Testimony of

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Madam Chair, members of the Committee, my name is Dr. Sarah Derr and I am a pharmacist by training and serve as the executive director of the Minnesota Pharmacists Association.

Thank you for reintroducing this important proposal that Minnesota pharmacy believes can make a difference in patient lives, generate stability for providers serving the over 1.1 million Minnesotans who receive their health care coverage from the State of Minnesota and save the State and ultimately taxpayers millions of dollars. House File 8 would eliminate the Managed Care and commercial pharmacy benefit managers from management of the State of Minnesota's Medical Assistance drug spend and move to a direct fee for service drug spend model. Currently, 28 state Medicaid administrators in the U.S. have implemented a direct fee for service Medicaid drug spend model or cost based transparent model.

An additional 12 states, including Minnesota, are now contemplating the elimination of their state's use of an MCOs to manage their Medicaid drug spend. Today Minnesota has about 75-80% of the MA drug spend management under contract with PBMs through their MCOs. This legislation envisions the State of Minnesota moving to direct fee for service drug spend model that would cover all beneficiaries who have MA health insurance.

One example is West Virginia where the Medicaid agency started managing the Medicaid managed care prescription drug benefit directly in July 2017, an actuarial study forecasted a $30 million savings for the state. We now know from the West Virginia Bureau for Medical Services report, West Virginia actually saved $54.4 million for the first year and continued to save in 2020.

Recent studies of Medicaid managed care programs in Ohio and New York as well as a scathing state auditor's report in Pennsylvania have indicated that PBMs are overcharging taxpayers for their services in Medicaid managed care, reimbursing pharmacies low for medications dispensed, billing the state Medicaid program high for the cost of those medications, and retaining the difference, called "spread." Medicaid agencies in Ohio, New York, Georgia, Louisiana, Texas, and Arkansas have moved to eliminate such "spread pricing" in their state

Medicaid programs. In another related cost savings and efficiency effort, twelve states have prohibited spread pricing as of 2020; four states (Arkansas, Kentucky, Nebraska, and Washington) reported plans to eliminate spread pricing in FY 2021; and Maryland indicated that a spread pricing prohibition would take effect in January 2021

The promise that PBMs were going to save states money has not been realized and in fact, based on the 2019 Minnesota Management and Budget fiscal note and the current savings for this proposal in the recently released Governor's budget, we know that the State, Minnesota citizens and health care providers will all do better under this model. The Governor's proposed budget states that they would like to:

"Reduce prescription drug prices statewide:
Under [this] proposal, the Department of Human Services (DHS) will administer the pharmacy benefit for MA beginning in 2023…By moving management of the pharmacy benefit to DHS, the state will have greater visibility and transparency into drug pricing and operations. This new pharmacy program will rely on the state's preferred drug list process, which is established and maintained transparently with consumer-patient and provider input…."

We support HF8's premise and promise, however, any move to a 100% fee for service model will also need to account for patient access and provider compensation. Relying on transparent, reasonable, and mutually agreed on provider reimbursement while keeping the patient's best interest in mind will be essential to a successful, efficient and adequate drug spend for the MA population.

As you are aware, as of July 2019, all managed care organizations and the State's current fee for service drug benefit for Medical Assistance and Minnesota Care are required to use a Uniform Preferred Drug List, managed by the Minnesota Department of Human Services. These changes were designed to assure the most appropriate drug therapy for patients, reduce disruptions in therapy when a patient moves from one plan to another and minimize drug costs to the State.

In closing, we look forward to working with you, your House colleagues, the Governor and the Minnesota Senate to advance this important bill. Thank you and I am happy to answer any questions.