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Partial transcript: Oregon Legislature Joint Interim Task Force On Fair Pricing of Prescription Drugs (HB 4005), October 25, 2018

OR4AD partial transcription from official meeting video available at: http://oregon.granicus.com/MediaPlayer.php?clip_id=25225

Meeting agenda available at: <https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeAgenda/JFPRX/2018-10-25-10-00>

Meeting documents: <https://olis.leg.state.or.us/liz/201711/Committees/JFPRX/2018-10-25-10-00/MeetingMaterials>

OR4AD written public comments on Task Force Draft Report available at: <https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeMeetingDocument/151076>

OR4AD submittal (“A primer on prescription drug rebates: Insights into why rebates are a target for reducing prices. The role of rebates in drug coverage decisions and insurer finances,” Milliman, May 2018): <https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeMeetingDocument/150964>

Task Force Draft Report available at: <https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeMeetingDocument/151020>; Task Force Draft Report version revised 10/25/2018 available at: <https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeMeetingDocument/151077>

Task Force Transparency Proposals referenced in this transcript available at: <https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeMeetingDocument/151021>



Time	Speaker	Transcription
0:19	Charles Fournier, OR4AD	<p>Task force members, chairs: What do you get when you bring together insurers, PBMs owned by insurers, providers paid by insurers, and a consumer representative appointed by Gov. Brown who happens to represent an organization which . . . that is a joint venture with an insurer, United HealthCare?</p> <p>You get this report. This report is a tour de force. It manages even to discuss drug pricing in Oregon without mentioning once the Oregon Prescription Drug Program—a program created in 2006 to address the crisis we are currently facing—that for 11 years has failed to provide underinsured and uninsured Oregonians access to low net prices.</p> <p>I won't go through all the defects, misleading statements and falsity included in [the] report. I filed a written comment this morning. I will just say that the requirement included in the draft report that health insurance carriers only report on 50% of the rebate receivables is a patent attempt to exonerate insurance carriers of cost accounting and benefit design practices that would otherwise appear to breach Oregon Insurance Code Section 1302(b)(4), Section 1557, and section 1201(2)(a) of the Affordable Care Act as well as Section 27-18 of the the Public Health Service Act, that may in fact amount to a breach of the False Claim Act. This draft report merely documents the refusal by task force chairs—the insurance commissioner, and OHA's Chief Medical Officer and Director of Delivery System Innovation—to address insurers' misleading and discriminatory practice of reporting to the insurance-buying public plan cost that is <u>not</u> their net cost and the insurers' injurious use of benefit design where some individual members with chronic medical conditions are pay- . . . are required to pay additional condition-specific premium payments based on stated plan cost that is not a cost.</p> <p>In 2014, more than 300 patient advocacy groups wrote to the Health and Human Services Secretary, Ms. [Sylvia Mathews] Burwell, to complain about some insurers' tactics that are (I quote), "highly discriminatory against patients with chronic health conditions and may violate the non-discrimination provisions of the Affordable Care Act." At that time even Washington State insurance commissioner Mike Kreidler agreed and stated (I quote), "There is no question that discrimination is creeping back." Then he said, "The question is whether we are catching it or not."</p>



Time	Speaker	Transcription
		<p>Instead of attempting to catch discrimination by health insurers in Oregon, this Task Force is recommending hiding it—and actually condoning it—in breach of both state and possibly federal laws.</p> <p>Thank you.</p>
0:23	Mark Griffith, OSPIRG and OCAP	<p>Good morning. I'd like to thank the co-chairs and the members of this Task Force for the thoughtful work that you are doing on this important issue of drug price transparency. My name is Mark Griffith. I'm the health care advocate for the Oregon State Public Interest Research Group, which is colloquially known as OSPIRG, speaking today on behalf of my organization and the—our thousands of individual members throughout the state of Oregon.</p> <p>We think there's a lot of good ideas in the Task Force's draft report to the legislature. We're heartened to see near-total consensus from the group on increasing transparency around formularies, prior authorization, and other cost-control strategies applied by insurance carriers. We're also glad to see a high degree of consensus around exposing the flow of money and incentives in the pharmaceutical supply chain, with recommendations touching on manufacturer patient assistance programs, PBM rebates, and medical provider markups. Further, we strongly support requiring pharmaceutical companies to disclose their funding for patient advocacy and medical research nonprofits to the Oregon Government Ethics Commission.</p> <p>However, we're disappointed that the most comprehensive proposal in the draft, requiring disclosure of information from multiple stakeholders throughout the supply chain, was the only recommendation that did not receive consensus support in preliminary voting. We encourage the members of the Task Force to consider mutually contributing to a comprehensive solution without blindly objecting to any proposal that implicates your specific interests as part of a wider commitment.</p> <p>We'd also like to reiterate, as we have before, that while reforms throughout the supply chain are desirable, the root of the problem remains the high list prices set by manufacturers. When surveyed over the summer, the members of this Task Force identified list price as the cost factor with the most influence over increasing drug prices.</p>



