STATEMENT

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Concerning Oregon Senate Bill 872

March 19, 2019

The Pharmaceutical Research and Manufacturers of America (PhRMA) supports SB 872's efforts to look beyond biopharmaceutical manufacturers to the broader supply chain which has played a significant and growing role in determining the cost of medicine to patients. While there are elements of this bill that PhRMA supports, there remains significant concern related to SB 872's failure to protect confidential and proprietary information as required by state and federal law, as well as requiring that the "wholesale price" be included in DTC advertising.

Discussions about the cost and affordability of medicines are important. No patient should have to worry about whether they can afford the health care they need. However, the notion that spending on medicines is the primary driver of health care cost growth is false - and ignores cost savings that medicines provide to the health care system overall. Medicines lead to fewer physician visits, hospitalizations, surgeries and other preventable procedures – all of which translate to lower health care costs. New medicines are making crucial contributions to medical advances, changing the direction of healthcare as we know it.

Prescription medicines have transformed the trajectory of many debilitating diseases and conditions, including HIV/AIDS, cancer, and heart disease, resulting in decreased death rates, improved health outcomes, and better quality of life for patients. Better use of medicines could eliminate up to $213 billion in US health care costs annually, which represents 8% of the nation's health care spending.[1] Better use of medicine yields significant health gains by avoiding the need for other, more costly, medical services.

Meaningful transparency that is helpful to patients must include the entire supply chain of stakeholders

SB 872 correctly recognizes the role of other supply chain entities in prescription drug costs. There are a variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy benefit managers (PBMs), wholesalers, hospitals, and government agencies like Medicaid. For example, pharmacy benefit managers and payers—which dictate the terms of coverage for medicines—use their control over which medicines patients can access as leverage to negotiate substantial rebates and discounts. The role these entities play, and the impact they have on patient cost and access is acknowledged by this legislation, which is an important step toward addressing concerns in a realistic and comprehensive manner.

[1] IMS Institute for Health Care Informatics

According to a 2017 Berkley Research Group (BRG) report[2], in 2015 branded manufacturers paid health plans and pharmacy benefit managers approximately $57.7 billion in rebates and fees, paid $28 billion in Medicaid rebates, nearly $6 billion to close the Medicare Part D "donut hole", nearly $5 billion to Tricare and the Federal Supply Schedule in discounts, $3 billion for the ACA fee, and nearly $7 billion to support patient cost sharing assistance. In fact, brand manufacturers provided more than $379 million in Medicaid rebates toward Oregon's Medicaid program in 2017.

Further, the BRG report notes that brand biopharmaceutical companies realized just 39% of total gross drug spending, which is based off the list prices of medicines before rebates, discounts and fees are calculated. This is down from 41% in 2013 due to increases in the rebates and discounts paid to PBMs and payers. Only 47% of net drug expenditures were realized by manufacturers. Increased rebates and discounts have largely offset increases in list prices and reflect the competitive market for brand medicines. The same study found that the percent of branded drug spend going to supply chain entities has gone up over the last three years while the amount realized by the manufacturer has decreased.

Insurers, PBMs, and insurance benefit design determines what patients pay at the pharmacy counter

New therapies are transforming care for patients fighting debilitating diseases like cancer, hepatitis C, high cholesterol and more. In the midst of all this progress, spending on medicines grew just 0.4 percent last year according to one of the nation's largest PBMs. Unfortunately, it doesn't feel this way for patients. Insurers are increasingly using high deductibles, which result in patients paying the full list price for their medicines, even if their insurers receive significant discounts. And middlemen, like pharmacy benefit managers and insurers, have been shifting more of the costs of health care to patients for years – with deductibles increasing 350 percent since 2006. Ultimately, your insurer determines what you pay for your medicine out of pocket. Private payers receive significant rebates and discounts, yet these negotiated discounts are not shared with patients who pay a deductible or a coinsurance -- a percentage of costs a patient is responsible for paying out of pocket -- for their medicine at the pharmacy.

There is no one price for a medicine, as prices paid by wholesalers, pharmacies, PBMs, hospitals and health plan sponsors all vary and are determined by negotiations between stakeholders, each with varying degrees of negotiating power. For example, large pharmacy benefit managers (PBMs) that negotiate on behalf of Oregon health plan sponsors and manage benefits for tens of millions of patients across the country can leverage their national market power to obtain substantial discounts and rebates on brand medicines for Oregonians.

