AMERICAN COLLEGE OF RHEUMATOLOGY
POSITION STATEMENT

SUBJECT: Drug Pricing

PRESENTED BY: Committee on Rheumatologic Care

FOR DISTRIBUTION TO: Members of the ACR
Centers of Medicare and Medicaid Services
Pharmacy Benefit Management Companies/Managed Care Entities
Members of Congress

POSITIONS

1. All patients should have safe, convenient and affordable access to rheumatology treatments that control disease activity and prevent permanent joint and organ damage, thereby limiting disability and early death.
2. The ACR supports rational policies that mitigate rapid escalations in pricing of rheumatologic drugs.
3. Transparency should be encouraged in the policies used by pharmaceutical manufacturers, pharmacy benefit managers and health insurance companies to determine prescription drug prices.
4. The ACR believes that a safe and efficient biosimilar approval pathway and marketplace will improve access to treatment by lowering costs.
5. Any comprehensive proposal to deal with rising drug prices must simultaneously address these primary concerns: cost to the healthcare system, continuity of care, and out of pocket affordability to patients.
6. The ACR support preserving patient access to physician-administered drugs by recognizing the rheumatologists' role in providing specialized, continuous care.

BACKGROUND

The past 40 years has brought about dramatic improvement in the ability to treat rheumatic disease. Due to rigorous scientific study, the optimal medication, dosing, and timing of treatment are better understood than at any time in history. The modern medication development process, to include clinical trials, has improved the understanding of medication dosing, timing of use, length of treatment and toxicities. Advances in bioengineering have resulted in new classes of medications, such as the biologic medications first approved for rheumatology diseases in 1998. Biologic medications now represent some of the most powerful therapies available for those afflicted by rheumatology diseases. Many diseases that once led to high levels of morbidity are now better controlled with significant reductions in disability and pain and improvements in overall health (1).

Unfortunately, these improvements have been associated with higher costs, with subsequent limitations in access for some. Historically, as medication patents expire and drugs become generic, costs are significantly reduced with resulting increase in access for patients of all income levels. Unfortunately, in

recent years perturbations in this process have arisen. Hydroxychloroquine and methotrexate, two generic drugs that have become the backbone of rheumatoid arthritis treatment by virtue of their effectiveness and affordability, have seen shortages and dramatic price swings from month to month (2). Colchicine, long a staple in the treatment of acute gout, had its price increase over 5000% in 2010 after market exclusivity was given to URL Pharma for completing a safety study on this drug that predated the establishment of the FDA (3). The rapid increases in the price of many established treatments have led many Americans to struggle with paying for necessary medications (4). Generic drug price escalations such as those for methotrexate, hydroxychloroquine and colchicine are not unique to rheumatologic care, and the FDA and federal government have become increasingly involved (5, 6).

In addition to increases in the cost of medicine, the price of insurance coverage has continued to rise yearly with both higher premiums and deductibles (7). The increased financial burden on patients can lead to decreased health care use that has included prescription abandonment, lack of initiation of recommended medications, and lack of persistence with medications (8).

While newer biologic medications have brought about improved control of disease, especially in those with severe disease, the cost of these interventions is notably higher and rising yearly. The current mechanism for those with private insurance to obtain biological and newer small molecule medications involves a complex interaction that involves the manufacturer, the Pharmacy Benefit Manager (PBM), and the Insurer. The PBM acts as the "middleman" in this transaction, generally deriving concessions from manufacturers (such as rebates on the drug price), in return for placing certain drugs on payer formularies. The disposition of these concessions is rarely clear, although it is clear that PBMs derive significant profit. It appears that the need for manufacturers to offer rebates on drugs increases the pressure to raise list prices (9). There is clear evidence of list prices escalating, with the cost for adalimumab (Humira®), a biologic medication that is used to treat a number of rheumatologic and other inflammatory conditions, increasing over 100% in the past 5 years (10). The yearly price hike has dramatically outpaced inflation despite the lack of clinically significant modifications to the medication or major changes in the production process. The overall process of pricing and contracting is hidden from public view, such that the exact nature and profit margin taken by those involved is not disclosed to the largest stakeholder in the process, the patient.

