HOUSE BILL REPORT
HB 1541

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to prescription drug cost transparency.

Brief Description: Addressing prescription drug cost transparency.

Sponsors: Representatives Robinson, Johnson, Harris, McBride, Doglio, Wylie, Peterson, Cody, Stonier, Frame, Sawyer, Macri, Sells, Orwall, Jinkins, Senn, Tharinger, Stanford, Riccelli, Fitzgibbon, Ormsby, Gregerson, Hudgins, Ortiz-Self, Ryu, Farrell, Tarleton, Pollet, Clibborn, Fey, Kilduff, Reeves, Kagi, Chapman, Pellicciotti, Bergquist, Goodman, Lovick and Slatter.

Brief History:
Committee Activity:
Health Care & Wellness: 2/1/17, 2/7/17, 2/17/17 [DPS].

Brief Summary of Substitute Bill

- Requires issuers and drug manufacturers to report certain prescription drug pricing data to a data organization contracted by the Office of Financial Management (OFM).
- Requires the data organization to summarize the prescription drug pricing data and provide reports to the Legislature and the OFM.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 12 members: Representatives Cody, Chair; Macri, Vice Chair; Caldier, Clibborn, Jinkins, Maycumber, Riccelli, Robinson, Rodne, Slatter, Stonier and Tharinger.

Minority Report: Do not pass. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Harris and MacEwen.

Minority Report: Without recommendation. Signed by 1 member: Representative DeBolt.

Staff: Alexa Silver (786-7190).

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Background:

Prescription Drug Purchasing Consortium.
Pursuant to statute, the Health Care Authority (HCA) established a prescription drug purchasing consortium. State-purchased health care programs must purchase prescription drugs through the consortium, and local governments, private entities, labor organizations, and uninsured and underinsured residents may voluntarily participate in the consortium. In 2006 Washington and Oregon formed the Northwest Prescription Drug Consortium (Northwest Consortium) to expand their purchasing power. The Northwest Consortium offers access to retail pharmacy discounts, pharmacy benefit management services, rebate management services, and a prescription discount card for uninsured residents.

All-Payer Health Care Claims Database.
The Office of Program Management (OFM) is directed by statute to establish an all-payer health care claims database to support transparent public reporting of health care information. Last July the OFM selected a lead organization and data vendor to coordinate and manage the database. The database will collect claims data from the Medicaid program, Public Employees' Benefits Board programs, all health carriers, third-party administrators, and Department of Labor and Industries programs. Claim files submitted to the database will include pharmacy claims.

State Agency Work on Prescription Drug Costs.
Last year, two agencies reviewed issues related to prescription drug costs. The Department of Health convened a task force to evaluate factors contributing to out-of-pocket costs for patients, including prescription drug cost trends. The HCA and the Office of Financial Management (OFM) prepared a report on prescription drug costs and potential purchasing strategies at the request of legislators. The report describes increases in state agency spending on prescription drugs in recent years, current cost drivers, strategies to slow the rate of prescription drug spending, and policy options.

Summary of Substitute Bill:

The Office of Financial Management (OFM) must use a competitive procurement process to select a data organization to collect, verify, and summarize prescription drug pricing data provided by issuers and drug manufacturers. "Prescription drugs" include generic, brand name, and specialty drugs, as well as biological products.

Issuer Data.
By March 1 of each year, an issuer must submit the following prescription drug cost and utilization data for the previous calendar year to the data organization:

- the 25 prescription drugs most frequently prescribed by in-network providers, and the issuer's total spending for these drugs;
- the 25 costliest prescription drugs by total health plan spending, and the issuer's total spending for each of these drugs;
- the 25 drugs with the highest year-over-year increase in prescription drug spending, and the percentages of the increases for each of these drugs;

- enrollee spending on prescription drugs; and
- a summary analysis of the impact of prescription drug costs, as compared to other health care costs, on health plan premiums or on spending per medical assistance enrollee, disaggregated by the state Medicaid program, Public Employees' Benefits Board programs, and the individual, small group, and large group markets.

Employer-sponsored self-funded health plans and Taft-Hartley trust health plans may voluntarily provide this data.

Manufacturer Data.
Beginning October 1, 2017, drug manufacturers that sell prescription drugs in or into Washington must submit the following data regarding each "covered drug:"

- the length of time the drug has been on the market, and whether the drug is generic or brand name;
- the drug's pricing history in the United States for the previous five years;
- the total financial assistance given by the manufacturer through assistance programs, rebates, and coupons; and
- an economic justification of the price increase.

The manufacturer must report the data at least 60 days in advance of a qualifying price increase. The OFM must make the reported data publicly available on its website.

A "covered drug" is a prescription drug that increases in price by: (1) 10 percent or $10,000, whichever is less, over a 12-month period; or (2) 25 percent or $25,000, whichever is less, over a 36-month period. "Price" means the manufacturer's list price for the drug to wholesalers or direct purchasers in the United States, excluding discounts, rebates, or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of prescription drug pricing.

