February 21, 2019

An Open Letter to the House Business and Labor Committee Regarding House Bill 267

Dear Chair Dunigan, Vice Chair Malloy, and Members of the Committee:

On behalf of National Taxpayers Union (NTU), I write to offer our comments on House Bill 267, which we understand has been scheduled for a hearing today before the Committee. This bill would establish a state-level prescription drug importation program under certain conditions. As many of you may know, NTU has in the past worked with lawmakers in your chamber, on your Committee, as well as the sponsors of this legislation to protect the taxpayers of Utah. It from this position of great respect that we offer the following views and concerns on important programs based on NTU's decades of institutional experience at the federal and state levels. As a nonpartisan taxpayer organization, we intend to focus on the fiscal aspects of importation.

HB 267 begins from a challenging premise – that the Utah Department of Health design its own importation program from Canada that will "comply with existing state and federal law [e.g., 21 U.S.C. 384]; and … reduce the risk to the public's health and safety; and … [compile] an estimate of the reduction in the cost of covered products and health insurance premiums to Utah consumers." Yet, since 21 U.S.C. 384 was modified in 2003 to permit importation under certain conditions, no U.S. Secretary of Health and Human Services has certified that federal importation could occur without endangering public health and with cost savings to consumers. Furthermore, federal law did not envision individual state pathways to developing importation. The very process of a state attempting to implement importation on its own through an "application" to the federal government therefore carries immediate administrative and potentially legal costs.

Ensuring consumer safety likewise carries a considerable financial burden to government agencies, and therefore taxpayers. In 2004, a Department of Health and Human Services report estimated that approximately 10 million packages entered the United States with imported prescription drug products; developing a federal regime to screen all these packages for safety would add up to nearly $3 billion—or approximately the total potential savings from an importation regime, according to the Congressional Budget Office (CBO). It would be a mistake to assume that some 15 years later, improvements in tracking, testing, and monitoring shipments have erased these costs. The significant outlays necessary to preserve the integrity of the pharmaceutical supply chain – especially due to the proliferation of counterfeit Internet pharmacies – could still easily overwhelm whatever price breaks drug importation could produce nationwide or in Utah. Policing transshipments that might be sent from Canada but actually manufactured elsewhere would remain difficult. Interestingly, not even the association representing U.S. pharmaceutical wholesalers, some of whose members would presumably benefit by the contracted portion of the proposed Utah program, has endorsed importation.

We would also note that the net impact of importation on consumers – and in the case of Utah's Medicaid and state employee insurance programs, taxpayers – remains uncertain, despite being informed by other states' generally negative experiences. Illinois, for example, terminated its importation program in 2008 after fewer than 4,000 residents availed themselves of the services. More recently, in December 2018, importation advocates hailed a report from Vermont's Agency of Human Services (AHS) which claimed that a wholesale Canadian-oriented importation regime there could allow commercial insurers to "see savings of between $1-5 million dollars." Yet, that same report also noted that administration of such a program "would likely come at

substantial cost to the state, requiring upfront investment and appropriations." Such funds could not be raised painlessly through taxes on the pharmaceutical industry, which would then be left with unappetizing choices of passing along the cost to other customers, reducing research or employee benefits, or cutting returns to shareholders (many of whom are, ironically, institutional entities such as state pension funds). On the question of whether the benefits of a potential Vermont importation program would outweigh its costs, AHS demurred.

Nonetheless, HB 267 carries with it a fiscal note estimating that Utah's Medicaid program could realize an annual savings of pharmacy costs amounting to $20 million annually. Without the benefit of the methodology behind this fiscal note, it is difficult to evaluate how it might comport with Utah's actual experience. When CBO conducted a cost estimate for a wide-scale importation program in 2003, it projected that federal programs (including Medicaid) would experience savings of roughly 0.5 percent on all their prescription drug expenditures. As CBO commented, one reason for this low figure is that government agencies "already pay among the lowest prices in the market." If anything this trend has accelerated since 2003, with increased penetration of generics as well as increased government domination of drug-market share.

While it is unclear to us how comprehensive the figure is, the Department of Health's Medicaid and CHIP Annual Report indicates that "pharmacy services expenditures" in SFY 2017 amounted to less than $125 million. As the report indicates, this does not include managed care drug expenditures. Yet, even if the "all-in" amount of Utah Medicaid drug costs was $250 million, or $500 million, applying CBO's 0.5 percent factor would yield far lower savings calculations than the $20 million reported with HB 267. It is perfectly understandable that expert analyses can differ with one another. At the very least, however, we recommend your thoughtful exploration of the fiscal note during your hearing.

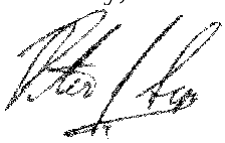
On the other hand, innovator drugs produced for the U.S. market have yielded proven savings for taxpayers. In general, even high-priced pharmaceuticals tend to be a better long-run value because they replace hospital stays, surgeries, recovery therapies, and other costly activities that would have to occur in their place. A National Bureau of Economic Research study put a fine point on this equation, concluding that every dollar spent on prescription drugs leads to a $2.06 reduction in overall Medicare expenditures. The state's Medicaid system is likely benefitting in a somewhat similar fashion.

Even without these practical considerations, importation as a policy is problematic for taxpayers. Voluntarily negotiated rebates could shrink, or other countries' price controls – which already take a heavy toll on private-sector drug research and development – would seep into Utah's health care system. As a recent NTU Policy Paper warned, "importing self-destructive policies from abroad causes collateral damage here at home. That damage extends to, but is not limited to, our own exports, our workers, our shareholders, our efforts to liberalize and strengthen standards of international commerce, and the long-term savings that innovative drug therapies deliver for taxpayer-funded health care programs."

We would recommend that Utah policymakers evaluate alternatives to importation and other strategies relying on artificial price constraints, many of which have been outlined in a recent NTU Issue Brief dated December 6, 2018. Although its recommendations are federally-focused, some could answer to Utah's purposes.

Should you, your colleagues, or your staff have any questions or require any other information as you deliberate the fiscal aspects of health care policy, NTU is at your service. Thank you for your consideration.

Sincerely,



Pete Sepp, President