OREGONIANS FOR AFFORDABLE DRUG PRICES NOW!

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December 4, 2018

Jesse O'Brien
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350 Winter St. NE
Room 410
Salem, OR 97309

Re: OR4AD Public Comment to the Prescription Drug Price Transparency Rulemaking Advisory Committee (HB 4005)

Mr. O'Brien:

I attach with this letter OR4AD's transcription of the closing segment of the November 13, 2018, meeting of the Prescription Drug Price Transparency Rulemaking Advisory Committee (HB 4005), prepared from DFR's video recording.

The attached transcription includes the public comment presented at the close of that November 13 meeting by OR4AD director Charles Fournier. We further draw your attention to the extended discussion during the meeting of net cost accounting as the only viable basis for reporting on the "25 most costly drugs" under HB 4005. We note that DFR's draft language signals its recognition that such a list can only be prepared on a net cost basis, and we again remind you that DFR's obligation is to interpret the law to the benefit of the insurance-buying public.

We remain troubled that after 6 months the Rulemaking Advisory Committee has failed to stipulate the cost-accounting rules governing price offsets and to establish an auditable process to calculate and report net prices—as well as to stipulate an audit process to guarantee that the ranking of "most costly drugs" is based on the actual net prices, taking into account all rebates, fees, and other discounts paid by manufacturers to insurance carriers in relation to in-state drug purchasing transactions, irrespective of whether those payments were made to the in-state plan or to out-of-state corporate entities.

The clear need for an auditable process is demonstrated by the repeated admissions on the record by carriers that rebates or price offsets owed for in-state transactions are being accounted as general revenue and allocated to out-of-state corporate entities instead of being recognized as in-state plan assets.

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In order for the state to have the tools for auditing the accuracy of carriers' submitted rankings of 25 most costly drugs, the state will need to maintain a database of average net prices on the model of the Oregon Average Actual Acquisition Cost (OR-AAAC) database, and then to benchmark these average actual net prices against existing and available databases maintained by outside vendors such as IQVIA or SSR Health.

Thank you for directing DFR's attention to this crucial matter.

Regards,

Charles Fournier, J.D.
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Oregonians for Affordable Drug Prices Now
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Attachment –

Partial transcription of November 13, 2018, meeting of the Prescription Drug Price Transparency Rulemaking Advisory Committee (HB 4005), including public comment from OR4AD's Charles Fournier

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November 20, 2018

Partial transcript: Prescription Drug Price Transparency Rulemaking Advisory Committee (HB 4005), November 13, 2018

OR4AD partial transcription from official meeting video available at: https://dfr.oregon.gov/help/committees-workgroups/Pages/video-audio/20181113-prescriptionprice-transparency-video.aspx

Meeting agenda available at: https://dfr.oregon.gov/help/committees-workgroups/Documents/prescription-price-transparency/20181113-agenda.pdf

Third Draft HB 4005 Rules available at: https://dfr.oregon.gov/help/committees-workgroups/Documents/prescription-price-transparency/20181113-third-draft-rules.pdf

Time	Speaker	Transcription
1:28	**Jennifer Baker, Cambia**	[. . .] **But we don't understand why you have added that language regarding . . . in determining this list "the insurer must include the total annual spending, including the net impact of rebates and other price concessions." Where that is not . . . I mean, I don't see where that is stated in the bill.**
1:28	**Jesse O'Brien, DCBS**	Well, in the bill it . . .
1:28	**Jennifer Baker, Cambia**	Because you're almost word for word for the bill. It says, for sub (b) "the 25 most costly drugs as a proportion of the total annual spend."
1:28	**Jesse O'Brien, DCBS**	Right. I mean, my . . . my feeling is that to— what we're really trying to get at with this, and **what I think was intended by this section, was the total cost of these products, and that that. . . that should look at [Baker interjects: Right, and I] offsets to the costs as well.**

