
Prescription Drug Affordability Board

2022 Annual Report

November 1, 2022



Members of the Prescription Drug Affordability Board

Representative Gary Merchant (Chairman)

Representative James Murphy

Senator Sharon Carson

Senator Cindy Rosenwald (Alternate)

Senator Tom Sherman

Representative William Marsh (Alternate)

Dr. Robert Woodward (Alternate)

Todd Fahey (Clerk)

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INTRODUCTION

Creation of the Prescription Drug Affordability Board was via legislation introduced in legislative year 2020 and signed into law during July 2020 as RSA 126-BB (appendix J). The board consists of five members with expertise in health care economics or clinical medicine, who shall not be, or be directly related to, anyone affiliated with, employed by, or representing the interests of a public payor, pharmaceutical or pharmacy company, pharmacy benefits management company, or health insurance provider and who shall complete a conflict-of-interest statement. Two members and two alternate members shall be appointed by the president of the senate, two members and two alternate members shall be appointed by the speaker of the house, one member and two alternate members shall be appointed by the governor.

The board is administratively attached in the Department of Health and Human Service (DHHS) as a self-funded, independent board.

Legislative intent was to create a board to identify strategies that optimize spending by public payers for pharmaceutical products while reasonably ensuring prescriber assess to needed pharmaceutical products. To achieve this goal, the board shall determine annual spending targets for prescription drugs purchased by public payers based upon a 10-year rolling average of the medical care services component of the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index, medical care services index, plus a reasonable percentage for inflation and minus a spending target for pharmacy savings as determined by the board.

Focus of the board this year continues to be the establishment of the regulatory and operational framework necessary for the board to meet its statutory obligations.

The board met nine times during the past year - October 26 and November 30 in 2021 and January 24, March 28, April 25, May 23, July 25, August 22, September 26, and October 10 in 2022.

BOARD MEETING SUMMARIES

October 26, 2021 meeting (appendix A) – this meeting continued to focus on organization issues including the collection of assessment fees and the executive director position’s funding. Representative Gary Merchant, Representative William Marsh, Senator Tom Sherman, Todd Fahey. Via Zoom Representative James Murphy, Staci Hermann were in attendance.

DHHS Chief Financial Officer, Kerrin Rounds, reviewed various financial issues with the Board, including presenting an item to the Fiscal Committee to add an accounting unit for the Board and adding fee funds for entities that are allowed under the statute. He reported that the Executive Director position is being finalized in Administrative Services.

Office of Professional Licensure’s Director, Lindsey Courtney, J.D. forwarded Representative Merchant a spreadsheet of all of the entities that have the Board of Pharmacy’s Application for Manufacturer, Wholesaler, Distributor, Broker permit attached to them. Whether or not each type identified in the application was eligible for an assessment fee, based upon the statute, was discussed. Additional administrative and assessment issues, including the appeals process, were identified.

November 30, 2021 meeting (appendix B) - Attorney Phillips and Attorney Berry worked on crafting the notification letter to be sent to manufacturers and their responsibility to register and report pricing data. Attorney Berry spoke about the process of registering and reporting, via the Board website. David Wieters, DHHS, displayed and reviewed the Smartsheet form functions for registration.

The terms of LSR 22-3071 were discussed, and Attorney Rob Berry reviewed the progress and changes of the Rules updates.

Tyler Brannen, NH Insurance Department, displayed and reviewed his presentation (appendix K) on PBMs (Pharmacy Benefit Management). He clarified their function and role within the pharmaceutical world. Tyler spoke about the various statutes that govern PBMs.

Heather Cascone of the Pharmaceutical Care Management Association displayed and reviewed her presentation on the Role of Pharmacy Benefit Managers in the Health Care System. Heather clarified that PCMA represents the nation’s PBMs. She stated the purpose of the presentation was to highlight how PBMs lower costs and provide value to the purchase of prescription drug benefits.

January 24, 2022 meeting (appendix C) – this meeting focused on rules, legislative updates, and a PhRMA presentation.

Todd Fahey gave an overview of the work to date, made by himself and Attorney Rob Berry. Mr. Berry reminded the Board that they are not yet in the formal rulemaking stage. He believed that can begin at the end of March, following the March Board meeting.

Representative Murphy spoke about HB 1566, an amendment to the statute to change the Executive Director position from classified to unclassified, and also to establish a non-lapsing fund for fees. It was

scheduled to go to subcommittee on Friday, January 28.

Nick Doherty, Policy Director for the New England region of the Pharmaceutical Research and Manufacturers of America, discussed national trends and how they affect patient's out-of-pocket costs, specifically the disparity between the list price of medicine and the cost to patients. Todd Fahey asked for follow-up from MR. Doherty on who commissioned the Price Waterhouse report in 2017.

March 28, 2022 meeting (appendix D) – this meeting included discussions relating to preparing and moving the rules relating to PDAB through the regulator process, updates from the Administrative Rules Coordinator, Allyson Zinno and a virtual presentation from the Pharmacy Services Administration (appendix N).

Following the discussions, the Board approve the draft Rules as amended by Todd Fahey.

Scott Pace, an independent pharmacy owner, pharmacist and attorney described the Pharmacy Services Administration Organization role in the pharmaceutical supply chain. Some of the essential functions of the PSAO are to interpret contracts on behalf of the pharmacy owner, claims reconciliation and audit support. Dr. Pace mentioned there being about six large PSAOs on operation currently. Three are owned by Healthcare distributors, such as Cardinal Health, and three are independent.

April 25, 2022 meeting (appendix E) – this meeting focused entirely on scrutinizing Rule details.

Attorney Robert Berry reviewed the recent changes to the Rules Draft. Most edits were grammatical in nature, with some discussion on interpreting language, as well. After the Rules were passed, Representative Merchant reviewed the remaining Rules process with the Board, Allyson Zinno and Attorney Berry.

May 23, 2022 meeting (appendix F) – this meeting discussed the appropriate definition of a “new drug” as might be affected by ownership changes, heard an update on the fiscal impact statement request, received one presentation on NH drug utilization and costs (appendix M) and another on perspectives on how the healthcare dollar is spent.

The Board agreed that it would be best to try to amend the Rules to reflect the requirement that a company selling a drug for the first time be required to report the drug's previous price if it had been previously sold by another company.

Andrew Chalsma, NH DHHS Director of Data Analytics & Reporting, presented a New Hampshire Drug Utilization and Cost Summary for SFY 2020 and SFY 2021. Andrew noted that there this data does not capture any PBM agreements or rebates.

Heidi Kroll, of Gallagher, Callahan and Gartrell, representing America's Health Insurance Plans (AHIP), delivered a presentation in conjunction with Sergio Santiviago, the vice president of drug policy for AHIP. The PowerPoint presentation addressed high priced drugs and the payer perspective. Some categories covered were how the healthcare dollar is spent, the medical loss ratio, what factors affect/do not affect drug prices.

July 25, 2022 meeting (appendix G) – this meeting was split between more in-depth discussions of the DHHS cost and utilization data, an update on Board Rules, and a presentation from the National Community Pharmacists Association.

Andrew Chalsma and Emily Kachanian, from DHHS, expanded upon May’s presentation of drug utilization and cost. They discussed looking at the cost trends over time and, if one drug has a noticeable change, taking a deeper dive into the specifics of that one drug. Andrew explained the data comes from what is reported by the insurance companies and Pharmacy Benefit Managers (PBMs). It is not based on actual paid amount, rather the expected amount, or co-pay, based upon the member’s benefit plan.

A discussion followed around the specific goals of the Board, and what the best plan of action would be to accomplish them. Senator Tom Sherman asked about where the biologic drugs fall into this report, given how expensive they are. Andrew talked about different ways to get to that information, and how it could be broken down. Senator Sherman talked about the idea of affordability not only to the patient but to the state, wherein Medicaid costs should be considered. Senator Rosenwald talked about focusing on the drugs that are chronic use. Andrew discussed how the data will change once we are able to isolate the municipal plans from the commercial plans. He also reiterated that the strategy the Board decides to take, regarding the data analysis, will be very important moving forward.

Attorney Robert Berry provided an update on the where the Rules are in the process. He believed there was substantial work that needed to be done for a final draft in preparation for the next meeting of the Board and for the Joint Legislative Committee on Administrative Rules (JLCAR) in September. Allyson Zinno clarified that in order for the Rules to make it to JLCAR for September they needed to be formally submitted by August 25.

Matt Magner, representing the National Community Pharmacists Association (NCPA), presented a PowerPoint to the Board, with a short examination of the community pharmacy’s role in addressing drug prices. Matt reviewed who makes up the Association, explaining the community pharmacists are the most accessible healthcare provider. He outlined the drug costs concerns at the pharmacy and potential solutions. Following the presentation, Matt and the Board discussed the clawbacks and DIR fees in greater detail.

August 22, 2022 meeting (appendix H) – this meeting mainly focused on Board Rules, but included discussions raised by public comments.

Attorney Robert Berry and Allyson Zinno reviewed, in detail, each change that was made to the twenty-four pages of Board Rules. Some key changes: the definitions of manufacturer and pricing unit were updated, based on SB 450, and the number of alternates to the Board was updated.

Donald Pfundstein brought up his concern about the Board not addressing the issue brought up in his letter from June 16, outlining the need for establishing a spending target for prescription drugs purchased by public payers and the need for the language of the Rules to be easily understood by everyone. A short discussion with the Board followed.

Heidi Kroll, AHIP, discussed the issue of cost to the public payers by hospital-administered drugs.

A representative from the insurance department discussed what he considers gaps in the wording of the intent of the Board, and the obligation of the Board to amend the wording. Senator Tom Sherman clarified the original intent of the Board, as he was the prime sponsor, and took the comment under advisement.

September 26, 2022 meeting (appendix I) **UPDATE ON BOARD RULES:** Allyson Raadmae provided an update on the Rules, mentioning the many changes suggested by OLS, and recommending another meeting on the Rules prior to October 14. **UPDATE ON EXECUTIVE DIRECTOR:** Robert Berry provided an update about the position. He advised it may take up to 6 months to go through the entire process. **REVIEW PRESCRIPTION DRUG USAGE REPORTS:** Dr. Robert Woodward reviewed his modifications to the drug usage report that had been previously prepared by Andrew Chalsma. Robert discussed, in detail, the trends he feels should be focused on. A lengthy discussion followed with the Board. **PUBLIC COMMENTS:** Members of the public who provided comment include Curtis Barry,

Heidi Kroll and Donald Pfundstein, representing PBMs and AHIP, respectively. Comments were made throughout the presentation, as well as at the end.

October 10, 2022 meeting (appendix J) – this meeting focused on updates to board rules. Allyson Raadmae clarified that the changes to be reviewed were made based upon comments on the Final Proposal by the Office of Legislative Services (OLS). Most of the changes were based on terminology, with the purpose of clearing up any ambiguity or redundancy. There was a short discussion around the issue of remote meetings; that they are not allowed. Allyson reminded the Board that this can be revisited at a later date, and that Rules are always open for revision, even after approval. The main point of the Rules discussion involved the proposed inclusion of wording as suggested by Donald Pfundstein. The final outcome, which was agreed upon by all, was to add a number 7 under Section 301.01 (e), to read as follows: *Claims databases, including but not limited to the all payors claims database, New Hampshire comprehensive health information system (NH-CHIS), all prescription drug spending whether billed under the prescription drug benefit or the medical benefit.* Representative Jess Edwards brought up the three concerns: The fact that the Board's budget isn't set, whether or not levying taxes and fees is constitutional and the Board's methodology of pulling prescription information from a formulary. It was decided that these concerns will be addressed with Representative Merchant offline. Heidi Kroll, AHIP, brought up her concern with the wording around spending targets.

INITIAL DATA RESULTS

NH RSA 126-BB:5 Paragraph IV asks the NH Prescription Drug Affordability Board (NHPDAB) to report annually the 25 costliest prescription drugs, the 25 most frequently prescribed prescription drugs, and the 25 prescription drugs with the highest year-over-year cost increases. The New Hampshire Comprehensive Health Care System (NHCHIS) was utilized to provide this information as required by statute.

The New Hampshire Comprehensive Health Care Information System

The NHCHIS was created by NH state statute to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices." The statute also required that the New Hampshire Insurance Department (NHID) and the NH Department of Health and Human Services (NH DHHS) partner on the project. The same legislation that created the CHIS also enacted statutes that mandated that health insurance carriers submit their encrypted health care claims data and Health Employer Data and Information Set (HEDIS) data to the state.

The net result is that the NHCHIS is an all-payer claims database that collects claim and membership data from Commercial carriers, including Medicare Advantage and Medicare supplemental policies, including Medicare Part D. The CHIS data is not necessarily representative of all NH residents, as the data from small carriers with less than 10,000 members per month and carriers not regulated by the state are not reported. Additionally self-insured data is only voluntarily reported and data for uninsured patients is not collected. Only data that has been paid by a carrier is included and payment amounts do not account for manufacturer coupons or the like. The NH Medicaid data includes data from the Managed Care plans and is representative of all paid claim utilization for the specified dates of service. As such the NH Medicaid data is more complete.

The most recent calendar year of prescription drug data available is 2021.

The following sections present the three data tables mandated by NH RSA 126-BB:5 Paragraph IV. Analyses in the coming years will direct attention to the board's statutory requirement to focus attention on public payers.

The 25 Prescription Drugs with the Highest Amounts Paid (Expenditures)

The 25 generic prescription drugs with the highest Amounts Paid (Expenditures) cost \$449,347,174 in 2021 or 25.5% of the \$1,759,165,005 total expenditures on prescription drugs in the NHCHIS data set for that year (Table 2). Apixaban, a treatment to prevent blood clots, and Dulaglutide, a therapy to prevent diabetes 2, top the list at \$58,508,330 and \$35,070,394 respectively.

Table 1: 25 Drugs with the Highest Amounts Paid (Expenditures)

Generic Drug Name	Total Paid Amount	Total Paid Rank
Apixaban	\$58,508,330	1
Dulaglutide	\$35,070,394	2
Insulin Glargine	\$30,277,014	3
Rivaroxaban	\$24,207,739	4
Empagliflozin	\$23,102,602	5
Fluticasone Propionate HFA Inhal	\$22,945,499	6
Insulin Lispro	\$22,117,415	7
Semaglutide	\$18,742,263	8
Buprenorphine HCl-Naloxone HCl SL	\$18,370,212	9
Levothyroxine Sodium	\$18,242,727	10
Fluticasone-Salmeterol	\$18,234,982	11
Adalimumab Pen	\$18,194,572	12
Budesonide-Formoterol Fumarate Dihyd	\$16,687,697	13
Lisdexamfetamine Dimesylate	\$15,802,663	14
Sitagliptin Phosphate	\$15,221,646	15
Tiotropium Bromide Monohydrate Inhal	\$12,856,788	16
Amphetamine-Dextroamphetamine	\$10,672,283	17
Buprenorphine HCl-Naloxone	\$10,270,336	18
Elexacaf-Tezacaf-Ivacaf & Ivacaftor	\$9,557,422	19
Insulin Detemir	\$9,054,838	20
Albuterol Sulfate Inhal	\$8,594,067	21
Pantoprazole Sodium	\$8,537,560	22
Ustekinumab	\$8,478,808	23
Methylphenidate HCl	\$7,891,231	24
Buprenorphine HCl SL	\$7,708,086	25
Total of the group of 25	\$449,347,174	
Total of all prescription expenditures	\$1,759,165,005	
Top 25 as a Percent of the Total	25.5%	

Source: DHHS analyses of NHCHIS data that includes commercial payors, Medicare Part D, and Medicaid claims paid to pharmacies. These data do not include payments for prescription medications made as part of medical claims.

The 25 Most Frequently Prescribed Drugs

Obviously, the high expenditures may be due to the high utilization (measured here as high Days Supply) or high unit price (measured here as high Cost Per Day).

The 25 most frequently prescribed prescription drugs sum to 327,519,148 daily doses. Expenditures these 25 most prescribed drugs total \$102,435,643, which is only 5.8% of the \$1,759,165,005 expenditures in the total data set.

Table 2: 25 Most Frequently Prescribed Drugs

Generic Drug Name	Total Paid Amount	Total Paid Rank	Days Supply	Days Supply Rank
Levothyroxine Sodium	18,242,727	10	54,650,037	1
Atorvastatin Calcium	6,444,136		28,099,783	2
Omeprazole	6,134,631		23,488,707	3
Pantoprazole Sodium	8,537,560	22	22,355,235	4
Lisinopril	2,545,480		22,260,916	5
Amlodipine Besylate	1,782,962		15,647,253	6
Metformin HCl	4,349,422		13,192,117	7
Metoprolol Succinate	4,428,293		12,173,875	8
Metoprolol Tartrate	1,723,427		12,065,411	9
Losartan Potassium	2,283,088		10,948,387	10
Sertraline HCl	2,752,225		10,795,236	11
Hydrochlorothiazide	652,254		10,050,987	12
Fluoxetine HCl	4,458,733		9,862,827	13
Gabapentin	4,135,774		8,953,317	14
Famotidine	3,615,146		8,941,355	15
Simvastatin	1,012,225		8,067,578	16
Bupropion HCl	6,871,625		7,997,808	17
Escitalopram Oxalate	2,255,886		7,599,858	18
Rosuvastatin Calcium	3,549,738		7,380,901	19
Trazodone HCl	1,547,124		6,484,738	20
Amphetamine-Dextroamphetamine	10,672,283	17	5,616,421	21
Furosemide	661,731		5,605,175	22
Tamsulosin HCl	1,521,749		5,124,781	23
Montelukast Sodium	1,431,764		5,095,133	24
Citalopram Hydrobromide	825,660		5,061,312	25
Total of the 25	\$102,435,643		327,519,148	

Source: DHHS analyses of NHCHIS data that includes commercial payors, Medicare Part D, and Medicaid claims paid to pharmacies. These data do not include payments for prescription medications made as part of medical claims.

25 Prescription Drugs with the Largest Expenditure Increase Between CY 2020 and CY 2021

Of interest, there is a general correspondence between the 25 prescription drugs with the highest expenditures in 2021 and the 25 prescriptions with the greatest expenditure increase over 2020. For example, the two costliest prescription drugs in 2021 (Apixaban and Dulaglutide) were also the drugs with the largest payment increase between 2020 and 2021. In fact, 17 of the top 25 prescription drugs with the greatest payment increases were also among the top 25 total payment amounts in 2021.

