Committee Report

CONSENT CALENDAR

March 20, 2019

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on Commerce and Consumer Affairs to which was referred HB 659,

AN ACT relative to reporting of internal pharmaceutical costs. Having considered the same, report the same with the following resolution: RESOLVED, that it is INEXPEDIENT TO LEGISLATE.

Rep. Edward Butler

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**Commerce and Consumer Affairs**
Bill Number:	**HB 659**
Title:	**relative to reporting of internal pharmaceutical costs.**
Date:	**March 20, 2019**
Consent Calendar:	**CONSENT**
Recommendation:	**INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

The recent Commission To Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs heard from the Department of Administrative Services (DAS) about their recent negotiation which ended with a successful contract for pharmaceutical benefits. However, no one in DAS appeared to know about what the impact on the overall cost was from issues like spread pricing, rebates or administrative or other costs. This bill ultimately became an effort to work with DAS to consider whether those details would be useful in the contracting process, but agreement could not be reached.

Vote 20-0.

Rep. Edward Butler
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

CONSENT CALENDAR

Commerce and Consumer Affairs

HB 659, relative to reporting of internal pharmaceutical costs. **INEXPEDIENT TO LEGISLATE.** Rep. Edward Butler for Commerce and Consumer Affairs. The recent Commission To Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs heard from the Department of Administrative Services (DAS) about their recent negotiation which ended with a successful contract for pharmaceutical benefits. However, no one in DAS appeared to know about what the impact on the overall cost was from issues like spread pricing, rebates or administrative or other costs. This bill ultimately became an effort to work with DAS to consider whether those details would be useful in the contracting process, but agreement could not be reached. **Vote 20-0.**

Original: House Clerk
Cc: Committee Bill File

HB536: OTP – This legislature has enacted several laws to provide protection of our privacy. This is yet another of those efforts and it focusses on biometric information, which is any means by which a person can be uniquely identified by evaluating one or more distinguishing biological traits. Traits such as imagery of the iris, retina, fingerprint, face, hand, palm patterns and the like. This bill, if passed, will restrict businesses from obtaining, using or disclosing biometric information unless agreed to or to which the consumer 'reasonably expects'.

HB658: ITL -- Relative to price increases of drugs under the managed care law. The Committee believes that the intent of this bill is already covered in similar legislation this session and, therefore, is not needed.

HB520: OTPA – Relative to availability of diaper changing stations in public restrooms. This bill requires new construction of public accommodations after 1/1/2021 to install and maintain at least one diaper changing station that is accessible to all genders. It also requires similar installation for renovations, after 1/1/2025, in public buildings of $50,000 or more (amended from $30,000). The Committee heard testimony from new and young fathers who believe that this accommodation is long overdue. The amendment also repeals the provision requiring diaper changing stations if and when the Building Code Review Board adopts, and the legislature ratifies, this provision as part of the state building code.

HB659: ITL -- relative to reporting of internal pharmaceutical costs. The recent Commission on Pharmaceutical Costs heard from DAS about their recent negotiation which ended with a successful contract for pharmaceutical benefits. However, no one in DAS appeared to know about what the impacts of the overall costs were from issues like spread pricing, rebates or administrative or other costs. This bill ultimately became an effort to work with DAS to consider whether those details would be useful in the contracting process but agreement could not be reached.

Voting Sheets

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on HB 659

BILL TITLE: relative to reporting of internal pharmaceutical costs.

DATE: March 11, 2019

LOB ROOM: 302

MOTIONS: **INEXPEDIENT TO LEGISLATE**

Moved by Rep. Butler Seconded by Rep. Weston Vote: 20-0

CONSENT CALENDAR: YES

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep Rebecca McBeath, Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

EXECUTIVE SESSION on HB 659

BILL TITLE: relative to reporting of internal pharmaceutical costs.

DATE: 3-11-19

LOB ROOM: 302

MOTION: (Please check one box)

☐ OTP ☒ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ____ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. Butler Seconded by Rep. Weston Vote: 20-0

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ____ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. ________ Seconded by Rep. ________ Vote: ____

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ____ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. ________ Seconded by Rep. ________ Vote: ____

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Adoption of Amendment # ____ (*if offered*)

☐ Interim Study (2nd year)

Moved by Rep. ________ Seconded by Rep. ________ Vote: ____

CONSENT CALENDAR: ✓ YES ____ NO

Minority Report? ____ Yes ____ No If yes, author, Rep: ________ Motion____

Respectfully submitted: [signature]

Rep Rebecca McBeath, Clerk

1/14/2019 3:15:04 PM
Roll Call Committee Registers Report

2019 SESSION

Commerce and Consumer Affairs

Bill #: HB659 **Motion:** ITL **AM #:** _____ **Exec Session Date:** 3-11-19

Members	YEAS	Nays	NV
Butler, Edward A. Chairman	✓		
Williams, Kermit R. Vice Chairman	✓		
~~Gidge, Kenneth~~ N. McConnell	✓		
Abel, Richard M.	✓		
McBeath, Rebecca Susan Clerk	✓		
Bartlett, Christy D.	✓		
Herbert, Christopher J.	✓		
Van Houten, Constance	✓		
~~Fargo, Kristina~~ M. Kurz	✓		
Indruk, Greg L.	✓		
Muscatel, Garrett D.	✓		
Weston, Joyce	✓		
Hunt, John B.	✓		
~~Sanborn, Laurie J.~~ HOELZEL	✓		
Osborne, Jason M.	✓		
~~Costable, Michael~~ WUELPER	✓		
Plumer, John R.	✓		
Barnes, Arthur E.	✓		
Potucek, John M.	✓		
~~Warden, Mark~~ Fields	✓		
TOTAL VOTE:	20	0	

Sub-Committee Minutes

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 659

BILL TITLE: relative to reporting of internal pharmaceutical costs.

DATE: 3-8-19

Subcommittee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Comments and Recommendations:

_____

_____

_____

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote:

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote:

_____ Amendment Adopted _____ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote:

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote:

_____ Amendment Adopted _____ Amendment Failed

Respectfully submitted,

Rep. _____
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 659

BILL TITLE: relative to reporting of internal pharmaceutical costs.

DATE: March 6, 2019

Subcommittee Members: Reps. Butler, Bartlett, Fargo, Muscatel, Weston, Hunt, Barnes and Potucek

Comments and Recommendations: Narrow review to state contract - amendment - Rep. Butler.

Respectfully submitted,

Rep. Kristina Fargo
Subcommittee Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 659

BILL TITLE: relative to reporting of internal pharmaceutical costs.

DATE: 3/6/19

Subcommittee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Comments and Recommendations:

- narrow review to State Contract
- amendment - Rep. Butler

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

Respectfully submitted,

Rep. Kristina Fargo
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 659

BILL TITLE: relative to reporting of internal pharmaceutical costs.

DATE: February 21, 2019

Subcommittee Members: Reps. Butler, Bartlett, Fargo, Muscatel, Weston, Hunt, Barnes and Potucek

Comments and Recommendations: Hold for review.

Respectfully submitted,

Rep. Kristina Fargo
Subcommittee Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 659

BILL TITLE: relative to reporting of internal pharmaceutical costs.

DATE: 2-21-19

Subcommittee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Comments and Recommendations:

hold for review

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

Respectfully submitted,

Rep. Kristina Fargo
Subcommittee Chairman/Clerk

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

PUBLIC HEARING ON HB 659

BILL TITLE: **relative to reporting of internal pharmaceutical costs.**

DATE: **February 19, 2019**

LOB ROOM: **302** **Time Public Hearing Called to Order:** **11:55 a.m.**

Time Adjourned: **12:34 p.m.**

Committee Members: **Reps. Butler, Williams, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, Barnes, Potucek and Warden**

Bill Sponsors:
Rep. Butler **Rep. Marsh** **Rep. Knirk**

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

***Rep. Ed Butler** - Prime sponsor of the bill. Required insurance company annual report. Spread amounts, drug rebate amounts - broader range of data and will protect confidentiality.

Tyler Brannan, NH Insurance Department - No position. Look at drug rebates now but would do in greater detail. Smaller company may only see what charged back to them. Need adequate disclosure, especially to clients, will be cost.

Rep. Williams: Confidential data, are going to feel comfortable kept proprietary and will come from the right place? ANS: Carrier responsible to report to department. Most contracts say must comply with state law. Detail now not in public domain, helpful to have in law. Some trust between department and carriers, some level of risk with disclosure. Insurance department some authority over third party administrators give authority to ask?

Rep. Hunt: Large companies - wouldn't payments be co-mingled with MERISA plans? ANS: Can become competitive. Two issues - 1) Insurance company writing 1 plat okay to PBA and insurance department sees only that? 2) How to do solvency? ANS: Insurance department reviews premiums that stay for one year - insurance company has to keep reserves for solvency. Some scrutiny (suggesting) department has more authority. Competition should put right pressure/eases for larger company.

Paula Rogers, Anthem - Opposes the bill. Overwhelming request. Some issues in Executive Council towns now. Where did bill come from? Transparency - thinks about consumer and policy maker transparency. Information largely proper farcy in this bill. Will promote consumer transparency propose of information helpful to insurance department, etc. Where is Pharmacy Board on this? Suggests caution. Anthem sends department lots of information already.