Time	Speaker	Transcription
	Mark Griffiths, OSPIRG and OCAP (continued)	<p>Further, Dr. Sood’s presentation to the Task Force in August showed that for every \$100.00 spent at the pharmacy counter, an estimated \$41.00 accrues to manufacturers, whose estimated \$14.00 profit from that \$100 spend exceeds the \$8.00 estimated profit from every other entity in the supply chain combined. With this context, it’s clear that further legislative action specifically targeting pharmaceutical manufacturers is ultimately necessary to make a real dent in the problem of high prescription drug prices.</p> <p>While that could include additional transparency requirements on manufacturers, beyond the mandates that already exist in 2018 House Bill 4005, more concrete actions we think will ultimately be needed. How can transparency motivate manufacturers when they are led by executives like Nostrum Laboratories’ Nirmal Mulye, who stated in September, “I think it’s a moral requirement to make money when you can, to sell the product for the highest price”?</p> <p>Transparency throughout the supply chain is commendable. We encourage the Task Force to support a comprehensive proposal that addresses transparency by multiple stakeholders instead of casting blame at other parts of the industry. However, we would also like to remind the legislators who are present that list price is at the heart of the problem, and more concrete measures will ultimately be needed to address the issue of high-cost prescription drugs.</p> <p>Thanks for your time and consideration.</p>
0:43	Saamil Pandya, PhRMA, on proposal Government Entity 2: Annual report from state agencies on the 10 highest spend, 10 highest increased cost, and 10 most prescribed drugs purchased	<p>Just want to make a . . . just one small suggestion is that since this is Medicaid—a state agency—so they’re aware of what their final costs are, to make this ‘net costs after rebates and discounts’ so they know what the state is actually spending their money on. And so, it’s . . . if that is . . . if the objective is for the state to be able to identify which medicines they’re actually spending their money on, it should be net of rebates and discounts that manufacturers provide. That’s all that . . . ultimately the request I would have.</p>
0:44	Sen. Steiner Hayward	<p>I think that’s a valid concern, and the way I would modify then this is to say the highest cost and call out the rebates and discounts separately because [<i>Moderator Sam Imperati interrupts: In other words, “Show the work.”</i>] show the work—show the work that’s been done negotiating show what the initial cost was and then show what it is. That . . . that would be my suggestion to . . . to bring in that concern that you raised.</p>



Time	Speaker	Transcription
0:44	James Slater, CareOregon	I would concur, because I think that until we get through the technicality of how we do this, this would be the most straightforward way for all of us to learn—and the consumer wants us to understand why and the detail provided with why it got there and these elements that you’re citing would demonstrate that.
0:44	Robert Judge, Moda	In opposition to the proposal, this option that was just described, reasons being is when you start injecting rebates into the equation I think you’re introducing a level of complexity that some, you know, timing of rebates when they get paid . . . you know, rebates are collected and paid for many groups at a national level and breaking it down by utilization inside of a particular state is . . . is challenging. So I think that’s . . . that’s an idea that probably should merit discussion inside a bill when it goes forward but not have it laid out inside this proposal because I just think you’re introducing at the last minute a lot of complexity that needs to be discussed.
0:45	LuGina Mendez-Harper, Prime Therapeutics (BCBS)	So, that was my concern as well, is that rebates are paid after utilization. So you would need to figure out, if an annual report you would need to try and work around that . . . like . . . Do you just set a date and say rebates as of this date that have been paid, knowing that more are coming in? It’s a moving target. So that was . . . that’s my concern there.
0:45	Representative of generics manufacturers	Even as a nonvoting member, thank you for allowing me to comment on this. I do believe it needs to be added in there that it’s highest cost per patient otherwise you’re going to end up with a list of the disease state that is most prevalent in the state, not necessarily the cost of the drugs in the state.



Time	Speaker	Transcription
0:46	Saamil Pandya, PhRMA	I don't want to belabor the point. I just— all I'm saying is that we have . . . we've learned a lot through this process. I hope we know more about the supply chain than when we started six months ago. Dr. Sood came and presented here, and one of the things that—it's on page 17 of the draft report—is a pie chart that he has. He shows that 42% of the WAC price, the list price of a drug, is going to somebody other than the generic or brand manufacturer. And so, the amount of rebates and price concessions that . . . that manufacturers pay . . . this is not an insurmountable thing. I mean, the insurance companies would do completion factors all the time on . . . on rebate retention. Rebates are amounts that are . . . that are estimated out, or you could do an estimate . . . like other states do. Like you could do an initial estimate and then you do a true-up after after six months after that . . . so to be able to get to an annual report. <i>[Moderator Sam Imperati interrupts: Rep. Noble Oh I'm sorry, go ahead]</i> I'm just saying is it's—we've learned something, we've learned a lot through this process, that this is a lot more to it than just the list price, that our final work product should reflect what we've learned over the last six months.
0:46	Rep. Ron Noble	Just a quick comment. There's no doubt in my mind that it's probably a very complex issue. I would just suggest in my just little bit of knowledge about business that it's probably part of the business plan already and some of those complexities are already modeled out in any . . . any business that's going to survive. So I would . . . I just believe the information is there, it's just a matter of getting it in the right format.
0:47	Robert Judge, Moda	Just as an example, this applies to government and presumably public sector side. There are federal regulations that prohibit disclosure of rebates for Medicaid. This seems to imply that when you start factoring rebates and—taking the last comment about having the rebates treated separately, you're going to run right up against federal regulation. So I think that you've got a lot of complexity here that is probably better dealt with in legislation, not in concept.
1:05	On proposal Govt. Entity 4: External audits for state government receipt of and use of pharmaceutical rebates	(General conversation on rebates and which entities in Oregon would be encompassed by the reporting requirement here, whether audit would be specific to Medicaid program or would encompass other state programs. Andrew Stolfi and Dana Hargunani clarify that this provision would encompass other state programs beyond Medicaid.)