In fact, just three PBMs control over 70 percent of the national marketplace. Proposed mergers and vertical integration would further increase this consolidation. Because of the consolidated negotiating power of these purchasers, net prices of brand medicines increased only 1.9 percent in 2017, compared to a 6.9 percent increase in list prices.[3] The magnitude of these manufacturer price concessions is material. Total rebates and discounts paid by manufacturers have increased from $74 billion in 2012 to $166 billion in 2018.[4] The question is who is getting all that money?

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[2] Berkley Research Group, The Pharmaceutical Supply Chain:
https://www.thinkbrg.com/media/publication/863_Vandervelde_PhRMA-January-2017_WEB-FINAL.pdf

[3] IQVIA Institute. Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022. April 2018

[4] https://www.wsj.com/articles/dont-blame-drug-prices-on-big-pharma-11549229031

However, the single most significant factor in determining how much Oregon patients pay for a prescription is insurance benefit design, not the list or net price of a medicine. After accounting for all rebates and discounts, prices for brand medicines have grown at rates in the low single digits for the past five years, yet many patients have experienced rapidly increasing out-of-pocket costs as insurers have steadily raised co-payments and deductibles and employed use of percentage-based co-insurance to be paid by patients. Over the past 10 years, there has been an increase in patient cost-sharing as compared to health plan costs. For workers with employer sponsored health insurance, out-of-pocket spending in the deductible phase increased by 230% and coinsurance payments increased by 89%, compared to a 56% increase in payments by health plans.[5]

Hospital prescription drug markups are significant

Hospitals also markup the cost of prescription medicines, which increases the cost of those medicines to the overall health care system. Medical-benefit drug costs are more than twice as much in the hospital outpatient setting versus the physician office for commercial patients receiving treatments for autoimmune disorders and oncology, for example. Due to these types of hospital markups, the hospital outpatient setting is typically the highest cost setting for administration of medical benefit drugs.[6] For commercial payers, hospitals are often paid two to three times as much for prescription medicines as physician offices. These hospital markups translate directly into higher drug spending—regardless of how manufacturers set list prices.[7] Medicines charged to patients in the hospital setting were marked up nearly six times in 2013 (5.9 cost-to-charge ratio).[8] Inflated hospital charges are passed along to insurers, patients and consumers in the form of exorbitant bills and increased premiums.

Confidential trade secret information must be protected

The unprecedented breadth of HB 4005's disclosure obligations, both in the 2018 legislation and as reflected in the Department of Consumer and Business Services' (Department) rule, presents serious constitutional concerns, including under the Takings Clause, the Dormant Commerce Clause, the Supremacy Clause, and the First Amendment. As we have previously expressed, PhRMA would like to reiterate the importance of protecting against the disclosure of confidential trade secret information, as required by law. It is well established that trade secrets are private property, and, as such, the state cannot "take" (i.e., disclose) trade secrets without providing just compensation. Nor may the state deprive manufacturers of their property interests in their trade secrets without being afforded due process. Under HB 4005 (2018) and the Department's rule, however, we are concerned that the state could publish a manufacturer's most confidential and proprietary trade secrets on the Internet without providing manufacturers with "[t]he fundamental requirement of due process"— "the opportunity to be heard at a meaningful time and in a meaningful manner."[9]

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[5] Claxton G, Levitt L, Long M, et al. Increases in cost-sharing payments have far outpaced wage growth. Peterson-Kaiser Health System Tracker. October 4, 2017. https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/

[6] Medical Pharmacy Trend Report: 2016 Seventh Edition. Magellan RX Management. 2017

[7] Fein, AJ. New Data: How Outrageous Hospital Markups Hike Drug Spending. Drug Channels. 2016.

[8] Bai G, Anderson GF. US hospitals are still using chargemaster markups to maximize revenues. Health Affairs. 2016 Sep 1;35(9):1658-64.

[9] *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976)

Requiring the "wholesale price" could cause confusion, treatment delays for patients, and violates the First Amendment

This bill requires the "wholesale price" to be included in DTC advertising. However, this proposal suffers from several problems. First, it will be confusing to patients because the price they pay at the pharmacy counter is determined by their insurance benefit design and usually not the wholesale price. Second, this policy poses serious legal problems by violating the First Amendment. Lastly, the biopharmaceutical industry is already working toward a voluntary solution. This includes voluntarily using DTC television advertisements to direct patients to more information about the cost of their medicines—including medicine list price and typical out-of-pocket costs or other context about the potential cost of the medicine and available financial assistance—combined with a first-of-its-kind patient affordability platform with robust price, cost and financial assistance information. Patients need the right kind of information to make informed choices. This proposed policy would do more harm than good.