Rep. Williams: Impression each compare required and make report already, would add few categories? ANS: Could be broad, what system goes into? Seems need for groundwork, need more comprehensive discussion.

***Holly Stevens, New Futures** - Supports the bill. Ohio - spread pricing not reported. insurers don't know how much PBM's are taking in greater transparency.

Rep. Williams: Spread pricing? ANS: Manufacturers set prices, but pharmacies see, PBM's can negotiate prices until manufacturers, but insurer doesn't know about price basically mark-up on needs.

Rep. Hunt: Between PBM and insurance companies, if wanted to know, would write into contract? ANS: Bigger bias about to do. Not enough competition and insurance companies don't shop around? ANS: Three major PBM's and consolidation.

April Alexander, PCMA - Opposes the bill. Spread pricing - when have PBM, do RFP/wen client chooses, structures contract and sets compensation/client may do spread contract. Client no more than X for a drug, but can keep difference (pass - through contract possible). Spread compensation for services in Ohio - PBM's helped save state millions. PBM's competitive until each other. Websites - about 90% passed back to PBM's client on bill - mandate on health insurance carriers, not PBM's, lots of proprietary information involved. Why only looking at PBM's, not others in supply chain (wholesales, pharmacy) no additional need to go deeper with information.

Rep. Williams: Ration of companies with spread contract vs. administrative fee, 1 spread encourages squeezing one manufacturer? ANS: No figure, has no figures, client decides how to structure contract.

Rep. Hunt: Company chooses PBM for cheapest price? ANS: Believe cost is a piece and a piece of insurance companies aspects goal to do affordable with great services.

Respectfully submitted,

Rep. Constance Van Houten
Acting Clerk

HOUSE COMMITTEE ON COMMERCE AND CONSUMER AFFAIRS

PUBLIC HEARING ON HB 659

BILL TITLE: **relative to reporting of internal pharmaceutical costs.**

DATE: 2-19-19

ROOM: 302 **Time Public Hearing Called to Order:** 11:55

Time Adjourned: 12:34

(please circle if present)

Committee Members: Reps. Butler, Williams, McBeath, Gidge, Abel, Bartlett, Herbert, Van Houten, Fargo, Indruk, Muscatel, Weston, Hunt, Sanborn, J. Osborne, Costable, Plumer, Barnes, Potucek and Warden

Bill Sponsors:
Rep. Butler Rep. Marsh Rep. Knirk

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

*① Rep. Ed Butler, prime sponsor
② Tyler Brannen, NH Ins. Dept.
③ Paula Rogers, Anthem
*④ Holly Stevens, New Futures
⑤ April Alexander - PCMA

HB 659

(1) Rep. Ed Butler, prime sponsor
req. ins. co. annual report -
(written testimony
→ spread amounts, drug repate amounts, → broader range of data + will protect confidentiality

(2) Tyler Brannen - NH. Ins. Dept
no position
look at drug rebates now but would do in greater detail
smaller company may only see what charged back to them
need adequate disclosure - esp. to clients
will be cost

Q - KW - confidential data, are going to feel comfortable kept proprietary + will come from the right place

A - carrier resp. to rpt to dept., most contracts say must comply with state law detail now not in public domain, helpful to have in law, some trust betw. dept + carriers, some level of risk with disclosure

HB659

Q-KW - wis dept some authority over 3rd party administers, qui authority to ask?

(A) Yes

Q-JH -
large co. - wouldn't paym'ts be co-mingled with MEWSA plans

(A) can become competitive

Q-JH - 2 issues
1- wis. co writing 1 flat ok. to PBA + wis. dept. sees only that?
2 how to do solvency?

A - wis dept reviews premium that stays for 1 year - wis. co. has to keep reserves for ~~solvency~~ solvency - some scrutiny (suggesting dept has more authority) // competition should put right pressure / easiness for larger company

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(3) Paula Rogers, Anthem
overwhelming request - oppose some issues in Exec council tomorrow.
where did bill come from?
transparency - thanks about consumer + policy maker transparency

HB659

info largely proprietary—
in this bill
will promote consumer
transparency
purposes/ info? helpful to
ins. dept? etc.
where is Pharmacy Bd. on this?
suggests caution
Anthem sends dept. ~~lots~~
lots of info already
Q-KW - impression each company
required to make report
already, would add few
categories
A - could be broad, ~~what~~
what system goes into?
seems need for groundwork,
need more comprehensive
discussion

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(4) Holly Stevens, New Futures
in support + written testimony
~~Ohio - PBM 223+~~
Ohio — spread pricing not
reported
insurers don't know how
much ~~they~~ PBMs are taking in
greater transparency?
Q-KF - spread pricing?
A - manuf. set prices, but
pharm. sell, PBM's can
negotiate prices with manuf.,
but insurer doesn't know about price

HB659

basically mark-up on meds
Q - JH - Retro PBM & ins co - if wanted to know would write into contract
A - bigger has clout & do
Q - JH - not enough competition & ins companies can't shop around
A - 3 major PBMs & consolidation

(5) April Alexander — PCMA
oppose
spread pricing - when hire PBM, do RFP / when client chooses, structures contract & sets compensation / client may do spread contract — client no more than X for a drug, but can keep difference (pass-through contract possible)
spread = compensation for services
in Ohio - PBMs ~~lost~~ helped save state millions
PBMs competitive with each other
rebates - about 90% passed back to PBMs client

HB659

on bill — mandate on health ins carriers, not PBMs, lots of proprietary info involved

why only looking at PBMs, not others in supply chain (wholesaler, pharmacy)

~~health care~~

no additional need to go deeper in info

Q - KH - ratio of companies w/ spread contract vs. administrative fee / spread encourages squeeze on manufacturer

A - ~~no fig~~ has ~~no fee~~ has no figures, client decides how to structure contract

Q - JH - co. chooses PBM for cheapest price

A - believe cost is a, percent a piece of ins. companies' aspects & goal, to do affordably w/ great services

blue sheet

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 659 Date 2-19-19

Committee Commerce & CA

**** Please Print All Information ****

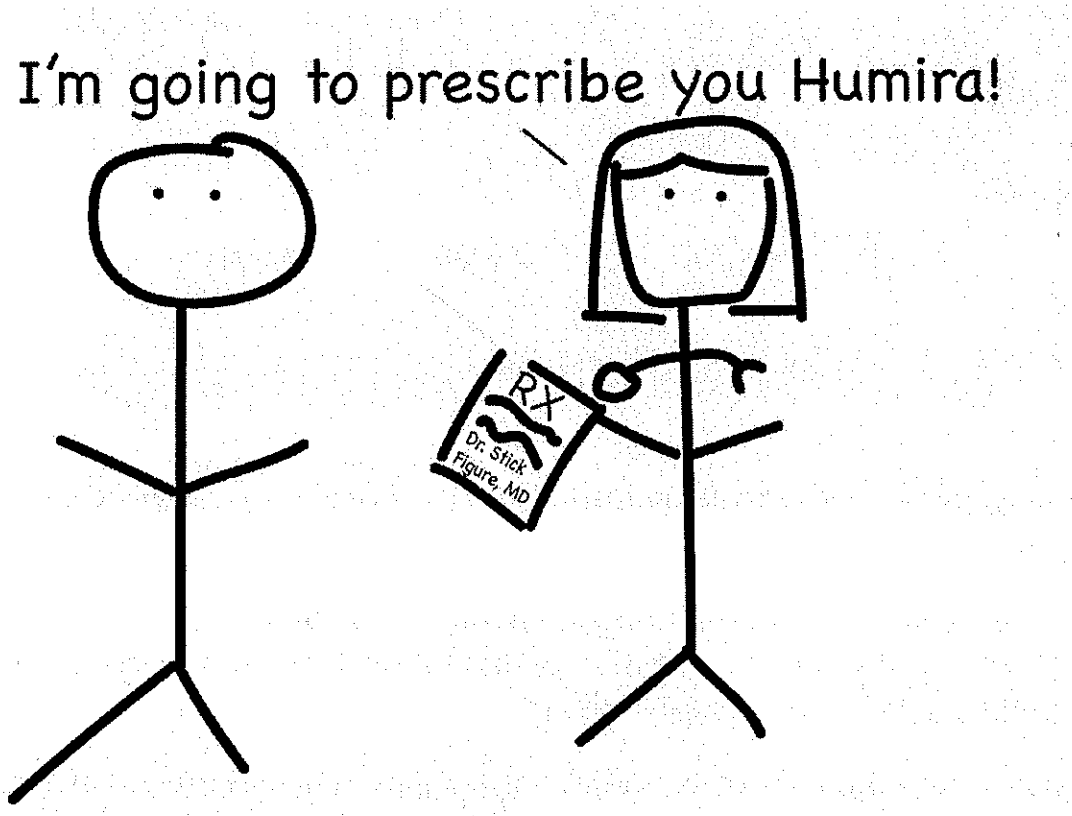
Name	Address	Phone	Representing	(check one) Pro	Con
Rep. William Marsh			Carroll 8	✓	
Lindsey Nadeau			Cigna		✓
Stefani Reardon			Harvard Pilgrim		✓
Richard A Cohen			NHPA	✓	
Jim Isaac			AARP		
Fran Wendelboe			NHIPA	✓	
Heidi Kroll			AHIP		X

