Senate Bill 2170

Testimony of Senator Howard C. Anderson Jr. of District 8

Chairman Lefor and members of the House Industry Business and Labor Committee. This bill is about getting access to lower prescription drug prices for the North Dakota Public Employee Retirement System and the North Dakota Workers Compensation Program and then, by design, the rest of North Dakotans when and if the plan works for those programs.

This is actually a great opportunity for drug manufactures if they would just open their eyes. They complain about insurance and pharmacy benefit managers getting rebates and how much that takes from them. I say "get on board with North Dakota and cut the middle men out of the system and just give us a good price".

Others will speak to the prices they pay for medications and the experience they have had with the same, or very similar (a conciliation to the manufacturers) medications purchased in Canada, or other countries. This is a very real risk to our citizens as we are forcing them out of the country to get medications they must have.

This idea was developed as a model bill by the National Academy of State Health Policy with input from the American Association of Retired Persons and others. This is not price controls, this is a negotiating tool to put pressure on manufacturers to give us a good price. Much like the person who goes to Bill at Bill's Ford to bargain for a car. Bill gives him a price and he goes to Joe's Ford down the street and says, "gee I can get the same car at Bill's ford for one thousand dollars less, how about a deal".

There is no importation required in this scenario. Reference pricing is built on the ability to get data on the published prices paid by the four most populated provinces in Canada, getting the average or perhaps taking the lowest one and then saying, "This is what North Dakota would like to pay for these drugs".

Some will say, "why Canada"? Well there are many countries with lower prescription prices than the United States. But we like Canada, particularly here in North Dakota. They are our neighbors. If we go to Canada or know Canadians, we are comfortable they get good drugs and have good health care. When a drug is approved by Health Canada, we are as comfortable with it as one approved by our own Food and Drug Administration. Therefore comparing our price to theirs is comparing apples to apples.

Most of us have never heard a good explanation of why the same drug a few miles across the border sells for 40%, 30% or even sometimes 20% of the price for the same drug in North Dakota.

Will lower drug prices stifle innovation? The evidence says no. Look here for an enlightening article.

https://www.nashp.org/will-laws-to-lower-drug-prices-harm-innovation-the-evidence-says-no/

19 billion of Federal money for vaccines. The drug industry relies heavily on public funding for all forms of drug development. Taxpayer-funded research for each of the 356 drugs approved by the US Food and Drug Administration in the last decade totals $230 billion. Despite this level of public investment in drug development,

manufacturers face few restrictions on what they can charge for their drugs in the United States despite taxpayers' investments.

Oklahoma was the first state to begin this approach and I have heard some Oklahomans express that they need others to get on board so the manufacturers will decide they need everyone's business and not refuse to sell to our small states, which is one of the risks. There are penalties in the bill for a manufacturer withdrawing products, but we would hope that will not become necessary.

Now Canada may not be happy with us piggybacking on their successful efforts to hold prescription drug prices down in their country. There is a risk, if we are successful, prices might rise north of the border. They might also go down here. Perhaps we could get President Biden to trade lower drug prices for the Keystone XL pipeline.

I did see a recent article where 93 Canadian drug company executives were complaining that Canadian efforts to lower drug prices even more were going to cause delays in new product launches, etc. Just like we hear on this side of the border.

Here is how the Canadians look at their pricing system: Based on a letter from Counsel General Delouya

In terms of pharmaceutical medicines, Canada is a price setter rather than a price taker. Canada's Patented Medicine Prices Review Board (PMPRB) sets introductory ceiling prices for brand-name drugs. It also limits the amount by which the makers of patented drugs can raise their prices every year. The maximum allowable price is determined in Canada by looking at the price of the same drug in other countries, the price of other similar drugs, or a combination of both.
Another body, the pan-Canadian Pharmaceutical Alliance (pCPA) conducts joint provincial/territorial/federal negotiations for brand name and generic drugs in Canada to achieve greater value for publicly funded drug programs and patients using the combined negotiating power of participating jurisdictions. Between 2013 and 2017, agreements reached by the pCPA have resulted in substantial savings.
I urge the North Dakota Legislative Assembly to re-examine SB 2209 and 2212 with a view to the development of domestic solutions that are more in line with those employed by other industrialized countries, including Canada. **We would be happy to share with you and other legislators how we are working to address high drug prices in Canada and connect you to relevant officials in this regard.**

This bill seeks to give North Dakotans the same power over pricings as reflected above in a letter from Ariel Delouya the Counsel General of Canada.

We obtained a list of the top drugs in spending from our PERS system. I asked the analysist from the National Academy of State Health Policy to run the possible savings based on the bills design and for the top 25 in the list. They came up with a potential savings of $21,228,212.15 over just those 25 drugs.

Thank you,

Howard