PIONEER HEALTH

Testimony

Testimony of William S. Smith, PhD, Senior Fellow and Director, Life Sciences Initiative, Pioneer Institute, on S. 2651

Submitted to Senate Committee on Ways and Means, Michael J. Rodrigues, Chair, February 4, 2022

Dear Chair Rodrigues and Vice Chair Friedman:

Thank you for the opportunity to testify in opposition to S. 2651, legislation that would impose price controls on one of Massachusetts most important economic sectors, biopharmaceuticals.

I have three major concerns about this legislation. First, it is based upon the false premise that drug prices and drug costs are rapidly rising. They are not. (I explain the latest data on drug prices and costs below.) Second, some analysts who assert costs are rapidly rising fail to acknowledge the role of rebates and other cost offsets, so their conclusions are erroneous. Finally, I fully recognize that many consumers are having challenges paying for their prescription drugs, but this is not due to rising costs, but to insurance benefit designs that increasingly require large out-of-pocket expenditures by patients, particularly when those patients are prescribed a specialty drug.

I want to repeat that my opposition the bill is not based upon a belief that drug costs are easily afforded by all patients. To the contrary, I believe there is a significant affordability crisis for patients who have high out-of-pocket expenses. However, based upon a careful examination of the drug cost data, it is clear that this affordability crisis is not driven by drug prices or drug costs, but by poor insurance benefit design.

Supporters of S. 2651 have argued in their **press release**, that the bill is necessary because of "rapidly rising prescription drug costs." This assumption is simply false. Drug costs and drug prices are not "rising rapidly," just the opposite. The latest healthcare data from the Center for Medicare & Medicaid Services indicates that *overall* U.S. healthcare expenditures are indeed rising rapidly, by 9.7 percent from 2019 to 2020. However, prices for brand name drugs have been dropping for four straight years. For some of the largest drug manufacturers, one **analysis** documented price declines of 3.1 percent in 2020, the fourth straight year of declining prices. Other **analyses** have pointed to similar declines of 2.9 percent in 2020.

Average prices do not, of course, determine how much health plans must spend on drugs. Utilization rates — how many drugs are people taking — also determine overall drug costs. Cigna, which is the second largest pharmacy benefit manager in the U.S., recently reported its overall drug *cost* data for the health plans that they serve. Cigna **reported** that three-quarters of the increase in drug costs for their plans was due to greater utilization, not rising prices, and that drug costs rose 4 percent overall. However, when rebate revenue from drug makers was included in the analysis, *drug costs only rose .9 percent, or less than 1 percent*.

Some policy makers in Massachusetts seem to be disregarding the national data and moving forward with price controls because of data from the Boston-based Center for Health Care Information and Analysis, which claims that spending on biopharmaceuticals rose 3 percent between 2018 and 2019. A closer look at that data raises doubts about it. First of all, the Center's 2021 report argues that the 3 percent rise is due to a spending increase from $8.1 billion in 2018 to $8.3 billion in 2019. Is $8.1 billion to $8.3 billion a 3 percent rise? According to my calculator, a rise from $8.1 billion to $8.3 billion actually represents a rise of 2.4 percent, a figure that happens to be identical to the overall inflation rate for 2018.

The drug pricing data in the Center's 2021 report has other infirmities. For example, the Center's analysis seems to undervalue the level of rebates provided by the industry. According to the **Technical Appendix** in the Center's report, they calculated the level of rebates by "collecting data from health plans." The problem with this approach is that pharmacy benefit managers (PBMs), acting on behalf of health plans, skim a certain percentage of rebates and keep the money for themselves, never passing the full amount to health plans. If you are only relying on rebate information from health plans, you are undercounting. While no one knows what percentage of rebates are kept by PBMs, one of the largest PBMs at the time, Medco, filed a **10-K report** with the Securities and Exchange Commission in 2011 indicating that they kept 12.2 percent of rebates. The Center's analysis therefore may be undercounting rebate payments by double digits. In short, PBMs are responsible for a portion of this 2.4 percent growth rate.

I do not question the motives of the Senators who have supported S. 2651 because I am sure that they are hearing from constituents who are upset about their bills at the pharmacy counter. And these constituents are correct: consumers are paying more and more out of their pockets in the form of coinsurance, copayments, and other charges — and these out-of-pocket increases are happening as brand drug prices are *falling*. New **data** from the Center for Medicare and Medicaid Services (CMS) indicate, for example, that in 2020, while overall spending on hospital care was $922 billion higher than spending on prescription drugs, out-of-pocket spending on prescription drugs by consumers was $14 billion higher than out-of-pocket spending for hospital care. Out-of-pocket costs for consumers grew by **$1 billion** in 2020; this increase has not been caused by drug prices but by insurance benefit design.

Despite declining drug prices, and modest growth in drug costs, health plans, including Medicare, are socking consumers with higher and higher out-of-pocket costs. If you have a 20 percent coinsurance requirement from your health plan, and you are prescribed a $50,000 oncology drug, you will be asked to shell out $10,000 from your own wallet. This exorbitant level of coinsurance may keep premiums lower for the healthy enrollees, but the sick patient who has high coinsurance and ends up on a cancer drug may not be so keen on his or her insurance benefit.

Some may argue that many of the new high-cost drugs entering the market are unaffordable by the healthcare system. The data does not support this position. Between now and 2025, the healthcare system will save $128 billion as a result of branded drugs losing their patents and generic replacements entering the market. Largely because of these patent expirations, the **forecast** for net price growth for branded drugs is 0 to –3% through 2025. Negative price growth.

While the Senate legislation does cap out-of-pocket costs for insulin, a worthy proposal, thousands of other patients must take drugs for cancer, for autoimmune diseases, for arthritis, and for other conditions that require costly infused or injected specialty drugs. Because of patent expirations, the healthcare system can easily afford to reduce the out-of-pocket costs for these patients. I commend the Senate's attempt to address the drug affordability problems of patients, but I respectfully submit that some Senators may be looking in the wrong place.

Thank you kindly for the opportunity to testify.

If you or your staff have questions, I can be reached at:
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