Testimony

The true story of America's sky-high prescription drug prices

By Sarah Kliffsarah@vox.com Updated May 10, 2018, 9:19am EDT

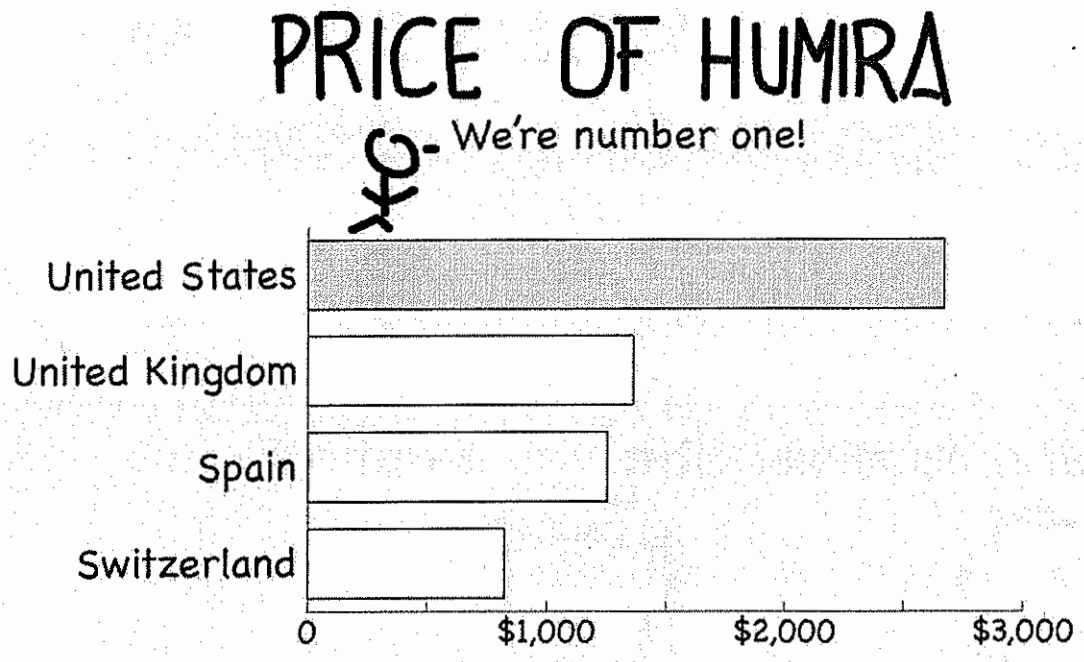
Let's say you're at the doctor. And the doctor hands you a prescription.



The prescription is for Humira, an injectable medication used to treat a lot of common conditions like arthritis and psoriasis. Humira is an especially popular medication right now. In 2015, patients all around the world spent $14 billion on Humira prescriptions — that's roughly the size of Jamaica's entire economy.

Let's say your doctor appointment is happening in the United Kingdom. There, your Humira prescription will cost, on average, $1,362. If you're seeing a doctor in Switzerland, the drug runs around $822.

But if you're seeing a doctor in the United States, your Humira prescription will, on average, run you $2,669.



How does this happen? Why does Humira cost so much more here than it does in other countries?

Humira is the exact same drug whether it's sold in the United States, in Switzerland, or anywhere else. What's different about Humira in the United States is the regulatory system we've set up around our pharmaceutical industry.

The United States is exceptional in that it does not regulate or negotiate the prices of new prescription drugs when they come onto market. Other countries will task a government agency to meet with pharmaceutical companies and haggle over an appropriate price. These agencies will typically make decisions about whether these new drugs represent any improvement over the old drugs — whether they're even worth bringing onto the market in the first place. They'll pore over reams of evidence about drugs' risks and benefits.

The United States allows drugmakers to set their own prices for a given product — and allows every drug that's proven to be safe come onto market. And the problems that causes are easy to see, from the high copays at the drugstore to the people who can't afford lifesaving medications.

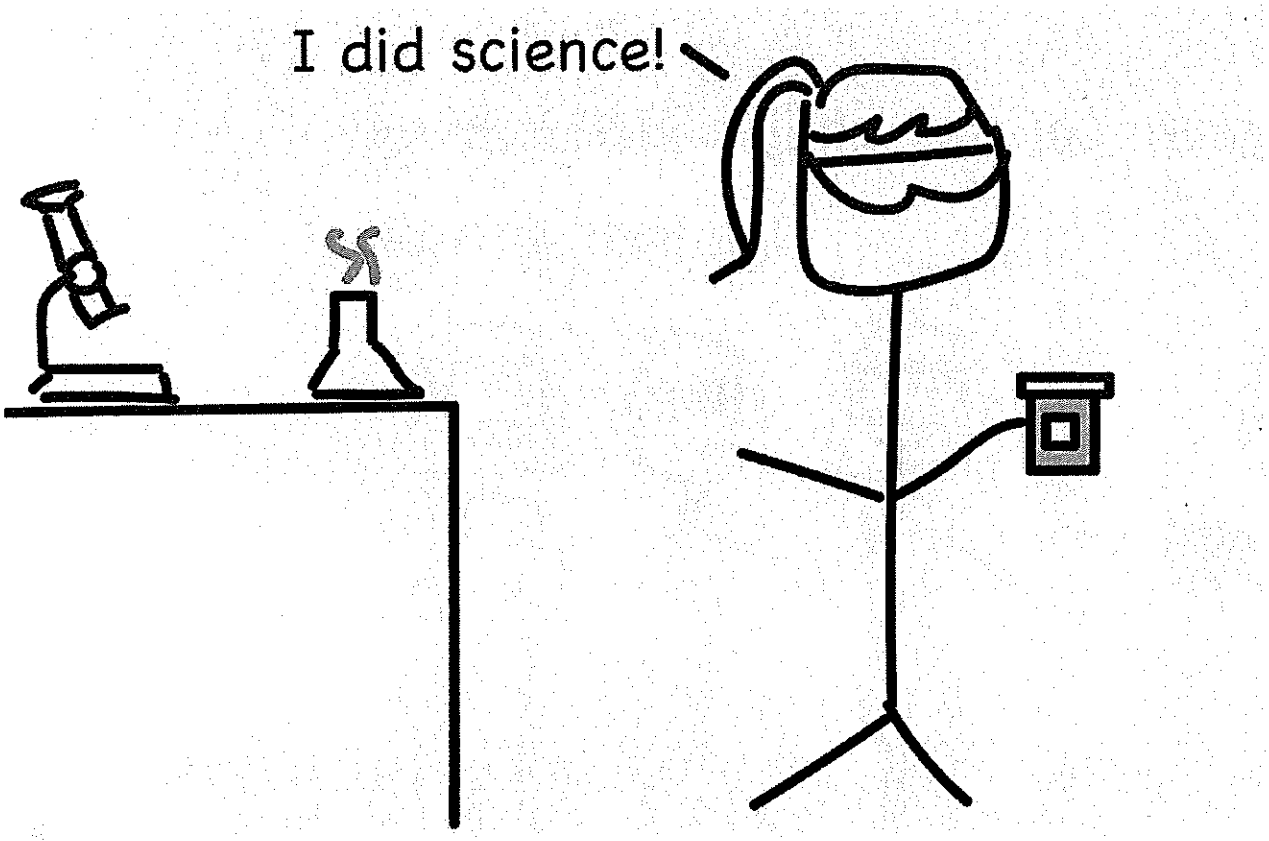
What's harder to see is that if we did lower drug prices, we would be making a trade-off. Lowering drug profits would make pharmaceuticals a less desirable industry for investors. And less investment in drugs would mean less research toward new and innovative cures.

There's this analogy that Craig Garthwaite, a professor at Kellogg School of Management who studies drug prices, gave me that helped make this clear. Think about a venture capitalist who is deciding whether to invest $10 million in a social media app or a cure for pancreatic cancer.

"As you decrease the potential profits I'm going to make from pancreatic cures, I'm going to shift more of my investment over to apps or just keep the money in the bank and earn the money I make there," Garthwaite says.

