Testimony of the National Academy for State Health Policy Regarding H8220

Chair Donovan and Esteemed Members of the Health and Human Services Committee,

My name is Drew Gattine and I am a Senior Policy Consultant for the Center for Prescription Drug Pricing at the National Academy for State Health Policy (NASHP). NASHP is a non-partisan forum of state policy makers that works with states 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" this bills, but to share information and to help answer questions.

In 2017 NASHP created the original model bill creating a state Prescription Drug Affordability Board (PDAB) and released a revised model in 2022. H8220 which would create a Drug Cost Review Commission has many similar elements of the NASHP PDAB model and, if passed, would create an entity in Rhode Island that has many similar characteristics to PDABs enacted in other states.

As we know high drug prices and dramatic annual increases in the price of prescription drugs are a significant driver in the unsustainable cost of health care for Americans. Sometimes price increases can arguably be justified by changes in the market, or an increase in the cost of production or by a reassessment of the clinical value of the product. But in many cases, they are

not. Often drug companies set high prices on life-sustaining products simply because they can and because manufacturers know that in a market that does not effectively regulate the cost for life saving products that people need, they can get away with increasing pricesand setting launch prices at a rate that far exceeds any alleged need to cover increased costs.

Prescription Drug Affordability Boards (PDABs)

In 2017, NASHP released its first model bill to create a state-based PDAB. PDABs can be used to limit – and even lower – prescription drug costs by analyzing the affordability of high cost drugs and imposing upper payment limits (UPLs), a ceiling on the amount that a payer can reimburse for the purchase of a drug the PDAB determines to be unaffordable.

Since NASHP released its initial model, seven states (Colorado, Maryland, Maine, Minnesota, New Hampshire, Oregon and Washington) have enacted PDABs. Maryland was the first in the nation to pass a PDAB in 2019 and has a process to phase in setting upper payment limits, starting with public purchasers. In 2021, Colorado created a PDAB with broad authority to set upper payment limits across all payers within the state. Oregon also created its PDAB in 2021. In 2022, the legislature in Washington State created a PDAB that also has authority to set upper payment limits. In the 2023 legislative session, Minnesota became the seventh state to create a PDAB and the Minnesota PDAB will have the ability to set upper payment limits.

NASHP convenes a regular meeting of the seven states that have created Prescription Drug Affordability Boards ("PDABs") so that they can share technical expertise and other knowledge and experience.

In 2022 NASHP developed a revised PDAB model that reflects lessons learned, best practices, and shared experience. The model also incorporates experiences from states that have implemented comprehensive drug price transparency laws.

Although there are differences among the various enacted PDABs, the Boards with the greatest potential to directly impact the cost of drugs have been given the statutory authority to set upper payment limits (UPLs). UPLs are a maximum rate applicable to payors and purchasers. UPLs are not price control – manufacturers are still free to set the wholesale price – but they do create a limit above which purchasers are not allowed to pay. As mentioned, the PDABs in Colorado, Maryland, Washington and Minnesota have this tool at their disposal. The legislation before this committee would give a Rhode Island the ability to set an upper payment limit if it determines a drug to be unaffordable.

If passed, Rhode Island's Drug Cost Review Commission will be well positioned to have a direct impact on costs. It shares many of the other characteristics that states have found to be important when implementing PDABs:

- The Board is appointed and is designed to operate independently. It is comprised of people with expertise but requires them to be free of any conflict of interest.
- It is designed to seek the engagement from stakeholders and is required to conduct its work in public.
- It sets clear criteria for what drugs will be subject to review based upon cost and covers both prescription and generic drugs and biologics. It looks at high launch prices and annual price increases. It also sets specific criteria for how the Board will assess affordability.
- As mentioned above, similar to the PDABs in Colorado, Maryland, Washington and Minnesota, the Rhode Island commission would have the ability to take action by setting a ceiling rate that health care payers and others in the distribution chain are allowed to pay. It builds significant safeguards for appeals by any interested entity.

PDABs and similar entities such as the commission contemplated in H8220 are designed to conduct their work in a methodical and analytical way, leveraging data and seeking stakeholder input. The work of the PDAB involves 1) gathering information about the cost of drugs; 2) selecting drugs based upon defined criteria; 3) assessing affordability of those drugs; and (only after concluding that a drug is unaffordable) 4) determining whether to move forward with setting a UPL. The decision to actually implement a UPL is a determination that is ultimately left to the Board. The Board can set an upper payment limit only if it determines that a drug presents an affordability challenge to the health care system in Rhode Island or high out of pocket costs for Rhode Island people.

During the legislative process manufacturers and business interests routinely oppose the creation of PDABs, arguing that rate-setting in the form of upper payment limits is not permitted under the Dormant Commerce Clause and federal patent law. As it has with other model bills, NASHP has designed its model PDAB bill to withstand these anticipated legal challenges. A copy of NASHP's legal analysis specific to PDABs is available on our website, along with a Q&A and Blog.

As the Committee continues its work on this bill NASHP is available to support your work as necessary.

Thank you.

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