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Time	Speaker	Transcription
1:29	**Jennifer Baker, Cambia**	Right, right, and I understand that, but again, I **highlighted in my comments that—was it 88%?—of drugs don't have any rebates. So it's problematic to begin with, and it's also kind of a gamesmanship on the part of manufacturers to try and like reduce a drug, but not reduce a drug. I mean, like, it's difficult to assess that, and it's clearly not in the legislation**, so it's . . . it's again, I'm trying to understand that, there was . . . **I get where your . . . your feelings are on that, but I don't see where the legislation gives you that authority.**
1:29	**Jesse O'Brien, DCBS**	Well, . . . I mean . . . I . . . the legislation, **the legislation talks about "total annual spending," and I think that "total" is the part that we are seeking to define here.**
1:30	**Jennifer Baker, Cambia**	So you believe that . . .
1:30	**Jesse O'Brien, DCBS**	But I . . . I . . . **The intent here is not to take any position on the broader debate about the role of rebates within the system. It's just to say that we want these lists to be reflective of the total actual cost that carriers are experiencing,** and . . .
1:30	**Jennifer Baker, Cambia**	Ultimately the consumer, right? So therefore if you want us to include those, we would also want to also see all the rebates that are being offered. If we're, kind of, using that broader definition, correct?
1:30	**Jesse O'Brien, DCBS**	Well, this isn't revealing what the the rebates actually are. It's just listing the drugs.
1:30	**Jennifer Baker, Cambia**	No, and I'm not saying they would necessarily need them to itemize what rebates the offer, but perhaps like—an average. [O'Brien interjects: *I mean, for what it's worth*] Annual spending. A total annual . . . I don't know . . . I mean like, How many rebates do they offer, as opposed to what we can calculate, what we've received.
1:31	**Robert Judge, Moda**	Maybe if I can help on that [Baker interjects: *That would be great.*] I think the issue that I see with it is, you know, every carrier has its own formulary, its own preferred items—and what's preferred can carry a rebate or it may not carry a rebate—and **when you start having individual carriers report their top spend it might be the same drug reported but they'll be different costs. It could look like, I think that it paints a picture that may not be a picture that carriers want to have painted because of the impact of rebates that they choose or choose not to take advantage of.** So it's . . . you know, I worry how information gets reported and, I don't know, a report can be applied and used or get interpreted without having full insight into formulary deliberations on the part of insurance companies.

Time	Speaker	Transcription
1:32	**Jesse O'Brien, DCBS**	I mean, I guess one of the questions I have is how much this qualification would impact the ranking of drugs. It seems to me that **if it would impact the ranking of drugs, then there is a public interest in . . . in wanting to know what the actual total costs of these drugs is that's getting paid out.** And if it wouldn't affect the ranking that much, then I'm not sure what the issue is, I guess.
1:32	**Anne Murray, Bristol-Myers Squibb**	Maybe if the reporting of the 25 most costly drugs . . . I mean, **wouldn't the reporting of the 25 most costly drugs to an individual plan necessarily include the rebates when you report that? Because how do you assess what's most costly if you don't utilize the price you actually paid?**
1:32	**Jennifer Baker, Cambia**	Only because we don't have the rebate when we pay for the drug. Right? I mean . . .
1:33	**Anne Murray, Bristol-Myers Squibb**	But you know what it is.
1:33	**Jennifer Baker, Cambia**	We know what it might be.
1:33	**Robert Judge, Moda**	We know what we're going to bill for it.
1:33	**Jennifer Baker, Cambia**	It's not always going to be . . . We can anticipate it, hopefully, But that's not necessarily a guarantee, right?
1:33	**Anne Murray, Bristol-Myers Squibb**	That the percentage stays the same?
1:33	**Jennifer Baker, Cambia**	That the rebate's going to be received.
1:33	**Robert Judge, Moda**	**So to give you an example, if you use a rebate aggregator, as a lot of carriers do, you don't see what the rebate percentage is. You have no idea what the rebate percentage is. You just know you get a rebate on that product.**
1:34	**Anne Murray, Bristol-Myers Squibb**	**Well, the folks who negotiated the rebate would know what the rebate is.**
1:34	**Robert Judge, Moda**	**But they're not reporting, right? It's the carriers that are reporting. These rebate aggregators rebate nationally, and they apportion out a portion of what they get from manufacturers to the carriers in their states.** So, you know, we know maybe when a thousand of a product gets dispensed it has a rebate associated with it. In our modeling we know what the rebate value could be, but we have no idea what the rebate percentage is. So how do you calculate that?