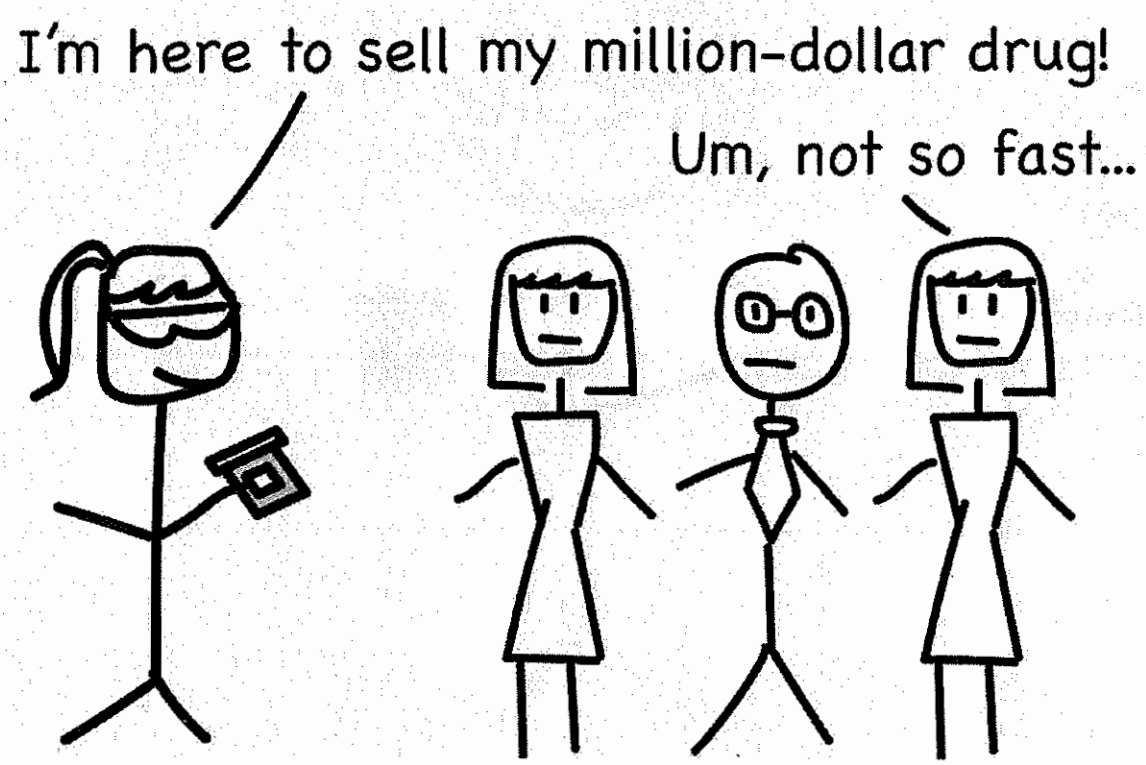
Right now America's high drug prices mean that investing in pharmaceuticals can generate a whole bunch of profits — and that drugs can be too expensive for Americans to afford.

Let's say you're a pharmaceutical executive and you've discovered a new drug. And you want to sell it in Australia. Or Canada. Or Britain.



You're going to want to start setting up some meetings with agencies that make decisions about drug coverage and prices.

These regulatory bodies generally evaluate two things: whether the country wants to buy your drug and, if so, how much they'll pay for it. These decisions are often related, as regulators evaluate whether your new drug is enough of an improvement on whatever is already on the market to warrant a higher price.



So let's say you want to sell your drug in Australia. You'll have to submit an application to the Pharmaceutical Benefits Advisory Committee, where you'll attempt to prove that your drug is more effective than whatever else is on the market right now.

The committee will then make a recommendation to the country's national health care system of whether to buy the drug — and, if the recommendation is to buy it, the committee will suggest what price the health plan ought to pay.

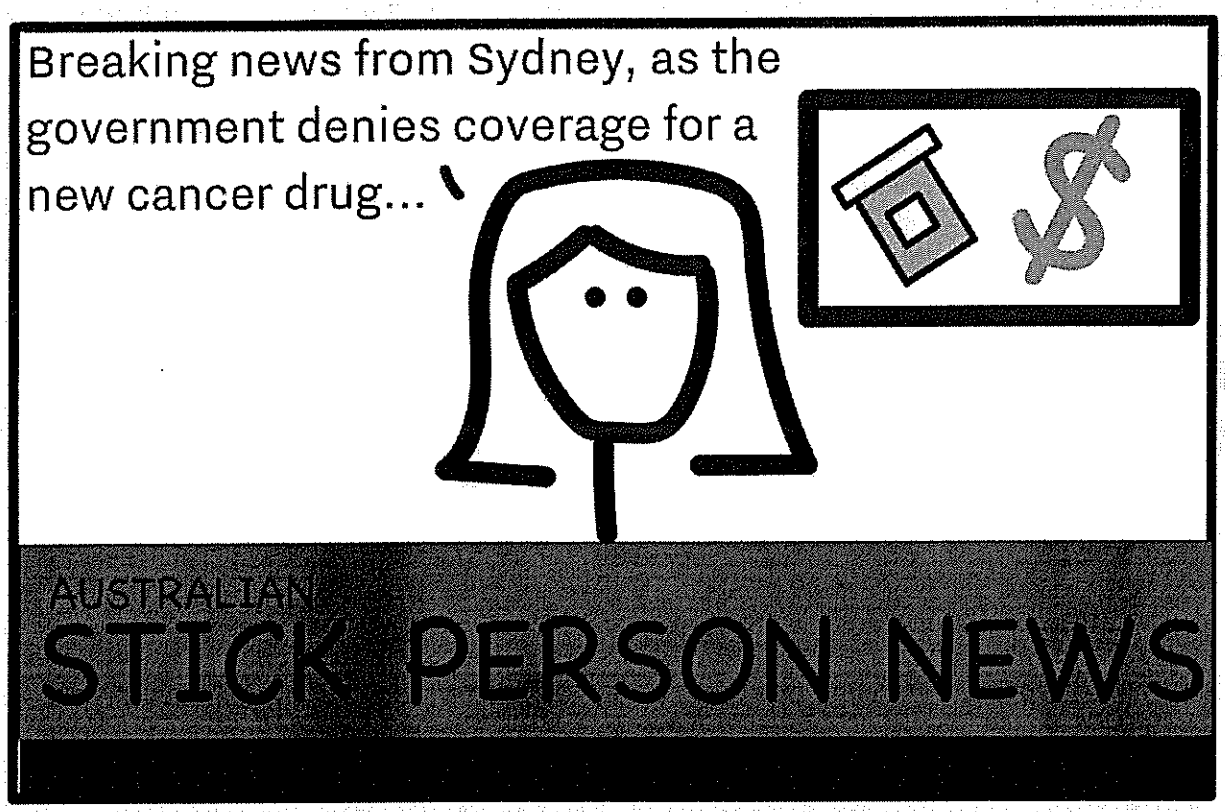
Australia's Pharmaceutical Benefits Advisory Committee is not easy to impress: It has rejected about half of the anti-cancer drug applications it received in the past decade because their benefits didn't seem worth the price.

But if you do succeed — and Australia deems your drug worthy to cover — then you'll have to decide whether the committee has offered a high enough price. If so, congrats! You've entered the Australian drug market.

Other countries regulate the price of drugs because they see them as a public utility

Countries like Australia, Canada, and Britain don't regulate the price of other things that consumers buy, like computers or clothing. But they and dozens of other countries have made the decision to regulate the price of drugs to ensure that medical treatment remains affordable for all citizens, regardless of their income. Medication is treated differently because it is a good that some consumers, quite literally, can't live without.

This decision comes with policy trade-offs, no doubt. Countries like Australia will often refuse to cover drugs that they don't think are worth the price. In order for regulatory agencies to have leverage in negotiating with drugmakers, they have to be able to say no to the drugs they don't think are up to snuff. This means certain drugs that sell in the United States aren't available in other countries — and there are often public outcries when these agencies refuse to approve a given drug.



At the same time, just because there are more drugs on the American market, that doesn't mean all patients can access them. "To think that patients have full access to a wide range of products isn't right," says Aaron Kesselheim, an associate professor of medicine at Harvard Medical School. "If the drugs are so expensive that you can't afford them, that's functionally the same thing as not even having them on the market."

It also doesn't mean we're necessarily getting better treatment. Other countries' regulatory agencies usually reject drugs when they don't think they provide enough benefit to justify the price that drugmakers want to charge. In the United States, those drugs come onto market — which means we get expensive drugs that offer little additional benefit but might be especially good at marketing.

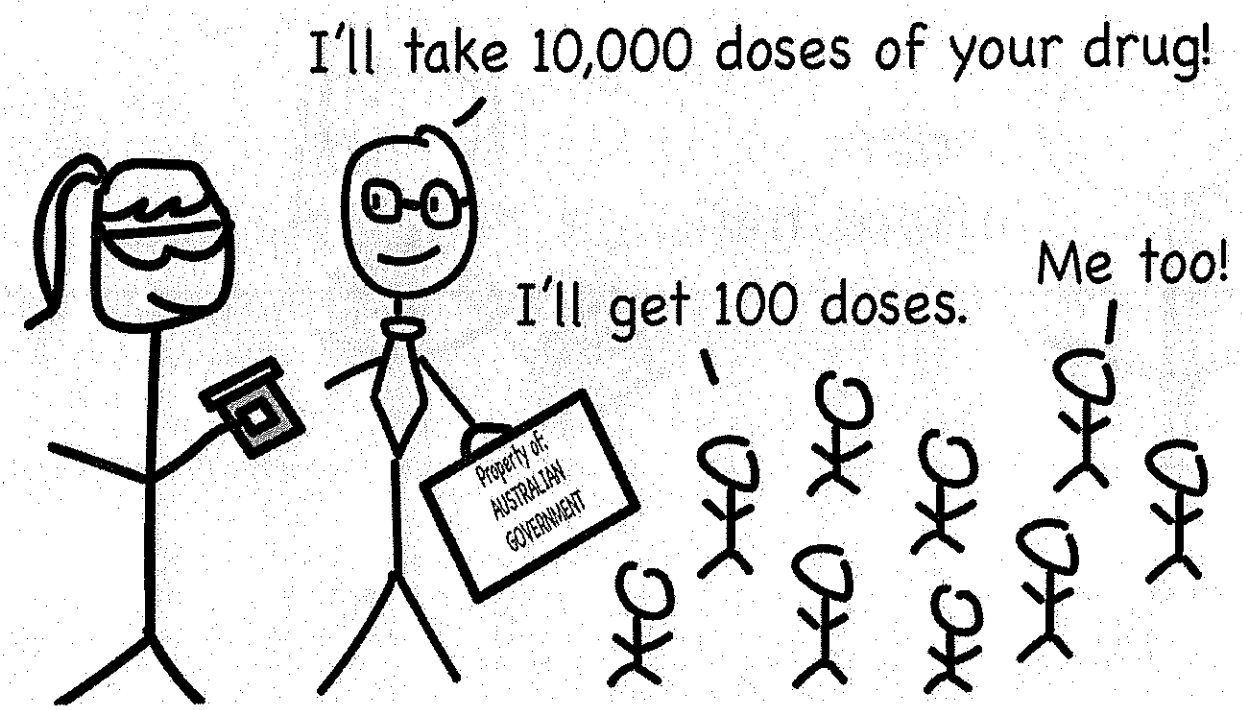
This happened in 2012 with a drug called Zaltrap, which treats colorectal cancer. The drug cost about $11,000 per month — twice as much as its competitors — while, in the **eyes of doctors**, offering no additional benefit.