Time	Speaker	Transcription
1:07	James Slater, CareOregon	So the intent was that . . . you recall in other language in these proposals there was “50% must be passed on to the individual.” In this instance that wasn’t kept for Medicaid, and this is a great way to address that, right? Like how, if we’re going to be looking at insisting that rebates get . . . affect the end user in a positive manner, ‘how do we say that for Medicaid?’ is really the essence here. And so: How do you take this concept of rebate in the Medicaid space, study it, continue to observe it so you understand that the net effect to the end user of Medicaid rebates, and there’s conceptions about where the dollars go—do they ultimately arrive in activities that benefit the consumer, the Medicaid member? There’s some important questions that we keep . . . need to keep asking about how these dollars are used, and are is this mechanism of those dollars in the best . . . the ongoing best idea.
1:08	LuGina Mendez-Harper, Prime Therapeutics (BCBS)	And when you’re saying “end users,” I want to make sure I understand it clearly, you’re talking about the patient or you’re talking about the state?
	Jim Slater, CareOregon	The Medicaid patient.
1:08	LuGina Mendez-Harper, Prime Therapeutics (BCBS)	The patient.
1:08	Robert Judge, Moda	Just a clarification, when we . . . since it’s Medicaid, are we talking fee-for-service Medicaid, managed Medicaid, the combined level of that, because you have the over 90 rebates that have the . . . some of those drugs the state gets paid, of course, for having drugs [inaudible] so it has a very very consequential impact. But if you look at managed Medicaid it’s <i>de minimis</i> in terms of the, you know, the supplemental rebates that are available. So I’m just trying to understand the intent. And then again rebates are an element—to go to LuGina’s point—so I struggle with the focus being rebates and its impact on outcomes.



Time	Speaker	Transcription
1:09	Saamil Pandya, PhRMA	<p>Yeah, with regard to impact on patients—I mean, typically patient cost-sharing in Medicaid is . . . is minimal, I mean patients don't have to pay a lot out of pocket in Medicaid. So that's, that's . . . the sharing the rebates to the patient is more of a commercial market thing there, that's there. The thing that I like about this and maybe if we can have some additional clarity at some point is also reporting on how the pharmaceutical rebates—the rebates paid by manufacturers—are reported and how they are used. In a number of states that money goes into the general fund. And so they use it to pay for roads and bridges or fixing potholes. Which is great for the state but it doesn't apply . . . it is not netted out. It should be netted out against prescription medicine spending, so that you're not reporting an inflated number for prescription medicine spending in Medicaid because those rebates have been applied somewhere else in the process. That's all.</p>
1:10	James Slater, CareOregon	<p>The last quick comment is that because of what was cited earlier there are legal laws where we can't always talk about the dollars of the rebate. So I think it's an onus on us to talk about in some other manner what we can reveal through this report about how these rebates aren't benefiting the people we serve. And yes they don't have out of pocket. But just like you said that doesn't mean the dollars are going directly to help them. They could be going to to a road or to something else. So I want us to talk about this valuable resource and make sure it's serving the Medicaid population. [<i>Unidentified speaker interjects: I agree.</i>]</p>
1:11	Sen. Steiner Hayward	<p>This is the second or third time the issue of the intersection between the state . . . these recommendations and federal law has come up. There is no question that we're going to have to wrestle with that as part of this.</p> <p>There's also no question that the federal government is considering a lot of ideas now around pharmaceutical price transparency and pharmaceutical price reduction.</p> <p>So federal law is likely to be evolving just as we are evolving state law around this, and I don't think that . . . the fact that currently something is in opposition to federal law should prohibit us from including it in the recommendations, because again that's going to have to be worked out down the road. And it wouldn't be the first or the last time that a state passed something that was theoretically against federal law and either was allowed to move forward with it anyway or took the feds to court. So I don't think we should . . . I think it's useful to know and to include in the commentary those concerns, but I wouldn't see it as a reason to exclude from the recommendations . . . from the ultimate recommendations.</p>



Time	Speaker	Transcription
1:12	Saumil Pandya, PhRMA	So just to give context on that . . . the best data that I have from 2016, the rebates in just Medicaid, not even looking at state employees and the commercial market and stuff. Manufacturers paid 357 million dollars back to the state. Now that money was then split between Oregon and the federal government based on the F map. But 357 million dollars that went back . . . that came back to the state from manu- . . . that manufacturers returned. That's a pretty sizable amount of money.
1:18	On proposal Manufacturer 6: Disclosure of total and average spending on patient assistance programs from manufacturers.	(Conversation regarding how to clarify distinction between program-specific versus drug-specific financial assistance from pharmaceutical manufacturers.)
1:20	Saumil Pandya, PhRMA	I just find it interesting. We don't want to pass . . . we don't want to pass rebates through to patients to reduce their cost-sharing amounts, but then we are sitting there and talking about assistance that manufacturers give for patients to reduce their cost-sharing as in some way in a negative light. And that's why I just . . . I found this to be a little bit of an odd duck.[<i>Sen. Steiner Hayward interjects: Wait, I . . .</i>]
1:20	Sam Imperati, Moderator	Apparently Sen. Steiner Hayward would like to respond to you.
1:21	Sen. Steiner Hayward	Sorry, I don't understand where the belief that we don't want to pass rebates on to patients comes from—because I haven't heard that at all. Unless I've missed something.
1:21	Saumil Pandya, PhRMA	Did I miss it? It was taken out of the language from the last iteration to the most current iteration. Later on, it's in one of the insurance proposals to pass 50% of rebates to people at the point of sale. That was taken out, from what I understood.
1:21	Sen. Steiner Hayward	Then I may have missed that omission, because that was not my expectation. But um . . . certainly was not my desire. [See also section 3:03, where this topic is again addressed but Sen. Steiner Hayward makes no objection to the weaker language.]