Time	Speaker	Transcription
1:34	**Anne Murray, Bristol-Myers Squibb**	**So how are you going to report what the 25 mostly costly drugs are to you?**
1:34	**Robert Judge, Moda**	**What we do is we do it based on collected dollars when we do our, kind of, rate-setting. Collected dollars, that goes toward expense.**
1:34	**Anne Murray, Bristol-Myers Squibb**	**Another thing that won't help the consumer at all, right?** Yet another number. No, I mean, add to the pile.
1:34	**Robert Judge, Moda**	So, I've commented on this earlier. I mean, the timing of rebates, how rebates are actually billed and collected and dispersed. It's challenging to get useful information—that's what we're after.
1:35	**Anne Murray, Bristol-Myers Squibb**	But you set your formularies, or your preferred drug lists. You do so in large part because of . . .
1:35	**Robert Judge, Moda**	No, not in large part, we go through a P&T process . . .
1:35	**Anne Murray, Bristol-Myers Squibb**	I understand P&T process. But one of the considerations would be cost.
1:35	**Robert Judge, Moda**	Yeah, at the end of the day, **when you're trying to figure out placement on formulary, we look at net cost, and there's modeling that gets done. That's projected, based upon the anticipated formulary shift and utilization.** It's not actual; it's projected, which is—
1:35	**Jennifer Baker, Cambia**	[inaudible aside to Judge] . . . changes throughout the year.
1:35	**Robert Judge, Moda**	Oh, yeah.
1:35	**Jesse O'Brien, DCBS**	So, we certainly don't want to expect carriers to provide information that it is literally impossible to provide because you do not have it. [Murray: *Us, too. Us, too, please.*] I would say, of everyone, we do not expect information that you literally cannot provide. But . . . so, the way this is currently worded, the lists would be looking at costs in the experience period, which is, generally the . . . It's not even the previous year, but . . . it's the year before the year when you are filing for a rate increase. How . . . how much of a lag is there on knowing what rebates you're going to get? When . . . when you're filing at that point, would you know more or less where things are at with the experience period?
1:36	**Robert Judge, Moda**	**When we're filing, we know based on the rebates that are collected, not rebates that are billed and outstanding.** So, when you . . . Rebates can start flowing in six months after utilization. Can be as long as two years after utilization.

Time	Speaker	Transcription
1:37	**Eric Lohnes, PhRMA**	How how often is the two-year scenario?
1:37	**Jennifer Baker, Cambia**	About as often as the calculation that we have up here . . . I mean we just don't know.
1:37	**Robert Judge, Moda**	The rebates, every month that I track it says how lagging is. [Lohnes interjects: *I'll have to take a look*.] **I'll probably get to within 80% of billed amounts within a year, and then the rest comes in over . . .**
1:37	**Eric Lohnes, PhRMA**	I feel like most of them come in—are required—within 30 to 60 days. I know this came up in the other Task Force discussion; I'll have to take a look.
1:38	**Robert Judge, Moda**	If we were Medicaid, we'd get it within 30 to 60 days of billing. If we were fee-for-service Medicaid, we'd get it. Everyone else in the commercial world, and that's . . . you bill within 45 days of close of period, so close of quarter, then rebates start flowing in within 45 days after that, so it could be six months after, I'm sorry 90 days— so it could be, **if you have a January 1 claim you could start expecting rebates on July 1.**
1:38	**Jesse O'Brien, DCBS**	Okay, so . . .
1:38	**Jennifer Baker, Cambia**	**And, again, there— it's a small portion of the drugs. Right? It's not the —**
1:38	**Eric Lohnes, PhRMA**	**There are significant rebates attached to some of these, which is why it's important.**
1:38	**Jesse O'Brien, DCBS**	So . . .
1:38	**Jennifer Baker, Cambia**	So you think it should be included even though it exceeds the scope of the language of the bill?
1:38	**Eric Lohnes, PhRMA**	I don't agree that it exceeds the scope. I think what they've done is they've provided basically—a stipulated definition of what they consider to be costly drugs—and this, they've provided a number of . . .
1:38	**Jennifer Baker, Cambia**	**So, where's "rebate" in that?**
1:39	**Eric Lohnes, PhRMA**	It would be included in the— their definition of costly drugs [Murray interjects: *"most costly drugs."*] most costly drugs, which essentially falls in that second sentence. I mean, I'm happy if you think every definition the department has included . . . I happy to go along with that if you want. Jesse can break out his red pen, and . . .
1:39	**Jennifer Baker, Cambia**	I feel like a lot of language exceeds the scope of the bill . . . I mean, I feel like it can't only—

