March 18, 2025

Chair Robert Bierman
Chair Jeff Backer
Centennial Office Building
St. Paul, MN 55155

Dear Chairs Bierman & Backer, Members of the House Health Finance and Policy Committee:

The Association for Accessible Medicines (AAM) and its Biosimilars Council are writing to express concerns regarding House File 1076. While we appreciate the intent to improve drug affordability and access, we believe certain provisions could unintentionally disrupt well-functioning aspects of the current drug market. Given the complexities of drug coverage and distribution, we respectfully request you consider the following suggestions as the bill progresses.

AAM represents manufacturers of finished generic pharmaceuticals and biosimilars, manufacturers of bulk pharmaceutical chemicals, and suppliers of other goods and services to the generic industry. AAM is committed to ensuring access to safe, quality, and effective medicines. The Biosimilars Council is a leading resource for information on biosimilars, which offer more affordable alternatives to brand-name biologic medicines.

Recommendation: Delete lines 2.14 and 2.20 from Subd. 2, which state, "(2) the wholesale acquisition cost of any other equivalent generic drug."

These provisions require a pharmacy benefit manager (PBM) or health carrier to include in its drug formulary the brand or any equivalent generic drug with the lowest wholesale acquisition cost (WAC). To comply with Subd. 2 (a)(2) and (b)(2) a comparison between the WAC price of competing generic drugs would have to be conducted by the PBM or health carrier. This requirement will not increase patient savings or increase access to lower-cost drugs as intended.

Generic payment rates are effectively managed through Maximum Allowable Cost (MAC) pricing. PBMs and health carriers set MAC prices to reimburse pharmacies for dispensing generic drugs, regardless of the manufacturer. Pharmacies are allowed to select the product, typically based on the lowest available cost, from any manufacturer or distributor. This system fosters competition among generic manufacturers, driving prices down to the benefit of patients. Requiring WAC comparisons would add an unnecessary layer of complexity without a clear benefit.

Recommendation: On line 3.4, delete "or generic drug with the lowest wholesale acquisition cost".

The same concerns stemming from Subd. 2. are contained in this provision. The requirement that a new version of a generic drug be compared with a version already on formulary is unnecessary. The formulary designed by the PBM or health carrier will cover any generic version of the equivalent brand drug regardless of which manufacturer produces it. The new and existing versions of the generic drug compete for market share, which is typically determined by the lowest available cost. This competition results in the deflation of generic drug prices to the benefit of patients.

Recommendation: Delete the first sentence in Subd. 4 (a) and Subd. 4 (b) starting on lines 3.14 and 3.23.

These similar provisions require a PBM or health carrier to structure its formulary to give preference to the generic or biosimilar drug or its reference brand drug with the lowest out-of-pocket (OOP) cost to the patient. This does not consider that variability in patient costs are determined by the coverage or plan design, not manufacturer price. The OOP is not determined until a drug product is added to a formulary and which tier the product is placed.

Recommendation: Substitute language in Subd. 4 (a) and (b) limitations on the use of utilization management tools.

Currently, the bill would prohibit the use of prior authorization or step therapy on the drug product with the lowest WAC price. AAM suggests this be changed to prohibit utilization management tools being used on any drug product with a lower WAC than the brand reference product. This will grant pharmacies and others within the supply chain to select appropriate drug products that present a lower cost for patients.

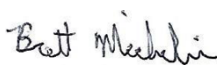
Additional areas of concern: Subd. 2 (c), (d) and Subd. 3 (b) require further study.

The provisions in Subd. 2 (c) and (d) require additional consideration due to differences in the sale and distribution between small molecule and biologic drugs. AAM is currently engaging our members and hope to have additional recommendations as the bill moves through the legislative process. However, AAM suggests you consider requiring "at least one" biosimilar with a lower WAC price than the reference brand drug be preferred on the formulary. WAC prices are transitory and may be changed more often than the formulary they are placed on.

Similar concerns are raised with Subd. 3 (b). Though the marketplace for biologics and biosimilars do not follow the same MAC process for distribution, requiring the lowest priced biosimilar or its reference product that becomes available will cause inconsistent changes to a formulary. The WAC price for a biosimilar can change rapidly to react to competition in the marketplace. Biosimilars and their reference brand biologic drugs are more often utilized at a health care facility than dispensed directly to a patient at a pharmacy counter. Prescribers must write each prescription for a particular biosimilar so having a formulary change every time a WAC is adjusted lower will cause unnecessary confusion.

