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Connecticut Proposal to Cap Drug Price Increases Could Portend a Shift in the Drug Pricing Debate

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On March 15, 2022, a drug pricing bill proposed by Connecticut Governor Ned Lamont's (S.B. 13) was referred to the state legislature's nonpartisan legal counsel responsible for drafting and processing official legislation. The proposed legislation, which would cap increases on pharmaceutical drugs to the rate of inflation plus 2%, is notable because it represents a relatively aggressive approach to addressing high drug prices. The legislation would also establish a program to authorize the importation of Canadian pharmaceuticals into the state.

While states have played a progressively central role in the drug pricing debate over the last decade - the upshot of the practical impact of rising drug prices on state budgets - most enacted legislation has focused on transparency or contracting restrictions on pharmacy benefit managers (PBMs) and manufacturers. A few states have passed laws to allow for importation of drugs from Canada, and a few others have placed caps on out-of-pocket spending on certain types of medication, such as insulin (out-of-pocket spending limits on insulin is also the subject of a Medicare demonstration, and a proposal included in President Biden's Build Back Better legislation).

However, express limits on price increases that are tied to inflation – referred to often as "inflation caps" – have generally been considered well outside the Overton window. This may be changing, however. Legislation similar to S.B. 13, which is based off of model legislation from the National Academy for State Health Policy (NASHP), was also introduced in Massachusetts, Hawaii, Maine, and Washington last year. The inclusion of Massachusetts stands out here given the legislation was proposed by the Republican Governor Charlie Baker.

Similar to the other state bills modeled after the NASHP model legislation, Connecticut's S.B. 13 imposes a penalty on noncompliant manufacturers of 80% of the difference between the revenue received from a given drug that exceeded the price cap and the revenue the manufacturer would have received if it had complied with the price caps. In essence, the manufacturer would only collect 20% of the revenue for a drug above the price cap. The legislation also requires a manufacturer to provide 180-days' notice prior to discontinuing the sale of a drug in the state.

It's unclear whether the legislation has any real chance of becoming law. As noted, similar legislation failed to advance in Connecticut last year, and the bill has already garnered its share of opposition from business groups and other industry trade organizations, with opponents of the bill

arguing that it will stifle innovation and lead to supply shortages for drugs. Others have simply argued, apocryphally, that the increase in drug prices is not a real issue. Similar arguments were made in opposition to the Massachusetts bill proposed last year, and have long been proffered by opponents of all forms of drug pricing legislation. While this is hardly the forum to interrogate and flesh out the trade-off between the various proposals floating around to limit drug prices and the resulting impact on innovation and supply, one can acknowledge that such concerns are not without merit while also recognizing that there are numerous examples of Western European countries imposing some form of reference pricing while continuing to provide a high level of access to medication.

A more interesting question is why are inflation caps suddenly becoming a part of the drug pricing debate in the U.S., and what does that say about political and economic realities of the moment, as the price of drugs continues to become a central political issue. Legislation like S.B. 13, along with federal and state proposals in recent years to tie drug prices to international index pricing, and caps on out-of-pocket spending for certain drugs, are part of a trend of drug pricing proposals that eschew indirect mechanisms to control prices – such as transparency or prohibitions on gag clauses that represented earlier state legislation on drug pricing – in favor of more direct and blunt policy approaches that appear to take the position that the easiest way to limit drug prices is to limit drug prices.

Despite this, S.B. 13 in nowhere near as radical as its proponents or opponents would argue. For one, it sets the reference price for a drug based on Wholesale Acquisition Cost (WAC), which is basically an estimate of the manufacturer's list price for a drug to wholesalers and direct purchasers, excluding any discounts or rebates. Post point-of-sale price concessions such as manufacturer rebates can significantly reduce the price paid for a drug, and its unclear how effective S.B. 13 would be at actually limiting price increases when it is tied to WAC. Further, while the impact on innovation of such legislation is up for debate, it is much harder to look past the fact that manufacturers could simply stop selling drugs in the state in response. As noted, the bill requires 6-months' notice for a manufacturer to discontinue selling the drug in the state, but there is nothing to expressly stop a manufacturer from pulling the drug, something that could lead to access issues for Connecticut residents. Despite the heavy presence of pharmaceutical manufacturers in the state, Connecticut lacks the sort of market power held by states like California, Texas, and New York, where most manufacturers would be loath to disengage with.

Still, it will be interesting to see whether the bill can garner any momentum, and whether more states will begin to seriously consider such measures. Either way, the Connecticut bill shows that we have entered a new stage in drug pricing debate - one where ideas that have previously been dismissed or ignored could begin to gain traction.

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