Also, the 25 with the largest expenditure increases between 2020 and 2021 increased their expenditures by 25.1%. [\$76,454,775/(\$380,992,973-\$76,454,775)]

Table 3: CY 2020 Year over CY 2021 Year Cost Increases

Generic Drug Name	2021 Total Paid Amount	Total Paid Rank	Days Supply	Cost Per Day	2020-21 Increased Payments	Payment Increase Rank
Apixaban	\$58,508,330	1	3,668,705	\$15.95	\$14,556,255	1
Dulaglutide	\$35,070,394	2	1,236,051	\$28.37	\$10,506,060	2
Semaglutide	\$18,742,263	8	688,006	\$27.24	\$9,263,503	3
Empagliflozin	\$23,102,602	5	1,334,606	\$17.31	\$7,742,788	4
Adalimumab Pen	\$18,194,572	12	68,825	\$264.36	\$5,186,367	5
Ustekinumab	\$8,478,808	23	22,622	\$374.80	\$3,638,020	6
Elexacaf-Tezacaf-Ivacaf & Ivacaftor	\$9,557,422	19	11,952	\$799.65	\$3,521,191	7
Rivaroxaban	\$24,207,739	4	1,531,697	\$15.80	\$3,320,343	8
Buprenorphine Extended Release	\$3,827,814				\$2,116,516	9
Lisdexamfetamine Dimesylate	\$15,802,663	14	1,463,120	\$10.80	\$1,556,681	10
Pantoprazole Sodium	\$8,537,560	22	22,355,235	\$0.38	\$1,470,894	11
Insulin Glargine	\$30,277,014	3	2,471,983	\$12.25	\$1,284,322	12
Buprenorphine HCl-Naloxone HCl SL	\$18,370,212	9	2,123,386	\$8.65	\$1,171,936	13
Buprenorphine HCl	\$7,501,854				\$1,158,736	14
Buprenorphine HCl SL	\$7,708,086	25	1,091,372	\$7.06	\$1,099,607	15
Famotidine	\$3,615,146		8,941,355	\$0.40	\$1,086,615	16
Buprenorphine HCl-Naloxone	\$10,270,336	18	1,096,171	\$9.37	\$1,044,307	17
Etanercept	\$5,130,590				\$976,321	18
Bictegravir-Emtrici	\$4,082,660				\$966,631	19
Sitagliptin Phosphate	\$15,221,646	15	968,164	\$15.72	\$938,234	20
Glecaprevir-pibrentasvir	\$4,847,975				\$876,493	21
Sofosbuvir-Velpatasvir	\$3,450,259				\$839,838	22
Omeprazole	\$6,134,631		23,488,707		\$775,543	23
Fluticasone-Salmeterol	\$18,234,982	11	1,990,150	\$9.16	\$681,518	24
Insulin Lispro	\$22,117,415	7	1,195,761	\$18.50	\$676,056	25
Total of the 25	\$380,992,973				\$76,454,775	
Total in NHCHIS	\$1,759,165,005				\$1,759,165,005	
Col Tot as a % of Total NHCHIS	21.7%				4.3%	

Average Expenditure Increase of the Top 25 = 25.1%

Source: DHHS analyses of NHCHIS data that includes commercial payors, Medicare Part D, and Medicaid claims paid to pharmacies. These data do not include payments for prescription medications made as part of medical claims.

SUMMARY

The initial year focused on building the rules and regulations foundation necessary for the board to meet the obligations established by RSA 126-BB. During the coming year, the board expects to finalize the operational foundation of the board, and to initiate the process of receiving and processing data to begin identifying strategies to optimize spending by public payers for pharmaceutical products and determine annual spending targets for prescription pharmaceutical products by public payers.

Goals for the coming year include:

1. Hiring and onboarding a staff
2. Establish the Advisory Council
3. Board educational presentations related to public spending on prescription drugs
4. Finalize MOU between board and DHHS
5. Optimize analyzed data to meet the board's statutory requirements.

APPENDICES

APPENDIX A - October 26, 2021 Board Minutes

NH Prescription Drug Affordability Board In-person / Remote Hybrid Meeting October 26 2021, 1:00 PM

NOTE: This meeting was recorded and a recording of the entire meeting is available at:

<https://www.dhhs.nh.gov/ombp/medicaid/nhpdab/previous-meetings.htm>

CALL TO ORDER: Representative Gary Merchant, Chair, opened the meeting at 1:06 P.M.

ATTENDING: Representative Gary Merchant, Representative William Marsh, Senator Tom Sherman, Todd Fahey. Via Zoom Representative James Murphy, Staci Hermann.

A quorum was established.

ABSENT: Senator Cindy Rosenwald, Senator Sharon Carson.

INTRODUCTIONS: Representative Gary Merchant introduced everyone and appointed alternate Representative Marsh as voting member for this meeting.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board. Senator Sherman asked to add to the agenda, a discussion around legislation to make the alternates more mobile; Representative Merchant agreed.

REVIEW AND APPROVE AUGUST MINUTES: Motion to accept minutes of the October meeting made by Senator Sherman; Todd Fahey seconded. Motion passed.

UPDATE ON RULES: Todd Fahey discussed the progress of the rules; noting that he and Attorney Robert Berry, DHHS, plan to have a substantive update by the next meeting or two.

DISCUSSION ON COLLECTING ASSESSMENT FEES AND FUNDING THE EXECUTIVE DIRECTOR POSITION:

DHHS Chief Financial Officer, Kerrin Rounds, told the Board that they are going to present an item to the Fiscal Committee to add an accounting unit for the Board and add fee funds for entities that are allowed under the statute. It will most likely be on the December agenda. The Executive Director position is being finalized in Administrative Services, and should line up with the funds being allowed to pay for that. Next task is to work with Accounts Receivable, on who can be billed. Will make sure the Board reviews them before it is moved forward.

Representative Merchant discussed the Board of Pharmacy application for Manufacturer, Wholesaler, Distributor, Broker that he downloaded from the Board of Pharmacy website. Office of Professional Licensure's Director, Lindsey Courtney, J.D. forwarded Representative Merchant a spreadsheet of all of the entities that have this permit attached to them. Whether or not each type identified in the application was eligible for an assessment fee, based upon the statute, was discussed. It was noted that only the Manufacturers report to the Board. Senator Sherman brought up the idea of an appeals process, with which the Board discussed the details of. Todd Fahey mentioned he and Rob Berry had previously discussed this and noted it this would be addressed in the rules. Senator Sherman and Representative Merchant agreed that they would reach out to Lindsey Courtney to get a break down of the number of different entities. Staci Hermann discussed the idea of fee assessment being relative to either the registered entity with the pharmacy vs. the parent company, and their respective revenue streams.

Kerrin Rounds suggested that they run the idea of a sliding scale for the fee schedule be run by the attorney General's office, as she is not sure if the assessment fee would be considered taxation. If it is, the NH constitution prevents you from taxing at different rates. Representative Merchant summarized the discussion by stating that the next steps involve working on an appeals process and getting a breakdown on the nature of the business based upon the permits and how they are being utilized. Many points were discussed on how to shore up revenue, and their validity within the law.

UPDATE ON LEGISLATION: Representative Murphy briefly discussed the LSR, and named its co-sponsors; when they can alter the wording to include the assessment fees. Board discussed needing an update on whether Senator Carson had filed the one for Conflict of Interest.

ANNUAL REPORT: Representative Merchant reviewed his draft of the report with the Board. Todd Fahey asked that we may want to include the expectation of a revenue stream. Motion to adopt the annual report as proposed made by Todd Fahey, seconded by Senator Sherman. Motion passed.

SCHEDULE MEETINGS FOR COMING MONTHS: Board agreed that they will meet the 4th Monday of each month, from 10:00-12:00, starting in January. Upcoming meetings include Tuesday, November 30, January 24, March 28 and May 23. No meeting in December.

RECESS INTO NON-MEETING MEETING WITH AG OFFICE

Brief discussion about the requirement for manufacturers to submit data to the Board, and the letter that will be sent to them reminding them of this requirement and related details.

ADJOURNMENT: Motion to adjourn made by Todd Fahey; motion seconded by Senator Tom Sherman. Motion passed with Representative Gary Merchant, Senator Tom Sherman, Todd Fahey, Representative William Marsh, Staci Hermann and Representative James Murphy all in favor.

Respectfully submitted:

Todd C. Fahey, Clerk

Nancy T. Plourde, Recording Secretary

APPENDIX B - November 30, 2021 Board Minutes

NH Prescription Drug Affordability Board

In-person / Remote Hybrid Meeting

November 30, 2021, 1:00 PM

NOTE: This meeting was recorded and a recording of the entire meeting, in addition to all presentations, are available at:

<https://www.dhhs.nh.gov/ombp/medicaid/nhpdab/previous-meetings.htm>

CALL TO ORDER: Representative Gary Merchant, Chair, opened the meeting at 1:06 P.M.

ATTENDING: Representative Gary Merchant, Representative William Marsh, Representative James Murphy (elevated from alternate to member, replacing Todd Fahey), Senator Tom Sherman, Senator Cindy Rosenwald. Todd Fahey via Zoom.

A quorum was established.

ABSENT: Senator Sharon Carson, Staci Hermann.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board. He stated, due to time constraints by Senator Tom Sherman, the Insurance Department and PBM presentations will be moved down towards the end of the agenda. Senator Sherman will be adding an agenda item related to an LSR. No objections were made.

REVIEW AND APPROVE OCTOBER MINUTES: Motion to accept minutes of the October meeting made by Senator Sherman; Representative Murphy seconded. Motion passed.

NOTIFICATION LETTER, MANUFACTURER REGISTRATION AND MANUFACTURER PRICING DATA:

Attorney Phillips and Attorney Berry worked on crafting the notification letter to be sent to manufacturers and their responsibility to register and report pricing data. Attorney Berry spoke about the process of registering and reporting, via the Board website. All instructions and related documents will be available on the website by early December. David Wieters, DHHS, displayed and reviewed the Smartsheet form functions for registration. Motion to accept the letter template and registration form made by Senator Tom Sherman, seconded by Representative William Marsh. Motion passed via roll call.

LSR 22-3071 Discussion: Senator Sherman displayed and reviewed the LSR's origin, related to discussions by the Board. The LSR is amended to allow for alternates to replace any member of the Board, versus being assigned to a specific member, as well as some wording changes to the Conflict of Interest aspect. Senator Sherman asked the Board if they would like him to add to the LSR, the ability for the Board to meet remotely, to maximize the chances of meeting quorum. All agreed to leave it as is, to ensure the original intent of the LSR passes. Motion to accept the LSR draft, as is, made by Senator Sherman, seconded by Representative Murphy. Motion passed via roll call.

RULES UPDATE: Attorney Rob Berry reviewed the progress and changes. He is hopeful there will be a full draft available for consideration at the next meeting in January, expecting comments at that time and then a redraft ready for March, followed by a formal submission for adoption process. A full adoption expected by June or July.

UPDATES ON STAFFING AND ASSESSMENT FEES: Attorney Berry spoke about an accounting unit being established prior to the job posting and filling; expecting to get to that point by February. **NH INSURANCE DEPT. AND PBMs:** Tyler Brannen, NH Insurance Department, displayed and reviewed his presentation on PBMs (Pharmacy Benefit Management). He clarified their function and role within the pharmaceutical world. Tyler spoke about the various statutes that govern PBMs.

PBM PRESENTATION: Heather Cascone, PCMA (Pharmaceutical Care Management Association), displayed and reviewed her presentation on the Role of Pharmacy Benefit Managers in the Health Care System. Heather clarified that PCMA represents the nation's PBMs. She stated the purpose of the presentation was to highlight how PBMs lower costs and provide value to the purchase of prescription drug benefits.

Various questions from the Board were addressed with Heather, to which she stated she would research the ones she did not know the answer to and follow up with the Board.

PUBLIC COMMENTS: None

Next Board meeting is January 24, 10:00 AM.

ADJOURNMENT: Motion to adjourn made by Representative Gary Merchant: seconded by Representative William Marsh; motion passed via rollcall.

Respectfully submitted:

Todd C. Fahey, Clerk

Nancy T. Plourde, Recording Secretary

APPENDIX C - January 24, 2022 Board Minutes

NH Prescription Drug Affordability Board In-person / Remote Hybrid Meeting

January 24 2022, 10:00 AM

NOTE: This meeting was recorded and a recording of the entire meeting, in addition to all presentations, are available at:

<https://www.dhhs.nh.gov/ombp/medicaid/nhpdab/previous-meetings.htm>

CALL TO ORDER: Representative Gary Merchant, Chair, opened

ATTENDING: Representative Gary Merchant, Senator Tom Sherman (late arrival), Todd Fahey, Senator Cindy Rosenwald (elevated to member in Senator Carson's absence and prior to Senator Sherman's late arrival), Staci Hermann; Representative James Murphy, remotely. A quorum was established.

ABSENT: Representative William Marsh, Senator Sharon Carson.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board. He asked that the PhRMA presentation be moved up in the agenda, to which all agreed.

REVIEW AND APPROVE NOVEMBER MINUTES: Representative Merchant moved to accept the minutes; seconded by Senator Rosenwald. Representative Merchant made a note about changing the elevation status to Representative Marsh, rather than Representative Murphy. Roll call to approve the minutes, with noted change, passed, with all in favor.

RULES UPDATE: Todd Fahey gave an overview of the work to date, made by himself and Attorney Rob Berry. Mr. Berry reminded the Board that they are not yet in the formal rulemaking stage. He believes that can begin at the end of March, following the March Board meeting. Mr. Berry will have an updated draft based on the public and Board input at that time. Mr. Fahey suggested the Board meet in February to specifically discuss the rules, as it will take quite a bit of time to go through them.

LEGISLATIVE UPDATE Representative Murphy spoke about HB 1566, an amendment to the statute to change the Executive Director position from classified to unclassified, and also to establish a non-lapsing fund for fees. It's going to subcommittee on Friday, January 28. Representative Merchant updated the Board on the question of alternates, and it was decided that the alternates can only replace the Board members they are assigned to, as to ensure that each section has representation.

PHRMA PRESENTATION Presenting was Nick Doherty, Policy Director for the New England region for PhRMA. The presentation's primary focus was to discuss the national trends and how they affect patient's out-of-pocket costs, specifically the disparity between the list price of medicine and the cost to patients. Some follow-up was requested of Mr. Doherty by Representative Merchant, related to breakdown of certain percentages in his presentation. Data regarding rebates and coupon cards was a topic that Board members also asked for follow-up on, specifically how they fall into the percentage of reported discounts, and the flow of dollars. Senator Rosenwald and Representative Merchant discussed recent legislation about PBMs and other entities' reporting obligations; will follow up with each other to

discuss details and relevancy. Todd Fahey asked for follow-up from MR. Doherty on who commissioned the Price Waterhouse report in 2017.

FINANCIAL UPDATE FISCAL COMMITTEE Robert Berry gave an update on the creation of the account to collect assessment fees. It was tabled based, essentially, on the lack of language in the rules regarding this. Representative Merchant discussed his ideas for options on how to move forward with funding the Board.

PRICING AND REGISTRATION UPDATE Nancy Plourde gave an update on the response to the December 14th, 2021 email to manufacturers regarding registration and reporting compliance.

NEXT MEETING FEBRUARY 25TH, 1:00, TENTATIVELY SET

PUBLIC COMMENTS: Holly Stevens, NAMI, commented on the reports being presented at recent meetings and suggested the Board be open to receiving presentations from neutral sources that have no vested interest in the supply chain. Ms. Stevens will follow up with any suggestion as to who could serve as a neutral party.

NON-MEETING MEETING WITH ATTORNEY

ADJOURNMENT: Motion to adjourn made by Representative Gary Merchant: seconded by Senator Tom Sherman. Motion passed.

Respectfully submitted:

Todd C. Fahey, Clerk

Nancy T. Plourde, Recording Secretary

APPENDIX D - March 28,2022 Board Minutes

NH Prescription Drug Affordability Board In-person / Remote Hybrid Meeting March 28 2022, 10:00 AM

NOTE: This meeting was recorded and all related documents and a recording of the entire meeting is available at:

<https://www.dhhs.nh.gov/ombp/medicaid/nhpdab/previous-meetings.htm>

CALL TO ORDER: Representative Gary Merchant, Chair, opened; introductions were made.

ATTENDING: Representative Gary Merchant, Senator Tom Sherman, Todd Fahey, Senator Cindy Rosenwald, Representative William Marsh, Representative James Murphy, remotely.

A quorum was established.

ABSENT: Senator Sharon Carson.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board. He asked that the discussion of future dates be moved up in the agenda, to which all agreed.

REVIEW AND APPROVE JANUARY MINUTES: Senator Sherman motioned to accept the minutes; seconded by Todd Fahey. Motion approved via roll call.

FUTURE MEETINGS: May 23, 10:00 AM, June 20, 10:00 AM and September 20, 10:00 AM.

UPDATE ON JOINT FISCAL COMMITTEE: Representative Merchant spoke with the chair of the Joint Fiscal Committee; plans to approve the Rules today and get them to both JLCAR and the Fiscal Committee. Representative Merchant also plans to appear before the Committee on April 15th to discuss the Rules. Senator Rosenwald suggested the best thing to do is give the Fiscal Committee a projected timeline rather than the Rules themselves, as they do not have the authority to approve them. Senator Sherman agrees that rather than giving Fiscal Committee the draft Rules, better to tell them that the Rules are in front of JLCAR. Representative Merchant plans to have them presented to JLCAR next week.

UPDATE ON PDAB SENATE BILL: Senator Sherman asked, as a courtesy from the public, if they have concerns over the bill, to have it brought up with the Board before bringing them to outside entities. Discussed having a much stronger Conflict of Interest, including criminal penalties, an updated appeals process, quorum issues and the non-lapsing account and unclassified-to-classified piece.

RULES: DHHS Administrative Rules Coordinator, Allyson Zinno, discussed the most recent updates to the Rules. The Board went through the Rules page by page, discussing many details including formatting changes and minor wording changes. Some of the wording was changed to reflect the wording of statutory definitions. Ms. Zinno made it clear that definitions are not something that can be altered. Motion to accept draft Rules as amended made by Todd Fahey, seconded by Senator Sherman. Motion passed via roll call.