The Value of medicine and the role it plays in improving health and controlling broader healthcare costs cannot be overstated

I. Medicines are a small, stable part of health care spending

National Health Expenditure data released earlier this year underscores this point showing medicine costs to be a small, stable part of health care spending. As part of new data released on February 20, 2019[10], CMS actuaries estimate that between 2018 and 2027, less than 10 percent of total growth in health care spending will be attributable to retail prescription medicine. As in past years, hospital care will contribute one-third of the growth. What may be more surprising to many is that the added costs of administering health insurance – such as billing and prior authorization reviews – is expected to contribute almost as much growth in spending over the 10-year-period as retail prescription drugs.

Additionally, the narrative that prescription drug prices continue to grow at a high rate is false. Contrary to common belief, the growth rate of prescription drug costs has slowed in recent years: Net spending on medicines grew by **1.5% in 2018**, according to the IQVIA Institute (formerly the IMS Institute), Express Scripts announced drug spending increased **only 0.4% in 2018**, down from 1.5% in 2017, CVS Health reported growth in drug spending was **only 1.9% in 2017,** down from 3.2% in 2016, Prime Therapeutics reported negative growth in drug spending**, at -0.2% in 2017**, down from 2.5% in 2016, and CMS reported that retail prescription drug spending growth was only **0.4% in 2017**, down from 2.3% in 2016. Prescription drug spending is at a historic low. And prescription drug costs are expected to remain a relatively small and stable share of total health care costs into the future. This, of course, does not necessarily reconcile with what patients are feeling at the pharmacy counter, which is why looking at the whole system is so important.

II. Drug costs are the only costs in the health care system that diminishes over time, and help patients stay out of more costly settings.

It is important to note that medicines are the *only* part of the health care system where costs decrease over time. When brand name medicines face brand competition, or when they lose their patent protection and generic drugs become available, prices drop, often significantly. Today, nearly 90% of all medicines dispensed in the United States are generic and cost pennies on the dollar.

[10] Health Affairs, National Health Expenditure Projections: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1627

III. Innovative therapies provide unique value in the health care system.

It is also important to remember that advances in medicine help control health care spending. Greater patient access to prescription medicines means fewer doctor visits and hospital stays and a decrease in costly medical procedures, all of which translate into lower health care costs overall. For example, in 2014, a new drug came to the market that provided a cure for more than 90% of patients with hepatitis-C, eliminating a lifetime of hospitalizations, debilitating symptoms, and treatments with harsh side effects and replacing it with a complete cure in just 12 weeks. Often, patients with hepatitis-C needed liver transplants, which could cost almost $500,000. Since 2014, several new treatments have come to the market, further driving down the price of the medicine. Clearly, innovation and progress in the pharmaceutical industry means better outcomes and quality of life for patients and their families as well as reduced health care costs to patients and the system.

Sharing negotiated discounts is an approach that would have an immediate impact and would reduce costs to patients at the pharmacy counter

According to SSR Health[11], on average, biopharmaceutical companies give back 40 percent of the list price of medicines as rebates, discounts, or other price concessions to insurance companies, the government, pharmacy benefit managers and other entities in the supply chain in order for a medicine to be covered. These rebates and discounts exceeded $166 billion in 2018 alone[12] and are growing every year. However, patients picking up their medicine at the pharmacy counter often do not benefit from these rebates and discounts.

No patient should pay more for their medicine than their insurer. Ensuring patients receive already negotiated savings on their medicines could save certain patients across seven states up to $2,360 a year, according to new analyses from Milliman[13]. This Milliman analysis builds on a previous study[14] that shows nationwide, sharing negotiated discounts could save certain commercially insured patients with high deductibles and coinsurance $145 to $800 annually and would increase premiums by only about 1 percent or less. Some patients may see their annual out-of-pocket spending reduced, while other patients may see a monthly reduction in pharmacy costs until they meet their plan out of pocket maximum. Sharing these rebates and discounts could have an immediate benefit for patients and achieve the shared goal of saving them money at the pharmacy counter.

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The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. Since 2000, PhRMA member companies have invested more than $600 billion in the search for new treatments and cures, including an estimated $71.4 billion in 2017 alone.

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[11] Ibid.
[12] WSJ, Don't Blame Drug Prices on Big PhRMA: https://www.wsj.com/articles/dont-blame-drug-prices-on-big-pharma-11549229031
[13] https://catalyst.phrma.org/new-data-show-how-sharing-negotiated-discounts-could-save-certain-patients-hundreds-of-dollars-at-the-pharmacy-counter
[14] Milliman, Point of Sale Rebate Analysis: https://www.phrma.org/report/point-of-sale-rebate-analysis-in-the-commercial-market