STATEMENT

PhRMA
RESEARCH • PROGRESS • HOPE

In Opposition to Minnesota House File 1246 (HF 1246)
Prescription Drug Price Transparency
May 4, 2020

Position: The Pharmaceutical Research and Manufacturers of America (PhRMA) opposes HF 1246 which would require significant reporting mandates, will not help patients, could threaten access to needed prescription medications, and potentially chill the innovation of future treatments.

Proposals to mandate disclosure of proprietary information by biopharmaceutical companies would neither benefit patients nor decrease healthcare costs.

The biopharmaceutical industry is one of the most heavily regulated industries in the United States. Companies already report extensive information on costs, sales, clinical trials, and total research and development (R&D) expenditures. Proposals to mandate public disclosure of confidential and proprietary information by biopharmaceutical companies ignore the large amount of information already publicly reported on an annual basis by companies and are based on the faulty assumption that prescription drug spending is the major driver of increases in healthcare costs.

HF 1246's significant reporting requirement that manufacturers submit multiple pieces of information (i.e. direct costs, the cost to manufacture, market, and distribute the drug, the financial assistance amount the manufacturer provided through patient prescription assistance programs, and more) does not reflect the total investment because of the long-term nature of research and development. Manufacturers pursue research efforts that include many failures and iterations on the path to development of a single approved drug. In fact, only 12% of medicines in the pipeline make it to approval. An 88% failure rate underscores how expensive and risky drug development is. Therefore, accounting for all the research activities that informed the development of a single product would be overly burdensome and challenging given that research costs are often spread across long periods of time, a wide range of therapeutic areas, and include a range of precompetitive and other research that would be difficult, if not impossible, to attribute to a single product. Additionally, much of the information that could be required to be disclosed is confidential and proprietary trade secret information protected by federal and state law. Mandating disclosure of proprietary trade secrets could undermine competitive forces in the market and could increase costs.

Drug costs are the only costs in the health care system that diminish over time.

It is important to note that medicines are the *only* part of the health care system where costs decrease over time. When brand name medicines face brand competition, or when they lose their patent protection and generic drugs become available, prices drop, often significantly. Today, nearly 90% of all medicines dispensed in the United States are generic and cost pennies on the dollar. One component of health insurance, however, is seeing significant increases. Health insurance and plan administration costs are rising at more than twice the rate of drug spending.

According to new 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 fact, nearly half (46%) of total spending on brand medicines went to the supply chain and other entities in 2018. This is a 13%-point increase from 2013, when other stakeholders retained 33% of brand medicine spending.

In addition, brand and generic biopharmaceutical companies, unlike other sectors of healthcare, rebate back more than $524 million in rebates to the state of Minnesota and federal government in 2018, which is 56% of total Medicaid spend on prescription drugs in the state.

If the intent of HF 1246 is to improve access and affordability to needed medicines, the language of the bill is misguided.

The legislation does nothing to address how much consumers ultimately pay for a medicine, an amount determined by insurers, not biopharmaceutical companies. For example, HF 1246 should do something to help patients afford their prescription medicines, such as passing on the rebates directly to the patients. Instead, these rebates are going to the plans and other supply chain stakeholders. Recent data shows that insurers are increasingly requiring patients to pay exorbitant out-of-pocket costs to access the medicines they need, far more than other health care services covered by an enrollee's health plan. This is contrary to the purpose of insurance—to spread the costs of health care utilization so that patients can access needed care, including medicines.

Today, a patient pays only about 3% for out-of-pocket hospital costs, but 13% or more for their medicines[3]. Additionally, insurers are increasing utilization management techniques to aggressively restrict a patient's use of medicine. Currently, three major pharmacy benefit managers (PBMs) negotiate steep discounts on prescription drugs for more than 70% of all prescriptions filled in the United States—Express Scripts alone covers 90 million Americans[4].

The biopharmaceutical industry is committed to working with lawmakers, patients, doctors, and other health care stakeholders to pursue policies that promote innovation and help ensure consumers have access to needed medicines.

HF 1246 is not the way to accomplish this important goal and, therefore, PhRMA respectfully urges lawmakers to oppose this bill.

The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier and more productive lives. Since 2000, PhRMA member companies have invested more than $900 billion in the search for new treatments and cures, including an estimated $79.6 billion in 2018 alone.

1 Ass'n for Accessible Medicines v. Frosh ("AAM"), 887 F.3d 664 (4th Cir. 2018), cert. denied, 139 S. Ct. 1168 (2019).
2 Berkeley Research Group (BRG). Revisiting the Pharmaceutical Supply Chain: 2013-2018.
https://www.thinkbrg.com/newsroom-publications-revisit-pharma-supply-chain.html
3 Avalere Health analysis of the US Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2015. https://meps.ahrq.gov/mepsweb. Accessed February 2018. Analysis includes individuals with any source of health care coverage, public or private; this includes individuals who had health coverage without coverage for prescription drugs, which can be expected to account for less than 2% of those with health coverage.
4 http://lab.express-scripts.com/lab/drug-trend-report