March 15, 2021

The Honorable Judy Lee, Chair Senate Human Services Committee
The Honorable Kristin Roers, Vice Chair Senate Human Services Committee
North Dakota Senate Human Services Committee Members
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: **HB 1032 – Relating to the Prescription Drug Cost Transparency**
PCMA Testimony in Opposition to HB 1032

Dear Chair Lee, Vice Chair Roers and Committee Members:

My name is Michelle Mack and I represent the Pharmaceutical Care Management Association commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs. To give you a bit of information on PCMA and what PBMs are and what they do, I am including a document describing this in addition to my testimony.

As we stated in the interim committee process, PCMA supports meaningful transparency across the supply chain, including transparency that empowers patients, prescribers, clients, and policymakers to make informed decisions that lead to optimal health outcomes and lower costs. HB 1032, does not achieve these goals and therefore we oppose and urge you to give HB 1032 a Do Not Pass recommendation.

In addition, the House Human Service Committee urged a DO NOT Pass on HB 1032; unfortunately, some of the House members who were not on the Committee and did not hear the testimony, made inaccurate statements on the Floor and urged the House to override the Committee and recommendation and pass the bill. The statements made were:

1. PBMs cause drug prices to increase;
2. PBMs charge as much as 50% of rebates and put those dollars in their pockets – that North Dakota consumers end up paying; and
3. Generic drug prices go up because of PBMs.

We would like to refute these statement and set the record straight as follows:

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According to researchers, PBMs, who are hired by plan sponsors (i.e. health insurance companies, large employer and other payers) to maximize the value of prescription drug benefits, help patients and payers save $962 per person per year in prescription drug costs,[1] equaling over $1 trillion over the next 10 years.[2] Plan sponsors use these savings to benefit patients by lowering premiums, deductibles, and cost sharing.

It is always the drug manufacturer who decides what the price of a given drug will be. PBMs do not set drug prices—rather, PBMs evolved as a means to lower the cost of drug benefits by negotiating price concessions with manufacturers and pharmacies on behalf of plan sponsors, such as large employers, government programs, and insurers. In addition, PBMs lower costs by encouraging use of generics, offering specialty pharmacy services, and helping patients with drug adherence. PBMs would not serve 266 million American through all kinds of health plans if they did not bring down costs.

PBMs negotiate rebates from manufacturers of brand name drugs that compete with therapeutically similar brands and generics. Manufacturers typically provide a rebate if their product is "preferred" which means it is assigned a copay lower than that of competing products. It must be noted that rebates are not offered on all brand drugs. Therefore, it is totally up to the manufacturer as to if a rebate is offered, how much is offered and for how long.

PBMs are transparent to clients on rebates, in accordance with contractual requirements. Nearly half of employer plan sponsors negotiating to receive manufacturer rebates elect to receive 100% of the rebate amounts and pay administrative fees to the PBM. Other payers negotiate for their PBMs to receive a portion of the rebates. Plan sponsors may negotiate any combination of these payment methods and other provisions, and always have the right to audit their PBMs' performance under their contracts. **On average, PBMs pass back 90 percent of negotiated rebates from drug manufacturers, which payers use to lower enrollees' and their own health spending.**

Finally, PBMs always have encouraged the use of generic drugs. According to the Association for Accessible Medicines (AAM), 90 percent

[1] Visante, The Return on Investment (ROI) on PBM Services, February 2020.
[2] Visante, Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers, January 2020.

> of prescriptions filled in the United States are generics. When a generic alternative to a brand drug is available, the generic version is substituted for the branded drug 97 percent of the time, a rate that has been steady since 2013. This would not be possible if PBMs didn't incentivize generics to branded drugs. Here again, the manufacturer sets the price of a prescription drug, not the PBM.

Going back to the bill at hand, we feel the need to ensure the protection of competitive and proprietary financial information. Therefore, we are **very concerned** about the data being collected by the Board of Pharmacy. The FTC issued a letter on this issue when the Mississippi legislature passed a law granting the Board of Pharmacy with the authority to regulate PBMs.

