

SB 2031 – Testimony by Dustin Gawrylow (Lobbyist #266) North Dakota Watchdog Network

Madam Chair,

I stand in opposition of Senate Bill 2031 on the basis that while there is definitely a problem with prescription drug prices, adding more government regulation to the mix is not the solution.

“There ought to be a law!” and “We have to do something!”

Those are two sentences that advocates of smaller government hate to hear, especially when said by typically conservative lawmakers.

The jist of this bill is to create a pilot program for the State Insurance Commissioner to be put in the position of negotiating with drug makers to lower prices for retired state employees. (If the pilot program “works” it is presumed it would be expanded.

One question that should be raised is: wouldn’t it be better to negotiate a deal with the health insurance company that provides all state employees with health insurance, and create a side-benefit for retirees that way? - sort of our North Dakota’s own version of Medicare Part D. It would seem that it would be easier for an existing insurance company to negotiate and cover these costs than trying to invent a new process and new bureaucracies to put the state’s insurance commissioner in charge of drug prices.

The most egregious feature of this bill is that it attempts to normalize deferring North Dakota policies to the policies of Canada. (*Bernie Sanders would love this idea!*)

Even more amazing is that recently, North Dakota State University published a paper regarding the dangers of pharmaceutical price controls.

We are expending tax dollars to develop academic research at our publically funded universities showing that these are bad policies - but yet some legislators want to push forward.

- 17 **19-25-04. Referenced drug identification.**
- 18 1. The public employees retirement system shall identify the twenty-five most costly
- 19 prescription drugs utilized under the public employees retirement system health
- 20 benefits coverage based upon net price times utilization.
- 21 2. Before October of each year, the public employees retirement system shall transmit to
- 22 the commissioner the list of prescription drugs referenced in subsection 1. For each of
- 23 these prescription drugs, the public employees retirement system also shall provide
- 24 the commissioner with data on the total public employees retirement system net spend
- 25 on each of those prescription drugs for the previous calendar year.
- 26 3. Using the information submitted under subsection 2, before December of each year,
- 27 the commissioner shall create and publish a list on the department's website of the
- 28 twenty-five drugs subject to the referenced rate and the referenced rate.
- 29 4. The commissioner shall determine the referenced rate by comparing the wholesale
- 30 acquisition cost to the cost from all the following sources:

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- 1 a. Ontario ministry of health and long term care and most recently published
- 2 on the Ontario drug benefit formulary;
- 3 b. Regie de l'assurance maladie du Quebec and most recently published on
- 4 the Quebec public drug programs list of medications;
- 5 c. British Columbia ministry of health and most recently published on the BC
- 6 pharmacare formulary; and
- 7 d. Alberta ministry of health and most recently published on the Alberta drug
- 8 benefit list.

Pharmaceutical Price Controls Destroy Innovation and Harm Patients

Raymond J. March, Ph.D.

December 2022

The IQVIA Institute (2021) forecasts total medical spending in the U.S. will reach between \$380-\$400 billion by 2025. A growing component of this jarring figure is prescription drug costs. Nearly 48 percent of Americans use at least one prescription drug daily (CDC, 2019). More people might use prescription drugs if they can afford them. A 2019 survey finds nearly 30 percent of prescriptions remain unfilled because patients fear they will be too expensive (KFF, 2020).

Skyrocketing health care costs have motivated politicians to step in and look for solutions. Price controls are their latest (of many failed) attempts to address pharmaceuticals. While price controls for drugs were once political rhetoric, they might soon become the next foolhardy attempt to fix healthcare woes. Colorado recently became the first state to implement a price cap on insulin (Zialcita 2021). Even North Dakota has considered similar policies. 2021's Senate Bill No. 2170 aimed to fine producers \$1,000 for charging higher prices than Canadian pharmacies and will be reintroduced in 2023.

North Dakota does have a prescription drug expenditure problem. In 2019, North Dakotans spent nearly \$1.5 billion on prescription drugs (Definitive Healthcare, 2022). This ranks amongst the highest per capita expenditures in the country. But price controls are no solution. At best, they fail. At worst, they create severe unintended consequences which harm consumers and producers.

