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June 7, 2023

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
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Re: AHIP presentation at the May 17, 2023 Board meeting

Dear Members of the Oregon Prescription Drug Affordability Board:

The Pharmaceutical Research and Manufacturers of America (PhRMA) had previously commented on May 14, 2023 regarding the Board's revised draft Affordability Review rules. PhRMA is now providing these comments on the May 17, 2023 presentation made by Mr. Sean Dickson from America's Health Insurance Plans (AHIP) to highlight several key examples of misleading elements in AHIP's presentation. PhRMA is concerned that this presentation provides the committee members with incomplete information about the costs of prescription drugs and cost-drivers in the health care system.

1. AHIP distorts health care costs in their "premium dollar" graphic.

AHIP's presentation makes it seem like brand medicines are the primary driver of insurance premium costs. But AHIP's own data show that this isn't true. The infographic AHIP presented, "Where does your Health Care Dollar Go?," gives the misleading impression that prescription medicines account for the largest share of insurance premiums. However, by breaking hospital inpatient, hospital outpatient, and emergency room spending into separate categories, AHIP's original infographic obscures the fact that hospital spending is by far the largest contributor to insurance premium costs. Combined, hospital costs account for nearly half (48%) of the insurance premium dollar, more than double that of prescription medicines.[1]

Furthermore, health plan profits and administrative costs take up a larger share of every premium dollar compared to brand medicines. When properly accounting for the share of spending that goes to supply chain intermediaries and generic medicines, innovative brand medicines compose less than 11 cents of the premium dollar.[2] The graphic also hides the fact that nearly 20 cents of every premium dollar is spent on administrative costs or retained by health plan as profit.

2. AHIP misrepresents growth in prescription spending without the context of overall growth in healthcare spending.

AHIP's claim that prescription spending is "growing at an unsustainable rate" is an attempt to obfuscate growth in spending across the entire health care system and blame it on the price of medications. Today, prescription medicines (branded and generic) account for just 14% of total health care spending.[3] Over the next decade, many

[1] PhRMA. https://catalyst.phrma.org/ahips-latest-misinformation-campaign-what-its-trying-to-hide April 2023.
[2] Analysis of the AHIP premium dollar. https://phrma.org/resource-center/Topics/Insurance-Coverage/The-AHIP-Premium-Dollar-Corrected-2
[3] Altarum Institute. "Projections of the Non-Retail Prescription Drug Share of National Health Expenditures." July 2022.

novel medicines will continue to transform patient care and meet current unmet needs, yet medicines are projected to remain at just 14% of total health spending.[4]

AHIP is conflating *spending* with *price*, which are completely different measurements. Spending growth is a measure of the change in total costs across a population over time[5]. Increases in spending can be due to growth in utilization per person, growth in population, price growth, and new products entering the market. Often, spending growth is a combination of all of these factors. Health care cost growth needs to be presented within the context of the entire health care system, which has seen increased spending across nearly all categories from hospital costs, labor costs, insurance premiums, and also general inflation. According to the most recent report from the Oregon Cost Growth Target Committee, total per person health care expenditures grew 3.5% in Oregon between 2020-2021.[6] The same report found, between 2020 and 2021, total medical expenses increased 5.6% on a per person per year basis, with claims spending increasing 6.7%. This was primarily driven by increases in hospital outpatient (+10.1%) and professional services utilization (+10.0%).

In fact, ample data sources show price growth in prescription medicine has significantly slowed, and the real prices plans and insurers pay for medicine is flat or declining. The growth of net prices, which reflects rebates and discounts paid by drug manufacturers to health plans and pharmacy benefit managers (PBMs), has been in line with or below inflation for the past five years. Specifically, brand medicine net prices stayed flat (0.0% growth) in 2022.[7] With respect to Medicare spending, the Congressional Budget Office found that the average net price per prescription fell from $57 in 2009 to $50 in 2018 in the Medicare Part D program.[8] In fact, even before rebates are factored in, data from the Bureau of Labor Statistics (BLS) show that list prices for prescription medicines are growing much slower than overall inflation (2.5% vs. 9.1% between June 2021 and June 2022).[9]

