**The drug industry already regulated by US DOJ and anti-trust division**

Hospital systems and large nursing home chains are regulated by Medicare, Medicaid, state licensing offices, departments of insurance, and depending on size, DoJ and DOJ anti-trust, and conditions of participation for each and every insurer network in which they participate. The Rx industry has the least regulation of any part of the health care system

**Price control mandates are anti-competitive**

* The legislation regulates what state-licensed entities can pay and charge for a drug with an upper payment limit. Manufacturers are not subject to price controls under the legislation.
* Pharmaceuticals are invaluable. Like clean water or electricity, for those who need them they are not an optional service. Like water or electricity, we must ensure that they are affordable. Competitive marketplaces balance profit maximization with consumer access to their product. The failure of the pharmaceutical industry to operate as a normal market has been well-noted. When an industry has monopoly opportunities, like public utilities, there is a need for policy that protects consumers from the excesses of a monopoly supplier or when the members of the industry support each other’s ability and incentive to raise prices.

**Price control provisions disrupt competition**

Price controls may disrupt competition, but the point here is that there is insufficient price competition in the pharmaceutical market today, and the consumer always suffers in this situation. States cannot set prices for a national company, but states can set healthcare payment rates for state-licensed suppliers, providers, and health plans – which is what our legislation would do.

**Price control provisions violate federal constitutional law**

* The bill is written in a way that only sets payment rates for state-licensed entities for drugs intended for use in the State. The legislation does not establish prices manufacturer set or discounts given outside the State.
* States regulate consumer payment rates for public utilities because they have monopolies in services that are vital to life and health. Unlike the early 1900’s when this regulation started in states around the country, public service companies were local. Today, our public services are generally owned by national and regional energy and telecom companies. However, state authority to regulate what consumers pay those companies is still under the authority of each and every state; each state decides on different consumer payment rates for public utilities.

**Price control provisions violate anti-trust law**

This legislation regulates *costs* and *charges* among state-licensed suppliers, providers and health plans. It does not regulate that national list prices of drugs. It does not regulate what manufacturers charge for drugs to be sold and used outside our State. This is not an anti-trust violation. The legislation is not a price control, it is rate setting for drugs intended for use in the State that are paid for and billed for by state-licensed suppliers, providers, and health plans.

We are simply treating certain pharmaceuticals like any other must-have commodity.

**The PDAB bill would reduce innovation**

There is a growing body of research literature found in Journal of the *American Medical Association*, *Health Affairs*, and the World Health Organization, among others, that finds that the industry rate of return on capital is sky high and profit margins in US pharmaceuticals greatly exceed that of other industries.

Making high-cost drugs affordable – so more people can buy them and health plans can cover more drugs -- should not be equated with a loss of revenue. Why would the industry presume that SELLING MORE product would lead to a devastating loss of income? No on is asking the industry to donate product. We are creating a system that will result in greater sales than occur today for these products.

**A PDAB would block investment in research and development to find cures**

Only pharma companies can decide where and how much to invest in R&D. A PDAB has nothing to do with those decisions. It is worth noting that

* Pharmaceutical industry is one of the most profitable industries in the world.
* The majority of industry revenues are generated in the US as compared to other countries – because we pay the highest prices.
* Other industries survive on much smaller margins.
* Much of the initial research for many drugs comes from academic communities funded by federal grants.

**Drugs are not affordable because of how insurers design their policies**

* Insurers have limits on profits – they must spend at least 80-85 percent of premium revenues on health care services. In contrast, there is no limit to how much pharmaceutical companies can make. Changing the insurance design to cover more drugs at full cost will simply drive up costs of healthcare overall.
* Insurance design is a symptom of the problem we have with unaffordable drugs. It is not the root problem. The patient is caught in the middle and a PDAB could rectify this equitably in the marketplace.

**The solution to drug costs is for industry rebates to be passed to consumers**

* Some insurance companies do pass a portion of the manufacturer rebate to the patient. This is helpful, but it only shifts costs around without reducing total drug costs.
* Other insurers use rebates to lower premiums overall, which is also important for a stable insurance market.
* The option that would actually reduce costs would be for pharmaceutical companies to provide the rebate, at the point of service, to the pharmacy or the physician rather than more complex process of getting some reduction to the patient while maintaining secrecy of the price concession. When the price concession goes directly to the pharmacy, pharmacy acquisition cost drops, the patient cost sharing is keyed to the pharmacy acquisition cost, and the insurer effectively benefits from the rebate when the pharmacy bills for reimbursement. This would be the most effective use of industry rebates. Pharma does not support this approach because it creates some level of manufacturer price transparency.
* An upper payment limit established by a PDAB would, effectively, get manufacturer discounts directly to the patient at the point of service in a very direct and efficient manner.

**Retail prescription drugs are not increasing in price as much as other sectors**

* National health expenditures grew 4.6% in 2019 while prescription drug spending grew 5.7%. Increased spending is driven more by price increases than utilization. In the first days of January, 2022, prices rose an average of 5% for 450 drugs.[[1]](#endnote-1)
* The pharmaceutical industry cites that prescription drugs are ten percent of total national health care spending. Of more direct concern for consumers is that prescription drugs consume 23% of our premium dollar – after accounting for rebates. [[2]](#endnote-2) This is equal to or more than inpatient hospital and physician spending categories.
* State taxes support some or all the pharmacy benefits for 25-30 percent of residents in many states.[[3]](#endnote-3) State governments and state residents have a large stake in constraining drug spending.

1. PharmaCompass, January 6, 2022 [↑](#endnote-ref-1)
2. America’s Health Insurance Plans, 2021, [↑](#endnote-ref-2)
3. The calculation would include State and local government employees and retirees, public school system employees and retirees, prison system employees, dependents, retirees; inmates; higher education employees, dependents and retirees; student clinics; Medicaid enrollees – all as a percentage of the total state population. [↑](#endnote-ref-3)