"In most industries something that offers no advantage of its competitors and yet sells for twice the price would never even get on the market," Peter Bach, an oncologist at Sloan-Kettering Memorial Hospital, wrote in a **New York Times op-ed**. "But that is not how things work for drugs. The Food and Drug Administration approves drugs if they are shown to be 'safe and effective.' It does not consider what the relative costs might be."

What happens when you don't price-regulate drugs? Just look at the United States.

The United States has no government panel that negotiates drug prices. There are thousands of health insurance plans all across the country. Each has to negotiate its own prices with drugmakers separately. Because Americans are fragmented across all these different health insurers, plans have much less bargaining power to demand lower prices.

In other words: Australia is buying drugs in bulk, like you would at Costco, while we're picking up tiny bottles at the local pharmacy. You can guess who is paying more.



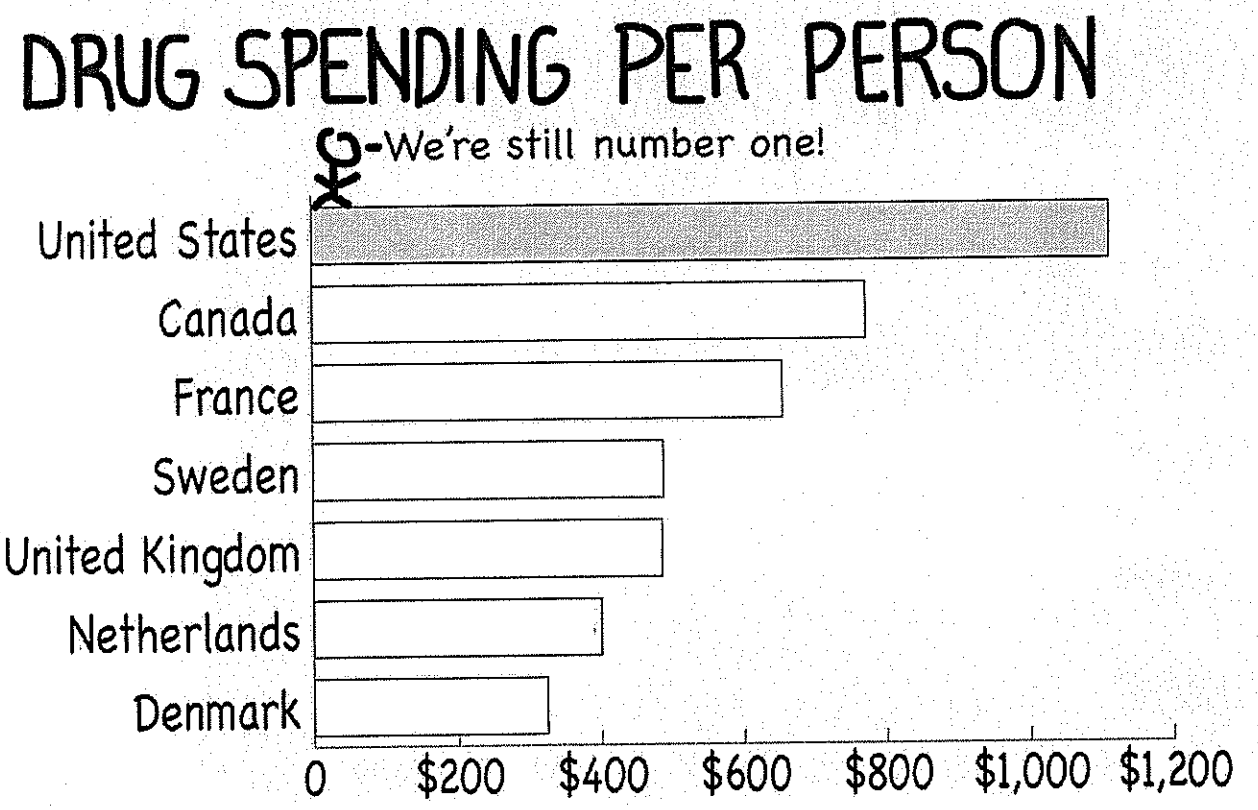
"You could say that American health care providers and pharmaceuticals are essentially taking advantage of the American public because they have such a fragmented system," Tom Sackville, president of the International Federation of Health Plans, says. "The system is so divided, it's easy to conquer."

There is one especially large health insurance plan in the United States: Medicare, which covers about 55 million Americans over the age of 65. But federal law expressly prohibits Medicare from negotiating drug prices or making decisions about which drugs it covers. Instead, Medicare is required to cover nearly all drugs that the Food and Drug Administration approves. This means that Medicare must cover drugs that aren't an improvement over what currently exists, so long as the FDA finds they're safe for human consumption.

Drugmakers know that as long as their products are safe, Medicare will buy them. "For Medicare, the sky really is the limit," on drug prices, says Jamie Love, who has studied drug pricing and directs the DC nonprofit Knowledge Ecology International.

Americans end up spending way more on prescription drugs than anyone else

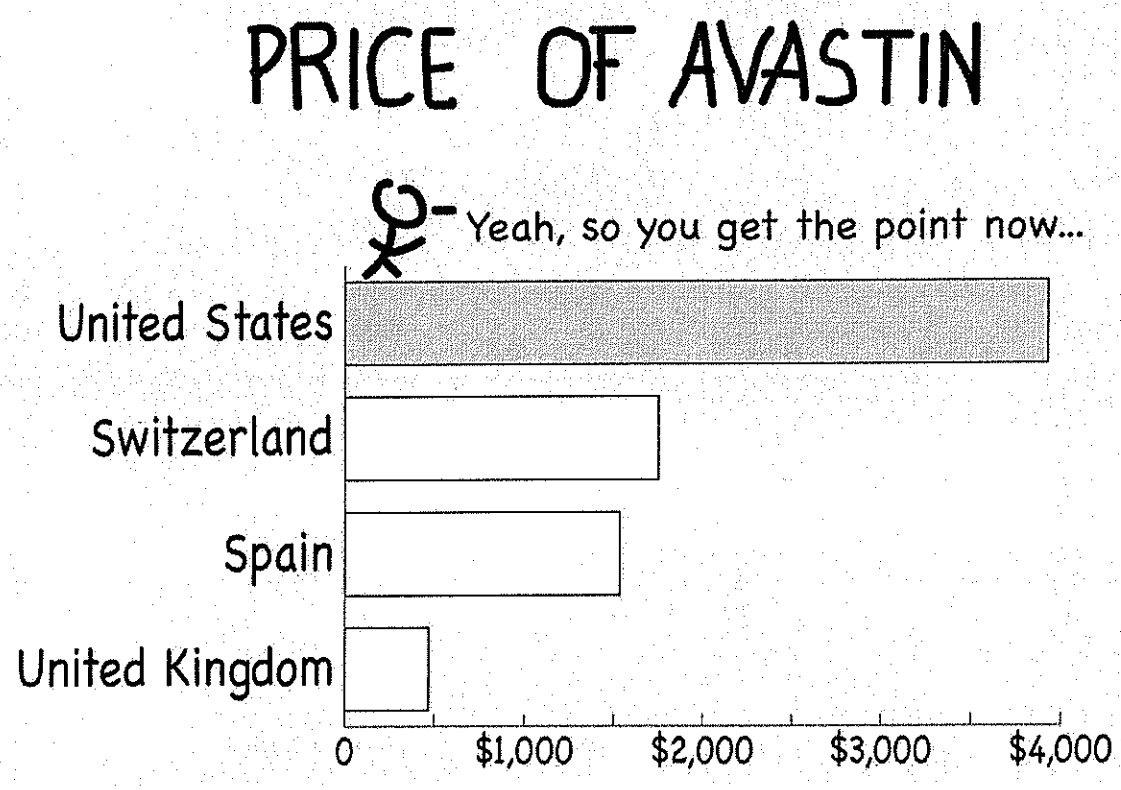
The result of this system is that Americans spend $858 per person on prescription drugs. That's about twice as much as Australians and three times as much as the Dutch.



