April 7, 2021

The Honorable Tina Liebling, Chair, Health Finance and Policy Committee
Minnesota Health Finance and Policy Committee Members
Minnesota House of Representatives
477 State Office Building
St. Paul, MN 55155

Re: **HF 2128 – Health Omnibus Finance Bill**
PCMA Testimony in Opposition to
Article 5 Prescription Drugs, Sections 8 – 13, 16, and 21-22

Dear Chair Liebling and Members of the Health Finance and Policy Committee:

My name is Michelle Mack and I represent the Pharmaceutical Care Management Association, commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

PCMA appreciates the opportunity to submit written testimony on HF 2128 which is the Health Omnibus Finance Bill. PCMA respectfully opposes Sections 8-13, 16, and 21-22 of Article 5 – Prescription Drugs. The language in these Sections will increase costs and we have outlined our issues below.

- **Article 5 Sections 8 and 21 – [62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

Our industry has significant concerns relative to the language in these Sections which we refer to as "frozen formulary". We believe this will restrict our ability to put downward pressure on pharmaceutical manufacturers to limit the increase of prescription drug costs and work with our clients to effectively manage formularies on their behalf.

A recently released report by Milliman shows that **this type of policy would cost Minnesota health care payers $75 million over five-years and the state's own analysis of a similar bill this year substantiates this**. PBMs help employers, insurers, and public health programs provide their members access to safe, effective, and affordable medications, but pricing in the drug market is volatile, and there are very few tools to incent drug manufacturers to reduce prices. Formulary placement and financial incentives (i.e., lower cost sharing) to use lower-cost generics and brand alternatives are among those tools. This bill threatens these cost saving mechanisms. If specific drugs are mandated to be covered, brand drug manufacturers have no incentive to provide price concessions on their drugs to make them more affordable for patients.

Significant market forces to drive down the cost of drugs will be eliminated under this bill. For example, imagine that a new generic alternative or competing brand medication were

introduced to the market. Under this language, even if these medications offered fewer side effects, a lower risk profile, or came at a lower cost for consumers, PBMs would be unable to encourage patients to use the new medication; favoring the more expensive brand medication and driving up costs for consumers. When hepatitis C drugs Sovaldi, Harvoni, and other competitors came to market, health insurers and PBMs would not have had the leverage to negotiate the deep discounts—around 40% off the list price—on these very expensive drugs in exchange for placement on the formulary as the preferred drug.

Currently, there are appeals processes which health plans and PBMs have in place for patients to access a non-formulary drug. The health plan or PBM works with a patient and his or her provider to provide access to non-formulary dugs where medically necessary and/or likely to create the best clinical outcome. We believe our appeals processes are fair and responsive. If the exception is allowed to drive the rule, then costs will go up, not down.

PCMA believes that these Sections will raise prescription drug costs for consumers, employers, and health plans. It removes important tools that PBMs use to delivery high quality services to health plans. Rather than protecting patients, 'frozen formulary' bills primarily increase costs.

❍ Article 5 Sections 9, 12, 13 – [62W.0751] ALTERNATIVE BIOLOGICAL PRODUCTS.

❍ Article 5 Section 22 – STUDY OF PHARMACY AND PROVIDER CHOICE OF BIOLOGICAL PRODUCTS.

It has been stated that the goal of the legislation in this Section is to increase the use of biosimilars and thus decrease the cost for consumers. Increasing competition in this evolving market can surely lead to lower costs to Minnesotans. Years ago, the PBM's were instrumental in supporting the Federal law that was enacted to grant the Food and Drug Administration (FDA) the ability to create a framework under which biosimilars and interchangeable biological products can be approved. Today still, we strongly support the increase in development and use of these drugs.