(VIRTUAL) PSAO PRESENTATION: Representative Merchant prefaced the presentation by stating his intention to educate the Board and public on the various aspects of the pharmaceutical supply chain. A PowerPoint presentation on the Pharmacy Services Administration

Organization (PSAO) was made by Scott Pace, an independent pharmacy owner, pharmacist and attorney, who also does consulting work for the Healthcare Distribution Alliance (HDA). The HDA represents a group of PSAOs. Dr. Pace discussed the benefits for him, as an independent pharmacy owner, to pay a PSAO to manage the various relationships necessary to run his business, such as working with health plans and PBMs. Some of the essential functions of the PSAO are to interpret contracts on behalf of the pharmacy owner, claims reconciliation and audit support. Dr. Pace mentioned there being about six large PSAOs on operation currently. Three are owned by Healthcare distributors, such as Cardinal Health, and three are independent. Dr. Pace continued to review the details of the scope of services of PSAOs, highlighting the fact that PSAOs have no involvement in price negotiations.

PUBLIC COMMENTS: In-person attendee asked if the Board intended to have the Wholesale/Distributor aspect presented, to which Representative Merchant confirmed.

ADJOURNMENT: Undebatable Motion to adjourn made by Representative Gary Merchant.

Respectfully submitted:

Todd C. Fahey, Clerk

Nancy T. Plourde, Recording Secretary

APPENDIX E - April 25, 2022 Board Minutes

NH Prescription Drug Affordability Board In-person / Remote Hybrid Meeting April 25, 2022 1:00 PM

NOTE: This meeting was recorded. All related documents (and a recording of the entire meeting) are available at: [New Hampshire Prescription Drug Affordability Board | New Hampshire Department of Health and Human Services \(nh.gov\)](https://www.nh.gov/health/human-services)

CALL TO ORDER: Representative Gary Merchant, Chair, opened; introductions were made.

ATTENDING: Representative Gary Merchant, Senator Tom Sherman, Todd Fahey, Senator Cindy Rosenwald.

A quorum was established.

ABSENT: Senator Sharon Carson, Representative William Marsh, Representative James Murphy.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board.

REVIEW AND APPROVE MARCH 28 MINUTES: Todd Fahey moved to accept the minutes; seconded by Sen. Cindy Rosenwald. Motion approved via roll call.

REVIEW AND DISCUSS UPDATED DRAFT OF BOARD RULES: Attorney Robert Berry reviewed the recent changes to the Rules Draft. Most edits were grammatical in nature, with some discussion on interpreting language, as well. Senator Sherman moved to accept the Rules as revised, Senator Rosenwald seconded. Motion approved via roll call. Representative Merchant reviewed the remaining Rules process with the Board, Allyson Zinno and Attorney Berry. This amended document is posted on the DHHS website, noted above, for review.

REVIEW DATE OF JUNE MEETING: Based on the Rules process schedule, the Board decided to have the meeting in July, rather than June. It is scheduled for July 25, 10:00-12:00.

PUBLIC COMMENTS: none.

ADJOURNMENT: Motion to adjourn made by Senator Sherman, seconded by Senator Rosenwald. Motion passed via roll call.

Respectfully submitted:

Todd C. Fahey, Clerk

Nancy T. Plourde, Recording Secretary

APPENDIX F - May 23, 2022 Board Minutes

NH Prescription Drug Affordability Board In-person / Remote Hybrid Meeting

May 23, 2022 10:00 AM

NOTE: This meeting was recorded. All related documents (and a recording of the entire meeting) are available at: [New Hampshire Prescription Drug Affordability Board | New Hampshire Department of Health and Human Services \(nh.gov\)](https://www.nh.gov/health/human-services)

CALL TO ORDER: Representative Gary Merchant, Chair, opened; introductions were made.

ATTENDING: In person: Representative Gary Merchant, Senator Tom Sherman, Senator Cindy Rosenwald, promoted to full member for quorum, Virtually: Representative William Marsh.

A quorum was established.

ABSENT: Senator Sharon Carson, Representative James Murphy and Todd Fahey.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board.

REVIEW AND APPROVE APRIL 25 MINUTES: Senator Rosenwald moved to accept the minutes; seconded by Senator Tom Sherman. Motion approved via roll call.

LEGISLATIVE UPDATE: Representative Marsh provided the update that SB40 passed.

DISCUSS “NEW DRUG” FOR REPORTING: Representative Merchant discussed whether or not it is considered a new drug when a company buys a product from another company and relabels it. There was a short discussion about how to best capture the price increase of the same product when one company sells it to another and that company then increases the price. All agreed that it would be best to try to amend the Rules to reflect the requirement of a company to report the previous price of a drug when they acquired it.

RULES UPDATE: Robert Berry provided an update on the fiscal impact statement request; on track for June 16 Public Hearing on the initial proposal. Anticipates sometime in July for official proposal. Potential for Rules to be adopted in August. Discussed the standard Rules process.

REVIEW DRUG EXPENSES: Andrew Chalsma, NH DHHS Director of Data Analytics & Reporting, presented a New Hampshire Drug Utilization and Cost Summary for SFY 2020 and SFY 2021. Andrew noted that there this data does not capture any PBM agreements or rebates. The full report is available at the above linked website. The Board asked if Andrew could provide updated numbers that reflect further analysis of the data at a future meeting, to which he agreed.

INSURANCE PRESENTATION: Heidi Kroll, of Gallagher, Callahan and Gartrell, representing America’s Health Insurance Plans (AHIP), delivered a presentation in conjunction with Sergio Santiviago, the vice president of drug policy for AHIP. The powerpoint presentation addresses high priced drugs and the payer perspective. Some categories covered were how the healthcare dollar is spent, the medical loss ratio, what factors affect/do not affect drug prices. Full presentation available

at the above linked website.

PUBLIC COMMENTS: None.

ADJOURNMENT: Representative Gary Merchant made an undebatable motion to adjourn.

*Due to absence from meeting, Clerk abstained from approval, but respectfully submits for PDAB approval: Todd C. Fahey, Clerk Nancy T. Plourde, Recording Secretary

APPENDIX G - July 25, 2022 Board Minutes

NH Prescription Drug Affordability Board In-person / Remote Hybrid Meeting

July 25, 2022 10:00 AM

NOTE: This meeting was recorded. All related documents (and a recording of the entire meeting) are available at: [New Hampshire Prescription Drug Affordability Board | New Hampshire Department of Health and Human Services \(nh.gov\)](#)

CALL TO ORDER: Representative Gary Merchant, Chair, opened; introductions were made.

ATTENDING: In person: Representative Gary Merchant, Senator Tom Sherman, Dr. Robert Woodward, Todd Fahey, Representative James Murphy; Virtually: Representative William Marsh, Senator Cindy Rosenwald.

A quorum was established.

ABSENT: Senator Sharon Carson.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board. Representative Merchant stated he wished to move the usage reports presentation up to the beginning of the meeting.

Representative Merchant introduced the new member of the Board, Dr. Robert Woodward, who proceeded to give an overview of his relevant experience.

REVIEW AND APPROVE MAY 23 MINUTES: Senator Rosenwald moved to approve the minutes, seconded by Representative William Marsh. Minutes approved via roll call.

UPDATE ON REVISED PRESCRIPTION DRUG USAGE REPORTS: Andrew Chalsma and Emily Kachanian, from DHHS, expanded upon last month's presentation of drug utilization and cost. They discussed looking at the cost trends over time and, if one drug has a noticeable change, taking a deeper dive into the specifics of that one drug. They talked about opening up the discussion around which measures the Board would like to track. Representative Merchant talked about the comparison of patient cost difference between Medicare and commercial plans; would like to look deeper into that. There was discussion around the data reflecting the out of pocket cost to the patient vs. overall cost, after rebates, discounts, etc. Andrew explained where the data comes from, which is what is reported by the insurance companies and Pharmacy Benefit Managers (PBMs). He talked about how there is not a way to fully examine those details. It is not based on actual paid amount, rather the expected amount, or co-pay, based upon the member's benefit plan. A discussion followed around the specific goals of the Board, and what the best plan of action would be to accomplish them. Senator Tom Sherman asked about where the biologic drugs fall into this report, given how expensive they are. Andrew explained that the data is based upon therapeutic class. Andrew talked about different ways to get to that information, and how it could be broken down. Senator Sherman talked about the idea of affordability not only to

the patient but to the state, wherein Medicaid costs should be considered. Senator Rosenwald talked about focusing on the drugs that are chronic use. Andrew discussed how the data will change once we are able to isolate the municipal plans from the commercial plans. He also reiterated that the strategy the Board decides to take, regarding the data analysis, will be very important moving forward. Representative Merchant asked for follow-up focusing on public payors.

UPDATE ON BOARD RULES: Attorney Robert Berry provided an update on the where the Rules are in the process. He stated he'd received all of the comments both from the public and the Office of Legislative Services (OLS). He believes there is substantial work that needs to be done for a final draft, which will be ready for the next meeting of the Board, and ready for the Joint Legislative Committee on Administrative Rules (JLCAR) in September; Allyson Zinno clarified that in order for the Rules to make it to JLCAR for September they need to be formally submitted by August 25. The Board discussed future dates based on this schedule. The next two meetings will be August 22 and September 26, both 10:00-12:00.

UPDATE ON EXECUTIVE DIRECTOR: Attorney Berry outlined the current process for approval.

ASSESSMENT FEES AND BUDGET: Attorney Berry is waiting to hear back from the DHHS finance group for guidance on expediting the collection of assessment fees.

NCPA PRESENTATION: Matt Magner, representing the National Community Pharmacists Association (NCPA), presented a PowerPoint to the Board, with a short examination of the community pharmacy's role in addressing drug prices. Matt reviewed who makes up the Association, explaining the community pharmacists are the most accessible healthcare provider. He outlined the drug costs concerns at the pharmacy and potential solutions. He also discussed the idea of expanding the pharmacist's role. Following the presentation, Matt and the Board discussed the claw backs and DIR fees in greater detail. A short discussion followed.

PUBLIC COMMENTS: Heidi Kroll asked Matt if he has an estimate of overpayments to the pharmacy. She also asked if there are potential rules in place for pharmacy transparency. Matt stated he will follow up.

ADJOURNMENT: Senator Tom Sherman made a motion to adjourn.

Respectfully submitted: Todd C. Fahey, Clerk Nancy T. Plourde, Recording Secretary

APPENDIX H - August 22, 2022 Board Minutes

NH Prescription Drug Affordability Board In-person / Remote Hybrid Meeting August 22, 2022 10:00 AM

NOTE: This meeting was recorded. All related documents (and a recording of the entire meeting) are available at: [New Hampshire Prescription Drug Affordability Board](#) | [New Hampshire Department of Health and Human Services \(nh.gov\)](#)

CALL TO ORDER: Representative Gary Merchant, Chair, opened; introductions were made.

ATTENDING: In person: Representative Gary Merchant, Senator Tom Sherman, Dr. Robert Woodward, Representative James Murphy; **Virtually:** Senator Cindy Rosenwald.

A quorum was established.

ABSENT: Senator Sharon Carson, Todd Fahey.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board.

REVIEW AND APPROVE JULY 25 MINUTES: Initially, Senator Rosenwald moved to approve the minutes, seconded by Senator Tom Sherman. Minutes approved via roll call. Later in the meeting, it was observed that Representative James Murphy had mistakenly been left off the list of attendees, and a roll call vote was made to revise the minutes.

UPDATE ON BOARD RULES: Attorney Robert Berry and Allyson Zinno reviewed, in detail, each change that was made to the twenty-four pages of Board Rules. Some key changes: the definitions of manufacturer and pricing unit were updated, based on SB 450, and the number of alternates to the Board was updated.

PUBLIC COMMENTS: Donald Pfundstein brought up his concern about the Board not addressing the issue brought up in his letter from June 16, outlining the need for establishing a spending target for prescription drugs purchased by public payers and the need for the language of the Rules to be easily understood by everyone. A short discussion with the Board followed.

Heidi Kroll, AHIP, discussed the issue of cost to the public payers by hospital-administered drugs.

A representative from the insurance department discussed what he considers gaps in the wording of the intent of the Board, and the obligation of the Board to amend the wording. Senator Tom Sherman clarified the original intent of the Board, as he was the prime sponsor, and took the comment under advisement.

A Motion to accept the Rules, as revised, was made by Representative James Murphy. The motion was passed via roll call vote.

ADJOURNMENT: Motion to adjourn made by Senator Rosenwald. Motion passed without opposition.

Todd Fahey was not in attendance, however, respectfully submits: Todd C. Fahey, Clerk,

Nancy T. Plourde, Recording Secretary

APPENDIX I - September 26, 2022 Board Minutes

NH Prescription Drug Affordability Board In-person / Remote Hybrid Meeting September 26, 2022 10:00 AM

NOTE: This meeting was recorded. All related documents (and a recording of the entire meeting) are available at: [New Hampshire Prescription Drug Affordability Board](#) | [New Hampshire Department of Health and Human Services \(nh.gov\)](#)

CALL TO ORDER: Representative Gary Merchant, Chair, opened; introductions were made.

ATTENDING: In person: Representative Gary Merchant, Senator Tom Sherman, Dr. Robert Woodward,

Todd Fahey. Virtually: Representative William Marsh.

A quorum was established.

ABSENT: Senator Sharon Carson, Senator Cindy Rosenwald, Representative James Murphy.

AGENDA REVIEW: Representative Gary Merchant reviewed the agenda with the Board.

REVIEW AND APPROVE AUGUST 22 MINUTES: Dr. Robert Woodward moved to approve the minutes, Senator Tom Sherman seconded. Motion passed.

UPDATE ON BOARD RULES: Allyson Raadmae provided an update on the Rules, mentioning the many changes suggested by OLS, and recommending another meeting on the Rules prior to October 14. The next meeting was set for October 10, 9:00.

UPDATE ON EXECUTIVE DIRECTOR: Robert Berry provided an update about the position. He made slight modifications and should get it to Human Resources this week. He advised it may take up to 6 months to go through the entire process.

ASSESSMENT FEES: Robert Berry stated that he was told we need to have the Rules in place before collecting the fees.

REVIEW PRESCRIPTION DRUG USAGE REPORTS: Dr. Robert Woodward reviewed his modifications to the drug usage report that had been previously prepared by Andrew Chalsma. Robert discussed, in detail, the trends he feels should be focused on. A lengthy discussion followed with the Board.

PUBLIC COMMENTS: Members of the public who provided comment include Curtis Barry, Heidi Kroll and Donald Pfundstein, representing PBMs and AHIP, respectively. Comments were made throughout the presentation, as well as at the end.

ADJOURNMENT: Motion to adjourn made by Dr. Robert Woodward, seconded by Todd Fahey. Motion passed.

Respectfully submitted: Todd C. Fahey, Clerk Nancy T. Plourde, Recording Secretary

APPENDIX J - October 10, 2022 Board Minutes

NH Prescription Drug Affordability Board

In-person / Remote Hybrid Meeting

October 10, 2022 09:00 AM

NOTE: This meeting was recorded. All related documents (and a recording of the entire meeting) are available at: [New Hampshire Prescription Drug Affordability Board | New Hampshire Department of Health and Human Services \(nh.gov\)](https://www.nh.gov/health-and-human-services)

CALL TO ORDER: Representative Gary Merchant, Chair, opened; introductions were made.

ATTENDING: In person: Representative Gary Merchant, Representative William Marsh, Robert Woodward, Senator Tom Sherman. **Virtually:** Representative James Murphy.

A quorum was established by Representative Merchant, following the elevation of alternate to member status of Representative William Marsh and Robert Woodward; Senator Tom Sherman arrived following this action.

ABSENT: Senator Sharon Carson, Senator Cindy Rosenwald, Todd Fahey (due to technical difficulties).

AGENDA REVIEW: Representative Merchant established the meeting's purpose was to focus on the updates on the Board Rules.

UPDATE ON BOARD RULES: Allyson Raadmae clarified that the changes to be reviewed were made based upon comments on the Final Proposal by the Office of Legislative Services (OLS). Most of the changes were based on terminology, with the purpose of clearing up any ambiguity or redundancy. There was a short discussion around the issue of remote meetings; that they are not allowed. Allyson reminded the Board that this can be revisited at a later date, and that Rules are always open for revision, even after approval. The main point of the Rules discussion involved the proposed inclusion of wording as suggested by Donald Pfundstein. The final outcome, which was agreed upon by all, was to add a number 7 under Section 301.01 (e), to read as follows: *Claims databases, including but not limited to the all payors claims database, New Hampshire comprehensive health information system (NH-CHIS), all prescription drug spending whether billed under the prescription drug benefit or the medical benefit.* Representative Jess Edwards brought up the following three concerns: The fact that the Board's budget isn't set, whether or not levying taxes and fees is constitutional and the Board's methodology of pulling prescription information from a formulary. It was decided that these concerns will be addressed with Representative Merchant offline. Heidi Kroll, AHIP, brought up her concern with the wording around spending targets.

REVIEW AND APPROVE SEPTEMBER 26 MINUTES: Representative Merchant mentioned that, at the last meeting, his notes reflect a discussion about definitions for the Board's annual report. He recommended the minutes be amended to include this.

PUBLIC COMMENTS: Public comments were made throughout the meeting, rather than at the designated time.

ADJOURNMENT: Motion to adjourn made by Representative Merchant, seconded by Representative William Marsh. Motion passed.

APPENDIX K - N.H. Rev. Stat. § RSA 126-BB

Effective: July 1,
2022

126-BB:1 Definitions.

In this chapter:

- I. “Board” means the New Hampshire prescription drug affordability board.
- II. “Brand-name drug” means a prescription drug marketed under a proprietary name or registered trademark name, including a biological product.
- III. “Generic drug” means a prescription drug, whether identified by its chemical, proprietary, or nonproprietary name, that is not a brand-name drug and is therapeutically equivalent to a brand-name drug in dosage, safety, strength, method of consumption, quality, performance, and intended use. “Generic drug” includes a biosimilar product.
- IV. “Manufacturer” means a manufacturer of prescription drugs that are distributed in the state. A manufacturer excludes a packager, repackager, labeler, and relabeler unless the packager, repackager, labeler, or relabeler sets the price or controls the price of a prescription drug.
- V. “Pricing unit” means the smallest available package that can be used to dispense the smallest amount of a prescription drug.
- VI. “Public payor” means any division of state, county, or municipal government that administers a health plan for its employees or an association of state, county, or municipal employers that administers a health plan for its employees.
- VII. “Wholesale acquisition cost” means a manufacturer's listed price for sale to a wholesale drug distributor or other entity that purchases a prescription drug directly from the manufacturer, not including any price concessions.

