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Statement Opposing Legislation Creating Prescription Drug Affordability Board
Minnesota House File 17

Position: The Biotechnology Innovation Organization (BIO) respectfully opposes HF 17 that would create a Prescription Drug Affordability Board tasked with reviewing prescription drug costs and setting upper payment limits for specified prescription drugs. This bill does not address the root cause of the problems affecting patients, such as lowering out-of-pocket costs. Imposing government price controls like those proposed by this legislation will jeopardize patient access to innovative biopharmaceuticals.

HF 17 will not lower prescription drug costs for patients because it does not address out-of-pocket costs. Nearly 90% of patients[1] pay a given price when they visit a pharmacy based on what their health insurer determines. Out-of-pocket costs have been rising for patients because of decisions made by health insurers. Net of rebates and other price concessions, medicine spending grew by only 0.8% in 2020.[2] Despite this fact, many insurers require more and more patients to pay for their drug costs through deductibles and cost-sharing rather than an established copayment, increasing their out-of-pocket costs. A May 2021 Congressional Research Service report found that insurers are imposing higher levels of cost sharing and forcing some patients, i.e., the chronically ill, to pay a greater financial burden than others.[3] In fact, insurers require patients to pay almost 5 times more out of pocket for prescription drugs than for hospital care.[4] In addition, despite receiving significant rebates from manufacturers, "commercially-insured patients pay undiscounted list prices on one in five prescription brand name drugs, accounting for more than half of out-of-pocket spending on brand medicines."[5]

The premise that establishing upper limits does not impose price controls is a false narrative. Whether you call it establishing "Upper Limits" or a price control the effect is the same. This policy still regulates free-market prices and creates a price ceiling based upon a metric from Canadian health system that establishes their prices at a much lower level than in the US. While the legislation tasks the board with establishing a process for setting upper payment limits for certain medications, the bill utilizes arbitrary measures for the selection of such medications and prescribes no process for setting this "limit." The price control scheme is designed around the premise that prescription drug costs have ballooned out of control or are increasing at an unsustainable rate. Yet prescription drugs, including inpatient medicines, have and continue to make up about 14% of national health expenditures—both in the past and projected

[1] Kaiser Family Foundation accessed June 16, 2021. https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[2] "The Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025, IQVIA, June 2021.
[3] "Frequently Asked Questions About Prescription Drug Pricing and Policy," Congressional Research Service Report, Updated May 6, 2021.
[4] "BIO Analysis of Historical National Health Expenditure Data, Centers for Medicare & Medicaid Services. December 2020
[5] "Commercially-Insured Patients Pay Undiscounted List Prices for One in Five Brand Prescriptions, Accounting for Half of Out-of-Pocket Spending on Brand Medicines," Analysis from Amundsen Consulting, a division of QuintilesIMS, on behalf of PhRMA, 2017.

for the next decade.[6] And medicine spending on a per-patient-per-year basis, adjusted for inflation, grew by less than 1% between 2009 and 2018.[7]

Price controls only disincentivize biopharmaceutical companies from developing new, more effective therapies. Economists have estimated that government price controls can have a significant, damaging effect on the development pipeline. For example, one study found that an artificial 50% decrease in prices could reduce the number of drugs in the development pipeline by as much as 24%,[8] while another study found investment in new Phase I research would fall by nearly 60%,[9] decreasing the hopes of patients who are seeking new cures and treatments.

Price controls will dampen investment and would not allow companies to adequately establish prices that will provide a return on investment. The average biopharmaceutical costs $2.6 billion to bring from research and development to market.[10] Small and mid-sized innovative, therapeutic biotechnology companies which make up most of BIO's membership are responsible for more than 72% of all "late-stage" pipeline activity.[11] They sacrifice millions of dollars, often for decades before ever turning a profit, if at all. In fact, 92% of publicly traded therapeutic biotechnology companies, and 97% of private firms, operate with no profit.[12] The overall probability that a drug or compound that enters clinical testing will be approved is estimated to be less than 12%.[13] Only five out of 5,000 compounds become viable marketed products. Pricing must also account for the 4,995 failures before the company discovers that successful drug compound.

Legislative proposals such HF 17, target the most innovative medicines, disproportionately impacting patients with diseases where there is high unmet need and where low-cost treatment options are not available (e.g., rare diseases), running counter to the aims of personalized medicine, and availability of new treatments. Further troubling, the arbitrary nature of upper payment limits ignores the value that an innovative therapy can have to an individual patient—especially one who may have no other recourse—or the societal impact innovative technologies can have, including increased productivity and decreased overall healthcare costs (e.g., due to fewer hospitalizations, surgical interventions, and physicians' office visits).

For these reasons, BIO respectfully asks that you oppose HF 17, creating a Prescription Drug Affordability Board.

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[6] Roehrig, Charles. *Projections of the Prescription Drug Share of National Health Expenditures Including Non-Retail*. June 2019.
[7] IVQIA Institute for Human Data Science. *Medicine Use and Spending in the U.S.: A Review of 2018 and Outlook to 2023*. May 2019.
[8] Maloney, Michael T. and Civan, Abdulkadir. *The Effect of Price on Pharmaceutical R&D* (June 1, 2007). Available at SSRN: https://ssrn.com/abstract=995175 or http://dx.doi.org/10.2139/ssrn.995175
[9] Vernon, John A., and Thomas A. Abbott, "The Cost of US Pharmaceutical Price Reductions: A financial simulation model of R&D Decisions," *NBER Working Paper*. NBER, February 2005. https://www.nber.org/papers/w11114.pdf Accessed: April 18, 2019.
[10] DiMasi, JA, et al., Innovation in the pharmaceutical industry: New estimates of R&D costs. Journal of Health Economics. February 12, 2016.
[11] "The Changing Landscape of Research and Development: Innovation, Drivers of Change, and Evolution of Clinical Trial Productivity," IQVIA Report, April 2019.
[12] Ibid.
[13] Biopharmaceutical Research and Development, The Process Behind New Medicines. PhRMA, 2015. http://phrma-docs.phrma.org/sites/default/files/pdf/rd_brochure_022307.pdf