SENATE BILL REPORT
SB 5586

As Reported by Senate Committee On:
Health Care
Health & Long Term Care, January 25, 2018
Ways & Means, February 6, 2018

Title: An act relating to prescription drug cost transparency.

Brief Description: Addressing prescription drug cost transparency.

Sponsors: Senators Ranker, Rivers, Kuderer, Cleveland, Miloscia, Mullet, Saldaña, Keiser, Conway and Hasegawa.

Brief History:
Committee Activity: Health Care: 2/07/17.
Health & Long Term Care: 1/16/18, 1/25/18 [DPS-WM, DNP, w/oRec].
Ways & Means: 1/31/18, 2/06/18 [DP2S, w/oRec].

Brief Summary of Second Substitute Bill

- Requires issuers and drug manufacturers to report certain prescription drug pricing data on a yearly basis to a data organization contracted by the Office of Financial Management (OFM).
- Requires drug manufacturers to report price increases and written justification for the increase to purchasers.
- Requires the data organization to summarize the prescription drug pricing data and provide reports to the Legislature.

SENATE COMMITTEE ON HEALTH CARE

Staff: Greg Attanasio (786-7410)

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5586 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

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.

Signed by Senators Cleveland, Chair; Kuderer, Vice Chair; Conway, Keiser, Mullet and Van De Wege.

Minority Report: Do not pass.
Signed by Senators Rivers, Ranking Member; Bailey.

Minority Report: That it be referred without recommendation.
Signed by Senators Becker and Fain.

Staff: Greg Attanasio (786-7410)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5586 be substituted therefor, and the second substitute bill do pass.
Signed by Senators Rolfes, Chair; Frockt, Vice Chair; Braun, Ranking Member; Bailey, Becker, Billig, Brown, Carlyle, Conway, Darneille, Fain, Hasegawa, Hunt, Keiser, Mullet, Palumbo, Pedersen, Ranker, Rivers, Van De Wege, Wagoner and Warnick.

Minority Report: That it be referred without recommendation.
Signed by Senator Schoesler.

Staff: Sandy Stith (786-7710)

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, and labor organizations; 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 OFM is directed by statute to establish an all-payer health care claims database to support transparent public reporting of health care information. In July 2016, 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. In 2016, two agencies reviewed issues related to prescription drug costs. The Department of Health (DOH) convened a taskforce to evaluate factors contributing to out-of-pocket costs for patients, including prescription drug cost trends. The HCA and the 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 Bill (Second Substitute): The OFM must conduct a competitive procurement process to select a data organization that will collect, summarize, and prepare reports on prescription drug pricing data provided by drug manufacturers, insurance carriers, and issuers.

Issuer and Insurance Carrier Obligations. By March 1 of each year, insurance carriers and issuers must provide the data organization with:

- the 25 most frequently prescribed prescription drugs by health care providers in their network;
- the 25 costliest prescription drugs, and the issuer's total spending on each drug;
- the 25 prescription drugs with the largest year-over-year increase in spending, including the percentage increase; and
- a summary of the impact of prescription drug costs on health plan premiums.

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

Manufacturer Obligations. Beginning October 1, 2018, drug manufacturers that sell prescription drugs in Washington must provide the data organization with a description of the factors considered when increasing the wholesale acquisition cost of a prescription drug and an explanation of how the factors justify the increase. Manufacturers must also provide certain information about covered drugs they manufacture. A covered drugs is defined as:

- a drug the manufacturer intends to introduce to the market at a wholesale acquisition cost of $10,000 or more for a course of treatment or a 12-month period, whichever period is longer; or
- a drug that has a wholesale acquisition cost of more than $40 for a course of therapy, and the manufacturer increases the wholesale acquisition cost more than 10 percent, including the proposed increase and the cumulative increase that occurred within the previous three calendar years prior to the current year.