126-BB:2 New Hampshire Prescription Drug Affordability Board Established.

There is established the New Hampshire prescription drug affordability board to carry out the purposes of this chapter.

- I. The board shall consist of 5 members with expertise in health care economics or clinical medicine, who shall not be, or be directly related to, anyone affiliated with, employed by, or representing the interests of a public payor, pharmaceutical or pharmacy company, pharmacy benefits management company, or health insurance provider and who have completed a conflict of interest statement. A member may be a legislator but is not required to be a legislator. They shall be appointed as follows:
 - (a) Two members by the president of the senate. The president of the senate shall also appoint 2 alternate board members who will participate in deliberations of the board in the event a member appointed by the president of the senate elects to be recused as provided in RSA 126-BB:3 or is absent.
 - (b) Two members by the speaker of the house of representatives. The speaker of the house of representatives shall also appoint 2 alternate board members who will participate in deliberations of the board in the event a member appointed by the speaker of the house of representatives elects to be recused as provided in RSA 126-BB:3 or is absent.
 - (c) One member by the governor. The governor shall also appoint 2 alternate board members who shall participate in deliberations of the board in the event the member appointed by the governor elects to be recused as provided in RSA 126- BB:3 or is absent.
- II. Members shall be appointed to 5-year terms. Of the initial appointees, the member appointed by the governor shall serve an initial term of 5 years, one member appointed by the president of the senate and one member appointed by the speaker of the house of representatives shall serve an initial term of 4 years and one member appointed by the president of the senate and one member appointed by the speaker of the house of representatives shall serve an initial term of 3 years

III. A majority of board members shall constitute a quorum.

IV. The chair of the board shall be elected by an affirmative vote of at least 4 of the 5 members of the board.

V. Beginning no later than March 1, 2021, the board shall meet in public session at least every 12 weeks to review prescription drug information and to make recommendations pursuant to RSA 126-BB:5. The first meeting shall be called by the first-named appointee of the senate president.

(a) Each public meeting shall be announced 2 weeks in advance, and materials for the meeting shall be made public at least one week in advance.

(b) Each public meeting shall provide opportunity for comment from the public in attendance at the meeting, and the board shall provide the opportunity for the public to submit written comments on pending decisions.

(c) The board may allow expert testimony at public meetings and any meeting conducted in executive session as permitted by subparagraph (d).

(d) Notwithstanding requirements of RSA 91-A, the board may meet in executive session, except that any decision of the board shall be made in public.

VI. The board shall be administratively attached to the department of health and human services. The board may employ staff, including but not limited to, an executive director who shall be an unclassified employee. The executive director shall be appointed by and serve at the pleasure of the board.

126-BB:3 Conflicts of Interest.

The following provisions govern any conflict of interest for a member of the board, a member of the advisory council established in RSA 126-BB:4 or any staff member or contractor of the board.

I. When appointing a member of the board or the advisory council, the appointing authority shall consider any conflict of interest disclosed by the prospective member. A member shall elect to be recused from any board activity in the case in which the member or an immediate family member of the member has a conflict of interest. For the purposes of this paragraph, “conflict of interest” means an association, including a financial or personal association, that has the potential to bias or have the appearance of biasing an individual’s decisions in matters related to the board or the conduct of the board’s activities.

II. A board member or staff or contractor of the board with a conflict of interest shall elect to be recused. For purposes of this paragraph, “conflict of interest” means any instance in which a member of the board or an immediate family member of the member has received or could receive either of the following:

(a) A direct financial benefit of any amount deriving from the results or findings of a study or determination by or for the board; or

(b) A financial benefit from individuals or companies that own or manufacture prescription drugs, services, or items to be studied by the board that in the aggregate exceeds \$5,000 per year. For purposes of this subparagraph, “financial benefit” includes honoraria, fees, stock, or other financial benefit and the current value of the member’s or immediate family member’s already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings conducted under this section.

(c) A conflict of interest shall be disclosed in the following manner:

(1) By the board in the employment of board senior staff.

(2) By the governor, president of the senate, or speaker of the house of representatives when appointing members to the board and advisory council.

(3) By the board in describing any recusals as part of any final decision relating to a prescription drug.

(4) By the 5th day after a conflict is identified or, if a public meeting of the board will occur within that 5-day period, in advance of the public meeting.

(d) Conflicts of interest shall be publicly posted on the website of the board. The information disclosed shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual

elects to be recused from participation in any activity with respect to which the potential conflict exists.

(e) The board, the advisory council, a member of the board or staff, or a contractor of the board may not accept gifts, bequests, or donations of services or property that suggest a conflict of interest or have the appearance of creating bias in the work of the board or advisory council.

(f) A member of the advisory council who accepts a gift, bequest, or donation of services or property that suggests a conflict of interest or has the appearance of creating bias in the work of the advisory council shall disclose the gift, bequest, or donation publicly.

(g) Notwithstanding the prohibition in [RSA 21-G:25](#), I, any person whose employer cannot and will not directly benefit from action taken or not taken by the board may be appointed to, and serve as a member of, the board.

126-BB:4 Advisory Council.

A 12-member advisory council is established to advise the board on establishing annual spending targets pursuant to RSA 126- BB:5, I and determining methods for meeting those spending targets pursuant to RSA 126-BB:5, III. The advisory council shall consist of the following members:

- I. The governor, or designee.
- II. The commissioner of the department of administrative services, or designee.
- III. The commissioner of the department of corrections, or designee.
- IV. The commissioner of department of health and human services, or designee.
- V. The attorney general, or designee.
- VI. The director of the division of risk and benefits, department of administrative services, or designee.
- VII. The president of the New Hampshire State Employees Association, or designee.
- VIII. The president of the New Hampshire Education Association, or designee.
- IX. The executive director of the New Hampshire Municipal Association or designee.
- X. The chancellor of the university system of New Hampshire, or designee.
- XI. The chancellor of the New Hampshire community college system, or designee.
- XII. A representative of consumer interests, appointed by the governor, who shall serve a 3-year term.

126-BB:5 Powers and Duties of the Board.

The board has the following powers and duties:

I. (a) Beginning with the year 2022 and in consultation with the advisory council, the board shall identify strategies that optimize spending by public payors for pharmaceutical products while reasonably ensuring subscriber access to needed pharmaceutical products. To achieve this goal, the board shall determine annual spending targets for prescription drugs purchased by public payors based upon a 10-year rolling average of the medical care services component of the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index, medical care services index, plus a reasonable percentage for inflation and minus a spending target for pharmacy savings as determined by the board.

(b) The board shall determine spending targets on specific prescription drugs that may cause affordability challenges to enrollees in a public payor health plan. Such targets shall consider any medical cost offsets achieved by utilization of the drug.

(c) The board shall determine which public payors are likely to exceed the spending targets determined under subparagraph (a).

II. The board may consider the following data to accomplish its duties under this section:

(a) A public payor's prescription drug spending data, which the 3rd-party administrator or insurer for the public payor's health plan shall provide to the board on behalf of the public payor upon request notwithstanding any provision of law to the contrary, including:

- (1) Expenditures and utilization data for prescription drugs for each plan offered by a public payor.
- (2) The formulary for each plan offered by a public payor and prescription drugs common to each formulary.

(3) Pharmacy benefit management services and other administrative expenses of the prescription drug benefit for each plan offered by a public payor.

(4) Enrollee cost sharing for each plan offered by a public payor.

(5) Aggregate net spending on the prescription drug benefit.

(b) Data compiled by the department of health and human services. Prescription drug spending data provided to the board under this subparagraph is confidential to the same extent it is confidential while in the custody of the entity that provided the data to the board.

III. Based upon the prescription drug spending data received under paragraph II, the board, in consultation with a representative of each public payor shall determine methods for the public payor to meet the spending targets established under paragraph

I. While continuing to ensure adequate access by subscribers to needed prescribed pharmaceutical products, the board shall determine whether the following methods reduce costs to individuals purchasing prescription drugs through a public payor and allow public payors to meet the spending targets established under paragraph I:

(a) Negotiating specific rebate amounts on the prescription drugs that contribute most to spending that exceeds the spending targets.

(b) Changing a formulary when sufficient rebates cannot be secured under subparagraph (a).

(c) Establishing a common prescription drug formulary for all public payors.

(d) Prohibiting health insurance carriers in the state administering benefits for a public payor from offering on their formularies prescription drugs when the method described in subparagraph (b) is implemented.

(e) Purchasing prescription drugs in bulk or through a single purchasing agreement for use among public payors.

(f) Collaborating with other states and state prescription drug purchasing consortia to purchase prescription drugs in bulk or to jointly negotiate rebates.

(g) Allowing health insurance carriers providing coverage to small businesses and individuals in the state to participate in the public payor prescription drug benefit for a fee.

(h) Procuring common expert services for public payor, including but not limited to pharmacy benefit management services and actuarial services.

IV. By November 1, 2020 and annually thereafter, the board shall report its recommendations, including prescription drug spending targets, their strategies for optimization of affordability of prescription drugs for the state and all of its residents, the progress of implementing those recommendations, as well as the annual net spending by public payors on prescription pharmaceutical products as a measure of the efficacy of implementation of those recommendations to date, to the standing committees of the general court with jurisdiction over health coverage and insurance matters and to the governor. This report shall also contain the following information about prescription drugs, both brand name and generic:

(a) The 25 most frequently prescribed drugs in the state;

(b) The 25 costliest drugs as determined by the total amount spent on those drugs in the state; and

(c) The 25 drugs with the highest year-over-year cost increases as determined by the total amount spent on those drugs in the state.

V. The board may apply for and receive funds, grants, or contracts from public and private sources.

126-BB:6 Rulemaking.

The board shall adopt rules under RSA 541-A for the following:

I. Procedures for drug price transparency as required under RSA 126-BB:7.

II. The adoption of all fees under RSA 126-BB:8.

III. Proceedings for assessing civil fines under RSA 126-BB:10.

IV. The appeals process for assessments issued by the board under RSA 126-BB:8.

V. Any other matter required to implement this chapter.

126-BB:7 Drug Price Transparency; Non-disclosure Requirements.

- I. The board shall develop and implement policies and procedures for its collection, processing, storage, and analysis of clinical, financial, quality restructuring and prescription drug price data for the following purposes:
- (a) To use, build, and improve upon and coordinate existing data sources and measurement efforts through the integration of data systems and standardization of concepts.
 - (b) To coordinate the development of a linked public and private sector information system.
 - (c) To emphasize data that is useful, relevant, and not duplicative of existing data.
 - (d) To minimize the burden on those providing data.
 - (e) To preserve the reliability, accuracy, and integrity of collected data.
- II. The board shall adopt rules to ensure that:
- (a) Payors, providers, prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers file data as required by RSA 126-BB:9.
 - (b) Users that obtain health data and information from the board safeguard the identification of patients and health care practitioners.
 - (c) Payors, providers, prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers pay all assessments as required by RSA 126-BB:8.
 - (d)(1) Only the board and employees assigned to the board may access the information received pursuant to this chapter and only for purpose of effectuating the powers and duties granted the board by this chapter. The board shall limit access to any information that it receives pursuant to this chapter to the smallest number of employees and other personnel possible; and all such individuals shall, as a condition of employment, be required to execute non-disclosure agreements under which they are restricted from disclosing any information they may receive in connection with this chapter during their employment term and in perpetuity post-employment.
 - (2) If the board, its members, employees, or personnel willfully shares or discloses for unauthorized purposes information that is trade secret information, confidential, commercial or proprietary information, or information designated as “confidential” by the owner of the information, the board or the individual who made the unauthorized disclosure may be subject to any penalties available under federal and state laws, including trade secret misappropriation laws, to the extent permitted by law.

126-BB:8 Funding; Assessment of Fees.

- I. The expenses and cost of operation of the board shall be funded by reasonable user fees and assessments determined in rules adopted by the board.
- (a) Fees may be charged for the reasonable costs of duplicating, mailing, publishing, and supplies.
 - (b) Reasonable user fees shall be charged on a sliding scale for the right to access and use the health data and information available from the board. Fees may be charged for services provided to the department on a contractual basis. Fees may be reduced or waived for users that demonstrate a plan to use the data or information in research of general value to the public health or inability to pay the scheduled fees, as provided by rules adopted by the board.
 - (c) Annual assessments of not less than \$100 assessed against the following entities:
 - (1) Health insurance carriers and health maintenance organizations on the basis of the total annual health care premium.
 - (2) Third-party administrators.
 - (3) Health carriers that provide only administrative services for a plan sponsor.
 - (4) [Repealed.]
 - (d) Health care policies issued for specified disease, accident, injury, hospital indemnity, disability, long-term care or other limited benefit health insurance policies are not subject to assessment under subparagraph (c). For purposes of this paragraph, policies issued for dental services are not considered to be limited benefit health insurance policies.
 - (e) Annual assessments of not less than \$500 assessed by the board against prescription drug manufacturers, wholesale drug distributors, and pharmacy benefits managers, including those that process and pay claims on the basis of claims processed or paid for each plan sponsor.

II. The aggregate level of annual assessments under subparagraphs (c) and (e) shall be an amount sufficient to meet the board's expenditures authorized; provided that such amount shall not exceed 125 percent of the board's annual operating costs. The board may waive assessments otherwise due under subparagraphs (c) and (e) when a waiver is determined to be in the interests of the board and the parties to be assessed.

II-a. Any entity assessed a fee or other assessment under this section may appeal such action in accordance with RSA 541.

III. There is established a nonlapsing fund to be known as the New Hampshire prescription drug affordability board administration fund, which shall be kept distinct and separate from all other funds. The fund shall be continually appropriated to and administered by the board. All fees and assessments collected under this section shall be deposited in the fund. The board shall use the fund, consistent with the provisions of this chapter, to receive funds and to reimburse costs incurred by the board. The fund may be used to pay administrative, technical, legal support, or other costs incurred by the board under this chapter. The state treasurer may invest moneys in the fund as provided by law, and all interest received on such investment shall be credited to the fund.

126-BB:9 Drug Price Notifications and Disclosures; Confidentiality; Registration.

I. No later than January 30, 2021 and annually thereafter, a manufacturer shall notify the board when the manufacturer has during the prior calendar year:

- (a) Increased the wholesale acquisition cost of a brand-name drug by more than 20 percent per pricing unit;
- (b) Increased the wholesale acquisition cost of a generic drug that costs at least \$10 per pricing unit by more than 20 percent per pricing unit; or
- (c) Introduced a new drug for distribution in this state when the wholesale acquisition cost is greater than the amount that would cause the drug to be considered a specialty drug under the Medicare Part D program. For the purposes of this section, "Medicare Part D" means prescription drug benefit in accordance with the requirements of the federal Medicare Prescription Drug Improvement and Modernization Act of 2003.

II. (a) To develop the report under paragraph VIII, the board shall first assess public information that is readily available. To the extent there is no public information or not enough public information readily available to the board to produce its report, the board may request information from:

- (1) The manufacturer that provided notice to the board pursuant to paragraph I;
- (2) A pharmacy benefit manager or health insurance carrier providing services involving the drug that is the subject of the notification provided pursuant to paragraph I.

(b) Once the board requests information of a manufacturer, pharmacy benefit manager, or health insurance carrier, the entity shall have 60 days to produce the requested information regarding the prescription drug that is the subject of the request. If, after a complete review of all information and data available to the board or as received from the entities, the board makes a determination that additional data is required for a particular prescription drug to produce the report under paragraph VIII, the board may request that additional information from wholesale drug distributors that distribute the prescription drug that is the subject of the report. Once the board requests information of a wholesale drug distributor, it shall have 60 days to produce information regarding the prescription drug that is the subject of the request.

III. (a) Upon receipt of a request from the board relating to a specific prescription drug for which notice was provided pursuant to paragraphs I and II, a manufacturer shall provide to the board, in a form and manner specified by the board, (i) a written, narrative description, suitable for public release, of all factors that caused the increase in the wholesale acquisition cost of the listed outpatient prescription drug, and (ii) aggregate, company-level research and development costs and such other capital expenditures that the board, in its discretion, deems relevant for the most recent year for which final audited data are available.

(b) The data that a pharmaceutical manufacturer submits to the board under this section may be limited to the information and data that the pharmaceutical manufacturer includes in such pharmaceutical manufacturer's annual

consolidated report on Securities and Exchange Commission Form 10-K, or any other public disclosure.

(c) The board shall establish a standardized form for reporting information and data pursuant to this section after consulting with pharmaceutical manufacturers. The form shall be designed to minimize the administrative burden and cost of reporting on the office and pharmaceutical manufacturers.

(d) Upon a request from the board relating to a specific prescription drug for which notice was provided pursuant to paragraphs I and II, a pharmacy benefit manager or wholesaler shall provide:

(1) The dollar amount of all rebates or fees concerning the drug collected from the manufacturer that were covered by such health carriers during such calendar year; and

(2) The dollar amount of all rebates and fees, excluding any portion of the rebates or fees received by health carriers, concerning the drug collected from the manufacturer.

(3) Fees referenced in subparagraphs (1) and (2) shall exclude those that are determined to be bona fide service fees as defined by the United States Department of Health and Human Services and codified in 42 C.F.R. 414.803.

(e) The board shall establish a standardized form for reporting information pursuant to subparagraph (d) after consultation with pharmacy benefits managers and wholesalers. The form shall be designed to minimize the administrative burden and cost of reporting on pharmacy benefits managers and wholesalers.

IV. Information provided to the board as required by this section by a manufacturer, wholesale drug distributor, or pharmacy benefits manager that has not been publicly reported is confidential and not a public record under RSA 91-A, except that the board may share information:

(a) With the insurance department, to the extent necessary for the department to enforce insurance laws, as long as any information shared is kept confidential; and

(b) As long as it is not released in a manner that represents a breach of confidential information provided by a manufacturer, wholesale drug distributor, or pharmacy benefits manager.

V. Beginning January 1, 2021, a manufacturer, pharmacy benefits manager, and wholesale drug distributor subject to this section shall register annually with the board in a manner prescribed by the board.

VI. A manufacturer, wholesale drug distributor, or pharmacy benefits manager that submits a notification or report to the board pursuant to this section shall submit with the notification or report a signed written certification of the notification's or report's accuracy. Any confidential or proprietary information contained within such notification or report shall be clearly identified as such. Any breach of confidential information not so identified shall not be subject to RSA 126-BB:7, II(d).