Price controls for pharmaceuticals are a clear example of the dangers of well-intended but poorly thought out

policy- crippling suppliers from innovating new and cheaper products while also slashing patient access to much-needed (even life-prolonging) medical goods. North Dakota's characteristics and economic conditions would only make these consequences worse.

Price Controls: Bad in Theory, Worse in Practice

Prices play an indispensable role in the economy. They inform both buyers and sellers how much of a good is available. Higher prices motivate producers to find profitable ways to make more. They also encourage consumers to buy less (or buy something else).

When policies prevent prices from rising, consumers buy more while producers make less (or make something else). Price controls reduce patient availability when the product is prescription drugs while cutting motivation and resources for drug suppliers to invest and improve (now less profitable) goods (Calfee, 2001). Both parties are worse off- the worst outcome a policy can create.

This fundamental economic lesson applies to all products in all markets. Shuttenger (2014) reviews the use and effects of price controls extending back thousands of years and for hundreds of products. The results are always the same: less availability and rippling effects across other markets worsen an already difficult situation.

Numerous studies demonstrate that prescription drug prices, even when high, are no exception to this predictable pattern. Klye (2007) and Schulthess and Bowen (2021) find drug developers were less likely to dedicate funds to R&D and introduce new drugs within countries with pharmaceutical price controls. Eger and Mahlich (2014) similarly find that firms selling drugs in price-regulated European markets use less R&D spending. Philipson and Durie (2021) review the Lower Drug Costs Now Act proposed by the Biden Administration and estimated the act would cost between 167-342 new drug approvals while also reducing R&D spending by about \$952.2 billion to \$2 trillion across 18 years.

Cutting R&D comes at the cost of future innovation—meaning fewer pioneering medical discoveries, cheaper drugs, and lifesaving medications. Motkuri and Mishra (2018) find that India's efforts to implement price controls considerably reduced patient access to lifesaving drugs. In their illustrating but concerning paper entitled *The Cost of U.S. Pharmaceutical Price Reductions: A Financial Simulation Model of R&D Decisions*, Abbot and Vernon (2005) note that even modest price controls in the U.S. pharmaceutical market could truncate R&D expenditures across the pharmaceutical market by 5 percent. For reference, federal funding provided to Pfizer to produce the first authorized Covid-19 vaccine was only an 8 percent R&D increase.

Current drug availability will also sharply decrease because of decreased profitability (Ingram 2011). While some "blockbuster" drugs have high-profit margins, most prescription drugs made modest gains. Abbot and Vernon (2005) note that only 30 percent of drugs recoup their R&D expenditures once they reach U.S. patients.

Drug shortages caused by price controls are also well documented. Slin (2007) chronicles a decade of drug shortages in the United Kingdom through the 1950-1960s following their attempts to set price

controls to make drugs cheaper. Even price controls on more lucrative drugs fail to deliver on their goals. In 2019, Colorado became the first state to cap insulin co-pays to \$100 per month. Nearly a year later, a survey found 40% of Coloradan diabetics still rationed their insulin because of a lack of availability (March, 2021).

North Dakota and Minnesota residents frequently travel to Canada (which also uses price controls) to buy cheaper insulin (Davie, 2019). Consequently, Canadian pharmacies often restrict how many vials of insulin patients can purchase at a time—leaving Canadians with less access (Mueller, 2017).

What Prescription Drug Price Controls Would Mean for North Dakotans

Healthcare's complex network of insurance providers, employers, third-party agencies, and medical professionals means the harmful effects of price controls extend well beyond patients and drug producers. Price controls and ill effects cast a wide and devastating net in a state with predominantly rural health like North Dakota.

When drug producers lose profitability, they produce fewer drugs with lower profit margins. Consequently, cheaper drugs become harder to find and other drugs get prescribed for their secondary effects. Changing pharmaceutical prices also requires PBMs, PSOs, and similar organizations to renegotiate drug prices with pharmacies and insurance providers. The outcome is cost-shifting strategies that place further financial burdens on the drug providers (including wholesalers) and patients to cover the costs of drugs that remain on the market.