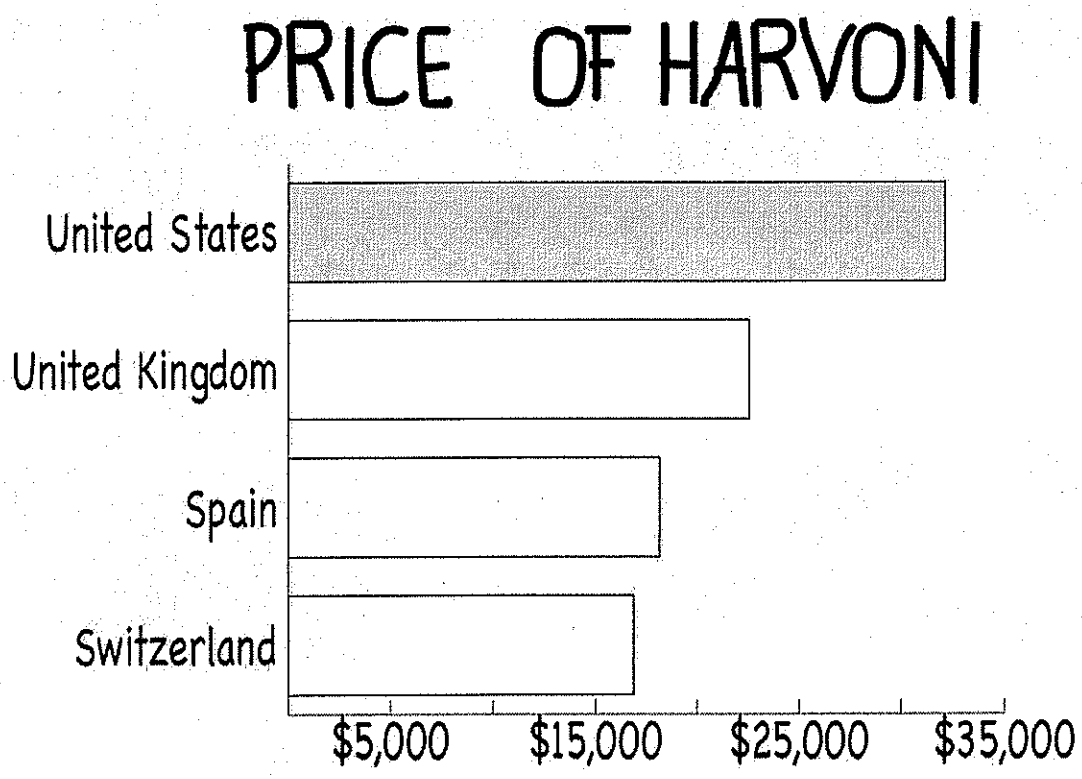
Americans aren't buying lots more drugs. We're just spending more on the ones we do buy.

There isn't much evidence that Americans use an inordinately high amount of prescription drugs. It's just that when we buy prescription medications, we pay more for the exact same product.

These are the prices for the cancer drug Avastin in different countries.



And these are the prices for Harvoni, a drug that cures hepatitis C.



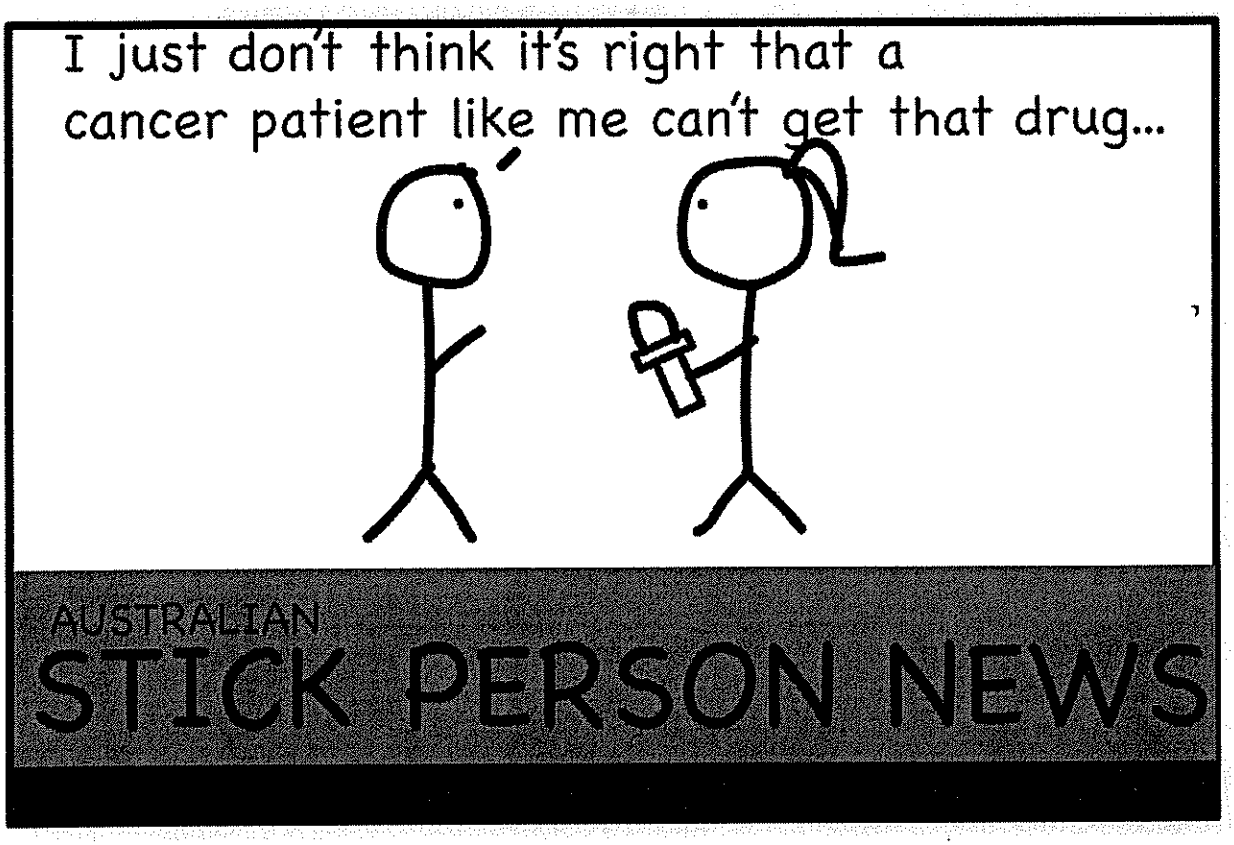
Pick any brand-name drug, and you'll almost certainly find that the price in the United States is significantly higher than in other countries.

What would happen if the United States started price-regulating drugs?

For one thing, we'd spend less on prescription drugs. If the United States set up an agency that negotiated drug prices on behalf of the country's 319 million residents, it would likely be able to demand discounts similar to those of European countries.

This would mean that health insurance premiums wouldn't go up nearly as quickly — they might even go down.

There would be trade-offs. We'd likely have to give up some of the choice of drugs that our insurance plans cover. If a national board made decisions about what prices were appropriate for drugs, it would need to have the ability to reject the drugs that didn't make the cut.



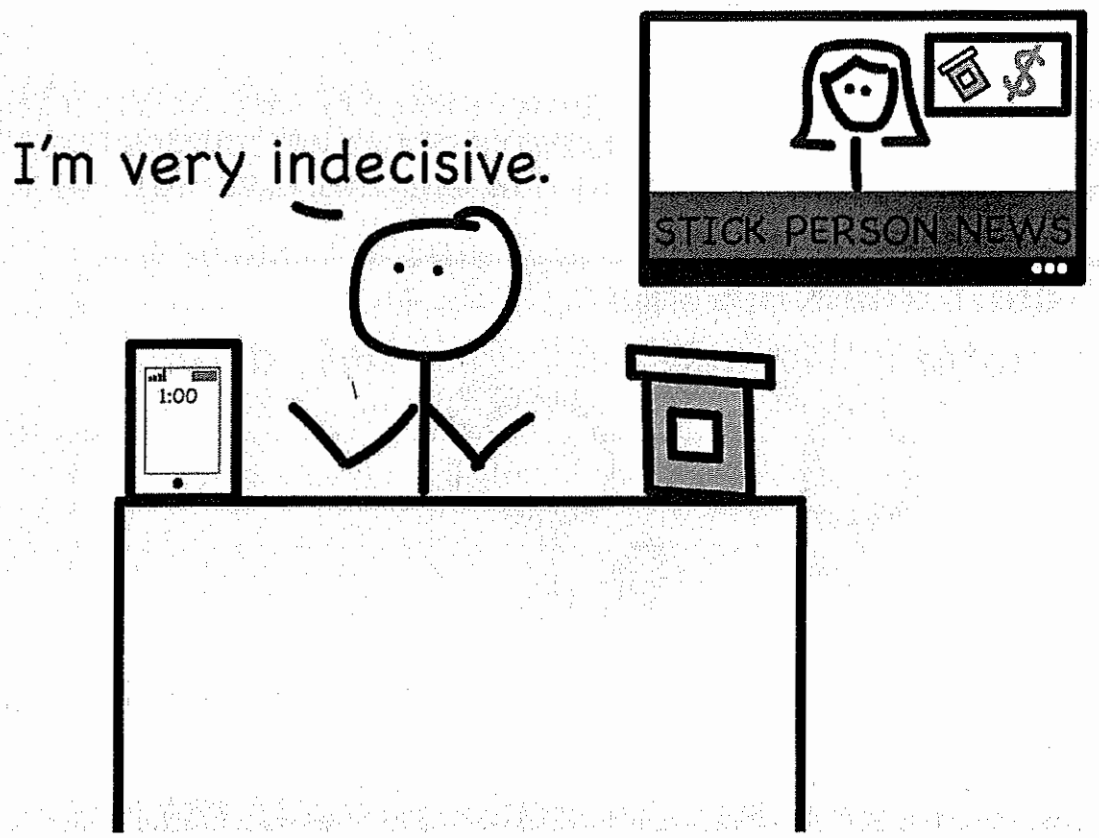
Consider the Veterans Health Administration, which does negotiate drug prices. It gets drugs that are usually **40 percent** cheaper than what Medicare pays. But it also covers fewer products.