VII. (a) The board may audit the data submitted by a manufacturer, wholesale drug distributor, or pharmacy benefits manager pursuant to this section. The audits shall only be conducted when the state has reasonable cause to believe information received is inaccurate. The board shall notify the entity to be audited with sufficient notice before conducting the audit. The costs of the audit shall be paid for by the manufacturer, wholesale drug distributor, or pharmacy benefits manager.

(b) The board may require a manufacturer, wholesale drug distributor, or pharmacy benefits manager subject to this section to develop a corrective action plan to correct any deficiencies the board finds with the manufacturer's, wholesale drug distributor's, or pharmacy benefits manager's compliance with this section.

VIII. Beginning November 1, 2021 and annually thereafter, the board shall produce and post on its publicly accessible website an annual report, including information developed from the notifications and disclosures received pursuant to this section on trends in the cost of prescription drugs, analysis of manufacturer prices and price increases, the major components of prescription drug pricing along the supply chain and the impacts on insurance premiums and cost sharing, and any other information the board determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state. The report may not disclose information attributable to any particular manufacturer, wholesale drug distributor, or pharmacy benefits manager subject to this section and may not make public any information that is confidential. The board shall submit the report required by this section to the standing committees of the general court with jurisdiction over health data reporting and prescription drug matters and the governor.

126-BB:9-a Criminal Penalty.

Any person who knowingly uses confidential information obtained pursuant to this chapter or knowingly discloses confidential information obtained pursuant to this chapter to any person not authorized to review such information shall be guilty of a misdemeanor.

126-BB:10 Civil Penalties.

When a person or entity that is a health care facility payor, prescription drug manufacturer, wholesale drug distributor, or pharmacy benefits manager violates any requirement of this chapter, that person or entity commits a civil violation for which a fine of not more than \$1,000 per day may be imposed. A fine imposed under this paragraph may not exceed \$25,000 for any one occurrence.

APPENDIX L – NHID: PBM REGULATIONS AND STATUTES



Rx Drug Affordability Board PBM Regulation – NH Insurance Statutes



Tyler Brannen
NHID Life & Health Director
November 30, 2021

Pharmacy Benefit Management

- Administering Rx benefits for:
 - a fully insured product = client of health carrier
 - a self-insured employer =
 - TPA
 - PBM
 - Utilization review entity

NH Insurance Statutes for PBMs

- **RSA 420-J Managed Care Law**
 - 420-J:7-b Prescription Drugs
 - 420-J:8 Provider Contract Standards
 - 420-J:7 Network Adequacy
 - 420-J:19 Medication Synchronization
- **420-E Licensure of UR Entities**
 - 420-E:4-a Uniform Prior Authorization Forms and Electronic Standard for Prescription Drug Benefits

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NH Insurance Statutes for PBMs

- **420-B:12 HMO Prohibited Practices**
 - “V. Every health maintenance organization which solicits bids from pharmacies for contracts to be preferred providers shall accept and list as preferred providers all pharmacies which meet the bid acceptable to the health maintenance organization.”

11/22/2021

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NH Insurance Statutes for PBMs

- 402-N Pharmacy Benefit Managers
 - Substantial overlap with RSA 420-J
 - Additional requirements include:
 - 402-N:2 Registration to do Business
 - 402-N:6 Pharmacy Benefits Manager Reporting
 - I. Each pharmacy benefits manager shall submit an annual report to the commissioner containing a list of health benefit plans it administered, and the aggregate amount of all rebates it collected from pharmaceutical manufacturers that were attributable to patient utilization in the state of New Hampshire during the prior calendar year.
 - 402-N:7 Authority to Examine and Directly Bill Pharmacy Benefits Managers for Certain Examinations

11/22/2021

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Not insurance

- **RSA 318 – Pharmacists and Pharmacies**
 - **Section 318:68**
 - I. A prescription drug manufacturer shall notify the department in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold set for a specialty drug under the Medicare Part D program. (*continues*)
 - **318:67 Definitions. –**
 - I. "Department" means the insurance department.

11/22/2021

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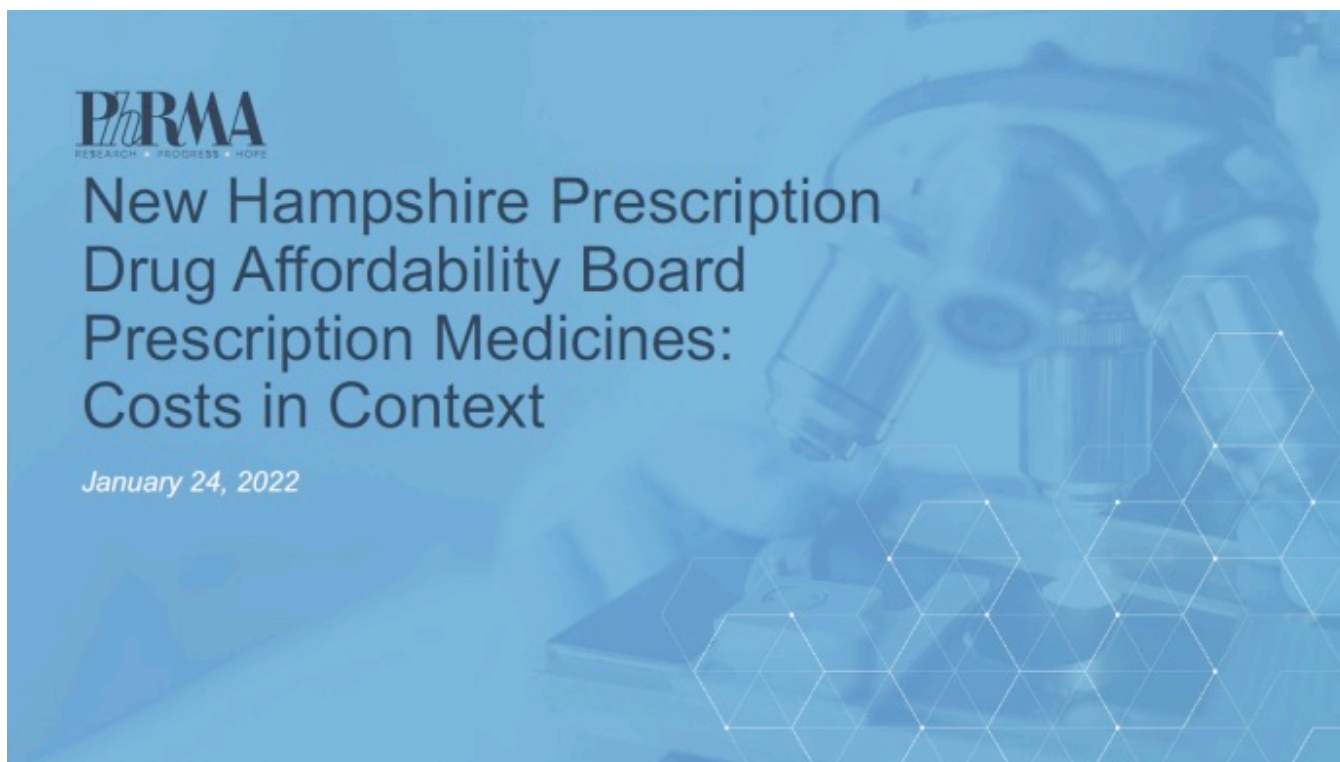
Thank You



Contact Information

Tyler Brannen
Life & Health Director
NH Insurance Department
Tyler.j.Brannen@ins.nh.gov

APPENDIX M – PhRMA: COSTS IN CONTEXT



Prescription Medicines: Costs in Context: www.phrma.org/ost

We are in a New Era of Medicine Where Breakthrough Science is Transforming Patient Care

53 New Medicines Were Approved by the FDA in 2020

The Washington Post

Cancer Death Rate

Cancer death rate posts biggest one-year drop ever

CBS

Game Changer

Newly approved drug being called 'game changer' for people who suffer from hemophilia

REUTERS

Coronavirus Vaccine

Reasons for hope: the drugs, tests and tactics that may conquer coronavirus



Source: US FDA, Center for Drug Evaluation and Research (CDER) Advancing Health through Innovation, 2020 New Drug Approvals.
Note: Due to lack of data availability, novel approvals are not inclusive of medicines approved by the Center for Biologics Evaluation and Research (CBER) in 2020.

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Though Growth in Medicine Prices and Spending Remains in Line With Inflation, Many Patients Still Struggle to Afford their Medicines

Brand Medicine Prices

Medicine Spending



declined
2.9%
in 2020

grew
0.8%
in 2020

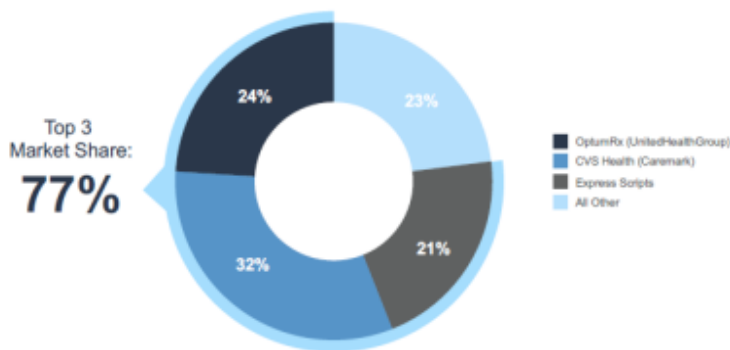


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3

Insurers and PBMs Have a Lot of Leverage to Hold Down Medicine Costs

Negotiating power is increasingly concentrated among fewer pharmacy benefit managers (PBMs).



Insurers determine:

FORMULARY
if a medicine is covered

TIER PLACEMENT
patient cost sharing

ACCESSIBILITY
utilization management through prior authorization or fail first

PROVIDER INCENTIVES
preferred treatment guidelines and pathways

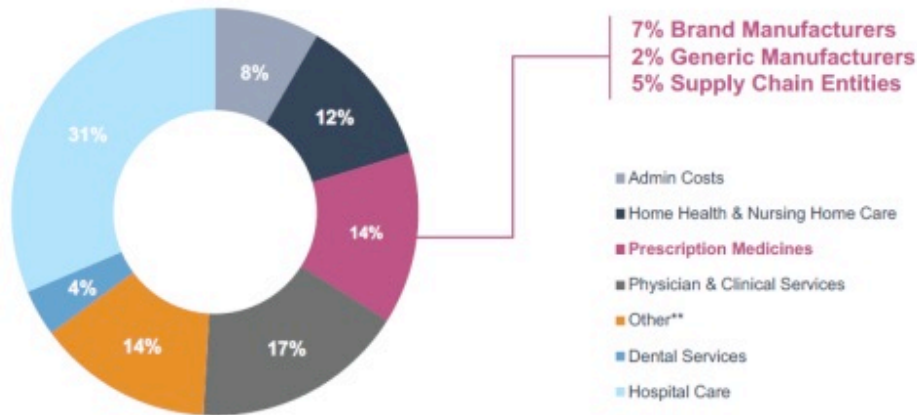


Source: Drug Channels Institute, March 2021.

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Spending on Retail and Physician-administered Medicines Represents Just 14% of Health Care Spending



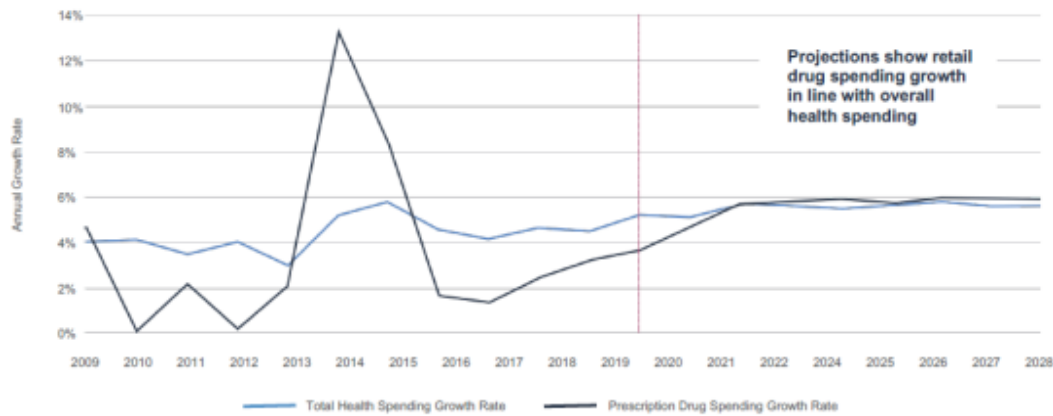
Source: PFMA analysis of CMS National Health Expenditures, Aflacur Institute, and Berkeley Research Group data. May not sum to 100% due to rounding.

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5

Medicine Spending is Projected to Grow in Line with Health Care Spending Through Next Decade

In 7 of the last 10 years, Retail Drug Spending Growth was below Total Health Spending Growth



Source: CMS National Health Expenditures Report 2020
 Note: Total retail sales include brand medicines and generics.

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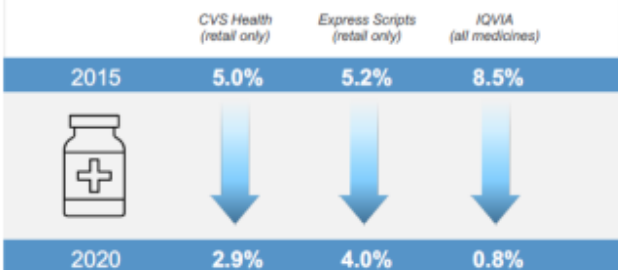
6

While Medicine Costs Are Slowing, It Doesn't Always Feel That Way for Patients

PBMs and Government Actuaries Report Slowing Growth in Medicine Spending

But High Patient Cost Exposure for Brand Medicines Is Becoming More Prevalent

Annual Growth in Net Prescription Medicine Spending

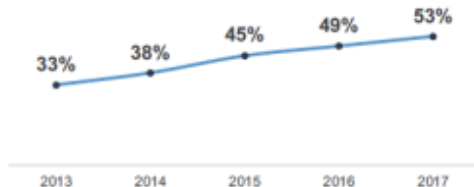


Source: CVS Health, Feb 2016, 2015 Drug Trend & May 2021, 2020 Drug Trend Report; Express Scripts, Mar 2016, Express Scripts 2015 Drug Trend Report & May 2021, 2020 Drug Trend Report; IQVIA, Use of Medicines in the U.S., May 2021.



Share of Total Patient Cost Exposure Accounted for by \$125+ Claims

(Commercial Claims; Brand Medicines; 2013-2017)

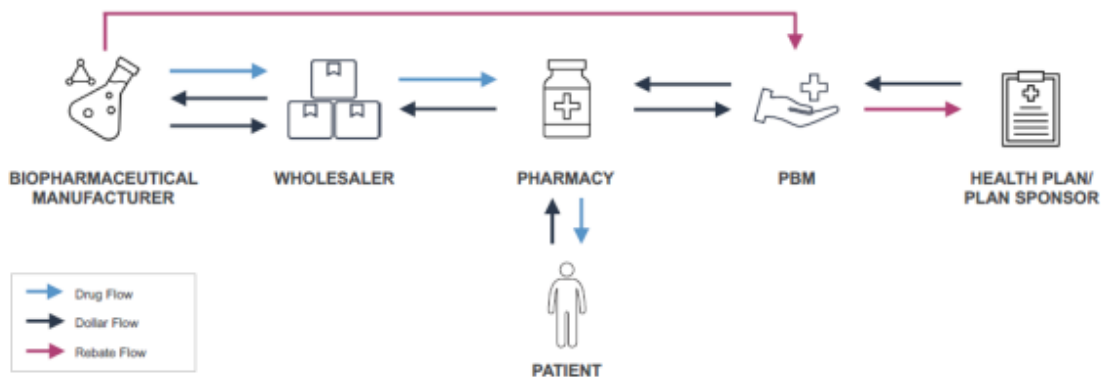


Source: IQVIA, Aug 2018, Patient Affordability and Prescriber Drugs.

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7

Many Stakeholders Have a Role in the Prescription Medicine Supply Chain



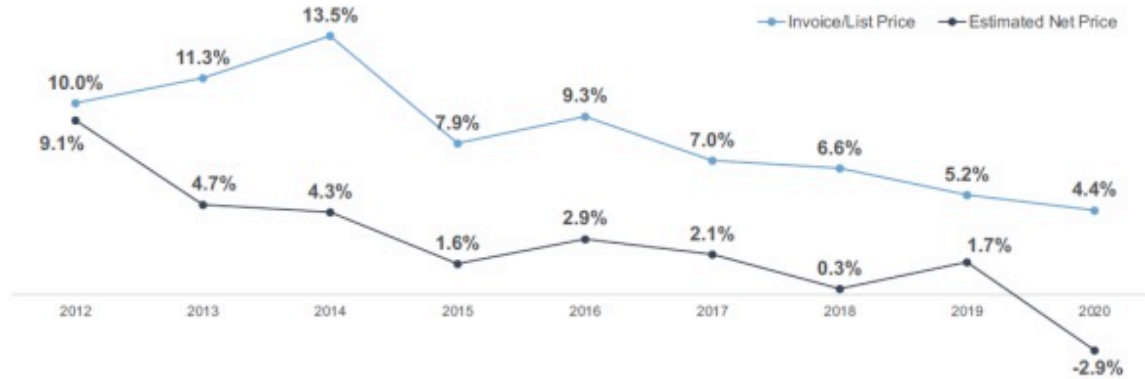
Source: PhRMA, Nov 2017, Follow the Dollar: Understanding How the Pharmaceutical Distribution and Payment System Shapes the Prices of Brand Medicines.

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8

The Gap Between List and Net Price Growth for Medicines is Driven By Rebates and Discounts

Average Price Growth for Brand Medicines, 2012-2020



Notes: Includes protected brand medicines only (i.e., brand medicines without generic versions available in the year indicated). Estimated net price growth reflects impact of all invoice rebates and discounts provided by manufacturers.
Source: IQVIA, Use of Medicines in the U.S., May 2021

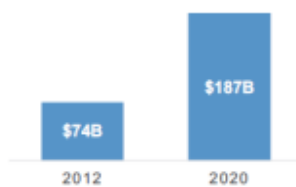
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Rebates and Discounts Lower the Net Prices of Medicines

Increasing Discounts and Rebates

Rebates, discounts, fees, and other price concessions have more than doubled since 2012



Note: Includes single-source brand medicines.
Source: Fein, A. "The 2021 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute, March 2021.



