired with a high-deductible plan. Allow them to invest the savings from switching to a high deductible into their HSA. Government is the largest single employer in Maine and putting purchasing power directly into the hands of so many patients will force the industry to cater more to direct payers.

10. The task force is required to develop at least 3 proposals for providing coverage for all. Which model or models should the task force pursue? Please rank in order of highest to lowest priority.

2.82	a. A design for a government-administered and publicly financed universal payer health benefits system that is decoupled from employment, that prohibits insurance coverage for the health services provided by the system and that allows for private insurance coverage of only supplemental health services
2.83	b. A design for a universal health benefits system with integrated delivery of health care and integrated payment systems for all individuals that is centrally administered by State Government or an entity under contract with State Government;
3.92	c. A design for a public health benefits option administered by State Government or an entity under contract with State Government that allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans; or
3.67	d. A design for a private system consistent with state and federal law
2.57	e. Other (please describe)

Task Force on Health Care Coverage for All of Maine
Structure of the Health Insurance Market Study Group
April 2nd Update

The Structure of the Health Insurance Market Study Group met on Monday, March 26, 2018. The following members of the Study Group were present: Rep. Anne Perry, Kristine Ossenfort, Joel Allumbaugh and Frank McGinty.

The Study Group developed the following draft framework after their initial discussion.

Intended Approach: The Study Group intends to focus on policy solutions that will target certain populations experiencing problems related to health insurance coverage in the existing market. The following examples were discussed:

- Individuals who have incomes below 100% of the federal poverty level who do not qualify for the APTC (advanced premium tax credit);
- Individuals who are “lightly subsidized” and particularly sensitive to health insurance premium increases; and
- Individuals who have incomes above 400% of the federal poverty level who do not qualify for the APTC (advanced premium tax credit).

Principles: The Study Group preliminary determined that any policy solutions should be organized around certain agreed-upon principles. One of the principles discussed in the initial meeting was the importance of elasticity in the health insurance market.

Barriers: Current federal law and uncertainty related to the action/inaction of the federal government are significant barriers to the possible policy solutions outlined below. The underlying cost of health care also has an impact on the health insurance market so there will be overlap with the efforts of the Cost Containment Study Group.

Possible policy options: The Study Group outlined several possible policy options, including, but not limited to *{suggested that group identify the pro’s and con’s of each policy option, the barriers to implementation, the avenues for implementation and the group’s position on each option before sharing with larger group}*:

- ❖ Development of a Section 1332 Waiver to resume operations of the Maine Guaranteed Reinsurance Association (MGARA);
- ❖ Statutory changes to MGARA, such as adding the ability to reinsure small group claims;
- ❖ Amend the definition of small group;
- ❖ Merge the individual and small group market;
- ❖ **Segregate the individual market risk pool;**
- ❖ Require an individual mandate to have health insurance coverage or consider other measures to incentivize the purchase of health insurance coverage;
- ❖ Consider state-level limits/restrictions on short-term health insurance policies;
- ❖ Consider impact of loss of federal funding to insurers for cost-sharing reductions.

Task Force on Health Care Coverage for All of Maine
Cost Containment Study Group
April 2nd Update

The Cost Containment Study Group met on March 28. The following are members of the Study Group: Sen. Brownie Carson, Rep. Paul Chace, Jeff Austin, Mark Hovey and Trish Riley.

The outline below summarizes the group's initial discussion of the following areas of interest:

1. Identify opportunities to reduce administrative overhead cost in the billing/claim processes
 - a. Workflow entire process including Consumer, Provider, Hospital, TPA, Insurer, PBM, etc.
 - b. Standard claim form
 - c. Redundant/overreaching/ bureaucracy/regulations i.e. Mandatory Charity Care
 - d. Additional choice of standard Medicare rules plus % w/ add ons and COLA
2. Identify opportunity to lower RX cost/growth rate
 - a. Rx Wholesale Importer
 - b. Individual Rx opportunity similar to CanaRx
 - c. PBM and Pharmacy transparency (discounts)
3. Change behavior to avoid medical care cost
 - a. Cardiac/Diabetes tax on tobacco, soda, alcohol, fast food, etc.

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States Looking for Cure to High Drug Prices



High Dollar Dilemma

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During his State of the Union speech in February, President Donald Trump declared his intention to address what he called "the injustice of high drug prices." He repeated the promise last month in New Hampshire during a press conference on opioids, vowing we would "be seeing drug prices falling very substantially in the not-so-distant future, and it's going to be beautiful."

But the particulars of his plan remain a mystery. Trump has promised those details are soon forthcoming, but states are not waiting around holding their breath. As prescription drug prices have continued to climb, over the last three years all but a handful have

adopted their own laws aimed at bringing those costs down.

According to the National Conference of State Legislatures, 44 states have adopted a total of 135 prescription drug pricing bills since 2015. States have introduced another 361 bills across 47 states this year alone. Those measures cover a wide spectrum of efforts, from requiring drug makers to justify price increases to removing so-called "gag orders" from pharmacy benefits managers (PBMs) that bar druggists from telling consumers about cheaper options for their medications.