In conclusion, AAM believes these recommendations will help ensure that House File 1076 achieves its goals without unintended consequences for the generic and biosimilar drug markets. AAM looks forward to working with you on this important issue as it moves through the legislative process, and we appreciate you considering our perspective. Please contact me at brett.michelin@accessiblemeds.org should you have any questions regarding these recommendations or additional concerns raised in this letter.

Sincerely,



Brett Michelin
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Association for Accessible Medicines

https://www.wsj.com/health/healthcare/same-drug-two-prices-why-the-higher-price-prevails-d24038c8

Same Drug, Two Prices: Why the Higher Price Prevails

Patients are paying hundreds of dollars more for a prescription than they would if their health plan chose to cover a lower-priced twin

By Peter Loftus Follow *and Jared S. Hopkins* Follow

Nov. 8, 2023 5:30 am ET

The way medicines are paid for in the U.S. has become so convoluted that some drugmakers are setting two prices for the same drug—and many health plans are choosing to cover the more expensive version.

The decisions mean some patients are paying hundreds of dollars more in out-of-pocket charges to fill a prescription for an identical medicine made by the same company.

Take the widely used insulin Humalog. Eli Lilly sells the drug for $274 a vial, as well as an identical but unbranded version for $25. Half as many Americans have insurance coverage for the less expensive product as for the higher-priced brand, which accounts for 61% of prescriptions.

Kevin Favro, who has Type 1 diabetes, sometimes rationed supplies of Humalog or used expired vials because the drug cost him so much under his health insurance plan. Earlier this year, he paid $630 out of pocket for a 100-day supply to meet his plan's deductible.

"I think it's disgusting how much we have to pay for it," said Favro, a 33-year-old lawyer in Irvine, Calif. After recently discovering he could pay less if he just bought the lower-priced duplicate himself through Amazon.com's online pharmacy, Favro is now paying $105 for a 125-day supply of vials.

For years, doctors and patients have criticized drugmakers for their high prices. The companies have responded, in part, by listing at least 10 drugs at a lower

Kevin Favro switched from taking Humalog for his Type 1 diabetes to a lower-priced duplicate through an online pharmacy. PHOTO: KEVIN FAVRO

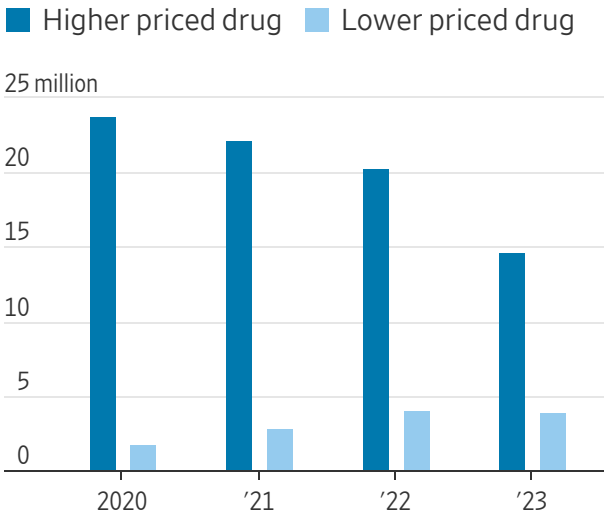
price.

Yet some drugmakers are also keeping the higher price they had been charging. Others are introducing a new drug with two prices simultaneously—one high, one low. And many health plans are choosing the more-expensive version, according to data analysis conducted for The Wall Street Journal.

The reasons reflect how the drug-payment system doesn't work like most markets.

Pricey Preferences

How prescription volumes differ between the higher- and lower-priced options for certain insulins and copies of AbbVie's Humira



Note: 2023 is through Sept. 30
Source: Iqvia

Health-insurance plans that pay for many medicines often use middlemen, called pharmacy-benefit managers, to negotiate how much the plans will pay. Usually, the PBMs ask for rebates from manufacturers in exchange for putting a drug on their list of covered medicines, called a formulary.

