Testimony of the National Academy for State Health Policy Regarding SB 1202

Senator Lesser, Representative Gilchrest, Senator Seminara, Representative Case, and members of the Human Services Committee,

My name is Drew Gattine and I am a Senior Policy Consultant for the Center for Prescription Drug Pricing at the National Academy for State Health Policy (NASHP). NASHP is a non-partisan forum of state policy makers that works to develop and promote innovative health care policy solutions at the state level. In 2017 NASHP created its Center for Drug Pricing to focus attention on steps that states can take to tackle the spiraling costs of prescription drugs and the impact they have on consumers, the overall cost of health care and state budgets.

At NASHP we believe that when it comes to health care, the states are a tremendous source of innovative ideas and solutions. We approach our work by engaging and convening state leaders to solve problems. We conduct policy analysis and research and we provide technical assistance to states. NASHP's Center for Drug Pricing develops model legislation for states and provides technical assistance and support to legislators and executive branch leaders who wish to move them forward. When these bills pass, NASHP continues to support states as they are implemented.

NASHP is a non-partisan organization. We recognize state policy reflects the unique situations in each state however, so we do not take positions on legislative proposals. I am here not "for" or "against" the bill, but to share information and to help answer questions.

In November 2022 NASHP released model legislation to use the Medicare Fair Price (MFP) as an upper payment limit (UPL). The bill before the Committee today, SB 1202, contains many of the same elements of the NASHP model.

This bill directs a state to leverage critical drug pricing provisions in the landmark Inflation Reduction Act (IRA). The IRA contains several provisions designed to help reduce the costs of prescription drugs, including provisions that will allow Medicare for the first time to negotiate the cost of several high-cost drugs. The price negotiation process will begin 2023 and Medicare will publish its negotiated price for the first ten drugs by September 1, 2024. Although the list of

drugs that will be subject to negotiated prices is not yet known, the list will include drugs that are costly to private health insurance plans and state purchasers. This bill directs a state to use the Medicare negotiated price as the UPL for drugs sold in the state. This means that the payment limits set by Medicare will apply to private and public purchasers including ERISA plans that choose to participate.

A state process that sets a UPL, basically a ceiling payment rate, is not price-setting. Manufacturers are free to set whatever price they chose. A UPL caps what a purchaser will pay. Determining maximum payment levels or payment rates for health care and other public goods is a state practice that has existed for decades. States regulate insurers and other public goods and services in markets with little or no market competition and set payment rates for health services through their public purchasing. This model act extends that precedent to prescription drugs by using Medicare's negotiated rate as reference points to set fair payment rates.

The process for selecting drugs and negotiating prices is described in detail in the Inflation Reduction Act. The federal Department of Health and Human Services (HHS) will compile a list of drugs that meet the criteria described in the statute. Negotiations are limited to single-source drugs that (1) are at least 7 years (small molecule) or 11 years (biologic) beyond FDA approval; and (2) account for at least $200 million spend across Medicare Parts B and D. The IRA excludes from negotiation drugs marketed as generic/biosimilar (or biologics with reference biosimilar pending entrance within 2 years), orphan drugs that treat a single rare disease, and plasma products. From those drugs, HHS selects the top 10 drugs in order of highest to lowest spending.

HHS will then review information submitted from the manufacturer and determine a Maximum Fair Price. Manufacturers can accept or propose a counteroffer. HHS then publishes the final Maximum Fair Price (MFP), which is binding.

It is not currently possible to determine the savings that Connecticut or other individual states would realize if they referenced the MFP because neither the drugs nor the prices have yet been determined. However, the savings estimated by Medicare are significant (estimated at $98.5 billion over ten years) and would undoubtedly translate into large savings at the state level. Depending on how long a drug has been on the market, the IRA ceiling price will be capped at 40% to 70% of average manufacturer price.

The UPL applies to all purchasers in the state, including commercial insurers, state entities and ERISA plans that elect to participate. The bill, like the NASHP model, requires purchasers to utilize savings to reduce costs for their members. Purchasers (including participating ERISA plans) must submit a report to the Insurance Department indicating how much they saved by participating and how they passed those savings on to consumers and how those savings helped to reduce cost disparities.

As the Committee continues its work on this bill NASHP is available to support your work as necessary. For further details on the legal issues related to reference pricing and UPLs, please

see a white paper authored by Professor Rachel Sachs with a detailed analysis of the patent law and commerce clause implications of upper payments for a similar model bill related to international reference rates.

The NASHP website also contains other materials (Written Q&A, Blog Articles, etc.) that may be useful material for the Committee. Thank you.

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