Time	Speaker	Transcription
1:21	LuGina Mendez-Harper, Prime Therapeutics (BCBS)	<p>So, I had abstained on this because I didn't have familiarity with how manufacturers fund these programs. I wasn't sure if they kept track of it by drug name, so that was one of the reasons that I abstained, because I just didn't have that expertise. But I think it makes sense to look at patient assistance programs because they're typically for brand-name drugs where there may be alternatives that would be less costly, so I think that's the con- . . . overall . . . the general concern. But again, I just didn't have the expertise to know how the money is tracked.</p>
1:22	Ryan Dunlap, Oregon Bioscience	<p>Yeah, I just want to comment on what I'm hearing other folks say. I kind of agree with it: You can look at this issue in two ways. One is that these programs are designed to help patients and provide access that they might not otherwise be able to afford to certain drugs—and the other way to look at it is it's because of these programs that lower-priced drugs aren't being prescribed.</p> <p>I would argue that that's a little bit of a cart before the horse. I think it's other areas of the supply chain that will determine whether these drugs are being prescribed, therefore whether the patient needs assistance.</p> <p>So I don't believe that the transparency here—while I agree with general transparency, and in fact overall patient assistance programs have been . . . are generally included in SEC filings where I grant you it's not as granular as we're asking here, I don't agree this is the right way to address that when really it should be at the point of prescription. If there's another lower cost drug available, why would prescribers be prescribing the higher-cost drug just because there's a patient assistance program?—and maybe I'm just not understanding.</p>



Time	Speaker	Transcription
1:24	Sen. Steiner Hayward	<p>I'll comment on that as one of those providing proscibers, will put that hat on. There are two reasons. The first is that sometimes even if the lower-cost drug is available it ultimately might be higher out of pocket for the patient if there's a patient assistance program available from the pharmaceutical manufacturer. So if you're really trying to dig into the nitty gritty it may turn out—even though ultimately it isn't better for the system—for your individual patient and the economics for that individual patient based on their plan design, it may be cheaper for them to get the brand-name drug with the assistance program than to get the lower-cost drug. So that's the first problem. That's the positive or sort-of positive reason.</p> <p>The less positive reason is that, despite lots of efforts, I think physicians and other prescribers are still swayed by pharmaceutical detailing, if they interact with it in one form or another, by articles in the literature that may not be completely transparent—and frankly consumers are swayed by direct-to-consumer advertising and put an enormous amount of pressure on [inaudible] providers. It's the same reason that many physicians have chosen to not have samples in their office any more, because samples are only available for brand name newer drugs and it means that the patient starts on that drug and then they don't want to switch. I spend an enormous amount of time negotiating with my mother when she gets freaked out when a generic gets substituted for her brand-name medication, because she's absolutely convinced that it's not working. Right?</p> <p>And I have to negotiate that long distance with her. So I deal with it on an almost weekly basis, because she forgets. So I'm just saying that those are the two reasons why I think it's relevant in this context.</p>
1:26	Saumil Pandya, PhRMA	<p>Again, saying, again stuff that we've picked up, information that we've gathered over the last six months, that 90% of all prescriptions dispensed in the United States are for generics already. And . . . and to piggyback on what Ryan's point is, the amount . . . the amount of money the patient has to pay for their medicine at the point of sale is determined not by the list price, not by anything else. It is determined by the insurance benefit design. So if the supply-chain entities feel as though their revenue is better . . . more positively impacted by putting one drug on a preferred tier than another drug, then you would have the drug . . . the patient . . . the amount the patient has to pay determined based on that. And so manufacturers try to help a patient get access to the medicine that their physician has prescribed for them. That's all this is. I don't think you can—9 digit NDCs—I don't agree with this at all.</p>



Time	Speaker	Transcription
1:29	Saamil Pandya, Pharma, on proposal Manufacturers 8: Require manufacturers to report on new drugs with price exceeding the price of other drugs within the therapeutic class.	<p>So, I'm a little confused by this, and I just wanted . . . if you guys can give me some additional clarity, it would be helpful. So we're talking about drugs that are not first in class, right? So you're talking about a medicine that it's a first in class medicine. So now you have a treatment for a disease for which there was previously no treatment so—hopefully a good thing for patients . . . people would regard it as a good thing for patients. So if that drug is there, our criticism is, “Well, some of these medicines don't have lots of rebates, because there's not, there isn't competition.”</p> <p>Having more medicines come on in the same therapeutic class effectively what it does in the competitive dynamic of how our industry works is it puts more products within that same therapeutic class, which the insurers pit against one another for them to compete for formulary access—they have to pay higher and higher rebates to get formulary access, thereby reducing the net cost of the medicine.</p> <p>It gives physicians choice on what to prescribe. Every—people's physiology is different. Both my parents have diabetes, but they're on different medicines—and they're on different medicines, because what works for my dad doesn't work for my mom. And the fact that there were multiple products within that therapeutic class assisted with that. And so, how . . . what that list price is when that new product comes on—that's the thing that I talked about when we first started—also factors in the dynamic of what type of rebating will be required to get formulary access for that product. And . . . I make . . . That's why I don't quite understand the logic of this. If you . . . if someone could explain to me that, I'd be very grateful.</p>
1:30	Andrew Stolfi, DCBS	<p>Di you say at the start that you read this as applying to drugs that are first in class, or are not?</p>
1:30	Saamil Pandya, PhRMA	<p>No, that are <u>not</u>. 'Cause you see the criticism is with first in class drugs you don't have rebates. The reason you have rebates is because there's other drugs that came on in that therapeutic class, which provided competition, and that's how the competitive dynamic works in many regards within this industry. And so why is that viewed as in somehow a negative, which I don't quite understand? We should be encouraging this.</p>
1:32	Sam Imperati, Moderator	<p>Sen. Steiner Hawyard?</p>



