STATEMENT

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In Opposition to Rhode Island House Bill 8220 (Representative Corvese)

May 9, 2024

Position: PhRMA respectfully opposes House Bill 8220 (HB 8220). PhRMA believes that discussions about the affordability of medicines are important, but the intention of this bill is for the government to decide drug prices, which could limit the prescription options available to Rhode Island residents. HB 8220 shortsightedly targets drug spending in ways that likely will have long-term, harmful effects on innovation and the development of new, life-saving therapies.

Specifically, HB 8220 establishes the Rhode Island Drug Cost Review Commission, a government-appointed Board to review prescription drug costs and value with the goal of setting price limits by way of an "upper payment limit" (UPL) for the entire drug supply system. Regulating drug prices in-state could lead to a shortage of or limit access to medicines for patients. Specifically, if a pharmacy or provider cannot obtain a medicine at the government price, the medicine may not be available to Rhode Island residents. By disincentivizing the development of innovative treatments, this legislation could threaten the positive effect that the biopharmaceutical industry has on Rhode Island's economy.

This legislation ignores that there are meaningful policies for addressing affordability without importing government price setting that could reduce treatment options.

PhRMA is increasingly concerned that the substantial rebates and discounts paid by pharmaceutical manufacturers, approximately $334 billion in 2023,[1] do not make their way to offsetting patient costs at the pharmacy counter. Patients need concrete reforms that will help lower the price they pay for medicines at the pharmacy, such as sharing negotiated savings on medicines with patients, making cost-sharing assistance count toward a plan's out-of-pocket spending requirements, and making monthly costs more predictable. These policies can be done without importing government price setting, which can reduce the options available to treat patients.

This legislation does not account for insurance benefit design issues that prevent discounts from flowing to patients, and HB 8220 assumes incorrectly that the price a patient pays is determined solely by drug manufacturers.

This legislation singles out the biopharmaceutical industry and ignores the variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy

[1] Fein, A. "The 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute. March 2024.

benefit managers (PBMs), wholesalers, and the government. The important role that these entities play in determining drug coverage and patient out-of-pocket costs is overlooked by the requirements of this legislation. For example, PBMs and payers—which dictate the terms of coverage for medicines and the amount a patient ultimately pays—negotiate substantial rebates and discounts.

According to research from the Berkeley Research Group (BRG), rebates, discounts, and fees account for an increasing share of spending for brand medicines each year, while the share received by manufacturers has decreased over time. In 2020 manufacturers retained only 49.5% of brand medicine spending while members of the supply chain retained 50.5%.[2] Increased rebates and discounts have largely offset the modest increases in list prices and reflect the competitive market for brand medicines.

The growth of net price prices, which reflects rebates and discounts, has been in line with or below inflation for the past six years.[3] Specifically, net prices for brand medicines averaged 0.0% growth in 2022.[4] Through the first three quarters of 2023, net prices declined by -3.0%.[5] Looking ahead, average net price growth is projected to be -5 to -2% per year through 2027.[6] This, of course, does not necessarily reconcile with what patients are feeling at the pharmacy counter, which is why looking at the whole system is so important. For example, despite manufacturers' rebates and discounts negotiated by health plans, nearly half of commercially insured patients' out-of-pocket spending for brand medicines is based on the medicine's list price rather than the negotiated price that health plans receive.[7]

Price controls on brand medicines raise constitutional concerns.

This bill raises constitutional questions, such as under the Due Process Clause, among other concerns, because the bill provides broad authority to the Commission, with very few standards or safeguards to ensure that authority is exercised in a consistent manner, as well as under the Supremacy Clause. The bill also raises constitutional concerns about Rhode Island's ability to regulate commercial activity beyond its own borders. See Nat'l Pork Producers Council v. Ross, 143 S. Ct. 1142, 1157 n.1 (2023); Association for Affordable Medicines v. Frosh, 887 F.3d 664 (4th Cir. 2018).

Requiring advance notice of price increases could harm consumers, interfere with market competition, and raises constitutional concerns.

HB 8220 would require manufacturers to provide 30 days advance notification of wholesale acquisition cost (WAC) price increases. The WAC price does not account for rebates, discounts, and other price concessions provided for prescription medicines and therefore, does not accurately reflect the true cost to an insurer or pharmacy benefit manager. According to IQVIA, in 2022, brand prescription medicine invoice prices (~WAC prices) increased by 3.7% but the associated net prices stayed flat (0.0% growth)

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[2] BRG: The Pharmaceutical Supply Chain, 2013–2020. January 2022.