Slowing Price Growth

In 2020, net prices for brand medicines *declined* by just

2.9%

in line with or below inflation for the fifth year in a row.

Source: IQVIA, Use of Medicines in the U.S., May 2021.

Large Difference Between List and Net Prices

On average, a brand medicine's net price is

44% lower

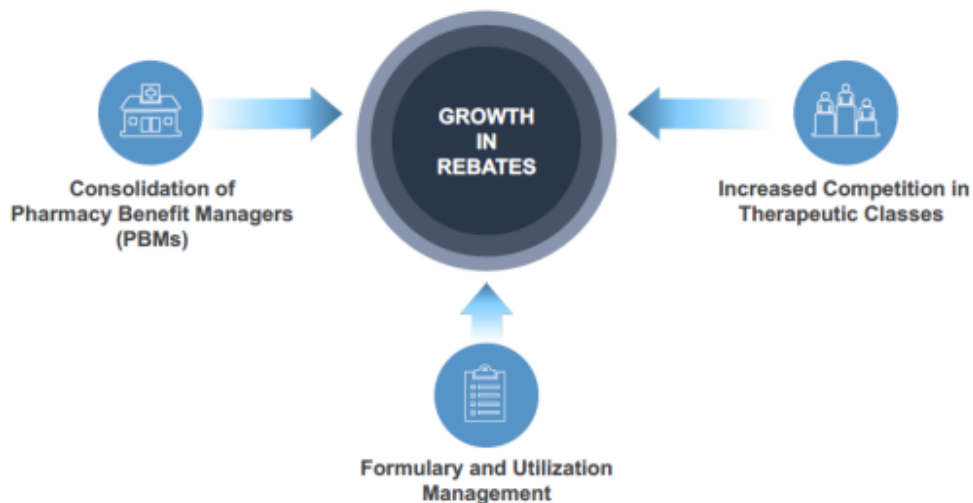
than its list price.

Source: IQVIA, Use of Medicines in the U.S., May 2021.

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A Range of Factors Has Contributed to the Increasing Role of Rebates in the Medicine Supply Chain



PERMA

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New analysis finds more than half of brand medicine spending goes to the supply chain, middlemen and other stakeholders

50.5%



Share of total brand medicine spending received by non-manufacturer stakeholders

180%



Growth in total brand medicine spending received by insurers, PBMs, the government and other payers from 2013 to 2020

12x



Increase in brand medicine spending received by health care providers through the 340B program

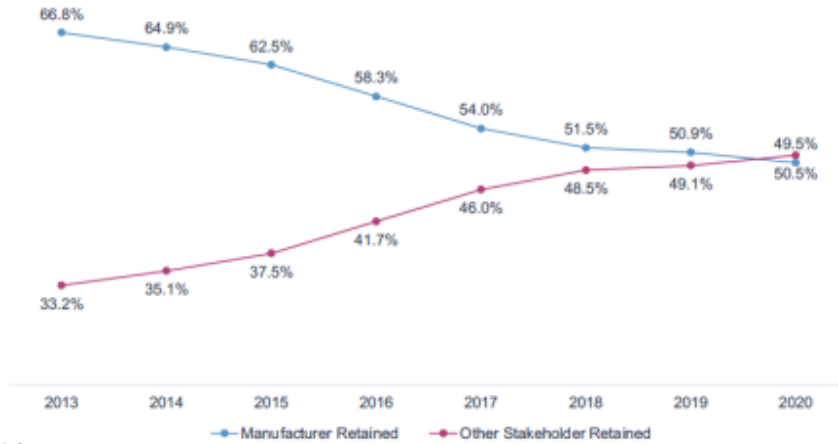
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More than half of every \$1 spent on brand medicines went to non-manufacturer stakeholders in 2020

Total Brand Medicine Spending (\$B) by Manufacturer and Other Stakeholders, 2013-2020

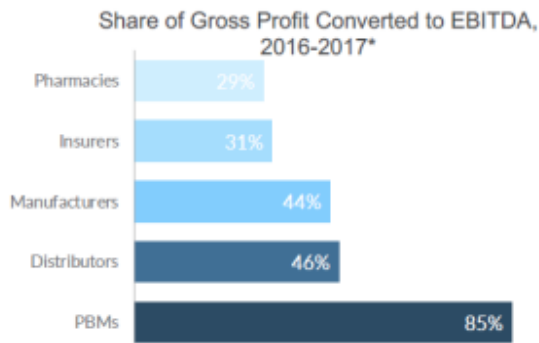


2020 marks the first year on record that the supply chain and other stakeholders received a **larger share of total brand medicine spending** than the companies that developed them.



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PBM Profit Margins Are Well Above Others in the Medicine Distribution and Supply Chain



*Calculated as EBITDA (earnings before interest, taxes, depreciation, and amortization) margin divided by gross margin



Analysts at Bernstein tried to get a better picture of how profitable these [supply chain] companies are by excluding the cost of the drugs that are included in their revenue. . . . By this analysis, pharmacy-benefit managers are exceptionally profitable."

Charley Grant, *Wall Street Journal*

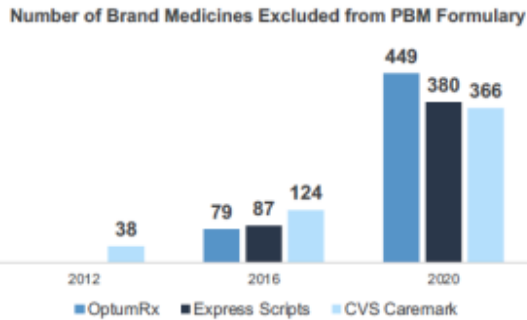


Source: Bernstein Research; NDP Analytics; Grant C

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Control Over Formularies Allows Payers to Negotiate Substantial Rebates and Discounts on Medicines

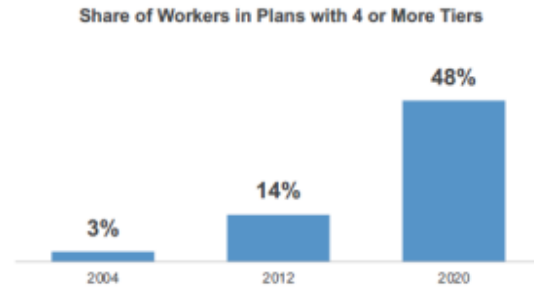
Brand Medicines Are Increasingly Excluded From PBM Formularies



Source: Koenda, "Skyrocketing Growth in PBM Formulary Exclusions Raises Concerns About Patient Access," September 2020.



Use of 4 or More Cost Sharing Tiers Has Bolstered Plans' Negotiating Power



Source: Kaiser Family Foundation, Oct 2020, 2020 Employer Health Benefits Survey, Section 9: Prescription Drug Benefits.

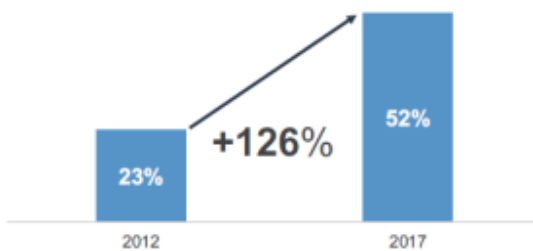
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Prescription Drugs Are Increasingly Subject to Deductibles and Coinsurance

Share of Employer-Sponsored Health Plans With a Prescription Drug Deductible is Increasing

Percentage of Employers With Deductibles for Prescription Drugs

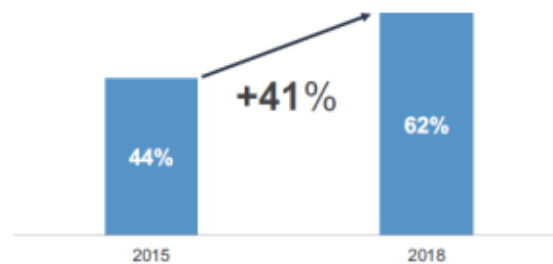


Source: PwC, Jul 2017, Health & Wellbeing Touchstone Survey Results.



Three-Year Jump in Average Percent of Drugs on Coinsurance Tiers in Part D

Average Percentage of Drugs on Coinsurance Tiers in Part D Plans



*Includes both brand and generic medicines.
Source: Avalere, Oct 2017, Avalere Health analysis using DataForm®, a proprietary database of Medicare Part D plan features, 2015 plan data.

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In Today's Rebate System, Patients Can End up Paying More for Medicines Than Their Health Insurer or Plan Sponsor Pays



A patient in the deductible phase pays the total cost, while their health insurer gets a rebate.



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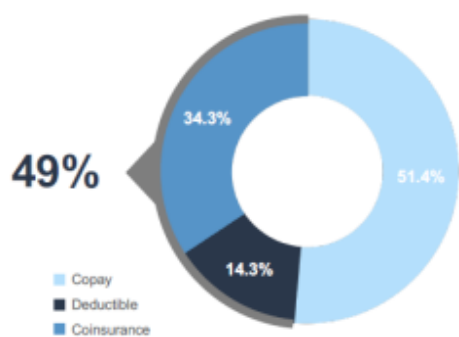
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Prescription Medicines: Costs in Context www.pdma.org/ost

Too Often, Negotiated Savings Do Not Make Their Way to Patients at the Pharmacy Counter

Half of commercially insured patients' out-of-pocket spending for brand medicines is based on the full list price

Cost sharing for nearly 1 in 10 brand prescriptions is based on list price

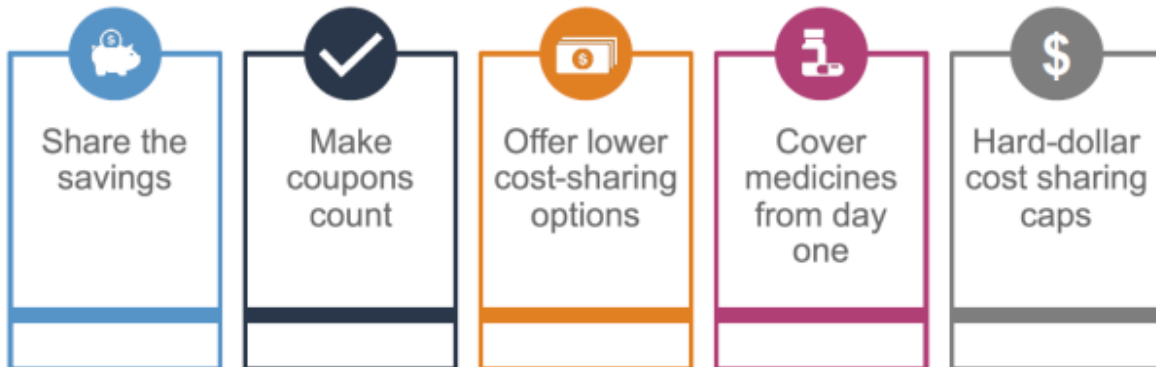


Source: IQVIA, August 2020

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Policies That Help *Patients Pay Less*



APPENDIX N – PHARMACEUTICAL SUPPLY CHAINS

Dr. Scott Pace

Pharmaceutical Supply Administrative Organization

The Role and Value of Pharmacy Services Administrative Organizations (PSAOs)

Scott Pace, PharmD, JD
 Partner
 Impact Management Group

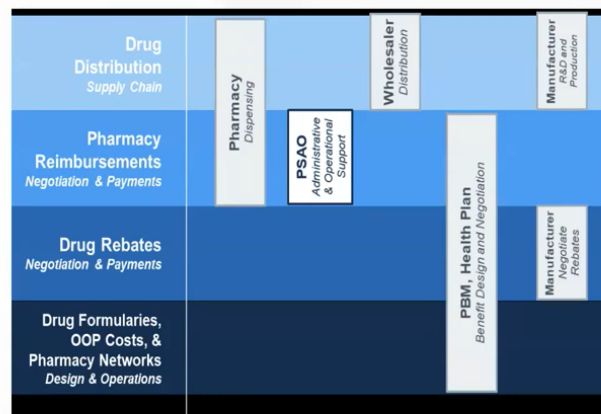
What is a PSAO?

PSAOs are service organizations that provide back-office support to independent pharmacies and small chains.

These services include, but are not limited to:

- Evaluation and navigation of Pharmacy Benefit Manager (PBM) contracts;
- Help desk to assist pharmacies with communications with the PBMs;
- Credentialing and compliance assistance;
- Central payment facilitation;
- Claims reconciliation;
- Performance tracking; and,
- PBM audit support.

For the services provided, PSAOs charge a flat monthly fee.



Who are PSAOs?

- In a 2013 report, the **Government Accountability Office (GAO) identified 22 PSAOs** owned by a mix of wholesalers, member pharmacies (of the PSAO), group purchasing organizations, and other private entities.
- Today it is estimated there are **fewer than 10 PSAOs** in operation.
- One analysis estimates that the six largest PSAOs in 2021 ranged from having **1,700 to 6,800 participating independent pharmacies each**, with a median of 4,250 per PSAO.

In Comparison:

- The percent of total U.S. prescription claims managed by the **six largest PBMs in 2018 was 95 percent**.
- The **top three PBMs control 77 percent** of the prescription market.
- The **second-largest PBM accounts for approximately 90 million plan members** and controlled 68,000+ pharmacies.

3

Scope of PSAO Services

Community pharmacies and/or small chains often do not have the infrastructure and expertise of their larger chain competitors. Some choose to contract with a PSAO to assist with managing their PBM interactions and “back-office” administrative duties.

Services Provided By PSAOs:	PSAOs Do Not:
<p>Managing insurer and PBM relationships, including fielding questions about claims, contracting, reimbursement, and payer/PBM audits</p> <p>Ensuring pharmacy clients understand their rights and responsibilities regarding responding to or appealing audit findings</p> <p>Assisting with regulation compliance and credentialing</p> <p>Aggregating claims to a single payment from a third-party payer on behalf of a PSAO's member pharmacies; individual payments are then disbursed to a PSAO's members</p> <p>Managing and analyzing pharmacies' payment and drug dispensing data to identify claims that have not been paid or were paid incorrectly</p>	<p>Dictate reimbursement rates</p> <p>Set Maximum Allowable Cost (MAC) rates</p> <p>Determine formulary listings or patient coverage</p> <p>Retain any portion of pharmacy reimbursement</p> <p>Create Direct and Indirect Remuneration (DIR)* fees — or retain any portion of DIR or dispensing fees</p> <p>Accept all contract terms</p> <p>Create networks or plan structures</p> <p><i>*In fact, PSAOs provide tools to help improve patient outcomes, which can in turn reduce DIR fees for pharmacies.</i></p>

4

Summary of State Policy Trends

National Landscape

- Inaccurate national campaign indicating that PSAs are equalizers in the pharmacy/insurer-PBM relationship.
- Inaccurate perception that wholesaler-owned PSAs have greater negotiation power.
- Inaccurate perception that PSAs impact the cost of pharmaceutical drug prescriptions
- State-proposed legislation blur lines between PSAs and other supply chain entities, such as insurers and PBMs.

Reality

- Government and supply chain studies note that PSAs — including those operated by wholesale distributors — do not level the playing field between PSAs and PBMs. All face difficulties in achieving fair contract terms.
- PSAs are administratively focused entities operating on a flat membership fee and do not impact patient out of pocket costs, formulary design, etc.
- PSAs should not be treated as insurers or PBMs.

5

Additional Notes

Incorporate the PSAO perspective:

If legislative proposals are being considered in your state that include PSAs, please reach out to pace@impactmanagement.com to discuss the PSAO perspective.

“If it ain’t broke, don’t fix it”:

PSAs are not PBMs or insurers and should not be treated as such. The need for greater regulation of PSAs is questionable at best.

Remember PSAs actual role:

PSAs do not notably impact the cost of medication and they are not responsible for patients benefit design. They are administrative support service providers. Additionally, not all PSAs are wholesaler owned, and not all wholesalers operate a PSAO business. Who owns a PSAO does not impact market influence or prices.