3. AHIP defends misaligned incentives that increase profits for plans and PBMs.

AHIP's argument that the rebate system is not driving up costs and is benefitting patients is not borne out by the data. Manufacturer price concessions can significantly lower the net prices of brand medicines, which were 49% lower, on average, than wholesale acquisition costs (WAC) (i.e., list prices) in 2021.[10] Net prices for brand medicines have increased at or below the rate of inflation for the past five years and are projected to remain flat or decline by up to 3% annually through 2025.[11]

According to a U.S. Senate Finance Committee report, "PBMs have an incentive for manufacturers to keep list prices high, since the rebates, discounts, and fees PBMs negotiate are based on a percentage of a drug's list price—and PBMs may retain at least a portion of what they negotiate."[12] Historically, PBMs often retain a portion of the

[4] *Ibid*.
[5] IQVIA. "The Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2026," April 2022.
[6] Oregon Health Authority. Health Care Cost Growth Trends in Oregon, 2020-2021. Portland, OR. May 9, 2023.
[7] IQVIA Institute for Human Data Science. The Use of Medicines in the U.S. 2023. Published April 2023. Accessed May 2023. https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2023.
[8] Congressional Budget Office. "Prescription Drugs: Spending, Use, and Prices," January 2022. Available at: https://www.cbo.gov/system/files/2022-01/57050-Rx-Spending.pdf.
[9] Bureau of Labor Statistics. "Table 2. Consumer Price Index for All Urban Consumers (CPI-U): U. S. city average, by detailed expenditure category," August 2022. https://www.bls.gov/news.release/cpi.t02.htm.
[10] IQVIA. "The Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2026," April 2022.
[11] *Ibid*.
[12] Senate Finance Committee. "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug," 2021.

rebates they negotiate on behalf of their commercial health plan and employer clients, denominated as a portion of a medicine's WAC, as compensation for their services.[13] In addition, the administrative fees that PBMs charge to plan sponsors and pharmaceutical manufacturers are commonly based on a percentage of list price and are usually retained in total by the PBM. Because rebates and administrative fees paid to PBMs are typically calculated as a percentage of a medicine's list price, government agencies, economists, and other experts have noted that PBMs may favor medicines with high list prices and larger rebates to maximize their revenue.[14] In doing so, the current PBM compensation model is causing patients to face a higher financial burden for their prescription drugs.[15] Public sources have also noted that manufacturer efforts to reduce list prices have been met with significant headwinds, including demand letters from PBMs requiring additional payments in the event of list price decreases.

AHIP's presentation attempts to obscure the growth in premiums and plan profits. Strikingly, insurance premiums in Oregon have grown by more than 200% since 2000.[16] Big insurers now generate more profits from their PBM business than they do delivering insurance coverage.[17] There is significant ownership overlap between PBMs, health insurers, specialty and mail-order pharmacies and provider organizations.[18] The combined market share of the three largest PBMs has grown significantly, from 48 percent in 2010 to 80 percent in 2021,[19] and just six companies control 96 percent of the PBM market.[20] PBMs and their health insurers continually rank higher on Fortune 500 lists than other industries including biopharmaceutical companies: #4 is CVS Health (Caremark and Aetna), #5 for UnitedHealth Group (Optum), and #12 for Cigna (Express Scripts).[21]

4. AHIP misrepresents policies that would actually lower patients' direct costs.

AHIP's presentation mischaracterizes policies we believe can help patients better afford their medications, without putting access to care at risk. Simply put, **consumers should benefit from market competition and pay based on the negotiated price for medicines – like they do for hospital and physician services**. Biopharmaceutical manufacturers provide significant discounts and rebates to PBMs and health plans, but many patients don't benefit from these discounts negotiated on their behalf. On average, pharmaceutical companies rebate approximately 49% of a medicine's list price back to insurance companies and middlemen like PBMs.[22] These rebates are intended to lower the costs of prescription medicines, but are often not directly reaching the patients at the pharmacy counter. While health plans claim that at least a portion of these discounts are used to reduce premiums, research demonstrates that sharing these rebates and discounts directly with patients at the pharmacy counter would have little impact on premiums and significantly benefit consumers. A recent study found that requiring health insurers and PBMs to share negotiated discounts and rebates at the pharmacy counter could save some patients $900 annually in out-of-pocket (OOP) expenses without significantly increasing their