Time	Speaker	Transcription
1:32	Sen. Steiner Hayward	<p>Thanks. Part of the problem is, you're right, in theory it does create more competition, but if you look at things like MS. drugs, until ocrelizumab came out, every single new drug that came out, some of which were basically in the same class as existing MS drugs, the price went up, and in response all the other prices went up.</p> <p>And it's, and I mean the data are very clear on this one. And this is one I have obviously strong personal knowledge and interest in. And so I can tell you that although in theory that's the way it should work, it doesn't, especially in drug- in disease categories where there is enormous amount of disability and where . . . where there are high-cost diseases, if you will, and where all of the drugs are expensive.</p> <p>You might see this happen with a new statin, if there were such a thing, and you did I think then, but those were not ridiculously expensive drugs. So, the experience—at least in some disease categories—is that that has not been the case.</p>
1:32	Sam Imperati, Moderator	So I have— LuGina?
1:32	LuGina Mendez-Harper, Prime Therapeutics (BCBS)	So I just wanted, I just want to be sure I understand this concept. So— this is talking about the price of the medicine. This has nothing to do with rebates. This is the second manufacturer coming out with a higher price and trying to figure out why that is. So—right? There's nothing about rebates in this.
1:32	Sam Imperati, Moderator	People are nodding in . . . in the affirmative. Ryan?
1:33	Ryan Dunlap, Oregon Bioscience	<p>Just on the same lines I think it is interesting that first of all drugs in the same class that you could even get away with a price increase if there were truly other options available. I think that's where we should be focusing our efforts. And so I agree with the comments that Saumil made. I also agree with the comments that Ms. Harper made in that I've been in a situation where we've launched a drug in a similar class and first of all there was no incentive to lower the price because it didn't help us get formulary access— and we paid a rebate that was more than double the rebate that our closest competitor, who had— the market leader—paid. And so if you do exclude rebates you're really missing a large part of the puzzle. So I voted no on this just because I think it misses the true point of where we should be focusing our efforts.</p>
1:33	Sam Imperati, Moderator	Thank you. James?



Time	Speaker	Transcription
1:33	James Slater, CareOregon	In support of this measure, . . . I think that . . . I'm not sure. My view of these is that these statements don't necessarily indicate that it's good or bad. It's about transparency, and it's about us learning and our consumers learning and in any instance when you have a drug that's vital, and it's the right one to use, and you see a significant price attached to it, particularly when it's above its other therapeutic choices, I think for us to learn there in the spirit of transparency is a good thing. And if it reveals very valid things like rebates or other things that ultimately reveal the story —to the good of the patient and to the good of the system—I think that's great. To the extent that it doesn't I think we need to learn that. So I support the transparency here.
1:34	Robert Judge, Moda	This might seem odd or strange but I get your . . . I buy your story, Saumil, in terms of your explanation. When you do have a . . . a new therapy come into a class, it does create the opportunity for rebates to establish preference for a drug to come on rebate—on formulary. Totally, that's . . . that's a fact. But the issue is the one that we do see, where we see list price chasing, so a product comes out at a higher price, others raise to meet it, and then the rebates kind of scale to that. The issue is price is what . . . where the problem starts and where the problem ends. Rebates are tied to list price.



Time	Speaker	Transcription
1:35	Saamil Pandya, PhRMA	<p>To that point, a story came out just yesterday, reading on my phone, I don't know that I can say the names of the companies themselves. So I'll just say there was one of our companies who put out a medicine. It was a PCSK-9 so a follow-on statin for people with high cholesterol. So a couple other companies had a competing product, and so they lowered the net price of their product by offering big rebates to one large—probably the largest—PBM. You can guess who that is.</p> <p>So they lowered the list price. So this company says, We're going to launch a new NDC for that same drug at a lower list price that brings the net for both products to basic parity. But one company is doing it with a big rebate, other company is doing it by lowering the list price, which everybody here says you want to see.</p> <p>That large PBM kicks the product who lowered their list price off of the formulary. Why? Because they make the money on the high list price.</p> <p>That was the thing—hopefully another thing that we learned through this entire process—is that 42% of—according to Dr. Sood—all the list price is being kept by someone other than the brand manufacturer. And everybody in the supply chain has their financial interest, their reimbursement tied to the list price of a product. So when we're talking about this and where the list price goes, there are market dynamics here at play, and that it's just the price, because even if you come in a lower list price . . . This is not the only case where this has happened. It happened with the Hep C products as well. When you lower, even when you come out with a lower list price, the supply chain entities make less money on the drug, so they don't cover it. And that is—that is a problem.</p>
1:36	Sam Imperati, Moderator	OK, thank you. Unfortunately, we have to go to votes.
1:37	Sen. Linthicum	Nope. You got one more here. And this is worth discussing, so it's worth putting my foot down. This is relevant because we say here, "the language is price." It's clear. Is it what . . . what price? List price? Net price? You know . . . gross? What are we talking about here? So this word "price" ought to have an adjective. There ought to be a descriptor, a qualifier, for what price it is we're actually talking about. 'Cause otherwise this . . . well, go ahead, if you trust the legislative grinder, go for it.
1:37	Saamil Pandya, PhRMA	Net price.
1:37	Sam Imperati, Moderator	So, the proposal is net price. What's your thought on net price?