Margot Sanger-Katz recently reported for the New York Times that "many older patients who get their health insurance from the V.A. also sign up for Medicare drug plans to cover medicines that the V.A. won't." At the same time, VA doctors **do say** their patients are generally able to obtain the medications they prescribe.

Economic research suggests that price regulation might mean less innovative drugs, too

Investors respond to economic incentives. When they see a market that will pay lots of money for their products, they'll put more money toward developing the type of drugs that market wants.

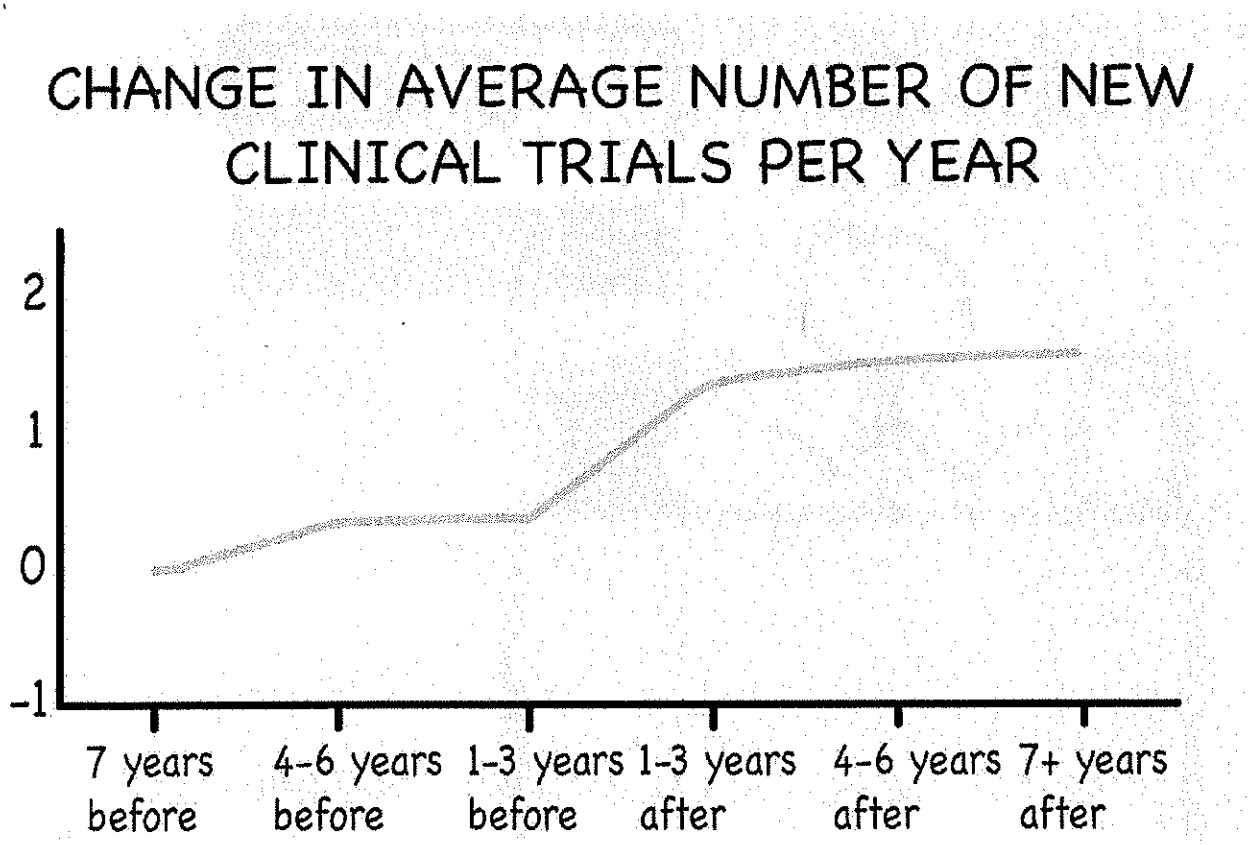
Consider the hypothetical venture capitalist from earlier, who is thinking about whether to fund a biotech firm or a social media startup.



Part of that decision will revolve around the type of business that interests her — and part around what profits she thinks can be made.

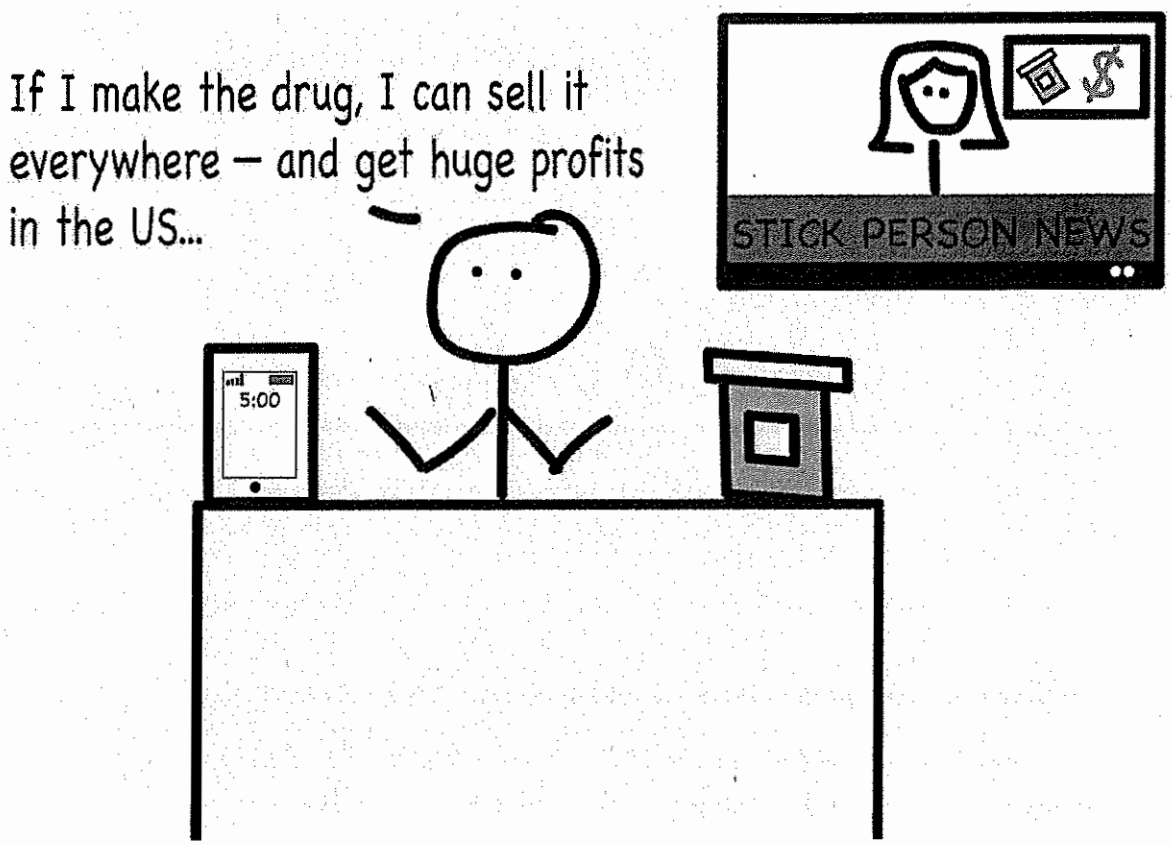
We've seen this happen in real life, too: When the government mandates the coverage of a new type of drug, there are more clinical trials to develop that particular treatment.

Consider the work of MIT economist Amy Finkelstein. She **looked at** what happened after Medicare began covering the flu vaccine for its millions of enrollees. And she found that with the usage of the flu vaccine guaranteed to increase, there was a 2.5-fold increase in clinical trials for new flu vaccines.



Separate research shows a significant increase in research dollars for drugs that the elderly typically take after Medicare began covering prescription drugs in 2005.

Right now, the United States' exceptionally high drug prices help subsidize the rest of the world's drug research. We benefit from that work with new and better prescriptions — and so does the rest of the world.