Unfortunately, the stated goal of increasing the use of biosimilars and lowering costs to consumers may not be achieved. The language in this Section *expressly limits PBM tools* (such as formulary development and management) specific to biosimilars—effectively hamstringing PBMs and plans where these tools are needed most. The language in this Section essentially creates an open formulary for these drugs. This will only lead to increased costs because there will be no incentive for the manufacturers of these drugs to compete on price. Biosimilar manufacturing is in its infancy – the existing incentive structure will drive them to get more efficient in their manufacturing capabilities and thus allow them to compete on price, just as happened with generics over the previous decades. While there are currently no interchangeable biosimilars on the market, there are several biosimilars and each year this list grows, which shows that the market is working. It should also be stated that these types of drugs are the largest growing segment of the market, which makes it even more important to get this right. These types of drugs, while may only account for approximately 1% of the utilization, they represent close to 50% of the cost.

It should be noted that public health care programs and the State Employee Group Insurance Plan are exempted from this bill and we wonder why the state would not benefit from the suggested cost savings.

Finally, we appreciate the study language to evaluate the impact of this legislation after the bill has become law. However, it might make more sense to conduct this research and analysis on the front end to determine the intended and unintended consequences on all stakeholders impacted by this bill.

❍ Article 5 Section 10 – [62W.11] GAG CLAUSE PROHIBITION.

PCMA supports the patient paying the lowest amount at the pharmacy counter, and opposes the use of "gag order" contract provisions that prevent in any way a pharmacist from discussing relevant information with a patient–the copay, therapeutic alternatives, over the counter options, and other items that are relevant to a patient's decision about their treatment. In all Medicare Part D plans, patients pay the lesser of their plan's cost-sharing amount or the cash price of the drug (also known as the "usual and customary price") at the pharmacy counter, and as an industry, PCMA member companies support this policy in the commercial market. Health plan members should always pay the best price–be that their copay or the pharmacy's cash price. In 2019, this "gag order" language was enacted as 62W.11 and we are currently awaiting the Department of Commerce to promulgate rules.

Though PCMA supports the patient paying the lowest possible price at the pharmacy, the language in this Section would allow for the disclosure of confidential contract terms that could lead to anticompetitive behavior. The bill language would allow a pharmacist to disclose confidential contract information, without any clear protections. These confidential contract terms serve as an underpinning to competition in the PBM-pharmacy marketplace. If pharmacies can disclose and subsequently compare reimbursements and other confidential information, it would undermine negotiations between PBMs and pharmacies, leading to anti-competitive behavior and potentially higher prescription drug costs for patients and payers. In addition, this legislation ignores the role of Pharmacy Services Administrative Organizations (PSAOs), which bargain on behalf of independent pharmacies and contract with PBMs. These PSAOs are an essential entity in any discussion or requirements around PBM and pharmacy contracts.

In addition, in 2019 62W.06 was enacted which requires numerous disclosures to be made to the plan sponsor, upon their request to the PBM, some of which are listed below:

1. De-identified claims level information in electronic format that allows the plan sponsor to sort and analyze the following information for each claim:
   (i) whether the claim required prior authorization;

(ii) the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;
(iii) any spread between the net amount paid to the pharmacy in item (ii) and the amount charged to the plan sponsor;
(iv) whether the pharmacy is, or is not, under common control or ownership with the pharmacy benefit manager;
(v) whether the pharmacy is, or is not, a preferred pharmacy under the plan;
(vi) whether the pharmacy is, or is not, a mail order pharmacy; and
(vii) whether enrollees are required by the plan to use the pharmacy;

2. The aggregate amount of payments made by the pharmacy benefit manager to pharmacies owned or controlled by the pharmacy benefit manager on behalf of the sponsor's plan.

The pharmacist does not have a contractual relationship with the plan sponsor, so we are not sure what is hoped to be accomplished by allowing pharmacies to have such conversations. Given all the disclosure requirements that are listed above, it seems that anything the pharmacy would hope to provide to the plan sponsor is already something they are aware or can ask on their own. Finally, we are still awaiting the Department of Commerce to promulgate the rules relative to this.

Allowing the pharmacy to talk to patients about reimbursement will only lead to disclosure of confidential contract terms that could lead to anticompetitive behavior. In addition, the plan sponsor already knows or has the ability to request any reimbursement questions that may exist directly from the entity they contract with, which is the PBM.

❍ Article 5 Section 11 – [62W.12] POINT OF SALE.