Data Organization Reports.
The data organization contracted by the OFM must compile the data submitted by issuers and manufacturers and prepare an annual report summarizing the data. The report must:

- identify overall spending on prescription drugs and spending by issuer;
- identify the 25 most frequently prescribed prescription drugs;
- identify the 25 costliest prescription drugs, disaggregated by program or market segment;
- indicate, for the most frequently prescribed and costliest drugs, which were included in a manufacturer's report to the data organization;
- identify the 25 prescription drugs with the greatest price increases during the previous calendar year;
- identify the minimum, maximum, and average price increases for the prescription drugs identified by issuers and manufacturers, expressed as a percentage;
- summarize certain data reported by manufacturers; and
- demonstrate the impact of prescription drug costs, as compared to other health care costs, on health insurance premiums, both overall and separately by program or market segment.

By November 15, 2018, and annually thereafter, the data organization must provide the report to the OFM and the Joint Select Committee on Health Care Oversight (Committee). The OFM must post the report on its website. Within three months of receiving the report, the Committee must hold a public meeting to receive a briefing from the data organization and consider the reasons for changes in rates, benefits, and cost-sharing in the health insurance market.

Enforcement.
The OFM may assess a fine of up to $1,000 per day if an issuer or manufacturer fails to comply with these requirements. Assessment of a fine is subject to review under the Administrative Procedures Act. Fines must be deposited in the Medicaid Fraud Penalty Account. The OFM may adopt rules necessary to implement the requirements of the bill.

Health Care Authority Report.
By November 15, 2018, the Health Care Authority (HCA) must provide the Legislature with an update regarding its review of, and any efforts to implement, value-based purchasing and return on investment pricing strategies for prescription drugs. The HCA must also provide any recommendations for improving transparency with respect to comparing drug prices with value metrics.

Substitute Bill Compared to Original Bill:

With respect to issuer reporting, the substitute bill adds requirements that issuers report their total spending on the 25 most frequently prescribed drugs and enrollee spending on prescription drugs. It also requires the analysis of the impact of prescription drug costs to be compared to other health care costs.

With respect to manufacturer reporting, the substitute bill removes reporting requirements for drugs that will be introduced to the market. It modifies the information that must be reported by removing itemized costs, pricing in Canada, and the manufacturer's profit attributable to the drug and by adding the length of time the drug has been on the market and whether the drug is generic or brand name. It also requires the justification of the price increase to be an economic justification.

With respect to the data organization's report, the substitute bill requires the report to demonstrate the impact of prescription drug costs as compared to other health care costs. The substitute bill also adds the Health Care Authority reporting requirement and modifies the findings and several definitions.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 17, 2017.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill will begin to shine a light on the black box of drug pricing. It will hold drug companies accountable, demand the reasons for their outrageous prices, and help the state take steps to make drugs more affordable. Consumers are advised by their doctors to get a specific treatment. Drugs costs have been rising significantly but are not any more effective as the price has increased. Sometimes patients have to pay out of pocket. People reduce doses or cut out needed care. People shouldn't have to choose between medications and putting food on the table. The most important factor for avoiding rehospitalization is medication compliance. The majority of Americans support legislation to require drug companies to report information about pricing.

At this pace, prescription drugs will outpace inpatient hospital spending as the top driver of health care costs. This is due to the cost per drug, not utilization. The key component of the trend is specialty drugs, but generics and some old-time drugs have also become more expensive. To keep health plans affordable, the plans have greater exposure for the consumer, like high deductibles. Health plans are doing all they can to manage costs.

(Opposed) In the prescription drug chain, manufacturers are only one part of the pricing. This bill focuses on the costliest drugs and provides an incomplete picture. It ignores the value of innovation, because there is no consideration of the savings generated. There are many unsuccessful attempts to develop drugs, and the costliest drugs are those that have achieved success. The bill imposes a heavy burden on small biotechnology companies that generate most breakthroughs. Many small and medium life sciences companies are conducting research and clinical trials but are not yet profitable. This bill ignores reality by assuming that research and development costs can be allocated to a single drug.

There is no other known context where private businesses have to disclose so much proprietary information. The information reported will interfere with the competitive market in which negotiations take place. Antitrust laws prevent signaling pricing information to competitors. The mandate to disclose anticipated prices in advance could impact the supply chain. That raises concerns for biologics, because manufacturers cannot respond to quick shifts in demand.

Prescription drug costs decline when they become generic. It is unclear how such an onerous process would actually help address drug costs, let alone out-of-pocket costs. This will be addressed on the federal level. There is already an all-payer claims database.

(Other) The Health Care Authority spends $1 billion per year on drugs after rebates. It would be helpful to include all players in the drug purchasing and supply chain, including wholesalers and pharmacy benefit managers.

Persons Testifying: (In support) Representative Robinson, prime sponsor; Bruce Wilson, Group Health Cooperative; Katharine Weiss, Washington State Labor Council; Charles Johnson, Community Psychiatric Clinic; Mel Sorenson, America's Health Insurance Plans; David Knutson, Association of Washington Healthcare Plans; and Lonnie Johns-Brown, Office of the Insurance Commissioner.

(Opposed) Brian Warren, Biotechnology Innovation Organization; Jeff Gombosky, Pharmaceutical Research and Manufacturers of America; Melissa Johnson, Life Science Washington; and Sheri Nelson, Association of Washington Business.

(Other) Donna Sullivan, Health Care Authority.

Persons Signed In To Testify But Not Testifying: Patty Seib, Molina Health Care.