Time	Speaker	Transcription
1:39	**Jesse O'Brien, DCBS**	All right, this is starting to get a little bit [inaudible]
1:39	**Anne Murray, Bristol-Myers Squibb**	She's got . . . she's got a good point there. My question is: **how do we get to what the most costly drugs are if we're not really looking at the cost they're paid for?**
1:39	**[unidentified speaker]**	Sure.
1:39	**Robert Judge, Moda**	I have a point that . . . I have a kind of . . . The first point you raised I think is more problematic than the impact of rebates you've collected on your premiums. Because if you look at drugs dispensed in a medical — in the medical benefit compared to drugs dispensed under a pharmacy benefit, and the impact on consumers. Right? The consumer. The medical claim is an all-in claim. Right? Some carriers can carve out the specific drug and the quantity that's been dispensed. But not all carriers can. NDCs typically aren't in the J-code that gets billed. So there is a challenge if you . . . if you want pharmaceuticals under the medical benefit to be rolled into the 25. And you may end up getting a bunch of top 25 medical benefit drugs, and not outpatient pharmacy drugs, and we'll have blown the purpose of what you're trying to do—which is to assess the impact on consumers of the rising cost of pharmaceuticals.
1:40	**Jennifer Baker, Cambia**	And, and, I would completely agree with that.
1:40	**Jesse O'Brien, DCBS**	So , the motivation . . . and this is by no means set in stone, but the motivation for including both is, on our part at least, the idea that we want what we get in the reports from the insurers to be able . . . to be something that can line up with the reports we're getting from manufacturers, and if we exclude large categories of costly drugs then that's not possible.
1:40	**Anne Murray, Bristol-Myers Squibb**	But we're reporting on WAC, so it's not gonna be . . . the fact—it's not going to match up.
1:41	**Jesse O'Brien, DCBS**	Well, it's at least the same drugs.
1:41	**Anne Murray, Bristol-Myers Squibb**	Maybe.
1:41	**Jesse O'Brien, DCBS**	Right.
1:41	**Jennifer Baker, Cambia**	So do . . . I mean, like, . . . you would be reporting though potentially on drugs [Murray interjects: *on WAC*] that go to the medical benefit as opposed to [Murray interjects: *Sure.*] but have a WAC increase. Right?

Time	Speaker	Transcription
1:41	**Anne Murray, Bristol-Myers Squibb**	In either of the new . . . or, or price increase?
1:41	**Jennifer Baker, Cambia**	Yeah, I'm genuinely asking. I don't have a—
1:41	**Anne Murray, Bristol-Myers Squibb**	Yes. I don't see a differentiation between the two. So I think we would.
1:42	**[unidentified speaker]**	I think those are good thoughts . . . We're the ones that suggested it because there was a concern that there are some costly drugs that roll up under the medical benefit. So it actually started off as a question. Do . . . Are we just going to be reporting then on those that are rolled into the drug benefit? Or are we also going to include these drugs? Because, you know, the way that our product is designed, certain drugs—the injectables—show up under the medical benefit. So it started off as a question: well if we really want the big picture, even though administratively more difficult, it would include these. So I think that if we end up not including them we just have to add caveat whatever we collect, that it's not including those.
1:42	**Robert Judge, Moda**	But I get your point, Jess, that you want to look at all drugs.
1:42	**Jesse O'Brien, DCBS**	Drugs.
1:42	**[unidentified speaker]**	If you've looking at them all.
1:42	**Robert Judge, Moda**	I get it.
1:42	**[unidentified speaker]**	Yeah, we just have to be . . .
1:42	**Jesse O'Brien, DCBS**	And . . . cost of drugs administered . . . administered through the medical benefit is not paid at a pharmacy counter by a patient but it is still passed along to consumers. And I think we want to get as full a picture.
1:42	**Multiple speakers at once.**	"Well, yes, but, it's different." "Yes. well." "But it is Jesse, it's different."
1:43	**Jennifer Baker, Cambia**	I don't think you see a dramatic—I mean, and I'd really want Robert's opinion on this because he knows better that I do—**you don't see a dramatic premium increase based on the medical drugs as you do increase on formularies.**
1:43	**Robert Judge, Moda**	**Well, drug trend on the pharmacy side is so much easier . . . more easily measured because you have very specific data that you're collecting.** For the medical side it's not so much.