With nearly 40 percent of North Dakotans living in a rural population, higher insurance premiums and lower coverages put many farther away from accessing pharmaceuticals (N.D. Chamber of Commerce, 2021). This is especially harmful as rural populations frequently have higher rates of diabetes and other

chronic health conditions (Smith, Humphries, and Wilson, 2008). Rising premiums are especially financially difficult for the already 9 percent of North Dakotans without any health insurance coverage (KFF, 2020).

Less access to drugs would also be particularly harmful to North Dakotans. Although North Dakota is one of the least populated states, it ranks 20th in the number of prescription drugs filled and 11th in the number of unique prescriptions filled annually. These figures indicate North Dakota patients need diverse and frequent pharmaceutical access (Definitive Healthcare, 2022).

Pharmaceutical price controls would also harm small businesses. Nearly 60 percent of U.S. employees receive some health insurance from work, making employers one of the largest health insurance providers. When the cost of providing health insurance to employees rises, so does the cost of retaining and hiring new employees, leading to fewer jobs. Baicker and Chandra (2005) estimate a 10 percent increase in health insurance premiums results in 1 fewer hour

worked per week with a two percent lower chance of being hired (health insurance premiums have risen 50 percent since 2000).

As categorized by the Small Business Administration, nearly 98 percent of businesses incorporated in North Dakota are small businesses (Boland 2021). Combined with a persistent state-wide labor shortage (O'Day, 2021), the secondary effects of pharmaceutical price controls would likely have a considerable negative impact.

Conclusion

Higher prices for vital goods like prescription drugs have falsely led many to call on price controls to make them cheaper. While well intended, price controls only attempt to limit price increases. Their actual effect is to limit innovation and access. Thousands of examples and a large body of research consistently find price controls fail to deliver while causing considerable harm. Implementing them in North Dakota would be a disastrous misdiagnosis.

Citations available upon request.

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North Dakota's Price Control Bill Threatens Prescription Drug Access

by Mattias Gugel January 10, 2023

As legislatures ramp up across America, states are seeing new attempts to help expand access and decrease the cost of health care for Americans.

Lowering the actual cost of health care — specifically prescription drug costs — requires an overarching look at the system patients use to obtain medicine. Waving a simple magic wand and enacting price controls won't solve the problem. In fact, it creates new problems for patients whose cures still need to arrive on the market.

As the nation's oldest taxpayer advocacy organization, National Taxpayers Union stands firmly on the side of taxpayers and patients as we look at reducing the costs taxpayers and patients pay for health care.

State legislators have already introduced [a bill in North Dakota](#) that creates a pilot program seeking to lower the prices of high-cost drugs in state-regulated health plans. NTU has voiced concerns about previous versions of this bill because the general enforcement mechanism of price setting will, unfortunately, backfire and create unintended consequences of lower access and reduced innovation in the prescription drug market. As a September 2019 [study by the Information Technology & Innovation Foundation](#) finds, "it is simply not true that government can impose significant price controls without damaging the chances for future cures."

North Dakota Senate Bill 2031 will further endanger access to lifesaving treatment for North Dakotans who need newly innovated pharmaceutical solutions to their health care problems. The cost of bringing a prescription drug to market is expensive. North Dakota patients shouldn't let the Canadian government's drug pricing system become their own and hinder the availability of the latest medications they need.

The current version of this bill also attempts to penalize companies that might pull their drugs from the state because of the proposed price-control schedule based on Canadian drug prices. Beyond the question of enforceability, the inclusion of this provision itself acknowledges that prescription drug access will diminish under a system where the government sets prices.

A recent December 2022 [report from North Dakota State University's](#) Dr. Raymond March concludes, "Thousands of examples and a large body of research consistently find price controls fail to deliver while causing considerable harm. Implementing them in North Dakota would be a disastrous misdiagnosis." He's right.

National Taxpayers Union stands ready to assist state lawmakers as they pursue a holistic and thorough look at how to find cost-saving measures for patients and increase competition for health care. However, the unintended consequences of this North Dakota bill need to be considered, and it should not pass.