The language in this Section requires that rebates negotiated by PBMs on behalf of health plan sponsors be applied to a patient's cost sharing at the point-of-sale. **This is a one-size-fits-all mandate and will do little to address the increasing price of drugs and will only serve as a windfall to drug manufacturers.**

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. One way PBMs help consumers obtain lower prices for prescription drugs is through the negotiation of rebates (discounts) with drug manufacturers. Negotiations between PBMs and manufacturers are the only tool available to leverage competition and drive lower drug costs overall. Rebates are typically used to keep costs down across the board as employers and other plan sponsors use the savings from rebates to lower premiums for everyone. While point-of-sale rebates are possible under certain plan designs, the decision to apply rebates at the point-of-sale or as a hedge against rising premiums, is and should be determined by the plan sponsor.

When considering mandatory point-of-sale rebates it is important to keep in mind that:

1. **Rebates have consistently been shown to save consumers money**: Recently, the Centers for Medicare & Medicaid Services (CMS) found that a federal proposal for point-of-sale rebates in Medicare Part D would **increase** premiums by up to **25%** and **increase** drug spending by **$196 billion**.[1]
2. Under the federal proposal, CMS actuaries predicted **manufacturers would keep at least 15%** of what they would have offer in rebates and also found that **drug spending would increase by $137 billion as they would have little incentive to lower their list prices, meaning consumers pay more.**[2]
3. **Mandatory point-of-sale rebates under the federal proposal would provide drug manufacturers a windfall of $40-$100 billion.**[3] The fact that drug manufacturers applauded a federal proposal to restructure rebates should reinforce that manufacturers, not consumers, taxpayers, and employers, would be the real winners.
4. **Point-of-sale rebates won't help the majority of patients who take generics or lower-cost brands.** Most brands do not have rebates; only those that have one or more competitors within the drug's class typically do.[4]

Additionally, mandatory point-of-sale rebates would require releasing confidential information that inadvertently discloses actual rebate amounts. Eliminating this type of confidentiality of rebate levels and undermining the negotiating power held by payers, including employers, would inhibit a PBMs' ability to negotiate a better price for consumers. Finally, the FTC has long noted that, "if manufacturers learn the exact amount of the rebates offered by their competitors…the required disclosures may lead to higher prices for PBM services and pharmaceuticals."[5]

By disrupting competition in the prescription drug market, mandatory rebates, whether at 100% of rebates or less, ultimately will increase the prices that all pay for health care and prescription drugs.

o Article 5 Section 16 – [151.335] DELIVERY THROUGH COMMON CARRIER; COMPLIANCE WITH TERMPERATURE REQUIREMENTS.

For PCMA and its member companies, the safety and efficacy of mailed prescriptions is of utmost importance and is well reflected in the level of precision and planning undertaken by

[1] CMS Office of the Actuary, "Proposed Safe Harbor Regulation" (August 30, 2018).
[2] A recent study, *Reconsidering Drug Prices, Rebates, and PBMs*, shows manufacturers alone set prices—independent of rebates. The study highlights top-selling Medicare Part D brand-name drugs (with steady price increases and no change in rebate levels) and Medicare Part B drugs, which have no negotiated rebates but extraordinary price increases.
[3] Ibid. CMS (August 30, 2018).
[4] Milliman, "Prescription Drug Rebates and Part D Drug Costs." (July 16, 2018). https://www.ahip.org/wp-content/uploads/2018/07/AHIP-Part-D-Rebates-20180716.pdf.
[5] FTC, "Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts.

mail-service pharmacies in the mailing of prescription drugs, including those with special handling requirements such as hemophilia, HIV, and cystic fibrosis medications.

There are federal laws that ensure prescription drugs delivered through the mail are safe for patients. In addition, the Minnesota Board of Pharmacy has oversight of all licensed pharmacies – this includes both in-state and out-of-state. The Board has very specific rules and regulations on prescription delivery which include a process a pharmacy is to use when utilizing the United States Postal Service or other common carriers to deliver a prescription drug. This includes ensuring safe delivery and compliance with temperate requirements as well as providing information to a patient on what they should do if the integrity of the medication they received is compromised in a shipment.

Thank you for your time and consideration and please contact me should you have any questions.

Sincerely,

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