Testimony of the National Academy for State Health Policy on SB 2031 - Relating to a prescription drug reference rate pilot program

Chair Lee and Members of the Committee,

My name is Drew Gattine and I am a Senior Policy Consultant with the National Academy for State Health Policy's (NASHP) Center for Drug Pricing. NASHP is a non-partisan forum of state policy makers that works to develop and implement innovative health care policy solutions at the state level. At NASHP we believe that when it comes to health care, the states are a tremendous source of innovative ideas and solutions. We approach our work by engaging and convening state leaders to solve problems. We conduct policy analysis and research and we provide technical assistance to states.

In 2017 NASHP created its Center for Drug Pricing to focus attention on steps that states can take to tackle the spiraling costs of prescription drugs and the impact it has on consumers, the overall cost of health care and state budgets. NASHP's Center for Drug Pricing develops model legislation for states and provides technical assistance and support to legislators and executive branch leaders who wish to move them forward. When these bills pass, NASHP continues to support states as they are implemented.

SB 2031 is based on one of NASHP's model bills. Because NASHP is not an advocacy organization we do not take a position "for" or "against" a bill but we do stand by to answer questions and provide technical support for sponsors and legislative committees.

I think we are all aware that when compared to citizens of other countries, Americans pay a lot more for prescription drugs and that the rising cost of prescription drugs is a huge driver in the overall annual increase in health care costs that Americans experience routinely. Other countries spend less for the same drugs because they set rates for prescription drugs. In the United States, rate setting is the norm for many health care services. Public programs like Medicaid or Medicare, and commercial payers routinely negotiate or set rates. But when it comes to prescription drugs, the United States has a very complicated payment and distribution system that begins with prices set by drug manufacturers. (Note that this bill does not set manufacturer prices or tell manufacturers that they cannot set whatever price they decide. It does set a top rate that government payers and health plans are allowed to pay.)

States could undertake to do this rate-setting themselves but the process is complicated and requires up-front investment. Most states don't have the infrastructure to do this analytical work. The good news is that other countries are already doing it and the results of that work are readily and publicly available for states to use.

This bill directs North Dakota Insurance Commissioner to implement a pilot program to bring the rate that purchasers pay for certain prescription drugs in alignment with Canadian prices. The Commissioner is directed to compare, based on a list provided by the Public Employees Retirement System (PERS), the amount that PERS pays for the 25 most costly drugs in the state with the price paid for those drugs in the four most populous Canadian provinces (Ontario, Quebec, British Columbia, and Alberta) and directs that this price becomes the ceiling rate for government purchasers and health plans in North Dakota. The provinces provide the rate information on publicly available websites and matching to the top 25 drugs in North Dakota can be accomplished easily by cross-walking to those websites.

The model bill applies to health plans and state entities other than Medicaid. Medicaid was excluded in acknowledgement of the unique design of the Medicaid pharmacy benefit that requires states to cover all drugs in exchange for substantial rebates. Including Medicaid would require up-front agreement by the federal government through either a waiver of state plan amendment. I realize that Representative Meier is proposing amendments to narrow the scope of the pilot project to just PERS.

Referencing North Dakota rates to Canadian rates should lead to significant savings to the state. The prices paid in Canada are typically 65-80% percent less than the price paid in the United States. Based on Information that NASHP received from ND PERS when a different version of this bill was introduced in 2021, using 2020 utilization numbers, referencing the top 25 drugs in terms of spending to the Canadian price as would have resulted in savings of over $21 million to the state. (This does not include the savings that would accrue in the commercial market.)

When a similar bill was introduced in 2021 in Oklahoma by Senator Greg McCortney (currently the Senate Majority Leader) the legislature's fiscal office estimated that referencing the 20 highest cost drugs to Canadian prices would save $50 million for the state employee health program.

The potential value to North Dakota residents would be the reduction of the cost of prescription drugs and the requirement that any savings, achieved either by health plans or by state payers, be used to benefit consumers. The bill requires that any savings generated by implementing the reference rates, whether generated by state entities or commercial health plans, be used to reduce the health care costs of the people of North Dakota. Lowering the cost of life-saving drugs should increase the ability of people who rely on those drugs to have better access. Pharmacy manufacturers, who continue to make profits in Canada and in other countries with lower prices than the US, will still be left with the necessary revenue to invest in research and development and bring new, innovative, drugs to market. The profits that pharmaceutical manufacurers make in the US by charging more to Americans than they do to

the citizens of other countries far exceeds their entire global R&D budget. There is room to set rates to expand access to affordable drug *and* to allow profit to incent continued innovation.

Only prescription drugs that are currently available in both North Dakota and Canada will be subject to the reference pricing, so this pilot project will not result in new drugs being unavailable. By definition, the impacted drugs are available in Canada, so the factors used to determine the price in Canada has not resulted in a decision by the manufacturers not to sell them there. This pilot project does not require North Dakota to consider quality adjusted life years (QALYs) or any other metric that some argue discriminate against people with disabilities and chronic illnesses.

As the Committee continues its work on this bill, NASHP is available to support your work as necessary. Prior to drafting its latest round of model legislation, NASHP engaged with a team of legal experts to design legally sound approaches that can withstand the inevitable challenges from manufacturers. NASHP has made our legal analysis available on our website. (https://www.nashp.org/the-national-academy-for-state-health-policys-proposal-for-state-based-international-reference-pricing-for-prescription-drugs/). The NASHP legal white paper focuses specifically on possible challenges related to patent infringement and the application of the dormant commerce clause. The NASHP website also contains other materials (Written Q&A, Blog Articles, etc.) that may be useful material for the Committee. (NASHP has also recently released a model bill that references pharmacy rates to the prices that Medicare will be negotiating with manufacturers under the Inflation Reduction Act. That model bill and supporting materials are also available at the NASHP website.)

Thank you.

Drew Gattine
NASHP Center for Drug Pricing
Email: dgattine@nashp.org
Phone: (207) 409-3477