> "[b]ecause pharmacists and PBMs have a competitive, and at times, adversarial relationship, we are concerned that giving the pharmacy board regulatory power over PBMs may create tensions and conflicts of interest for the pharmacy board."[3]

Similarly, the FTC has opposed regulatory boards composed of market participants in other industries. In *North Carolina State Board of Dental Examiners v. Federal Trade Commission,* the United States Supreme Court looked into the question as to whether the state board could decide that a certain procedure could only be performed under the supervision of a dentist, thereby driving lower priced non-dentists out of the market. The FTC questioned the North Carolina Board of Dental Examiners' ability to regulate an industry in which they were active participants noting, '"common sense and economic theory…. dictate the conclusion that Board actions in this area could be self interested"[4]

We believe that the Department of Insurance would be the appropriate agency for such competitive data. The Board of Pharmacy is comprised of active market participants whose access to market sensitive data could result in a conflict of interest and undermine competition in the prescription drug marketplace.

The industry worked with various stakeholders in Texas throughout the process there to amend similar language on disclosure. A key amendment included in the final passage of Texas HB 2536 aggregates the rebate information reported by PBMs and health plans before publishing the data. This important clarification protects proprietary, private business and competitively sensitive information. PCMA respectfully requests the insertion

[3] FTC letter to Representative Mark Formby, Mississippi House of Representatives, (March 22, 2011).

[4] Emory University School of Law, "Legal Studies Research Paper Series". Joanna Shepherd 2013

of similar language such as the following:

> ***"The Insurance Commissioner shall collect and aggregate all the collected data and publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's Internet website. The combined aggregated data from the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager or health plan [Carrier/Insurer]"*** in the section entitled "*Disclosure of pharmacy benefit manager information"* and the section entitled "*Disclosure of health insurer spending information"*.

PCMA also suggests the following language be included so the data submitted to the Department of Insurance is not subject to open records requests, except for the aggregated and de-identified data that is in the published report.

> **Rulemaking - Forms - Services - Records.**
>
> 4. A report received by the ~~board~~ **commissioner** is ~~an exempt~~ a **confidential** record as defined by section 44-04-17.1.

North Dakota open records laws have three classes of public records. Given the sensitive nature of the information within this bill's scope, it is more properly deemed "confidential information" rather than "exempt record."

In addition, PCMA respectfully requests the section involving penalties be either updated or removed from the bill. If anything, administrative penalties imposed by the regulator would be more appropriate to levy than civil penalties, especially when reporting to the Department of Insurance.

As I indicated above, drug manufacturers are responsible for setting the list price of drugs. No evidence exists to suggest that rebates cause higher drug prices. A study of list prices and rebates for the top 200 most prescribed drugs between 2011 and 2016 indicated that there is no correlation between rebates and list price increases or launch prices for individual drugs.[5] Of these drugs, there were prices that increased significantly, some that increased slightly, and some rebates that were high, and some that were low. Top brand

[5] Increasing Prices Set by Drugmakers Not Correlated with Rebates, Analysis prepared by Visante on behalf of PCMA, Jan. 2017, available at: https://www.pcmanet.org/wp-content/uploads/2017/04/Visante-Study-on-Prices-vs.-Rebates-By-Category-FINAL-3.pdf.

drugs that offered little to no commercial sector rebate during this time period still increased their prices, and manufacturers are increasing drug prices regardless of rebate levels negotiated by PBMs. Among the top 200 brand drugs by 2016 sales, the launch prices for drugs introduced from 2012 to 2016 were double the launch prices for those introduced prior to 2012. There was no correlation found between the prices and rebates.

Again, pharmaceutical manufacturers set drug prices. Therefore, the language on page 3 beginning on line 20 relating to the factors that led to drug price increase will likely yield better information if the language is amended to read as follows:

> ***"A definitive statement regarding the factor or factors that caused the increase in the wholesale acquisition cost and an explanation of the role of each factor's impact on the cost."***

PCMA requests that the due date for annual data collection be changed to July 1st to ensure comprehensive reporting of information for the preceding calendar year. This request will allow for a complete and accurate accounting of information that by its nature lags at least one quarter behind. Stated differently, while information can be reported on April 1st of each year, it will not represent complete information for the preceding calendar year.

PBMs negotiate on behalf of their clients and consumers to help drive down the cost of prescription drugs by using market-based tools that encourage competition among drugmakers and drugstores. PBMs support and practice transparency that empowers patients, their providers, plan sponsors, and policymakers, so that there is informed decision-making that can lead to lower prescription drug costs.

We appreciate your interest and commitment to keeping the costs of drugs affordable for the citizens of North Dakota and look forward to working with you in your efforts to pass meaningful legislation.

Thank you for your time and consideration. I'd be happy to answer any questions.

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