Biological medications for rheumatologic diseases have been available since 1998 with the FDA approval of etanercept (Enbrel®). Many products that began the wave of available biological medications are now off of patent or nearing the end of their patent. Several biosimilar medications, drugs that are nearly identical in chemical structure to the original biologic and produce comparable clinical outcomes, are now available in the US with many more close to FDA approval. These clinically biosimilar drugs have lowered the price of the original biological medications in Europe by close to 80% in some cases due to competitive bidding and a marketplace with more governmental driven healthcare (11, 12). In the US, however, despite 7 biosimilar medications being approved for rheumatoid arthritis (as of early 2019), only 2 are being actively marketed. This discordance is rooted in litigation and in settlements between the manufacturers of the bio-originator (the original biologic drug) and the biosimilar medications. Many of the biosimilars that are approved in the United States are currently in use in Europe, but will take years to be available in the United States (13). Even when the biosimilar medication is available and marketed in the United States, there has been a significant lag to obtain market share. The slow uptake has been limited due to a business model that makes the established, more expensive bio-originator more lucrative to the insurer and PBM and thereby distorts price competition. The shift toward mergers of large companies and inflated drug prices has diminished the

expected price decline of biologics with the availability of biosimilar medications (13). Despite the slow change in pricing, recent evidence does demonstrate that biosimilar competition can drive the price of biologic medications lower in the United States. In 2018, the first significant changes in infliximab pricing were noted, with a drop of close to 30% being reported (14). Infliximab is currently the only market where the bio-originator competes directly with two biosimilar medications.

A number of treatments for rheumatologic conditions are administered by the provider in the office setting. Many of these are administered parenterally by the medical provider in a monitored setting. Rheumatologists must acquire these drugs in a timely fashion for patient treatment, inventory, and store them to ensure drug delivery in a safe setting by expert clinical personnel. As such, rheumatologists occupy a critical "patient focused" segment of the drug distribution channel, and rely upon revenue from drug purchasing to maintain these services. Recently, both commercial and government payers have proposed removing rheumatologists from this process with concern related to the cost of these medications and concern over drug choice being driven by profit.

When evaluated in depth, however, it is of note that recently the cost of the intravenously administered drugs (given in an office setting) have essentially matched inflation while the self-administered drugs have increased much more dramatically (in some cases over 100% in 5 years) (10, 15). Other analysis has demonstrated that the choice in medication for Medicare Part B drugs was not influenced by reimbursement to the provider (16). The unintended consequences of limiting the administration of medications given in the office could not only increase the overall cost, but it could also limit access for many. The resulting loss of patient access to safe treatment in a monitored setting would have a negative impact on the health and outcomes of this most vulnerable of patient populations.

Care of those afflicted with rheumatic disease takes place in a large spectrum of practice settings from small practices to large hospital-based systems. As policy is developed to help slow health care expenditures, caution must be exercised to minimize the disruption in the patient-provider relationship across these settings. Any changes that are considered should take into account the financial impact on the patient and the ability of the practice to care for the patient. A reduction in reimbursement has the potential to reduce patient access to less expensive medications, such as intravenous biological medications, or even to their local rheumatologist.

In aggregate, the dramatic increases in the cost of essential medication, lack of competition for the most expensive medications and changes in the private insurance landscape across the United States have left many patients struggling to afford the necessary treatment for their disease. Any future changes in policy will need to give consideration to the multitude of factors that affect the cost of care. Thoughtful policy change will help ensure that all patients receive safe, convenient and affordable access to rheumatology treatments.