[13] PBM Accountability Project. "Understanding the Evolving Business Models and Revenues of Pharmacy Benefit Managers," December 2021.
[14] Medicare Payment Advisory Commission. "Report to the Congress: Medicare Payment Policy. Chapter 13: The Medicare Prescription Drug Program (Part D): Status Report." March 2021.
[15] *Ibid*.
[16] Oregon Health Authority. Health Care Cost Growth Trends in Oregon, 2020-2021. Portland, OR. May 9, 2023.
[17] https://www.fiercehealthcare.com/content/which-payer-raked-most-cash-last-year-answer-likely-wont-surprise-you
[18] https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html.
[19] Fein AJ. "The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger." Drug Channels. April 5, 2022.
[20] Sweeney E. "Lawmakers ask FTC for retrospective review of PBM mergers," Fierce Healthcare. July 2018.
[21] Fortune Magazine, 2023 Fortune 500 rankings. https://fortune.com/ranking/fortune500/
[22] IQVIA. "Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025." April 2022.

premiums.[23] The study found that legislation like this may increase member premiums between 0.1% and 0.5%.[24] West Virginia passed legislation in 2021 to share negotiated discounts and rebates with patients at the pharmacy counter. A review of the state's 2023 insurance rate filings indicates that premium increases there are in line with national premium increases for 2023, demonstrating that sharing rebates with patients at the pharmacy counter does not significantly raise premiums.[25]

Lowering patient OOP costs could also reduce costs to the health plan and health care system. A large body of evidence demonstrates how better use of medicines can reduce other sources of health care spending across a broad range of chronic conditions.[26] In fact, better use of medicines could eliminate $213 billion in U.S. health care costs annually, amounting to 8% of the nation's health care costs.[27] Recognizing that lower cost sharing can improve patient access to medicines, some PBMs have already adopted point-of-sale (POS) rebate pass-through programs for their commercial market customers. Within two months of implementing such a program for fully insured group health plans, OptumRx observed up to a 16 percent improvement in medication adherence.[28] In 2019, CVS Health started to offer a benefit option that passes rebates for medicines at POS to its employees. Members in plans that implemented POS rebates saved more than $670 on average in OOP costs per eligible 30-day specialty prescriptions, and $155 on average per eligible non-specialty prescriptions, during the deductible phase.[29] Member savings for plans with POS rebates averaged 42 percent.[30]

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PhRMA and its member companies appreciate the opportunity to respond to AHIP's presentation to the Board. We continue to stand ready to present to the board as one of the many supply chain stakeholders who have already given presentations. If there is additional information or technical assistance that we can provide, please contact me, Dharia McGrew (dmcgrew@pharma.org).

Thank you,

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[23] Milliman. Measuring the Impact of Point of Sale Rebates on the Commercial Health Insurance Market. July 2021.
[24] Milliman. Measuring the Impact of Point of Sale Rebates on the Commercial Health Insurance Market. Jan 2022.
[25] PhRMA analysis of 2023 West Virginia health insurance rate filings.
[26] https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Industry-Profile-2022/Better-Use-of-Medicines-Can-Improve-Health-Outcomes-and-Reduce-the-Use-of-Costly-Medical-Care-2.pdf
[27] IMS. Avoidable costs in US healthcare: the $200 billion opportunity from using medicines more responsibly
[28] UnitedHealth Group. "Successful Prescription Drug Discount Program Expands to Benefit More Consumers at Point-of-Sale." March 12, 2019. https://www.unitedhealthgroup.com/newsroom/2019/2019-03-12-prescription-drug-program-expands-to-benefit-consumers-point-of-sale.html
[29] CVS Health. "Strategies Designed to Lower Plan Member Cost: Study Finds Health Care Costs a Barrier to Seeking Care". September 3, 2020.
[30] *Ibid*.