January 30, 2023

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 294 – Requiring Prescription Drug Benefit Transparency and Disclosure ("Frozen Formulary")**
PCMA Testimony in Opposition of HF 294

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 275 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 294 and acknowledges and appreciates Representative Elkins for looking at ways to balance a complicated system. However, our industry has significant concerns about the bill, specifically Article II, Section 3 that is entitled, "Prescription drug benefit transparency and management" or we refer to it 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.

We applaud Representative Elkins for including language that would limit pharmaceutical manufacturers from increasing the wholesale acquisition cost of a drug on a formulary. This shows an acknowledgement that there is a cost association to the frozen formulary portion of this bill. A report recently released by Milliman shows that **this type of policy would cost Minnesota health care payers $75 million over five-years and the in previous legislative sessions, the state's own analysis substantiates this**. Unfortunately, the state does not have the authority to limit what pharmaceutical manufacturers charge. 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.

It should be noted that a drug formulary is a list of drugs that a health plan will cover under a plan sponsor's pharmacy benefit, representing the current clinical judgment of health care providers who are experts in the diagnosis and treatment of a wide range of conditions. There are different types of formularies—open, closed, or tiered—and each type can be customized to meet a specific health plan's objectives. Agreements with manufactures tend to be multi-year, rather than annual, and most manufacturers produce many drugs.

It is also noteworthy that many commercial insurance plan years are rolling. This means that a specific covered life may be added, dropped, or renewed at any point during the year, not just on January 1st. It is important to maintain this flexibility in an effort to control costs for employers, employees, and individuals.

Moreover, while the language of HF 294 would not allow any formulary changes, the A2 amendment (if adopted) would have an exemption for health plans operating that administer Medical Assistance (MA) and MinnesotaCare under Minn. Stat. § 256B.69, as well as county-based purchasing plans (CBPs) under Minn. Stat. § 256L. Both of which allow for formulary changes each calendar quarter. According to the Minnesota Department of Health, this covered life population is equal to over 1 million Minnesotans.

Passage of the language in Article 2, Section 3 of HF 294 would limit the ability to respond when a manufacturer brings a "me too" drug to market, would stifle competition, and incent a manufacturer to raise their price and ride it all year after they are locked in a formulary because the manufacturer would not need to negotiate with the PBM or health plan.

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 HF 294, 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.

In closing, PCMA believes that HF 294 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 such as HF 294 primarily increase costs.

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

Sincerely,

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