REFERENCES

1. Kievit, W, Fransen, J, Maarten de Waal, M, den Broeder, AA and van Riel, Piet LCM. 2013. "Treatment changes and improved outcomes in RA: an overview of a large inception cohort from 1989 to 2009." *Rheumatology* 52: 1500-1508. doi:10.1093/rheumatology/ket166.
2. Kesselheim, AS, Avorn, J, and Sarpatwari, A. "The High Cost of Prescription Drugs in the United States." *JAMA. doi:10.1001/jama.2016.11237* 316 (8): 858-871. doi:10.1001/jama.2016.11237.

3. Kesselheim, AS and Solomon, DH. Incentives for drug development--the curious case of colchicine. N Engl J Med. 2010 Jun 3; 362(22):2045-7. doi: 10.1056/NEJMp1003126.
4. Bernstein, S. 2017. "The Rheumatologist." *The Rheumatologist Website.* June 14. Accessed 1 11, 2019. https://www.the-rheumatologist.org/article/rheumatologists-concerned-high-healthcare-costs-may-encourage-patients-forgo-delay-treatment/?singlepage=1&theme=print-friendly.
5. Gottlieb, S, and Woodcock, J. 2018. "FDA is Advancing New Efforts to Address Drug Shortages." Accessed 1 12, 2019. https://www.fda.gov/NewsEvents/Newsroom/FDAVoices/ucm626108.htm
6. Gottleib, S. "Statement on new steps to enhance competition, access and lower drug prices". Published Jan. 3, 2018. Accessed Feb 3, 2018. https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm591184.htm
7. Claxton G, Rae M, Long M, Damico A, Whitmore H, Foster G. 2016. "Health Benefits In 2016: Family Premiums Rose Modestly, And Offer Rates Remained Stable." *HEALTH AFFAIRS* 35 (10): 1908–1917. doi:10.1377/hlthaff.2016.0951.
8. Doshi, JA, P Li, VP Ladage, AR Pettit, and EA Taylor. 2016. "Impact of Cost Sharing on Specialty Drug Utilization and Outcomes: A Review of the Evidence and Future Directions." *Am J Manag Care* 22 (3): 188-197.
9. Grant, C. "Hidden Profits in the Drug Prescription Chain" The Wall Street Journal Online. https://www.wsj.com/articles/hidden-profits-in-the-prescription-drug-supply-chain-1519484401. Accessed Feb 3, 2019.
10. Hakim, D. "Humira's Best-Selling Drug Formula: Start at a High Price. Go Higher." The New York Times. *Published* Jan 6, 2018. Accessed Jan 11, 2019. https://www.nytimes.com/2018/01/06/business/humira-drug-prices.html.
11. Ashok J, Upton A, Dunlop WC, Akehurst R. 2015. "The Budget Impact of Biosimilar Infliximab (Remsima) for the Treatment of Autoimmune Diseases in Five European Countries." *Adv Ther* 32: 742–756.
12. Mehr, S. "Abbvie's Humira Price Cuts Don't Win the Business in Denmark" Published Nov 21, 2018. Accessed Feb 3, 2019. https://biosimilarsrr.com/2018/11/21/abbvies-humira-price-cuts-dont-win-the-business-in-denmark
13. FDA Statement. "Remarks from FDA Commissioner Scott Gottlieb, M.D., as prepared for delivery at the Brookings Institution on the release of the FDA's Biosimilars Action Plan." July 18, 2018. Accessed Jan 12, 2019. https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm613881.htm
14. Sagonowsky, E. "As competition heats up, U.S. prices for Remicade and biosims slip: analyst" Published Dec 11, 2018. Accessed Feb 3, 2019. https://www.fiercepharma.com/pharma/amid-biosim-competition-remicade-prices-gradually-slipping-analyst
15. The Moran Company, "Trends in Weighted Average Sales Prices for Prescription Drugs in Medicare Part B, 2007-2017. December 2017.
16. Xcenda Original Research: Do Providers Choose Treatment Based on Payment Amount? Published Sept 19, 2018. Accessed Feb 3, 2019. https://www.xcenda.com/news-and-events/news/0918_xcenda-research-medicare-part-b-provider-utilization

Approved by Board of Directors: 02/2019