Time	Speaker	Transcription
1:42	**Jennifer Baker, Cambia**	It's just something for you to consider. I'm not . . . it's not one way or another, for sure. And I understand the true underlying intent here. And I really want us to be reporting the most expensive drugs to consumers in a way that can be understood and . . . and is not arbitrary in terms of —that . . . that actually show an increase to the consumer directly on an annual basis.
1:43	**Jesse O'Brien, DCBS**	Ok, well I think we should move on, and it's . . . it's just about time for public comment. But the folks on the phone have been pretty quiet. Does anyone want to weigh in on anything? Going to take [interjection from unidentified speaker: *Are they on mute?*] I certainly hope not. If you are talking on the phone, you're on mute. But I'm going to take silence with "willingness to move on." So, we do have one person signed up for public comment. Mr. Fournier, do you want to come up?
1:45	**Charles Fournier, OR4AD**	Yeah, thank you. Charles Fournier with Oregonians for Affordable Drug Prices Now. Just a clarification before we start. I think we had a couple of questions before. We do not work with or for Strategies 360, like [Ms.] Helstein on the phone, and we are not receiving any funding from any corporate actor sitting [at] this table. Now that we have that off . . . **I think the point made by Cambia is true. Branded drugs now amount for what? 9.7% of all scripts in volume, and they generation about—what?—$128 billion dollars in rebates, which is about 44% of claim expenditure—so it's not really a "detail."** I want to focus on the third part of the insurance disclosure requirement, which is Part Number (d). Almost all the terms in that part are undefined. I want specifically to address "impact" and "cost." "Impact" is undefined. What's impact? Is that relative impact or the absolute impact? But mostly the term "cost." **Cost is comprised of two parts: the acquisition cost of the drug and then the rebate offsets the plan collects. And the plan collects offsets from two sources--the manufacturers and certain plan members.** Manufacturers obviously pay a rebate. So—one of the issues we have here is that the state does not maintain any database or any data set that allows it to audit rebate disclosure. The s— Carriers in Oregon are required to disclose rebates as part of their annual financial disclosure requirement and . . . through the NAIC supplemental health care exhibit form to their blanks. **(continued)**

Time	Speaker	Transcription
	Charles Fournier, OR4AD (continued)	Now one of the issues we have here, is that, as Mr.—Robert—has testified today and in other forum, manufacturers [*sic* = *correctly* **"insurers"**] **misreport rebates to states through a process of collecting and channeling their rebates earned on drug purchasing in Oregon through their holding corporations, thus— and not reconciling this rebate offset with the drugs purchased in state.** I mean, this is obvious in the NAIC supplemental health care exhibit data reported on the annual basis as well as in CMS data reported on the annual basis by state and by carrier for the purpose of calculating the Medical Loss Ratios since 2010. I made a little exercise for Oregon and for Minnesota. **In Minnesota in 2017, the insurer carriers reported on their individual plans an aggregated rebate of 7% while the national average is 44%.** Same thing 2016, '15, '14. '14 again 7%. At that time it [the national average] was 26%. So we have a systematic underreporting to the states and thus to CMS of the amount of rebates earned by the carriers on drug purchases in-state and therefore gross inflation and over-reporting of cost to plan. Now, that's the first part. Now obviously the second part is the **overcharging to patients, and that's the second offset amount that the carrier receives to offset the cost of the acquisition of the drug.** Once you receive a rebate, if you base—for certain condition-specific . . . an out-of-pocket payment on list price, you collect a second offset. That price offset should be reported, since it offsets the cost of the drug, and therefore has an impact on the ranking of the drug. So **condition-specific overcharging of certain patients with chronic medical conditions amounts to a price offset or an unallowable condition-specific premium payment, since it's not a cost.** But obviously the state again doesn't have any way to assess how much insurance carriers collect in the form of overcharging, because the state does not even audit its own program. I think OPDP rebate contracts have not been audited for what, 11 years? **(continued)**

Time	Speaker	Transcription
	Charles Fournier, OR4AD (continued)	And OPDP still states that they do not collect any rebates on the drug purchasing they are doing for their card members, which is either a lie or a gross—I would say—breach of contract from Moda Health and its PBM MedImpact. I think I would go for the first one, since otherwise they would be totally incompetent. Which might be also a possibility considering the financial trouble they are currently facing. But in conclusion, as drafted, the insurance disclosure requirement is vague, undefined, and unauditable, and I think there is still a lot of work to be done to protect the insurance-buying public of Oregon. Thank you.