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September 20, 2022

Malinda Southard
Executive Director
Patient Protection Commission

Re: Opposition to Subject 2, Topic 6: Creating of a Prescription Drug Affordability Board

Dear Ms. Southard:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on the proposal on the September 21, 2022 Patient Protection Commission agenda to create a Prescription Drug Affordability Board. Specifically, subject 2, topic 6 includes discussion of a PPC letter of support to, "Create a Prescription Drug Affordability Board. Expand on NRS 439B.630 and set "allowable rates" for certain high-cost drugs identified by the Board." Unfortunately, PhRMA must oppose that proposal for several reasons.

PhRMA believes that discussions about the affordability of medicines are important, but the intention of this proposal is for the government to decide drug prices, which could limit the prescription options available to Nevadans. Specifically, the proposal appears to implement a government-appointed Board to review prescription drug costs and value with the goal of setting price limits by way of an "allowable rate." Regulating drug prices in-state could lead to a shortage of or limit access to medicines for patients. Specifically, if a pharmacy or provider cannot obtain a medicine at the government price, the medicine will not be available to Nevada residents.

The proposal also appears to ignore that there are meaningful policies for addressing affordability without importing government price setting that could reduce treatment options.

PhRMA is increasingly concerned that the substantial rebates and discounts paid by pharmaceutical manufacturers, approximately $236 billion in 2021,[1] do not make their way to offsetting patient costs at the pharmacy counter. Patients need concrete reforms that will help

[1] Fein, A. "The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute. March 2022.

lower the price they pay for medicines at the pharmacy, such as making monthly costs more predictable, making cost-sharing assistance count toward a plan's out-of-pocket spending requirements, and sharing negotiated savings on medicines with patients. These policies can be done without price setting, which can reduce the options available to treat patients.

This proposal appears to assume incorrectly that the price a patient pays is determined solely by drug manufacturers.

This proposal singles out the biopharmaceutical industry and ignores the variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy benefit managers (PBMs), wholesalers, and the government. The important role that these entities play in determining drug coverage and patient out-of-pocket costs appears to be overlooked in this proposal. For example, PBMs and payers—which dictate the terms of coverage for medicines and the amount a patient ultimately pays—negotiate substantial rebates and discounts.

According to research from the Berkeley Research Group (BRG), rebates, discounts, and fees account for an increasing share of spending for brand medicines each year, while the share received by manufacturers has decreased over time. In 2020 manufacturers retained only 49.5% of brand medicine spending while members of the supply chain retained 50.5%.[2] Increased rebates and discounts have largely offset the modest increases in list prices and reflect the competitive market for brand medicines.

The growth of net price prices, which reflects rebates and discounts, has been in line with or below inflation for the past five years. Specifically, net prices for brand medicines declined 2.9% in 2020.[3] This, of course, does not necessarily reconcile with what patients are feeling at the pharmacy counter, which is why looking at the whole system is so important. For example, despite manufacturers' rebates and discounts negotiated by health plans, nearly half of commercially insured patients' out-of-pocket spending for brand medicines is based on the medicine's list price rather than the negotiated price that health plans receive.[4]

On average, it takes more than 10 years and $2.6 billion to research and develop a new medicine. Just 12% of drug candidates that enter clinical testing are approved for use by patients. Efforts to impart price controls on innovative manufacturers could chill the research and development of new medicines by taking away the incentives that allow manufacturers to invent new medicines. Price controls also could severely reduce patients' access to medicines, as is seen abroad.

PhRMA recognizes the access challenges faced by patients in Nevada with serious diseases. We

[2] BRG: The Pharmaceutical Supply Chain, 2013–2020. January 2022.

[3] IQVIA. "Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025." Published May 2021.

[4] IQVIA Institute for Human Data Science. Medicine spending and affordability in the United States. Published August 2020. Accessed August 2020. https://www.iqvia.com/insights/theiqvia-institute/reports/medicine-spending-and-affordabilityin-the-us

stand ready to work with the Patient Protection Commission to develop market-based solutions that help patients better afford their medicines at the pharmacy counter. We believe this proposal would not help patients better access breakthrough, innovative medicines and respectfully oppose the Patient Protection Commission's support of price controls through the "allowable rate" structure described under subject 2, topic 6.

Sincerely,

Asher Lisec
Deputy Vice President, State Policy
Pharmaceutical Research and Manufacturers of America