6

APPENDIX O – NH PRESCRIPTION COST AND UTILIZATION

Top 20 New Hampshire Drug Utilization and Cost Summary - Patient Cost by Therapeutic Class, SFY 2021
Source: EBI data as of 07/09/2022

Pharmacy Monthly Membership Averages SFY21	Average Membership
Commercial Insurance in CHS	564,129
Medicare Part D in CHS	182,236

Medicare SFY 2021 Top 25 Patient Total Paid

Drug Therapeutic Class	Patient Paid Amount	Count of Patients	Patient Paid per Patient
ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS	\$8,670,008	52,869	205
ANTI-DIABETICS	\$8,576,605	34,497	291
ANTI-COAGULANTS	\$8,296,944	25,008	272
OPHTHALMIC AGENTS	\$3,196,776	26,335	121
ANTI-HYPERLIPIDEMICS	\$3,014,336	103,087	29
ANTI-DEPRESSANTS	\$2,940,469	63,646	46
ANTI-NEOPLASTICS	\$2,628,802	5,872	448
ANTI-COAGULANTS	\$1,889,230	37,794	50
ANTI-HYPERTENSIVES	\$1,879,268	84,700	22
ULCER DRUGS	\$1,879,241	93,384	39
BETA BLOCKERS	\$1,856,190	62,505	29
ANALGESICS - OPIOID	\$1,703,578	32,083	53
DERMATOLOGICALS	\$1,560,648	41,819	37
THYROID AGENTS	\$1,461,305	36,735	40
VACCINES	\$1,424,960	30,422	47
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC	\$1,360,133	7,495	181
CALCIUM CHANNEL BLOCKERS	\$1,152,499	42,762	27
ANALGESICS - ANTI-INFLAMMATORY	\$1,090,372	25,119	42
ASSORTED CLASSES	\$1,048,629	1,521	794
URINARY ANTISPASMODICS	\$991,029	8,025	123

Commercial SFY 2021 Top 25 Total Patient Paid

Drug Therapeutic Class	Patient Paid Amount	Count of Patients	Patient Paid per Patient
ANALGESICS - ANTI-INFLAMMATORY	\$5,704,814	49,951	190
ANTI-DEPRESSANTS	\$8,599,929	301,350	85
ANTI-DIABETICS	\$8,596,611	28,555	301
DERMATOLOGICALS	\$8,400,134	69,529	121
ADHD/(ANTI-MARCOLEPSY)/(ANTI-OBESITY)/(ANOREXIA)	\$8,033,828	27,123	297
ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS	\$7,048,986	45,777	154
THYROID AGENTS	\$5,714,225	35,982	169
ANTI-COAGULANTS	\$5,036,312	9,257	528
ANTI-CONVULSANTS	\$1,710,126	85,516	81
ANTI-HYPERTENSIVES	\$1,705,736	69,365	39
ANTI-HYPERLIPIDEMICS	\$1,621,318	67,626	39
ULCER DRUGS	\$1,510,383	47,493	53
OPHTHALMIC AGENTS	\$1,138,954	23,240	97
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS	\$1,188,927	5,759	381
BETA BLOCKERS	\$1,093,977	37,578	55
MIGRAINE PRODUCTS	\$1,027,084	9,524	213
ANTI-PSYCHOTICS/ANTI-MANIC AGENTS	\$1,006,791	10,180	198
ANALGESICS - OPIOID	\$1,823,297	41,613	44
ANTI-VIRALS	\$1,797,647	17,278	104
GASTROINTESTINAL AGENTS - MISC.	\$1,736,756	5,321	326

Medicare SFY 2020 Year over SFY 2021 Year Patient Increases

Drug Therapeutic Class	Increase in Patient Paid Amount	Count of Patients Difference
ANTI-COAGULANTS	\$1,674,073	7,052
ANTI-DIARRHEALS	\$1,179,202	351
ANTI-COAGULANTS	\$896,795	3,827
ANTI-NEOPLASTICS	\$618,707	803
OPHTHALMIC AGENTS	\$540,787	3,397
ANTI-DIABETICS	\$433,032	5,380
ANTI-HYPERTENSIVES	\$428,400	12,393
ANTI-DEPRESSANTS	\$318,181	9,935
ULCER DRUGS	\$262,231	7,579
DERMATOLOGICALS	\$249,405	7,059
THYROID AGENTS	\$247,185	5,063
ASSORTED CLASSES	\$227,490	220
ANTI-INFECTION AGENTS - MISC.	\$207,000	2,808
ANALGESICS - OPIOID	\$202,432	5,119
GASTROINTESTINAL AGENTS - MISC.	\$177,589	894
URINARY ANTISPASMODICS	\$139,345	1,118
ANALGESICS - ANTI-INFLAMMATORY	\$128,992	4,419
CARDIOVASCULAR AGENTS - MISC.	\$126,881	543
BETA BLOCKERS	\$122,446	8,525
ANTI-PSYCHOTICS/ANTI-MANIC AGENTS	\$112,785	2,333

Commercial SFY 2020 Year over SFY 2021 Year Patient Increases

Drug Therapeutic Class	Increase in Patient Paid Amount	Count of Patients Difference
DERMATOLOGICALS	\$1,962,859	-8,162
ANALGESICS - ANTI-INFLAMMATORY	\$1,346,350	-5,471
ENDOCRINE AND METABOLIC AGENTS - MISC.	\$549,976	-754
MIGRAINE PRODUCTS	\$362,487	-244
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS	\$308,304	-2,578
ADHD/(ANTI-MARCOLEPSY)/(ANTI-OBESITY)/(ANOREXIA)	\$146,673	-551
RESPIRATORY AGENTS - MISC.	\$138,903	-21
VASOPRESSORS	\$96,728	238
VAGINAL PRODUCTS	\$76,275	-267
MEDICAL DEVICES	\$75,399	-2,950
CHEMICALS	\$39,477	84
ANTI-PSYCHOTICS/ANTI-MANIC AGENTS	\$22,816	-2,338
ANTIEMETICS	\$21,871	-3,643
GASTROINTESTINAL AGENTS - MISC.	\$20,994	-790
DIGESTIVE AIDS	\$10,922	-115
ASSORTED CLASSES	\$9,345	-36
BIOLOGICALS MISC.	\$8,325	6
AMINOGLYCOSIDES	\$1,993	27
ALTERNATIVE MEDICINES	\$1,940	169
NUTRIENTS	\$75	10

APPENDIX P – AHIP: ADDRESSING HIGH PRICED DRUGS



Addressing High Priced Drugs

New Hampshire Prescription Drug Affordability Board
May 23, 2022
Sergio Santiviago, Vice President, Drug Policy



About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Where Does Your Health Care Dollar Go?



Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive and improves health care affordability, access and quality for everyone. **Here is where your health care dollar really goes.**

This data represents how commercial health plans spend your premiums. This data includes employer-provided coverage as well as coverage you purchase on your own. Data reflects averages for the 2016-18 benefit years. Percentages do not add up to 100% due to rounding.
Content and Design: AHP—All Rights Reserved. © 2019 AHP



<https://www.ahip.org/resources/where-does-your-health-care-dollar-go>

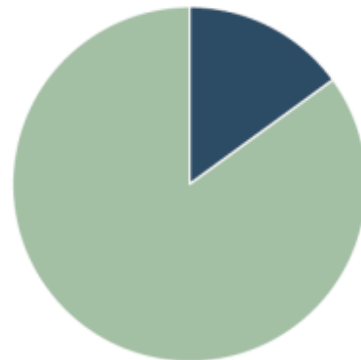
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Medical Loss Ratio

Health Plan MLR

Administrative Costs:

- Customer service lines
- Websites & online consumer tools
- Provider engagement
- Pharmacy benefits management
- Fraud & abuse prevention
- Accreditation costs & compliance with state laws
- Agent & broker commissions
- Operating costs (salaries, facilities, IT)
- Marketing and enrollment
- Claims administration



Medical Costs:

- Doctor's visits
- Other health care provider visits (i.e. physical therapy)
- Hospital stays
- Prescription drug costs (net rebates)
- Medicaid equipment and supplies
- Quality Improvement activities

If 85% MLR is not met, health plans provide rebates to policyholders

■ Large Group Admin Costs (15%) ■ Medical Costs (85%)

Small Group & Individual MLR is 80:20

4

What Drives High Drug Prices: Four Themes



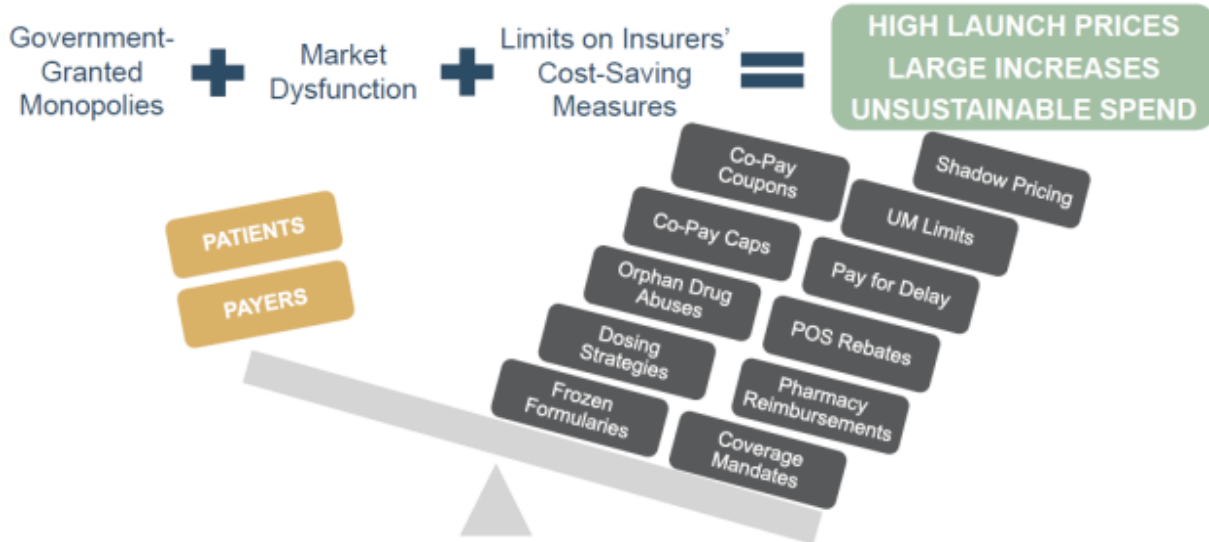
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What Does NOT Drive Higher Drug Prices: Rebates

- Health insurance providers are Americans' bargaining power, negotiating lower drug costs for everyone. Insurers pass on those savings directly to consumers through lower out-of-pocket costs and premiums.
- Some claim that negotiating for lower drug costs for millions of Americans makes drug prices go up. Common sense – and a growing body of research – says that's not true.
- Drug manufacturers only offer rebates to drugs that have competition so they can get better placement on formularies and be prescribed to more patients.
 - The most expensive drugs – those that have no competition – do not offer rebates.
- A recent [analysis](#) compared price increases for rebated and non-rebated drugs and found that price increases were roughly the same for both groups, so rebates were not driving higher price increases.
- The U.S. House Oversight Committee's multi-year [Drug Pricing Investigation](#) also concluded:
 - "This data, which has never before been shared with the public, **undermines industry claims that price increases are primarily due to increasing rebates and discounts paid to pharmacy benefit managers (PBMs).**"
 - "In addition, documents show that **PBMs secured contractual provisions that disincentivized drug companies from raising list prices. Without those provisions secured by PBMs, drug companies likely would have raised list prices more.**"

6

Other Factors Driving High Costs for Patients



7

Case Study: Copay Coupons

The House Oversight Committee's [Drug Pricing Investigation](#) found that drug makers use patient assistance programs as a sales tool – focusing on their rates of return, encouraging patients to stay on branded drugs, and subsidizing third-party foundations to drive sales and attract patients who otherwise might not have used the high-priced drug.

The Committee stressed that these programs “do not provide sustainable support for patients and do not address the burden that the company’s pricing practices have placed on the U.S. health care system.”

Studies prove that these promotions are used to increase sales, fueling increased drug spending.

- Drugs with coupons had a higher annual price growth (12-13%) than drugs without coupons (7-8%).
- Drug makers use coupons to keep prices high, even after lower-cost generics come to market. After a generic alternative entered the market, coupons increased spending on branded drugs by \$30-\$120 million per drug over 5 years.
- For one cancer treatment, one manufacturer projected a potential rate of return of \$8.90 for every \$1 spent on their copay assistance program.
- A National Bureau of Economic Research [working paper](#) studied MS drugs to estimate the broader impact of coupons and found:
 - Coupons raise negotiated prices of multiple sclerosis drugs by 8% and results in just under \$1 billion in increased U.S. spending annually.
 - Combined, the results suggest coupons increase spending on couponed drugs without bioequivalent generics by up to 30 percent.

8

Other Proposals That Perpetuate a Broken Market

Copay Caps

- Sets a maximum or fixed amount for a patient's cost sharing for a drug
- Balloon effect – may bring temporary relief to one patient while raising costs of other services and premiums for all
- Does nothing to address the underlying cost of the drug but instead empowers drug companies to raise their prices even more because there's less public visibility

Frozen Formulary

- Prohibits removal of a drug from a formulary or moving it to a higher cost tier
- Plans cannot replace drugs with new, clinically appropriate, and less expensive alternatives
- Health plans are committed to providing notice and alternatives for consumers when there is a change in formulary

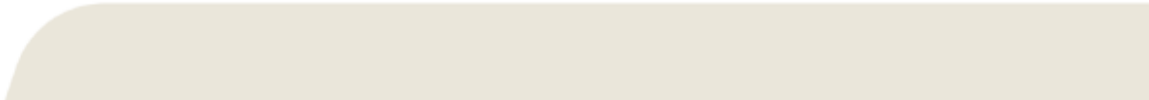
Point of Sale Rebates

- Requires rebates to go to specific patients at the pharmacy counter
- Insurers already pass on negotiated savings directly to consumers through lower out-of-pocket costs and/or premiums
- Delivering rebates to a small number of patients means taking those savings away from all consumers that receive them today
- Focusing on how savings are distributed is a deliberate tactic to avoid addressing the more serious issues surrounding the lack of competition, transparency, and accountability in drug pricing

9

Physician-Administered Specialty Drugs

A double-whammy of high prices and exorbitant markups



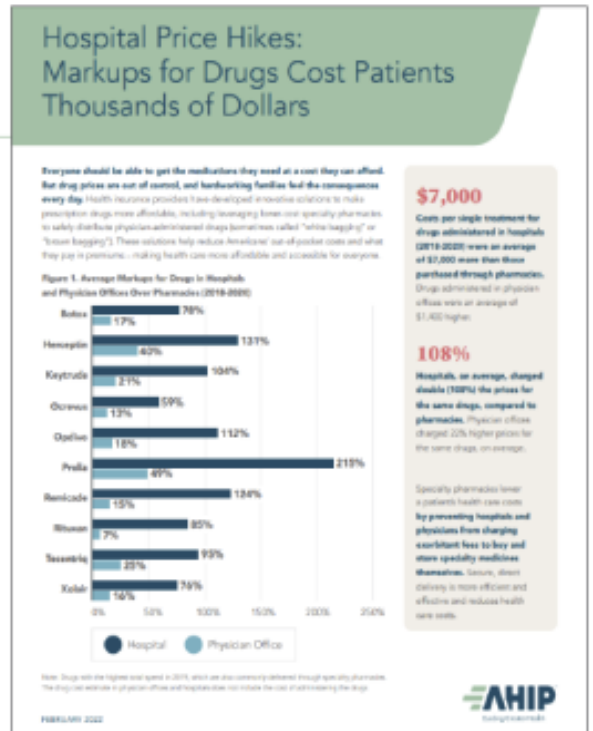
What are physician-administered drugs?

- Physician-administered drugs are those that cannot be self-administered by the patient or a caregiver. These drugs are typically infused or injected by a health care provider in a physician's office, clinic, infusion center, or hospital.
- These are commonly specialty drugs – high-priced medications that treat complex, chronic, or rare conditions (e.g., cancer, multiple sclerosis, rheumatoid arthritis) that commonly have special handling and/or administration requirements.
- The number and price of specialty drugs have rapidly increased in recent years. The price of a specialty drug can range from thousands to tens of thousands of dollars per regimen.
 - [AARP](#): In 2020, specialty drugs were 13x more expensive than brand prescription drugs
 - [JAMA](#): Specialty drugs are a leading contributor to drug spending growth
- Traditionally, these drugs are provided by hospitals or physicians' offices who purchase these drugs directly from the wholesaler and then bill the health insurer for both the drug and the administration cost.
 - This practice (often called "buy and bill") is wasteful and expensive for everyone except for the hospitals and doctors who are administering these drugs at their sites of care
 - As noted recently by the Journal of the American Medical Association (JAMA), under buy-and-bill practice, "physicians and hospitals face limited incentives to mitigate spending." ([JAMA](#))

11

The Result: Exorbitant Markups

- AHIP recently released a [study](#) that analyzed the cost of 10 physician-administered drugs. The study found:
 - Hospitals, on average, charged double for the same drugs, compared to specialty pharmacies. On average, physician offices charged 22% more for the same drugs.
 - Costs per single treatment for drugs administered in hospitals were an average of \$7,000 more than those purchased through specialty pharmacies. Drugs from physician offices were an average of \$1,400 higher.
- AHIP's findings confirm similar studies by other well-respected publications:
 - [JAMA Internal Medicine](#) (2021): The median negotiated prices for the 10 drugs studied ranged from 169% to 344% of the Medicare payment limit.
 - [Bernstein](#) (2021): Some hospitals mark up prices on more than two dozen medicines by an average of 250%.
 - [The Moran Company](#) (2018): Most hospitals charge patients and insurers more than double their acquisition cost for medicine. The majority of hospitals markup medicines between 200-400%.



Drug-by-drug breakdowns from AHIP study included in Appendix.

12

What are health plans doing to address high specialty drug costs?

- To combat the growing price of specialty drugs and exorbitant facility markups, payers (including public and private employers) are adopting innovative solutions to provide patients access to these expensive medications at lower costs.
- This includes contracting with specialty pharmacies to distribute these physician-administered drugs at lower costs.
 - **White bagging:** specialty pharmacy ships a patient's prescription directly to the provider (i.e. hospital or physician office) where it is held until the patient arrives for administration of the medication.
 - **Brown bagging:** specialty pharmacy ships the drug directly to the patient, who then brings the medication to the physician for administration.
 - In both programs, the health plan pays the provider for the service of administering the medication.

Health plans only use white or brown bagging when the drugs can be safely dispensed this way and only when the patient is an appropriate candidate for such forms of dispensing.

13

How does white & brown bagging help patients?

- **Lower Cost:** According to the AHIP study of physician-administered drugs commonly dispensed by specialty pharmacies, the hospital markup can be as much as \$19,000 over the specialty pharmacy price for one MS drug.
- **Seamless:** These programs are designed to be totally seamless and invisible to the patient. Thousands of patients successfully receive their drugs through brown and white bagging each year without issue.
- **Care Coordination:** Specialty pharmacies work with providers to ensure a seamless experience for patients and many health plans and specialty pharmacies provide patients and providers with 24/7 access to clinical specialists to provide additional support.
- **Protect Patient Safety:** Specialty pharmacies must meet extremely stringent safety requirements –they are subject to the same “supply chain safety” requirements as any other dispensing pharmacy but must also meet additional FDA requirements and additional accreditations. Specialty pharmacies employ sophisticated supply chain processes to ensure products shipped are equipped in packaging able to withstand adverse weather conditions for days after delivery.
- **Safeguards:** Health plans build in additional safety features and exceptions processes into their programs to ensure that there are no safety issues or delays in care for patients.

14

What are states doing to mitigate high specialty drug costs?

- Specialty drugs should be included in any consideration of drug price growth.
- Several states have adopted specialty pharmacy programs in their public employee programs with strong, positive results:
 - In a report from Indiana’s Department of Health, Purdue University detailed its history of cost saving with white bagging:
 - In January 2020, Purdue University began white bagging by carving out specialty drugs for employees to a single pharmacy benefit manager. The carve out **started with a single drug and resulted in a savings of more than \$179,000 over that year.** Per Purdue’s report, patient safety was not sacrificed.
 - The second round of prescriptions carved out resulted in savings of over \$100,000 within the first four months of transition.
 - **As of January 1, 2021, Purdue gained approval from the Indiana State Budget Director to move all specialty drugs to their PBM; this strategy saved them \$2.5 million on specialty medications in the first quarter of 2021.**
 - According to the report, “As with many transitions, disruptions did occur. Purdue reports that communication to providers and members was not as initially robust as it should have been. This was remedied, and a new communication process was implemented. This improved communication process resolved most concerns for members and providers.”

