STATEMENT

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In Opposition to Colorado House Bill 18-1260
February 27, 2018

Position: The Pharmaceutical Research and Manufacturers of America (PhRMA) opposes Colorado HB 18-1260 because it could disrupt the pharmaceutical supply chain in a way that negatively impacts patients and requires prescription drug manufacturers to report significant information related to drug pricing that will not lower patient out of pocket costs. By focusing disclosures on list price, the bill ignores the impact of manufacturer rebates and discounts on actual prescription drug costs to the healthcare system.

HB 18-1260 would bring little to no benefit for patients and Colorado's budget.

In an effort to bring more transparency to how prices for medicine are set, HB 1260 requires pharmaceutical manufacturers to notify payers of certain increases in the list price of a medicine 90 days prior to the increase taking effect. While well intended, the policies included in HB 1260 will provide minimal to no benefit to patients or payers, and increase the administrative burden on state agencies responsible for enforcement.

A patient's out of pocket cost for a medicine is determined by insurance benefit design; therefore, mandatory price reporting of a medicine's list price (i.e. Wholesale Acquisition Cost) has little bearing on what customers actually pay for a medicine. While transparency related to list prices does not lower patient cost sharing, transparency around whether PBM's and insurers share manufacturer rebates with enrollees could. Brand pharmaceutical companies only retain an average of 63% of spending on the list price of a drug.[i] The rest of the revenue goes to other members of the pharmaceutical supply chain including to PBM's and insurers in the form of steep discounts off the manufactures list price. HB 1260 does nothing to impose transparency on whether payers use manufacturer rebates to lower patient cost sharing.

The advance price increase notification required under HB 1260 would also do little to help the state Medicaid program. As a recipient of a large volume of price increase information, the Medicaid program would need to contend with the administrative burdens of constant price revisions and would not realize any benefits from speculative purchasing. The Colorado Medicaid program is insulated from WAC (list price) increases due to protections afforded by federal rules, the reporting requirements provided in HB 1260 will not afford the state any planning or horizon scanning benefit. As such, it is unclear what the Department of Healthcare Policy and Finance could do with this information that would have any impact on state prescription drug spending. Should the Department decide to use this information to anticipate increased state spending related to a

drug's price increase, any request for additional funding tied to this reporting could cause speculation in the pharmaceutical supply chain. Such disruptions can have serious, negative consequences for the state and patients – even those patients who do not receive health benefits from the state.

HB 18-1260 could cause disruptions in the pharmaceutical supply chain that negatively impact patients.

Notifications based on costs and future price increases could incentivize new speculative purchasing and problematic stockpiling that both industry and the federal government have fought to eliminate in recent years.
In the past, speculative purchasing was a practice used by distributors to profit from fluctuations in medicine prices. Manufacturers and primary distributors (wholesalers who purchase medicines directly from manufacturers) enter into agreements that manage the volume of medicines a distributor can hold. These arrangements enable the primary distributor to earn greater inventory management fees if they manage their inventories to pre-defined target service levels, and thus discourage arbitrage or stockpiling of inventory in amounts in excess of end customer need.

Advance price notification creates a new incentive for some distributors — especially those that do not enter into contractual agreements with manufacturers — to profit from purchasing medicine at the 'old' price and selling them at the 'new' price once the increase is made public. While medicine shortages can be caused by a variety of factors including production delays due to a lack of raw materials and components from suppliers,[ii] or discontinuations of medicine, they can also be caused by disturbances within the pharmaceutical supply chain. Those disturbances are often the result of distribution methods that restrict or deviate from the usual pharmaceutical supply chain.[iii]

A prime example of these atypical distribution methods is the practice of stockpiling medicine in advance of a price increase or hoarding in response to an impending shortage.[iv] In this scenario, a supply chain entity may be incentivized to re-sell a medicine to another intermediary, creating a "gray" market. Gray market distribution networks consist of a number of different entities – some doing business as pharmacies and some as distributors – that buy and resell medicines to each other before finally selling a medicine to a hospital or other healthcare facility. In the event this happens, product supply may be stretched thin and downstream prices may increase, exacerbating a medicine shortage.[v] While price transparency requirements, such as advance price notification, aim to provide the public with pertinent information on medicines, the potential consequences could become obstacles to the goals of access and affordability.

Furthermore, antitrust and other laws prevent competitors from "signaling" pricing decisions to competitors or engaging in conduct with competitors that could be viewed as collusion. By requiring manufacturers to report price increases, HB1260 creates potential for signaling to competitors (or testing the market regarding) planned pricing and price changes. This could encourage action by the company providing notice and its competitors that could lead to parallel price increases (as only one example of possible behavior). This can create an artificial price floor rather than a price ceiling, with the result that the advance notice requirement could actually unwittingly lead to an overall increase in such costs to the detriment of health insurance plans and their participants locally and, more importantly, nationwide.

HB 1260 ignores the facts about prescription drug spending and that insurers and pharmacy benefit managers ultimately determine patient cost sharing.

HB 1260 creates the false narrative that prescription drug spending overall is skyrocketing and should therefore be singled out when it comes to policy discussions around affordability. Prescription drug affordability is an extremely important discussion, but policies to improve affordability must consider the facts about prescription drug spending and the role all members of the supply chain play in what patients ultimately pay.