Of the latter, NCSL Health Program Director Richard Cauchi notes that since Minnesota became the first in 2004, 14 states have adopted gag order provisions, including eight so far in 2018: Kansas, Mississippi, South Dakota, Virginia, Utah, Florida, Indiana and West Virginia. A bill awaiting gubernatorial action in New York ([AB 8781](#)) is also expected to be signed into law.

According to the [LexisNexis State Net](#) database, similar bills are also currently still working their way through multiple statehouses (see [Bird's Eye View](#) in this issue). Those include Hawaii ([SB 3104](#)), Louisiana ([SB 241](#)), New Hampshire ([SB 354](#)) and South Carolina ([SB 815](#)), where bills have all passed the Senate. Bills have also cleared the House and are awaiting Senate action in three states: Kentucky ([HB 463](#)), Maryland ([HB 736](#)) and Arizona ([HB 2107](#)). Legislation in Washington ([HB 2296](#)) received unanimous approval in the Evergreen State House in February, but died in committee in the Senate last month.

Legislation pioneered in Vermont in 2016 is also sparking a growing number of transparency bills, which require drug manufacturers to offer justifications for significant price increases. That measure, signed into law by then-Gov. Pete Shumlin (D), requires state officials to annually identify 15 drugs "on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months." From there, drug makers must provide the state attorney general's office with acceptable reasons for those price hikes, with the information then being posted online for public viewing.

California and Nevada followed suit in 2017 with their own versions of the law. California's measure ([SB 17 2017](#)) applies to brand name and generic drugs with a wholesale cost of at least \$40 that have risen in cost by at least 12 percent in the preceding year, or by 32 percent in the last two years. It also requires drug makers to give at least 90 days advance notice of that increase. The bill Nevada Gov. Brian Sandoval (R) signed ([SB 539 2017](#)) applies strictly to diabetes medications.

After the failure of a price control bill last year that included mandated rebates and caps on drug co-pays, Oregon Gov. Kate Brown (D) signed legislation ([HB 4005](#)) in March of this year that requires pharmaceutical companies in the Beaver State to justify price hikes on drugs that cost \$100 or more a month, or that have gone up more than 10 percent in the last 12 months.

According to the [LexisNexis State Net database](#), at least 15 other states introduced some form of transparency bill this session. But states are exploring even more creative methods for keeping drug prices under control.

Eight have weighed or are still pondering bills that would bar so-called "non-medical switching," where a health plan forces a patient to stop taking the medication prescribed by their doctor in favor of a less expensive option. While that in theory would seem to lead to lower overall drug costs, a [report](#) from the Institute for Patient Access contends that forcing patients to use medications with potentially less efficacy than those prescribed by their doctor could lead to even more medical care and additional prescriptions.

At least 13 states have introduced or carried over measures this year similar to so-called "price gouging" legislation signed into law in Maryland in 2017. That bill ([HB 631 2017](#)) empowers the Old Line State to take legal action to block what it deems to be an excessive prescription drug price increase. And at least 10 more states have weighed bills to seek permission to contract with wholesale pharmacies in Canada, where drug prices are substantially lower than in the States.

Accessing Canadian pharmacies is hardly a new idea. Federal law has allowed it since 2003, with the caveat that states first receive permission from the U.S. Secretary of Health. Therein lies the rub: amidst fierce opposition to such imports by U.S. pharmaceutical companies, permission has never been granted even once, and current HHS Secretary Alex Azar – a former executive at Eli Lilly and company – has yet to indicate any willingness to be the first.

States are also not the only ones looking north for price relief. American consumers buy Canadian prescription medications online every day. But it is a process fraught with risk. According to the U.S. Food and Drug Administration, [only about 3 percent](#) of online pharmacies meet U.S. safety standards, and many alleged Canadian pharmacy sites are actually located in countries like China, Russia and India. Many sell meds that are unapproved or even counterfeit.

None of this was a deterrent for Utah Rep. Norm Thurston (R), a self-described "free market guy" who authored his state's measure ([HB 163](#)) earlier this year. He said escalating drug prices are not a result of good free market practices and that combatting them should not be a partisan issue.

"We would be bringing in drugs intended for the Canadian market, and therefore at Canadian pricing," Thurston [told Kaiser Health News](#) in February. "One would assume if we could come up with a program that meets the recommendations of federal law, what justification would the [Health and Human Services] secretary have for saying no?"

Azar, however, won't get the chance to decide, at least in regard to Utah. Thurston's measure cleared the House but died in committee in the Senate.

Big Pharma [has spared little cost battling these and other measures](#) at both the state and federal levels, and the industry is suing to block new laws in [California](#), [Nevada](#) and [Maryland](#).

Even so, states remain more than willing to continue devising solutions of their own. Anthony Wright, executive director of the advocacy group Health Access California, says there is a good reason for that.

"The federal level is even worse," he says. "The president talks a good game, but his solutions so far have been to just give the drug companies anything they want, including having a former Eli Lilly executive running HHS."

But as NCSL's Cauchi notes, we are probably a fair distance out from knowing which, if any, of these new state laws will produce the kind of results Wright and others are looking for either.

"All of these laws are definitely interesting, and other states are definitely watching to see what happens," he says. "But it does seem to be on the early side to have enough data to know how the implementation is going."

If, as the president says, the looming specter of a federal overhaul does become reality this year, the biggest question of all might be whether they will get that chance.



By Rich Ehsen