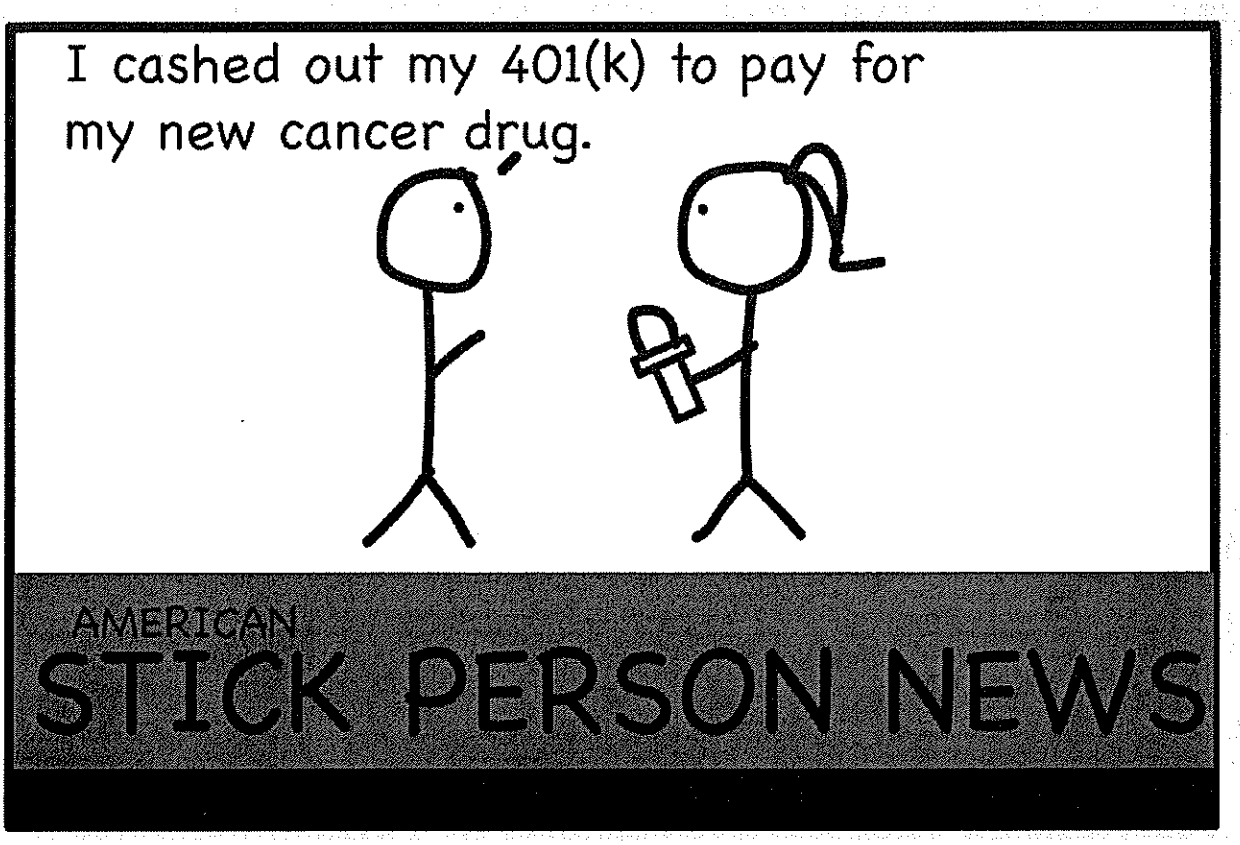
In other words: Right now, the United States is subsidizing the rest of the world's drug research by paying out really high prices. If we stopped doing that, it would likely mean fewer dollars spent on pharmaceutical research — and less progress developing new drugs for Americans and everybody else.

This is a central dilemma in drug pricing policy: Should we trade off some innovation for some access?

Every policy decision comes with trade-offs, and that's true of regulating drug prices. If the United States began to price regulate drugs, medications would become cheaper. That would mean Americans have more access to drugs but could also expect a decline in research and development of new drugs.

We might have fewer biotech firms starting up, or companies deciding it's worth bringing a new drug to market.

That might be okay: We might decide as a society that we are willing to trade some level of innovative to lower drug prices and make medication more financially accessible to those who need them right now.



It's a hard question to think about: Do we want to lower the price of the hepatitis C cure that hit the market for $84,000 — knowing that price controls might lead to less investment in pursuing other cures in the future?

"If you have hepatitis C today, you probably want to have the drug for a cheaper price," Garthwaite says. "If you have pancreatic cancer today, you probably want to do everything you can to get more money put into the research and development pipeline to cure that disease."

He adds, "This isn't an easy question to think about, how much innovation we're comfortable paying for — or the idea that we might be spending too much on innovation."

But it's a conversation that America's exceptionally high drug prices are forcing us to consider, as drug prices skyrocket — and **one in four** Americans report trouble paying for their prescription drugs.

Are we, as a country, comfortable paying higher prices for drugs to get more innovation? Or would we trade some of that innovation to make our drugs more accessible to those of all income levels?

February 19, 2018

The Honorable Edward Butler, Chair
House Commerce and Consumer Affairs Committee
Legislative Office Building Room 302
Concord, NH 03301

Re: New Futures' support of HB 659

Dear Chairman Butler and Members of the Committee:

New Futures appreciates the opportunity to testify in support of HB 659, which would require insurance carriers to provide information about spread amounts and rebate amounts. New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to improve the health and wellness of all New Hampshire residents. In this role, we work extensively with policy makers, health care providers and families to increase access to quality, affordable health care throughout the Granite State. In recent years, with the increasing cost of pharmaceutical drug prices, including generics that have been on the market for decades, transparency in the pharmaceutical industry is of particular concern to New Futures.

One factor leading to the increases in pharmaceutical drug prices is the rebates that drug manufactures provide to Pharmacy Benefit Managers (PBM). PBM are intermediaries between the health insurance companies and the pharmacies. They set the formularies, develop the plan's network of pharmacies, and negotiate price rebates with the prescription drug manufactures. These rebates are often in exchange for a drug being added to the formulary. Little is known about how much of the rebate is passed on to the health insurance companies and how much is kept by the PBM.

The rebates have increased, nearly doubling in the last few years, but the rebate amounts are not being passed along to the consumer nor are they passed along to the insurance company. This creates a conflict for the PBMs in that they have an incentive to include higher cost medications on the formulary to receive higher rebate amounts.

Last summer, I participated in the HB 1418 Commission to Study Greater Transparency in Pharmaceutical Costs and Drug Rebate Programs (Commission). Although the Commission heard testimony from many stakeholders, it did not have enough time to complete its study. The Commission was not able to come to a consensus around any legislative recommendations; however, individual Commission members did make suggestions for legislative change. One thing that was clear from the testimony is that increasing drug prices are not the result of any one entity type (i.e. manufacturers, PBM, insurers, etc.), but due to what is going on in the entire system. The problem is, the system is very opaque, and no one can see what is truly causing the skyrocketing prices.

One of the legislative suggestions that resulted from the Commission was to gather information on spread amounts and rebate amounts, which HB 659 would do. Spread amounts are the difference between what a PBM contracts to pay a manufacturer for a certain medication and what it gets reimbursed from the health insurance carrier. PBM contract to pay manufacturers less than they are

getting reimbursed and they keep the difference as profit. Little is known about the amount of the spreads or the rebates. PBM state that they save money for the insurers, which keeps premiums down. However, it is unclear if this really is the case. If the New Hampshire Insurance Department (NHID) had access to this data, it could assess whether or not PBM save money or end up costing insurers more, thus leading to higher premiums for consumers.

Until a governmental agency, such as the NHID, can begin taking a look at the business practices of manufactures, PBMs, insurers, wholesalers, and pharmacies to see what is driving the high cost of drugs, it will be unclear what legislative fixes are appropriate. Greater transparency into the entire system is necessary so that policy makers know how to remedy the problem, thus making pharmaceutical drugs more affordable to those who need them. HB 659 is one step and one bill among many this session that will lead to greater transparency. For those reasons, New Futures urges the Committee vote HB 659 ought to pass.

Please do not hesitate to contact me if you have any questions.

Respectfully submitted,

Holly A. Stevens, Esq.
Health Policy Coordinator

Bill as Introduced

HB 659 - AS INTRODUCED

2019 SESSION

19-0803
01/03

HOUSE BILL ***659***

AN ACT relative to reporting of internal pharmaceutical costs.

SPONSORS: Rep. Butler, Carr. 7; Rep. Marsh, Carr. 8; Rep. Knirk, Carr. 3

COMMITTEE: Commerce and Consumer Affairs

ANALYSIS

This bill requires the insurance commissioner to request data from health carriers regarding prescription drug benefits which are outsourced to a pharmacy benefit manager or similar entity as part of the preparation for the department's annual hearing requirement.

This bill is a result of the commission to study greater transparency in pharmaceutical costs and rebate programs established in 2018, 350.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 659 - AS INTRODUCED

19-0803
01/03

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to reporting of internal pharmaceutical costs.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraph; Health Coverage; Requested Information. Amend RSA 420-G:14-a by inserting after paragraph V the following new paragraph:

V-a. With respect to prescription drug benefits that are outsourced to a pharmacy benefit manager or similar entity, the commissioner shall request and health carriers shall supply information and data, no later than June 30. The information and data shall include spread amounts between payments to pharmacies and amounts paid to the pharmacy benefit manager by the carrier, drug rebate amounts from drug manufacturers to the pharmacy benefit manager or the carrier, and all administrative fees charged by the pharmacy benefit manager to the carrier, including, but not limited to, fees for wellness or disease management programs, analytic services, and claims processing. This requirement shall exist whether or not the pharmacy benefit manager or similar entity is affiliated with the carrier. The carrier may identify information as confidential and the department shall not publish those data on a carrier specific basis.

2 Effective Date. This act shall take effect 60 days after its passage.