[3] IQVIA. "Use of Medicines in the U.S. 2023: Usage and Spending Trends and Outlook to 2027." Published May 2023; Fein, A. "Tales of the Unsurprised: U.S. Brand-Name Drug Prices Fell for an Unprecedented Sixth Consecutive Year (And Will Fall Further in 2024)," Drug Channels. Access: https://www.drugchannels.net/2024/01/tales-of-unsurprised-us-brand-name-drug.html#:~:text=Net%20prices%20for%20brand%2Dname,%2D3.0%25%20minus%205.4%25). January 3, 2024.

[4] IQVIA. "Use of Medicines in the U.S. 2023: Usage and Spending Trends and Outlook to 2027." Published May 2023.

[5] Fein, A. "Tales of the Unsurprised: U.S. Brand-Name Drug Prices Fell for an Unprecedented Sixth Consecutive Year (And Will Fall Further in 2024)," Drug Channels. Access: https://www.drugchannels.net/2024/01/tales-of-unsurprised-us-brand-name-drug.html#:~:text=Net%20prices%20for%20brand%2Dname,%2D3.0%25%20minus%205.4%25). January 3, 2024.

[6] IQVIA. "Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2027." Published May 2023.

[7] IQVIA Institute for Human Data Science. Medicine spending and affordability in the United States. Published August 2020. Accessed August 2020. https://www.iqvia.com/insights/theiqvia-institute/reports/medicine-spending-and-affordabilityin-the-us

when accounting for rebates and discounts.[8] Patient premiums account for the discounted price paid by the insurer, thus, modest increases in net prices will not have any impact on a plan's overall costs. Such notification could also result in voluminous reporting that will in no way assist in making thoughtful changes to formulary design or budgeting decisions.

Advance notification of WAC price increases creates financial incentives for secondary distributors to enter the pharmaceutical supply chain, thus creating a "gray" market. Gray market distribution networks consist of a number of different companies – some doing business as pharmacies and some as distributors – that buy and resell medicines to each other before one of them finally sells the drugs to a hospital or other health care facility. As the medicines are sold from one secondary distributor to another, the possibility of counterfeit medicines infiltrating the supply of legitimate medicines increases, thereby threatening patient safety. In the past, this type of purchasing has caused great difficulty for hospitals. For example, during medicine shortages, hospitals are sometimes unable to buy medicines from their normal trading partners, usually one of the three large national "primary" distributors, AmerisourceBergen, Cardinal Health, or McKesson. At the same time, hospitals are deluged by sales solicitations from gray market companies offering to sell the shortage medicines for prices that are often hundreds of times higher than the prices normally paid.

Furthermore, the U.S. Court of Appeals for the Fourth Circuit overturned a Maryland drug pricing law in 2019 on grounds because it regulated the price of transactions that occurred outside of the state.[9]

This legislation could harm Rhode Island's economy.

On average, it takes more than 10 years and $2.6 billion to research and develop a new medicine. Just 12% of drug candidates that enter clinical testing are approved for use by patients. Efforts to impart price controls on innovative manufacturers could chill the research and development of new medicines by taking away the incentives that allow manufacturers to invent new medicines. Price controls also could severely reduce Rhode Island patients' access to medicines, as is seen abroad.

The biopharmaceutical sector is committed to bringing new treatments and cures to patients. This commitment to innovation supports high-quality jobs and is a vital part of Rhode Island's economy and its economic competitiveness. The biopharmaceutical sector directly accounted for 2,005 jobs in Rhode Island in 2020 and supported another 9,183 jobs for a total of 11,188 jobs. These jobs generated over $196.2 million in state and federal tax revenue for Rhode Island in 2020.[10] This bill could place these jobs, and tax revenue, in jeopardy.

PhRMA recognizes the access challenges faced by patients in Rhode Island with serious diseases. We stand ready to work with the Rhode Island legislature to develop market-based solutions that help patients better afford their medicines at the pharmacy counter. We believe this bill could risk patient access to current and future medicines and respectfully oppose the passage of HB 8220.

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[8] IQVIA. "Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2027." Published May 2023.

[9] *Ass'n for Accessible Medicines v. Frosh ("AAM")*, 887 F.3d 664 (4th Cir. 2018), *cert. denied*, 139 S. Ct. 1168 (2019).

[10] TEConomy Partners, LLC. The Economic Impact of the U.S. Biopharmaceutical Industry: 2020 National and State Estimates. Report prepared for PhRMA.