For those drugs, the manufacturer must provide:

- a history of cost increases for the past five years if the drug was manufactured by the company during that time;
- the wholesale acquisition cost of the drug at the time of the acquisition, the company from which the drug was purchased, and the purchase price, if it was purchased within the past five years;
- the year the drug was introduced to the market and at what wholesale price;
- the patent expiration date;
- if the drug is a multiple source drug, an innovator multiple source drug, a non-innovator multiple source drug, or a single source drug;
- an itemized cost for the production and sale of each drug; and
- the total financial assistance given through programs, rebates, and coupons.

Pharmacy Benefit Manager Obligations. By March 1 of each year, pharmacy benefit managers must provide the data organization with:

- the wholesale acquisition cost of each drug on the pharmacy benefit manager's formulary;
- any discounts, including the total dollar amount and percentage discount, and any rebate received from a manufacturer for each drug on the formulary;
- the total dollar amount of all discounts and rebates described above that are retained by the pharmacy benefit manager for each drug on the formulary;
- any reimbursements the pharmacy benefit manager pays retail pharmacies for each drug on the formulary;
- the negotiated price health plans pay the pharmacy benefit manager for each drug on the formulary;
- any ownership interest the pharmacy benefit manager has in a pharmacy or health plan with which it conducts business; and
- the results of any appeal filed pursuant to RCW 19.340.100(3).

Wholesaler Obligations. By March 1 of each year, pharmacy benefit managers must provide the data organization with:

- any discounts, including the total dollar amount and percentage discount, and any rebate received from a manufacturer for the 25 most frequently sold prescription drugs; and
- the wholesale price for the 25 most frequently sold prescription drugs to pharmacies and hospitals.

Data Organization Obligations. The data organization must compile the data collected from issuers and manufacturers and prepare an annual report summarizing the data to demonstrate the overall impact of drug costs on health care premiums. The report must include:

- the 25 most prescribed prescription drugs;
- the 25 most costly drugs by overall plan spending; and
- the 25 drugs with the highest year-over-year increase in total annual plan spending.

The data in the report must be aggregated so not to reveal information specific to individual health insurers. DOH must post the report on its website, beginning January 1, 2019, and by each January 1 thereafter. DOH must also share the data collected from insurers with the office of the insurance commissioner (OIC).

Enforcement. The OFM may assess a fine against issuers and manufactures of up to $1,000 per day for failure to comply with reporting requirements. When OFM fines an insurer pursuant to this section, it must inform the OIC.

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Second Substitute):

- Adds reporting requirements for pharmacy benefit managers and prescription drug wholesalers.
- Adds additional reporting requirements for health carriers.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Requires that DOH share information collected from insurance carriers with the OIC, and that OFM inform OIC when it fines an insurance carrier for failure to report data as required in the act. The substitute also changes the definition of covered drug.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony (Health Care): *Testimony from 2017 Regular Session*. PRO: The recent epi-pen situation provided an example of the dramatic price increases we see with pharmaceuticals. Drug prices impact our state budget directly with millions of dollars in prescription costs alone. The dramatic impact on the state budget and on household budgets warrants a look at the pricing data. We believe there should be transparency in the drug pricing. The increases in drug costs drive significant increases in health care costs. Our data shows the increased cost is driven by changes in drug pricing not utilization. The first step to controlling drug costs is transparency. Hold these companies accountable and demand information on these huge price increases we see. This bill brings much needed transparency to the complex health care system. There are no affordable options for many drugs and Americans want information on drug pricing. A recent Wall Street Journal article showed employers are spending 19 percent of health care spending on prescription drugs, which is nearing the expense for inpatient hospital costs. While specialty drugs represent about 1 percent of the services, they represent 35 percent of the trend in premiums. Increasing health care costs are largely attributed to rising prescription drug costs. The prescription costs are the main driver behind premium increases.

CON: Manufacturers are only one part of the pharmacy supply chain. The manufacturer data is proprietary information and should not be available to business competitors. Research and development costs cannot be isolated to a single drug, and the costs and development are not linear. This bill could have an undue influence on small companies working on research and development. A recent Congressional Budget Office study suggests that for every dollar spend on prescriptions, other health care expenses are reduced. This bill is focusing only on at the top of the pyramid, but the base of the pyramid is where it starts. It is impossible to separate some of these expenses. While our committee looks forward to controlling rising health care costs, this bill misses the mark. It follows the Vermont model and violates proprietary information. Action should be at the federal level.

