Testimony of the National Academy for State Health Policy Regarding SF 0168

Chair Klein and Members of the Commerce and Consumer Protection 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 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 it has 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.

The portion of SF 0168 that creates a prohibition on price gouging is based on a model bill that NASHP released in 2020. NASHP also created the original model bill creating Prescription Drug Affordability Board (PDAB) and has since released a revised model. The portion of SF 0168 that creates a PDAB in Minnesota has many similar elements to the NASHP model. Taken together these two strategies allow a state to tackle high costs related to both generic drugs (addressed in the anti-price gouging portion of the bill, which applies to only generics) and brand name drugs (included within the scope of review of the PDAB).

As we know 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 raise their prices on life-sustaining products simply because they can and because manufacturers know that in a market that does not effectively regulate price for life saving

products that people need, that they can get away with increasing prices at a rate that far exceeds their need to cover increased costs.

The Prohibition on Price Gouging

SF 0168 attempts to tackle the problem of increasing cost of generic drugs by prohibiting price gouging. There are a number of examples spikes in the prices of generic drugs, some of them notorious. We all remember the outcry in 2015 when Turing Pharmaceuticals raised the price of Daraprim from $13.50 to $750 per pill. But this isn't the only egregious example:

- In January 2019 Fluoextine, a generic version of the antidepressant Prozac, jumped from $9 per bottle to $69, an increase of $60 or 667 percent

- Oregon's 2022 annual prescription drug transparency report describes increases for two versions of generic isradipine capsules manufactured by Epic Pharma. Isradipine is used to treat high blood pressure and is also sold under the brand name Dynacirc. For one generic version, the WAC rose from $96.90 in 2015 to $976.37 in July 2021 (about 908% increase). It increased about $406 or by over 70% in 2021. For another generic version, Epic increased the WAC from $141.71 in 2015 to $987.53 in 2021 (about a 597% increase).

- According to data submitted to California's transparency program, an NDC for trimethoprim, an antibiotic used to treat bacterial infections manufactured by Mayne Pharma, had a WAC increase of 100% in September 2021. The WAC increased by over $90 to $186.

SF 0168 would make these and similar examples of price gouging illegal. Specifically, generic or off-patent drugs with price increases over 15% in a year, or over 40% in three years, would be referred to the state Attorney General for investigation. If found to have engaged in price-gouging, a company would have to roll back the inflated prices and pay back their profits from price gouging – either directly to consumers when possible, or to the state for consumer relief.

As the committee may be aware, a previous price-gouging bill enacted in Maryland was struck down by the Fourth Circuit. That ruling is considered by many legal experts to be an outlier and it has not been applied subsequently in any other case involving prescription drugs. However, when NASHP created the model act upon which SF 0168 is based it worked with a team of legal experts (including a former Maryland Assistant Attorney General who worked on the original case) to address the specific points of law raised issues raised by the court. To the end, this bill includes language making it clear that it applies to in-state transactions only in order to avoid violations of the dormant commerce. It also requires drug wholesalers to maintain a registered agent in-state. It designed to be very specific in scope to avoid any challenge based on vagueness. It is designed to apply only to generic and off-brand drugs in order to avoid any possible argument that the limit on price increases infringes the owner of any patents.

NASHP has made our legal analysis available on our website. The NASHP website also contains other materials (Written Q&A, Blog Articles, etc.) that may be useful material for the Committee as it considers the Anti-Price Gouging section of the bill.

The Creation of a Prescription Drug Affordability Board (PDAB)

In 2017, NASHP released its first model bill to create a state-based PDAB. Since then, six states (Colorado, Maryland, Maine, New Hampshire, Oregon and Washington) have enacted PDABs, and the model legislation is under consideration in a number of other states. PDABs can be used to limit – and even lower – prescription drug costs by 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. 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 bend the cost curve 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. SF 0168, if enacted, would give Minnesota's PDAB this important tool.

SF 0168 contains many of the same provisions that other states have found to be important in developing their 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.
- The bill leverages the investment that Minnesota has in data and drug price transparency.
- The bill sets very clear criteria for what drugs will be subject to review based upon cost, covers both prescription and generic drugs and biologics. It looks at high launch prices and annual price increases. It also sets criteria for how the Board will assess affordability.
- As mentioned above, similar to the PDABs in Colorado, Maryland and Washington this bill allows the Board to take action by setting an upper payment limit – basically a ceiling rate – that health care payers in the state are allowed to pay. It builds significant safeguards for appeals by any interested entity.

SF 0168 is unique and innovative in requiring that, with respect to drugs that are subject to the Medicare Fair Price (MFP) negotiated under the IRA, the UPL for those drugs will be equal to

the MFP. As states are assessing the impact of the IRA on their citizens, NASHP expects that states will continue to develop strategies to leverage the benefit of the Medicare negotiations.

NASHP has also published a legal analysis specific to PDABs which 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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