A higher-priced drug can result in a bigger rebate to the PBM. Drugmakers say they have to keep offering the costlier versions to gain a favorable spot on the formulary because the PBMs prefer the higher rebates and fees with costlier drugs. The manufacturers say their drugs' lower-priced twins do appeal to hospitals and health systems that pay for the medicines themselves.

PBMs say the rebates can substantially lower the plans' final costs for drugs. Some plans use the rebate money to help keep a lid on premiums for all their members.

For patients like Favro, whose health plans require a deductible or coinsurance, the rebates offer little help because their plans often peg out-of-pocket charges to the drug's list price.

"Patients are overpaying," said Stacie Dusetzina, professor of health policy at Vanderbilt University School of Medicine. "If you have to pay based on the list price, you're probably pretty worried about this."

She said patients should ask their doctors or pharmacists if a lower-priced option is available. There are also services, like GoodRx, that people can use to find the best prices for drugs.

For a sample of the two-priced medicines, about 78% of prescriptions dispensed in September were for the more expensive versions, according to an analysis for The Journal done by prescription tracker Iqvia Holdings.

The analysis included certain insulins and copycat versions of AbbVie's arthritis, skin and gut disorder drug Humira.

Pharmacy-benefit managers say drug companies set their own prices, and plans sometimes choose to cover the higher list price version of a drug because manufacturers' rebates make them cheaper even than the versions with lower list prices.

"We make decisions on what is the lowest net cost to a plan sponsor," said Harold Carter, chief pharma trade relations officer at Cigna Group's Express Scripts. The PBM also offers services aimed at capping out-of-pocket costs for individual patients.

Eli Lilly sells two versions of insulin drug Humalog: one for $274 a vial and an identical but unbranded version for $25. PHOTO: PABLO SALINAS/ASSOCIATED PRESS

Lilly had raised the list price of its Humalog insulin for many years through 2017, drawing criticism from patients and politicians. Yet Lilly said rising rebates paid to PBMs ate up the price increases, and its revenue from the product actually dropped.

In 2019, Lilly introduced the lower-priced, unbranded version, initially at a 50% discount to Humalog. Later Lilly cut the no-name product's price further—most recently to $25 in May.

The company introduced the lower-priced unbranded version to help patients who face high out-of-pocket costs. Lilly has said insurance coverage for the cheaper, unbranded version is lower than for branded Humalog because middlemen still prefer the higher fees and rebates associated with the higher-list-price Humalog.

Express Scripts, one of the country's largest PBMs, added the unbranded version to its list of preferred drugs only after Lilly cut the price all the way down to $25 this spring.

"It makes more sense to have a lower-price version out there, but I think the complexities of the U.S. payer system are what makes this kind of funky," said Stephen Pagnotta, a commercial official at drugmaker Boehringer Ingelheim.

In July, the company rolled out its immune disease drug Cyltezo. In October, Boehringer added a lower-priced version. Now, a two-pack of Cyltezo lists for

$6,577 and $1,350.

Cyltezo is among a handful of drugs that are copycats, or biosimilar versions, of Humira, a widely used brand-name therapy. Humira, from the company AbbVie, was among the world's top-selling drugs before losing patent protection earlier this year.

Humira is priced at $6,922 for a two-pack, or roughly $90,000 a year. It commanded roughly 99% of prescriptions compared with its biosimilar rivals through the end of September, according to Iqvia, even though versions of Cyltezo and some other copycats are priced lower.

All of Cyltezo's prescriptions are for the higher-priced version, Pagnotta said. Boehringer is talking with health plans about adding the less expensive twin to formularies.

Another of the Humira copycats, Amjevita from Amgen, lists for $40,500 or $85,494 a year. Amgen said it set two prices because some drug-benefit managers sought the rebates that come with higher list prices, while it also wanted to ensure patients could get the drug.

More than half of Amjevita's prescriptions filled were for the lower-priced option, Iqvia said.

Write to Peter Loftus at Peter.Loftus@wsj.com and Jared S. Hopkins at jared.hopkins@wsj.com

Appeared in the November 9, 2023, print edition as 'One Drug, Two Prices: Higher Price Wins Out'.

Further Reading

Eli Lilly Plans to Spend $27 Billion on New U.S. Plants