Time	Speaker	Transcription
1:37	Sen. Linthicum	I think net price is appropriate but I want . . . what I don't want is—well, and I see head-shaking so raise your card. You know lunch hour's not coming up that fast. It's worth discussing.
1:38	Sam Imperati, Moderator	All right, so I didn't see the order. I think LuGina was first.
1:38	LuGina Mendez-Harper, Prime Therapeutics (BCBS)	My suggestion is list price .
1:38	Robert Judge, Moda	It's . . . it's list price , but there's . . . it's . . . there's a simplification that is being made here that I think needs to be considered. It's not . . . the decision to put a product on formulary is not, "Oh, it has a better price. Therefore we're gonna." There's a profit . . . pharmacy and therapeutics committee review. Clinical evidence decides whether the drug is therapeutically effective, and they choose the drug that is most therapeutically effective first, and then you look at price, and price is determined by what you get off rebates . So in the example of PCSK-9, yeah, it's a PCSK-9 product, but is it as therapeutically effective as the alternatives? So to make . . . jump over that I think is communicating, to you know, the panel here that . . . information that we just don't have access to. So list price is where we need to go.
1:39	Saumil Pandya, PHRMA	Last point. People keep talking about . . . we talk about price, and it's been asked even by the President, " Why don't companies just drop their list prices? " This is why .
1:39	Sam Imperati, Moderator	James . . . and remember we're not looking for arguments at this point. We're looking for suggestions, for clarifications based on Sen. Linthicum's suggestion that we want more clarity, an adjective in front of that. So, suggestions?
1:39	James Slater, CareOregon	I want to speak specifically to net price. So, that . . . the difficulty with net price is net price is contextual. So, an average net price across different contracts, different PBMs . . . it's . . . it's very difficult to know what that means to you and your circumstance and your provider and your insurance carrier, because there's a specific net price that means something to you. And so it's much easier to talk about list price, where it's the same for everybody , and then talk about in the detail of the report why there's a difference and what does it mean. I think it would address Robert's comments, which I very much agree with, about clinical decision-making and the . . . and the effectiveness of the medicine in addition to the price. That's part of the justification of the price, if you think about it. So, anyways. There's some difficulty with net price.



Time	Speaker	Transcription
1:40	Sam Imperati, Moderator	John, then Andrew, then we're going to have to move on.
1:40	Jon Bartholomew, AARP	Also, when I was looking at this I was assuming it meant list price . Never assume. But I also note that in this proposal it says, "Report the rationale." And so, when it comes to, " Well, we price this because we know we're going to be giving a rebate that is going to make us on particular tiers, " rationale is a broad word, and so these other factors can be captured in the report under that rationale.
1:41	Andrew Stolfi, DCBS	So, just to say . . . I think list price makes sense for the reasons James said and for all the complicating factors about net price , Whose net—average? specific to others? And just remind everyone: Saamil, you had a good point about how, you know, a change in prices could lead to formulary changes and other effects. But just to remind everyone, this is one of many proposals. We already agreed to another proposal that deals with notification about formulary changes. So to, you know, to kind of look at all these things together as much as we can, so that this doesn't have to solve everything in this proposal, but this with other things can help to create the . . . the whole wheel of transparency.
1:41	Sam Imperati, Moderator	And I do note that we have a combined rebate proposal—that's Manufacturer 5 / PBM 3 / and Insurance 5 that we're going to take after lunch . So I think that it . . . it's clear that there's a need for more specificity as . . . as what version of price we're going to use. We're not going to be able to resolve that today. Perhaps . . . this will be . . . we'll have some more clarity when we get to the rebate one, but given the constraints of . . . of time and space I ask you to show us your cards. [<i>side exchange between moderator and co-chairs—is there consensus on list price?</i>] So the proposal from the co-chairs is that the word be put in "list price" into this column —right hand column, final proposal column. So I'm calling to wherever it says price the word "list" will precede it in the document. So that will be the amendment that Cassie is typing up, up on the screen. So with that change noted, please show us your cards and please call the roll.
1:43	On proposal Manufacturer 4: Inclusion of the monthly WAC cost of drug in Direct to Consumer advertising within the state of Oregon	(General conversation including Saamil Pandya describing PhRMA's new plans to disclose information beyond list price. Some conversation on HHS proposed rules regarding list prices in DTC ads. Note that Sen. Steiner Hayward here pushes for a state regulation as something that Insurance Commissioner Andrew Stolfi can enforce.)