In 2016, the Colorado Medicaid program spent about $8.45 billion dollars to cover about 1.4 million enrollees.[vi] [vii] Prescription drugs accounted for only 6 percent of total spending. Brand drugs alone accounted for only 4% of total spending. In the same year, hospital care represented 32 percent of total spending, and professional services were 21 percent.[viii] Not only was prescription drug spending drastically lower than other categories, but prescription drugs are a benefit that actually avert spending on the costliest services in the hospital and provider space. For example, in Colorado more than 3 in 10 Medicaid patients do not have their blood glucose levels under control. With improved diabetes control, Colorado Medicaid could save an average of $942 per beneficiary.[ix]

In the private insurance market, the top three PBMs administer prescription drug benefits for over 70% of covered lives in the U.S.[x] Health insurers and pharmacy benefit managers are powerful, sophisticated purchasers who use their leverage to negotiate steep discounts. This is why, after factoring in discounts and rebates, prices for brand medicines increased just 3.5 percent in 2016 and total spending on medicines increased just 4.8 percent last year.[xi] More recently, in February 2018, Express Scripts (one of the country's largest PBMs) released its estimates of 2017 drug spending showing historically low rates of growth in the commercial market. The report found that nearly half (44%) of commercial plans saw their drug spending per enrollee decrease in 2017. Additionally, prescription medicine spending grew at just 1.5% (net of discounts and rebates) for Express Scripts' commercial plans and total drug spending for Express Scripts' plans on the Health Insurance Exchanges decreased by 3.3% in 2017.[xii]

As a result of robust negotiation and competition in the marketplace, medicine costs are growing at the slowest rate in years. In fact, more than one-third of the initial list price of a medicine is rebated back to insurance companies, PBMs and the government, or retained by other stakeholders in the biopharmaceutical supply chain. Furthermore, rebates, discounts, and fees rebated back to payers nearly doubled between 2013 and 2015.[xiii] Too often negotiated savings do not make their way to patients who are increasingly being asked to pay more out-of-pocket for innovative medicines.

Unlike care received at an in-network hospital or physician's office, patients with high deductibles or coinsurance pay cost sharing based on the list price of a medicine, even if their insurer receives a steep discount. In fact, more than half of commercially insured patients' out-of-pocket spending for brand medicines is based on the full list price.[xiv] Sharing negotiated discounts could save certain commercially insured patients with high deductibles and coinsurance $145 to more than $800 annually and would increase premiums about 1 percent or less.[xv] In fact, in a recent issue brief, CVS Health, one of the largest PBM's, disclosed their policy to pass a share of manufacturer rebates through to their employees as a way to lower cost sharing.[xvi]

The biopharmaceutical industry is committed to working with Colorado lawmakers, patients, health care providers, and other health care stakeholders to pursue policies that promote innovation and help ensure consumers have access to needed medicines. However, HB 1260 is not the way to accomplish this important goal. Instead, HB 1260 could increase drug costs though disruption in the supply chain, while providing little to no benefit for patients and payers. There are better ways to lower prescription drug costs, without risking the negative and costly consequences of this legislation. Therefore, PhRMA respectfully urges lawmakers to oppose HB 1260.

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[i] Vanderveld, A., Blalock, E., Berkley Research Group, The Pharmaceutical Supply Chain: Gross Drug Expenditures Realized by Stakeholders. August 2017.

[ii] https://www.fda.gov/Drugs/DrugSafety/DrugShortages/ucm050796.htm#q4

[iii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278171/

[iv] Fox E, Birt A, James K, et al. ASHP guidelines on managing drug product shortages in hospitals and health systems. Am J Health System Pharm. 2009;66:1399–1406. https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/managing-drug-product-

[v] Wholesale Drug Distribution: Protecting the Integrity of the Nation's Prescription Drug Supply.
National Association of Boards of Pharmacy. August 2013

[vi] The Menges Group analysis of FY2016 CMS 64 reports and State Drug Utilization data files. Brand and generic expenditure totals are net of rebates. Data used were predominantly derived from CMS 64 reports. Brand and generic prescription drug costs in each state were derived through a set of tabulations performed by The Menges Group. Pre-rebate expenditures were tabulated using FY2016 CMS State Drug Utilization data files and CMS brand/generic indicators for each National Drug Code. Rebate information was obtained from CMS-64 reports. Brand/generic share of rebates estimated by The Menges Group. Post-rebate expenditures derived through Menges Group tabulations using above information.

[vii] Kaiser Family Foundation, Total Monthly Medicaid and CHIP Enrollment, point-in- time total for October 2016. https://www.kff.org/health-reform/state-indicator/total- monthly-medicaid-and-chip-enrollment

[viii] The Mendes Group

[ix] Chen, F. HIS Markit. Better Diabetes Control Can Save Medicaid 4 Billion Per Year. November 2017. https://ihsmarkit.com/research-analysis/better-diabetes-treatment-can-save-medicaid-over-4-billion-per-year.html

[x] Drug Channels. Prescription economics in the U.S. drug channel system. August 2017.
http://www.drugchannelsinstitute.com/files/Drug_Channel_Economics-Pembroke-August2017.pdf.

[xi] IMS Institute for Healthcare Informatics, National Sales Perspectives, March 2016

[xii] Express Scripts, 2017 Drug Trend Report. February 2017. http://lab.express-scripts.com/lab/drug-trend-report/2017-dtr

[xiii] Vanderveld., Blalock

[xiv] Vanderveld., Blalock.

[xv] Bunger., Gomberg., Hunter, Petroske. Milliman. Point of Sale Rebate Analysis in the Commercial Market: Sharing rebates may lower patient costs and likely has minimal impact on premiums. October 2017.

[xvi] Fein, A. June 2017. Will CVS Health's Point of Sale Rebates Deflate the gross to net bubble and disrupt the PBM business?. Drug Channels. Accessed February 28, 2018.