



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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March 8, 2019

Assemblywoman Pamela Hunter
New York State Assembly
LOB 553
Albany, NY 12248

Representative Tom Oliverson
Texas House of Representatives
Room E2.720
Austin, TX 78768

RE: BCBSA & AHIP Comments on NCOIL Model Act Concerning Prescription Drug Costs

Dear Assemblywoman Hunter and Representative Oliverson,

America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) appreciate the opportunity to provide comments on the National Council of Insurance Legislators (NCOIL) Model Act Concerning Prescription Drug Costs ("Model")

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies that collectively provide health coverage for one in three Americans. AHIP is the national association whose members provide coverage for healthcare and related services, offering health and wellness products in every insurance market, in every state, to individuals, families, small and large businesses as well as Medicaid and Medicare beneficiaries.

We share your goal of helping consumers who are facing rising prescription drug prices and a lack of meaningful and transparent information about these prices. However, we have concerns that the current Model imposes insufficient and inequitable transparency requirements that will not adequately achieve this goal. Our concerns are as follows:

1) The Model will not provide consumers and policymakers with meaningful, actionable information about the true price of pharmaceuticals

While we are pleased the Model seeks to address price increases through new reporting requirements for manufacturers, the data elements proposed in Section 4(b)(1) have little value for consumers or others researching ways to address drug prices. For example, the use of "aggregate, company-level research and development costs" has no value to a discussion about a price increase for a specific drug, since aggregate reporting of these costs avoids the relevant question of how these costs apply to the drug in question. The price increase reporting may be improved by including key elements already enacted in some states, such as the portion of research and development costs paid for with public funds, direct costs for marketing and distribution and profit margin.

Similarly, the disclosures outlined in Section 5 regarding rebates, fees and other payments collected by PBMs and passed on to health plans do not inform drug pricing. This is highly sensitive information that if disclosed publicly would threaten a PBM's ability to negotiate future discounts, raising the prices for consumers in future years. This confidential information about negotiated rebates, which is a critical part of lowering drug prices, does not serve a purpose in helping policymakers understand why prices are increasing.

2) Price increase reporting requirement is too low and creates inequitable disclosures

As health plans, we appreciate that the Model seeks to apply transparency standards to multiple parties in the drug supply chain. However, we do not believe the disclosure requirements meet a reasonably equitable standard. For example, the Model's price increase reporting requirement for drug manufacturers only requires notice for drugs with a price increase of 50 percent or greater, even though many existing state laws already use much lower thresholds. As a result, manufacturers would be able to raise the price of a drug by as much as 49.9 percent, which for a specialty drug could often be in the thousands of dollars. As long as the increase stays below that threshold, no disclosure of any of the development costs of that drug would ever occur.

Conversely, the transparency requirements for health carriers requires them to gather and distribute extremely broad information about premium rates, regardless of any change in drug price. Specifically, the information mandated in Sections 6(a)(1)(D) and (E) is difficult to ascertain, since it results from a highly complex calculation involving a multitude of factors related to utilization management (UM) programs. These programs do not exist solely to reduce drug costs; they also seek to improve quality and patient safety and ensure appropriate prescribing of the most effective drug. For example, health plans are using UM programs to reduce the number of opioid prescriptions and monitor quantity limits on such prescriptions as one strategy to confront the opioid epidemic. Carriers would be required to research, gather and provide this and all other information required in Section 6 regardless of whether the price of a drug were to change.

Taken together, the current Model creates a reasonable likelihood that health carriers will be required to provide detailed information while the very entity that sets the initial price and determines future price increases – the drug manufacturer – could avoid altogether disclosure of the very reasoning for a price increase.

Proposed Amendments

While we have concerns with the current Model generally and encourage NCOIL to continue consideration of this issue, we feel the following amendments would help improve it:

- 1) *Amend Section 4(b)(1) to include a ten percent increase as the reporting threshold;*
- 2) *Remove Sections 6(a)(1)(D) and (E)*
- 3) *Amend Section 4(b)(1) to require manufacturer disclosure of research and development costs for a specific drug, along with disclosure of the portion of research and development costs paid for with public funds, direct costs for marketing and distribution and profit margin.*

NOTE – These comments and recommendations are in addition to comments submitted by AHIP to NCOIL in a letter to Representative Oliverson and Senator Dan “Blade” Morrish on December 4, 2018.

We appreciate your consideration of our comments. We share the goal of working to ensure prescription drugs are more affordable and accessible for consumers. If you have any questions or want additional information, please contact Jeremy Crandall at (202) 626-4802 or jeremy.crandall@bcbsa.com or Leanne Gassaway at (202) 861-6365 or lgassaway@ahip.org.

Sincerely,



Leanne Gassaway
Senior Vice President, State Affairs and Policy
American’s Health Insurance Plans



Kim Holland
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