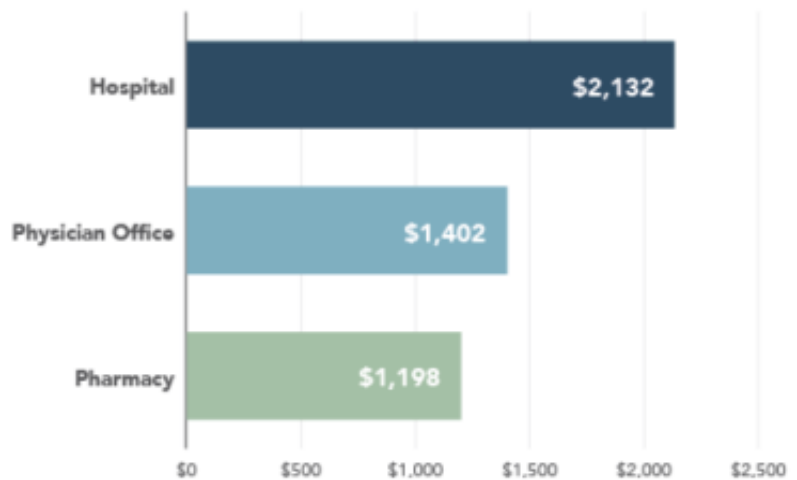
Appendix

BOTOX

- **US Sales (2020):** \$1.2 billion (excludes cosmetic use)
- **Manufacturer:** AbbVie
- **Indications:** chronic migraine, overactive bladder, incontinence, cervical dystonia, spasticity, hyperhidrosis
- **Average Markup Over Pharmacy (per single treatment):**
 - Physician Office: \$200 (17%)
 - Hospital: \$900 (78%)

Source: IBM Commercial Database, SEC, FDA
Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)



HERCEPTIN

- **US Sales (2020):** \$1.4 billion
- **Manufacturer:** Roche
- **Indications:** cancer (various)
- **Average Markup Over Pharmacy (per single treatment):**
 - Physician Office: \$1,900 (40%)
 - Hospital: \$6,100 (131%)

Source: IBM Commercial Database, SEC, FDA
Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)

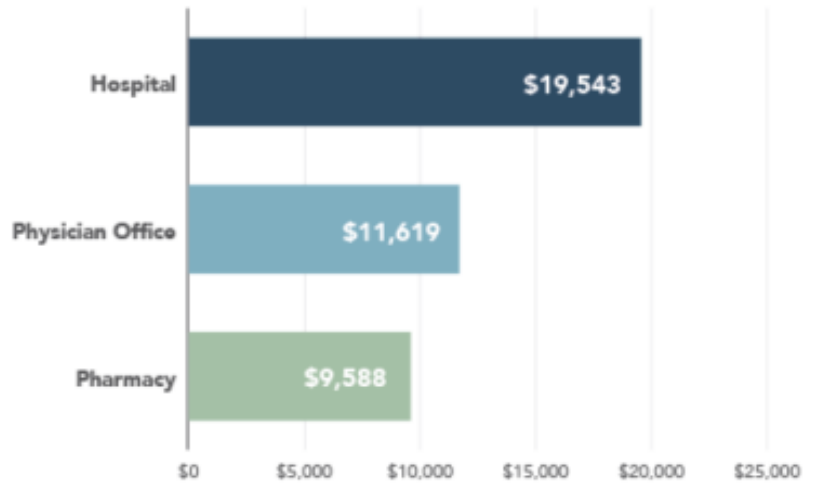


KEYTRUDA

- US Sales (2020): \$8.4 billion
- Manufacturer: Merck
- Indications: cancer (various)
- Average Markup Over Pharmacy (per single treatment):
 - Physician Office: \$2,000 (21%)
 - Hospital: \$10,000 (104%)

Source: IBM Commercial Database, SEC, FDA
Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)

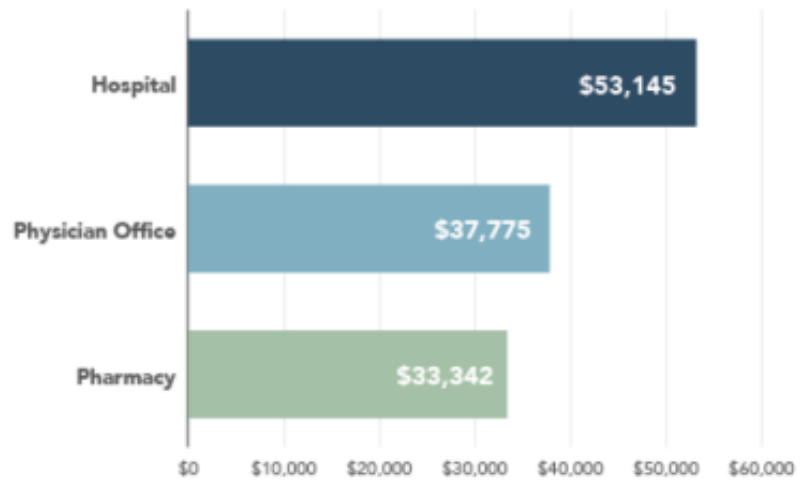


OCREVUS

- US Sales (2020): \$3.6 billion
- Manufacturer: Roche
- Indications: multiple sclerosis
- Average Markup Over Pharmacy (per single treatment):
 - Physician Office: \$4,400 (13%)
 - Hospital: \$19,800 (59%)

Source: IBM Commercial Database, SEC, FDA
Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)

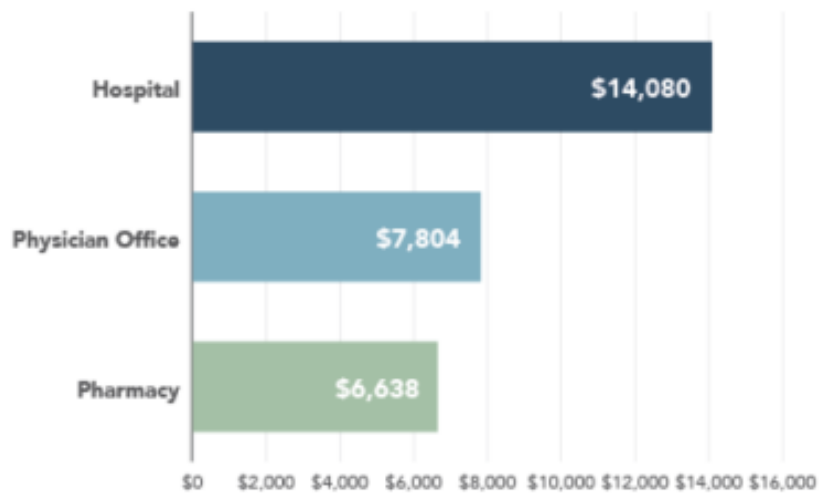


OPDIVO

- **US Sales (2020):** \$3.9 billion
- **Manufacturer:** Bristol-Myers Squibb
- **Indications:** cancer (various)
- **Average Markup Over Pharmacy (per single treatment):**
 - Physician Office: \$1,200 (18%)
 - Hospital: \$7,400 (112%)

Source: IBM Commercial Database, SEC, FDA
 Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)

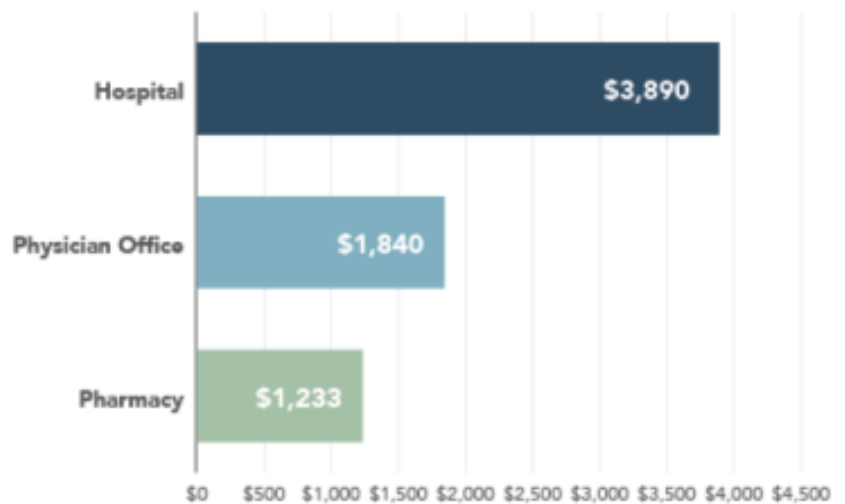


PROLIA

- **US Sales (2020):** \$1.8 billion
- **Manufacturer:** Amgen
- **Indications:** osteoporosis
- **Average Markup Over Pharmacy (per single treatment):**
 - Physician Office: \$700 (49%)
 - Hospital: \$2,700 (215%)

Source: IBM Commercial Database, SEC, FDA
 Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)

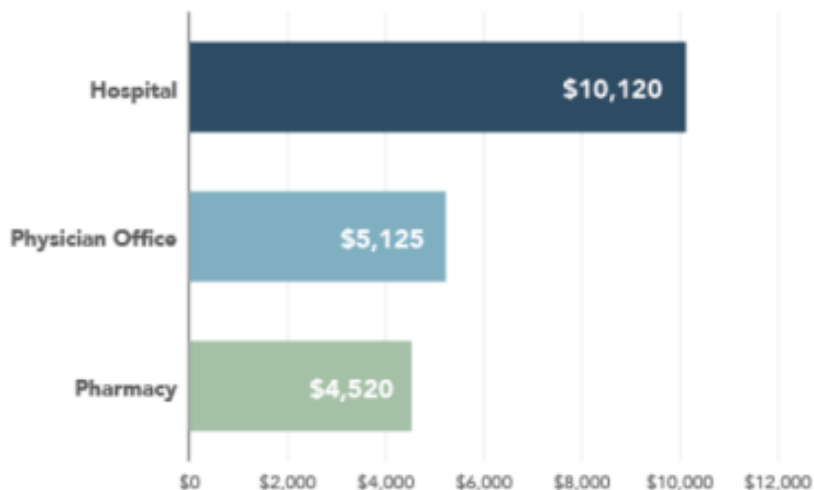


REMICADE

- **US Sales (2020):** \$2.5 billion
- **Manufacturer:** Johnson & Johnson
- **Indications:** rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, plaque psoriasis, and ulcerative colitis
- **Average Markup Over Pharmacy (per single treatment):**
 - Physician Office: \$700 (15%)
 - Hospital: \$5,600 (124%)

Source: IBM Commercial Database, SEC, FDA
 Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)

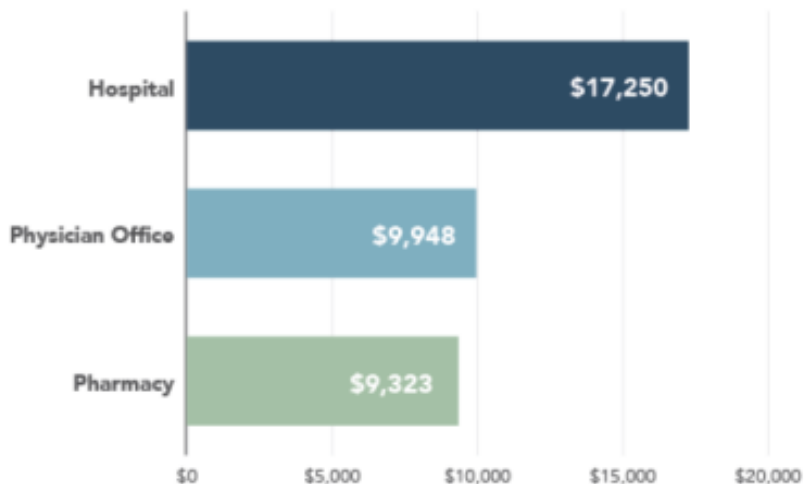


RITUXAN

- **US Sales (2020):** \$3.0 billion
- **Manufacturer:** Roche
- **Indications:** rheumatoid arthritis, cancer (various)
- **Average Markup Over Pharmacy (per single treatment):**
 - Physician Office: \$600 (7%)
 - Hospital: \$7,900 (85%)

Source: IBM Commercial Database, SEC, FDA
 Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)

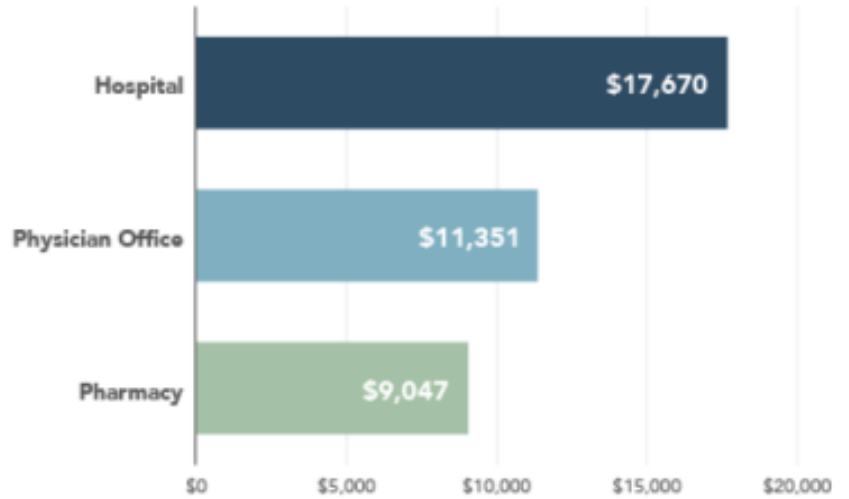


TECENTRIQ

- US Sales (2020): \$1.7 billion
- Manufacturer: Roche
- Indications: cancer (various)
- Average Markup Over Pharmacy (per single treatment):
 - Physician Office: \$2,300 (25%)
 - Hospital: \$8,600 (95%)

Source: IBM Commercial Database, SEC, FDA
 Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)

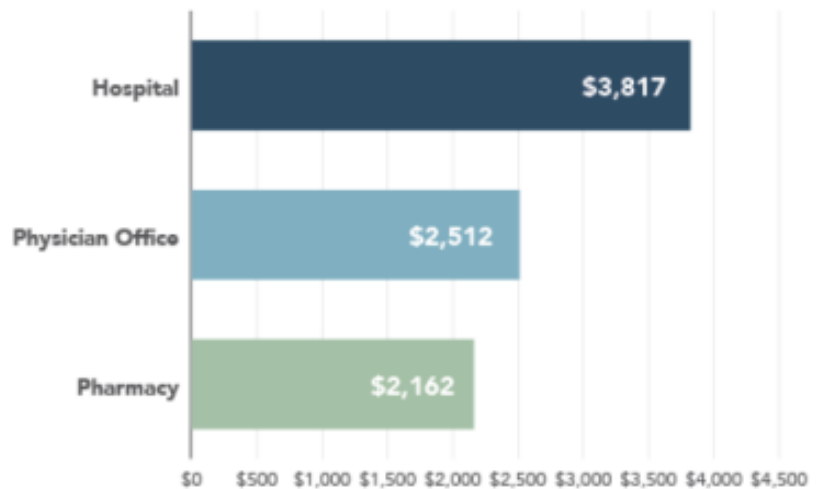


XOLAIR

- US Sales (2020): \$2.0 billion
- Manufacturer: Genentech & Novartis
- Indications: asthma
- Average Markup Over Pharmacy (per single treatment):
 - Physician Office: \$350 (16%)
 - Hospital: \$1,700 (76%)

Source: IBM Commercial Database, SEC, FDA
 Methodology: www.ahip.org/documents/202202-AHIP_1P_Hospital_Price_Hikes.pdf

Average Cost Per Single Treatment (2018-2020)



APPENDIX Q – NCPA: COMMUNITY PHARMACY’S ROLE IN ADDRESSING DRUG PRICES

Community Pharmacy’s Role in Addressing Drug Prices

New Hampshire Prescription Drug Affordability
Board

Matthew Magner, JD
Director, State Government Affairs



What differentiates our members

As community-based healthcare professionals and entrepreneurs, independent pharmacists are uniquely positioned to customize solutions to healthcare challenges affecting local communities and employers.





Profile of Community Pharmacists

- 19,400 pharmacies nationwide
- 18 independent community pharmacies in New Hampshire
- Local employers
 - Contribute to the tax base
 - Provide civic leadership
- 80% located in areas with populations <50,000
 - Essential health care providers in underserved areas
 - Local health care problem solvers
- Community pharmacists are the most accessible health care providers
 - Patients visit community pharmacists almost twice as often as physicians or other health providers.
(<https://www.jmcp.org/doi/pdf/10.18553/jmcp.2022.28.1.85>)



Drug costs concerns at the pharmacy

- Formulary issues: generic vs. brand drugs
- Narrow networks limiting access to community pharmacies
 - “On average, retail pharmacies provide lower generic drug costs than do mail-order pharmacies and higher rates of generic substitution.”
(<https://www.commonwealthfund.org/publications/issue-briefs/2021/aug/role-pharmacies-making-drug-purchasing-more-efficient>)
- Differences in reimbursements: affiliated vs. non-affiliated pharmacies
 - Florida Medicaid audit found MCO/PBM-owned pharmacies were reimbursed at higher rates than non-affiliated pharmacies for dispensing the same specialty drugs.
- Price concessions, rebates, and retroactive clawbacks: where do they go?





What can be done?

- Formulary issues
 - Ensuring pharmacists have the authority to work with patients and prescribers to find more affordable alternatives, even if its paying cash.
- Protect patient choice
 - Any willing pharmacy: 28 states
 - Anti-mandatory mail order provisions: 31 states
- Addressing reimbursements to affiliated pharmacies
 - 12 states have laws on the books



What can be done?

- Increased pharmacy reimbursement transparency
 - Reports to plan sponsors
 - Addressing spread pricing
- Remove retroactive reimbursement adjustments
 - Retroactive clawbacks and adjudication fees artificially inflate costs for those in deductible phase
 - Part D change to DIR fees in 2024
- Rebate passthrough
 - WV: rebates must be passed through to patient at the pharmacy counter





Expand the pharmacist's role

- Patients see pharmacists more than any other provider
 - Great opportunity to provide wide array of services beyond dispensing
- Two obstacles
 - Authority to practice at the top of their license
 - Means of reimbursement
- Expanding the pharmacist's role has direct benefits to patient outcomes.
 - Increased vaccination rates (<https://www.pharmacytimes.com/view/pharmacists-rise-to-the-challenge-of-expanded-roles>)
 - Promotion of value-based care (<https://www.commonwealthfund.org/publications/issue-briefs/2021/aug/role-pharmacies-making-drug-purchasing-more-efficient>)



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