Time	Speaker	Transcription
1:48	Jon Bartholomew, AARP	From a consumer perspective. Well, first let me just say, one of the things that this does, it does not prevent you from providing any other context. This says that you must to this; it doesn't say that you can't do more context. Right now, consumers are not compliant with their medications because of the costs associated with them. I mean, we asked our membership about what, you know, what do you do, and people will say, "I cut my pills in half—I go without," for a variety of reasons now. What this would help with is conversations with their doctors. They might be able to say, "I saw a commercial for this. I understand it's expensive. Is there an alternative treatment that is less expensive that works just as well?" The Doctor can say, "Oh, well there's a copay assistance program on this particular drug." It encourages better conversations with their physicians or providers, and that's why I'm supporting it.
1:56	Providers 2: Disclosure of hospital and medical provider markups on patient bills.	(Conversation related to hospital markups—specifically that Oregon's All Payer All Claims database reports what the hospital charges for a drug—including hospital's often large mark-up—not the price the manufacturer charges the hospital. Hospital markups as a factor that increases what Oregonians pay.)
2:37	Proposal Consumer: Disclosure of funding from pharmaceutical companies for nonprofit organizations advocating on behalf of patients or medical research	(Reporting requirements for nonprofits—discussion whether this is limited only to funding from pharmaceutical companies or should be broader, with consensus that the reporting should be broader, while protecting conversations on drug pricing that take place in the course of patient care. New language will be: "Disclosure of funding for nonprofit organizations advocating outside of patient care on issues regarding pharmaceutical treatment.")
3:00	Insurers 5: Certification of health insurance companies percentage of rebates applied to minimize consumer premiums or out-of-pocket costs.	(Transcription only covers the discussion of this item as it specifically relates to patients and rebate pass-through.)



Time	Speaker	Transcription
3:03	Saamil Pandya, PhRMA	One last thing. Sen. Steiner Hayward, this is the thing I was talking about in that second-to-last paragraph—says “ require commercial health insurers to certify through their annual filing documents the percent of rebates—so at least 50% of rebates—that were applied directly to offset consumer premiums, out-of-pocket costs. ” The part that was in the previous version was to take the remainder, should be to pass through to patients at the point of sale, but now that’s been removed from the document. That’s what I was talking about before. It’s that second to last paragraph, on the right-hand side.
3:03	Sen. Steiner Hayward	Oh, I see what you're saying.
3:03	Sam Imperati, Moderator	So you’re suggesting what specifically, that you would add back in?
3:04	Saamil Pandya, PhRMA	I’m just saying, is that . . . again, With respect, insurers are saying they take these rebates and use them to hold down premiums. But you’re only asking, you’re only saying that only half the rebates are to hold down premiums—you’re certifying only half the rebates are used to hold down premiums. But what happened to the other half?
3:04	Sam Imperati, Moderator	Right, so we get the argument. The question is to focus on the language that would make this right.
3:04	Saamil Pandya, PhRMA	So either 100% or “whatever is not certified to pass . . . used . . . certified to hold down premiums has to be passed through to patients at the point of sale.”
3:04	Sam Imperati, Moderator	Thoughts?
3:04	Andrew Stolfi, DCBS	Is your suggestion just to delete “at least 50%,” so that they have to— <i>[Interruption from John Santa, phoning in: This is John. Moderator: Wait a second, John. Hold on.]</i> Is it just to delete the text in parentheses there, so that insurers have to certify the percent of rebates that were applied directly?
3:04	Saamil Pandya, PhRMA	Or all of them. The claim is that . . . they . . . the reason why the argument is being made that you can’t pass through rebates at the point of sale is that it will raise premiums. And . . . and Robert, you’ve made that argument here. So if you are only certifying that half of the rebates are used to hold down premiums, then what happened to the other half? That’s important.
3:05	Sam Imperati, Moderator	Again, we get the argument. I’m not trying to be difficult. Andrew’s suggestion is, If you remove the words “Paren - at least 50% - end paren” does that not solve your concern?



Time	Speaker	Transcription
3:05	Saumil Pandya, PhRMA	With respect, not really. I think I would say, change the 50% to 100%. Like, certify that the rebates are actually being used to hold down premiums and patient costs. Either you do it you don't do it. Or, or . . . pass through . . . or even better yet, whatever you don't certify, pass the rest of it back to patients at the point of sale.
3:05	Jim Slater, CareOregon	That's different than transparency.
3:05	Sam Imperati, Moderator	That's not a transparency issue. That could be the next part for the legislature to consider. This just about exposure.
3:05	Andrew Stolfi, DCBS	Is the word certify, is it, should that be "report"?
3:05	Saumil Pandya, PhRMA	No, certify sounds more formal.
3:05	Andrew Stolfi, DCBS	Cause, cause, one way to read this is that health insurers have to apply at least 50% of the rebates to directly offset. Another way could be that health insurers just have to tell us what percentage of rebates are directly applied. So it's transparency versus mandating application. [Unidentified speaker: Right, right.] So . . . and, I think you could read it either way. So maybe . . . I don't know if certify is the right word. That's a question.
3:06	Sam Imperati, Moderator	OK, Robert?
3:06	Robert Judge, Moda	So I think the focus correctly is . . . is on transparency versus a mandate. So I'm fine with an insurer reporting—and certifying—what percent of rebates they are applying to help hold down premiums and/or pass through, but to put a mandate on it, I think . . . I don't . . . 50% 60? 20%? I don't know know the logic behind that. <i>[Interruption from moderator: John Santa on the phone—thanks for being patient, John.]</i> So I think Andrew's first recommendation— of striking the percent—makes sense, because what you're trying to do is get insurers to be transparent about how they're applying the rebates that they get, to either holding down premiums, or passing through on . . . point of sale. I just want to add to that, because I've said it a couple of times but I want to make sure it lands, this is an issue between whether you extend the value of rebates to a population or whether you pass through the value of a rebate to an individual. And it's . . . the notion of . . . of insurance is group pools help hold down costs. And this is a mechanism that we support.
3:07	Sam Imperati, Moderator	So, I'm going to ask everyone to be very concise . . . next up in the queue is John Santa. Thanks for being patient, John.



