Testimony of the National Academy for State Health Policy Regarding House Bill 7443 – An Act Relating to Food and Drugs – Prescription Drug Cost Protection

Representative Donovan and Members of the Health and Human Services Committee,

My name is Drew Gattine and I am a Senior Policy Consultant at the National Academy for State Health Policy (NASHP). NASHP is a non-partisan forum of state policy makers that works to develop and promote innovative health care policy solutions at the state level. 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 they have on consumers, the overall cost of health care and state budgets.

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. 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.

NASHP is a non-partisan organization. We recognize state policy reflects the unique situations in each state however, so we do not take positions on legislative proposals. I am here not "for" or "against" the bill, but to share information and to help answer questions.

In November 2022 NASHP released model legislation to use the Medicare Fair Price (MFP) as an upper payment limit (UPL). House Bill 7443 is based on the NASHP model.

These bills direct the state to leverage critical drug pricing provisions in the landmark Inflation Reduction Act (IRA). The IRA contains several provisions designed to help reduce the costs of prescription drugs, including provisions that will allow Medicare for the first time to negotiate

the cost of several high-cost drugs. The price negotiation process began 2023 when Medicare published the list of 10 drugs subject to initial price negotiations. These drugs include critical treatments for cardiovascular disease, diabetes, autoimmune disease and cancer. These drugs account for approximately $50 billion in annual spending by Medicare Part D. The negotiation process is on-going and CMS intends to publish the final negotiated price – the Medicare Fair Price (MFP) - for the first ten drugs by September 1, 2024.

This bill directs the state to use the Medicare negotiated price as the UPL for drugs sold in the state. This means that the payment limits set by Medicare will apply to private and public purchasers including ERISA plans that choose to participate.

A state process that sets a UPL, basically a ceiling payment rate, is not price-setting. Manufacturers are free to set whatever price they chose. A UPL caps what a purchaser will pay. Determining maximum payment levels or payment rates for health care and other public goods is a state practice that has existed for decades. States regulate insurers and other public goods and services in markets with little or no market competition and set payment rates for health services through their public purchasing. These bills extend that precedent to prescription drugs by using Medicare's negotiated rate as reference points to set fair payment rates.

The process for selecting drugs and negotiating prices is described in detail in the Inflation Reduction Act. The federal Department of Health and Human Services (HHS) compiles a list of drugs that meet the criteria described in the statute. Negotiations are limited to single-source drugs that (1) are at least 7 years (small molecule) or 11 years (biologic) beyond FDA approval; and (2) account for at least $200 million spend across Medicare Parts B and D. The IRA excludes from negotiation drugs marketed as generic/biosimilar (or biologics with reference biosimilar pending entrance within 2 years), orphan drugs that treat a single rare disease, and plasma products. From those drugs, HHS selects the top 10 drugs in order of highest to lowest spending.

HHS will then review information submitted from the manufacturer and determine a Maximum Fair Price. Manufacturers can accept or propose a counteroffer. HHS then publishes the final Maximum Fair Price (MFP), which is binding.

It is not currently possible to determine the savings that Rhode Island or other individual states would realize if they referenced the MFP because the prices have yet been determined. However, the savings estimated by Medicare are significant (estimated at $98.5 billion over ten years) and would undoubtedly translate into large savings at the state level. Depending on how long a drug has been on the market, the IRA ceiling price will be capped at 40% to 70% of average manufacturer price.

The UPL applies to all purchasers in the state, including commercial insurers, state entities and ERISA plans that elect to participate. This bill, like the NASHP model, requires purchasers to utilize savings to reduce costs for their members. Purchasers (including participating ERISA plans) must submit a report to the Insurance Commissioner indicating how much they saved by

participating and how they passed those savings on to consumers and how those savings helped to reduce cost disparities.

As the Committee continues its work on this bill NASHP is available to support your work as necessary. For further details on the legal issues related to reference pricing and UPLs, please see a white paper authored by Professor Rachel Sachs with a detailed analysis of the patent law and commerce clause implications of upper payments for a similar model bill related to international reference rates.

The NASHP website also contains other materials (Written Q&A, Blog Articles, etc.) that may be useful material for the Committee. Thank you.

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