Persons Testifying (Health Care): PRO: Senator Kevin Ranker, Prime Sponsor; Chris Cable, Group Health; Charles Johnson, Community Psychiatric Clinic, SEIU 1199NW; Katharine Weiss, Washington State Labor Council, AFL-CIO; Mel Sorensen, AHIP; Lonnie Johns-Brown, Office of the Insurance Commissioner.

CON: Jeff Gombosky, Pharmaceutical Research and Manufacturers of America; Melissa Johnson, Life Science Washington; Bill Clarke, Biotechnology Innovation Organization; Sheri Nelson, Association of Washington Business.

Persons Signed In To Testify But Not Testifying (Health Care): No one.

Staff Summary of Public Testimony on Proposed Substitute (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: Drug price transparency is an important step toward ensuing fair pricing. The affordability of a drug for consumers is more closely related to drug prices than utilization. Everyone should have access to the prescription drugs they need without facing financial barriers.

CON: Manufacturers are only one part of the prescription drug supply chain and should not be required to provide more information than other actors in the chain. There is little evidence that increased disclosures will result in lower prices and the requirements threaten investment in research and development. The bill places a heavy burden on small companies, while ignoring other cost drivers. Any transparency legislation should include information from the entire supply chain.

Persons Testifying (Health & Long Term Care): PRO: Senator Kevin Ranker, Prime Sponsor; Meg Jones, Association of Washington Healthcare Plans; Sybill Hippolite, SEIU 1199NW; Courtney Smith, Kaiser Permanente Washington.

CON: Jeff Gombosky, Pharmaceutical Research and Manufacturers of America; Michael Transue, Oregon Biosciences Association; Brian Warren, Biotechnology Innovation Organization.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: Our cost experience in the PEB medical plan is similar to cost experience in other plans across the nation. Prescription drugs are a leading driver of health care costs. The unit cost for drugs for 2017 in PEB was projected to rise by over twice that of the overall trend. Higher prescription drug costs contribute to higher per member per month costs to the state, which translates to higher premiums for members. Specialty drugs are a key cost driver. In the Uniform Medical Plan, the trend for specialty drugs was over ten times that of traditional drugs. Manufacturer drug pricing strategies were a contributor to rising prices based on a joint report in 2016 from Health Care Authority and Office of Financial Management. Prescription drug costs transparency is a national priority. Prescription drug costs are now exceeding inpatient costs for employer sponsored plans. This is a significant cost trend. Specialty drugs represent about 1 percent of drugs prescribed, but about 35 percent of the spend.

CON: Our objection to the bill is that it paints an incomplete picture of what goes into the pricing of prescription drugs. We believe that the standards that manufacturers are held to should be applied throughout the supply chain. Wholesale acquisition cost does not give the true pricing for prescription drugs, so this portion of the information would also be incomplete. Prescription drugs are one portion of health care where prices actually decline. When drugs go generic, prices drop an average of 80 percent. Innovation is mostly in small bioscience. The Patient Out of Pocket Task Force identified strategies that would help consumers with copayments and those key findings are not represented. This bill impedes

negotiations and drives prices up by requiring a 60-day notification on price increases. This is a national issue. You are spending money for very little in return. Other states are doing similar things, so you can already see what other states are producing. Advanced price notification is the subject of litigation in other states.

Persons Testifying (Ways & Means): PRO: Sybill Hyppolite, Service Employees International Union Healthcare 1199 NW; Courtney Smith, Kaiser Permanente Washington; Mel Sorensen, America's Health Insurance Plans.

CON: Jeff Gombosky, Pharmaceutical Research and Manufacturers of America; Bill Clarke, Biotechnology Innovation Association; Michael Transue, Oregon Biosciences Association.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.