Time	Speaker	Transcription
3:08	John Santa, OHPB/OHA	Yeah, thanks. Well, similar to a comment made earlier, I actually took that language to mean that 50% would be going to the individual and 50% would be going to the group. My own preference would be 100% goes to the individual, but I'd accept a compromise. [Unidentified speaker: Right.] So, I'm not sure I have a suggestion. But I took it as the first statement said 50% in some way or other is beneficial to the individuals that the . . . the rebate comes from.
3:08	Sam Imperati, Moderator	Thank you. Sen. Linthicum?
3:09	Sen. Linthicum	I think from a transparency perspective, striking the parenthetical clause "at least 50%" —“certify through their annual filing documents the percent of rebates that were applied directly to offset premiums or out-of-pocket costs and/or directly benefit the consumer.” We just hit all the categories. If it's only 10% there and it's 40% there and 70% there, let it be what it is, but we want transparency.
3:09	Sam Imperati, Moderator	So the emerging head-nodding is the removal of “at least 50%.” Any last quick call on any of this? So, I'll go this way. James
3:09	Jim Slater, CareOregon	So I concur with Sen. Linthicum on that suggestion, and you could after consumer put “parentheses–s” to . . . to Robert's point this could be consumer or consumers. How is it benefiting these people, and it could be at the individual level or it could be at the population. But certify what percentage make it to the benefit of these people and describe what's going on here.
3:16	Sam Imperati, Moderator	(Introducing item where insurers' report drug costs' impact on premiums expressed as a percentage —pages 18 and 19 of draft report—requiring insurers to report average prices or percentage, not by 9-digit NDC code—received numerous “3” votes—was a tie vote—a tie will be recorded as a “no recommendation”.)
3:17	Saamil Pandya, PhRMA	If you're taking reporting out for insurers at the 9-digit NDC level, why not take it out of the 9-digit NDC level for everybody? If you include aggregate reporting, you will get what you're looking for— it's to see where the . . . the holdups are where the money goes through the system — without violating proprietary contracts. All right? But if you start getting down to the product by product, form by form level, now you're violating . . . now you're crossing proprietary contracts. So you agreed to take it out for the insurers. Why don't you just take it out for everyone: have aggregate reporting all the way through the whole system?



Time	Speaker	Transcription
3:18	Sam Imperati, Moderator	Just to be clear, No one agreed to do anything. It was responsive to what the members were . . . were saying. And that’s not an LPRO position that it should be out for some and in for the others. It was simply just mechanically reporting what happened. So Robert, you were the propoentt of these changes in Insurer 1. You’ve heard what Saumil Said, basically that what’s good for the Goo for hte goose is goose or the gander, parity, etc. Response, commetn?
3:18	Robert Judge, Moda	Yes so, I think, well, and I stand by the changes that I proposed for the insurer side and I totally understand the comments that Saumil made and . . . and I believe just holistically, I still struggle with what this is trying to get at because the level of specificity that it’s requiring of each of the members of the supply chain I think is gonna run right up against confidentiality issues, industry issues [<i>interjection from unknown speaker: Commerce clause</i>] FTC issues. I mean, It’s gonna be a problem. So whether you keep it, If you aggregate—but what we’re doing for insurers which is really just what’s in HB 4005, along those lines, I think you’ll get a bunch of data that’s useless.
3:22	Erin Moller, Yakima Valley Farm Worker’s Clinic	We just have concerns from a 340B perspective. Because I think obviously transparency is what we’re going for, but I think if you look at that across the board, then the first thing people are going to see is what a community health center pays for these drugs. Right? And what we make from those goes back into our community to serve patients that wouldn’t be served otherwise. And I think what we’re worried about is if we keep this language in here without having language around 340B, we would be one of the first people at risk, maybe, for like “Why do you pay so much less for these drugs?” Whereas someone might be making a profit that they’re just making a profit with, and our profit dollars go directly back into serving patients that don’t have access to health care in our communities. And that is concerning to us, that the federal program might come under I guess fire.
3:22	Saumil Pandya, PhRMA	And I respect that. My only concern is that you’re a community health center, but there’s like large hospital systems which are providers that are operating in a very different world but are also 340B entities. But what you do with the money is a separate conversation. What they’re trying to get at is the transparency around what those spreads are. And so, I’m saying is that the fact that you use it for a noble purpose is . . . is good, but it’s like . . . i t’s a separate conversation from what they are getting at, what you’re trying to get at with regard to the transparency objectives that you’re looking for.



Time	Speaker	Transcription
3:40	Various speakers	(Discussion of other considerations for the legislature moving forward, or for Task Force to investigate in its second year. Examples include: state-pooled purchasing by all payers for certain conditions (e.g. Hep C); move to PBM fee-for-service model to reduce incentive for formulary gatekeepers to prefer high list price/large rebate. Moda proposes need for single state agency in charge of state's drug purchasing and recommends imitating Washington in moving toward value-based and outcomes-based pricing required in state plans; PhRMA agrees with value and out-comes based pricing but not with "legislative edict." Rep. Alonso-Leon points out the need for multi-language resources regarding health care. No one mentions ongoing rebate-capture in commercial insurance plans.)
4:02	Sam Imperati, Moderator	(Notes new release of Task Force draft report updated to show changes discussed in the day's meeting.)