Advisory Task Force on Lowering Pharmaceutical Drug Prices

Why It Matters To Employers

July 23, 2019

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Headlines attest to an extremely dynamic issue…

CNN politics

Drug makers resist pressure from Washington on prices

By Tami Luhby, CNN

Updated 11:48 AM ET, Thu January 3, 2019

CBS NEWS

Big Pharma ushers in new year by raising prices of more than 1,000 drugs

BY AIMEE PICCHI

UPDATED ON: JANUARY 2, 2019 / 6:55 PM / MONEYWATCH

ScienceDaily

Your source for the latest research news

Rising drug prices linked to older products -- not just newer, better medications

Date: January 7, 2019

Source: University of Pittsburgh

Summary: Drug companies

States Rush to Rein In Prescription Costs, and Drug Companies Fight Back

The New York Times

POLITICO

HHS Secretary Alex Azar — President Donald Trump's point person on lowering drug costs — has worked to keep the president on his side amid criticism from the pharmaceutical industry and fellow Republicans. | AP Photo/Alex Brandon

HEALTH CARE

Trump summons advisers to White House over drug price hikes

By DAN DIAMOND, ADAM CANCRYN and SARAH OWERMOHLE | 01/08/2019 12:39 PM EST

FINANCIAL TIMES

Pharma chief defends 400% drug price rise as a 'moral requirement'

Nostrum Laboratories' Nirmal Mulye says he is right to charge as much as possible and slams FDA

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Enter The Action Group: A powerful force for positive change

The Action Group is a coalition of public and private purchasers whose sole purpose is to represent the collective voice of those who write the checks for health care in Minnesota.

Action Group members collaborate with community stakeholders to drive innovations that

- support high-quality health care,
- create engaged consumers,
- and ensure the economic vitality of all Minnesota communities.

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Who we ask

Employers representing diverse industries including education, healthcare, financial services, manufacturing, retail, and other businesses

Who we ask

Cities, Counties, School Districts, and Other Affiliated Organizations

What they say: In their words

- "Ongoing concern is the unsustainable trend…2020 benefit plan year the estimated RX benefit plan expense is 9.5%..results in making benefit coverage less and less affordable for both employees and employers."
- "My main concern is that a highly respected, but very high cost specialty medication - $350,000 - $1,000,000 would be needed by 100 – 200 people and we would have to decide if we could afford to include it on our formulary…"

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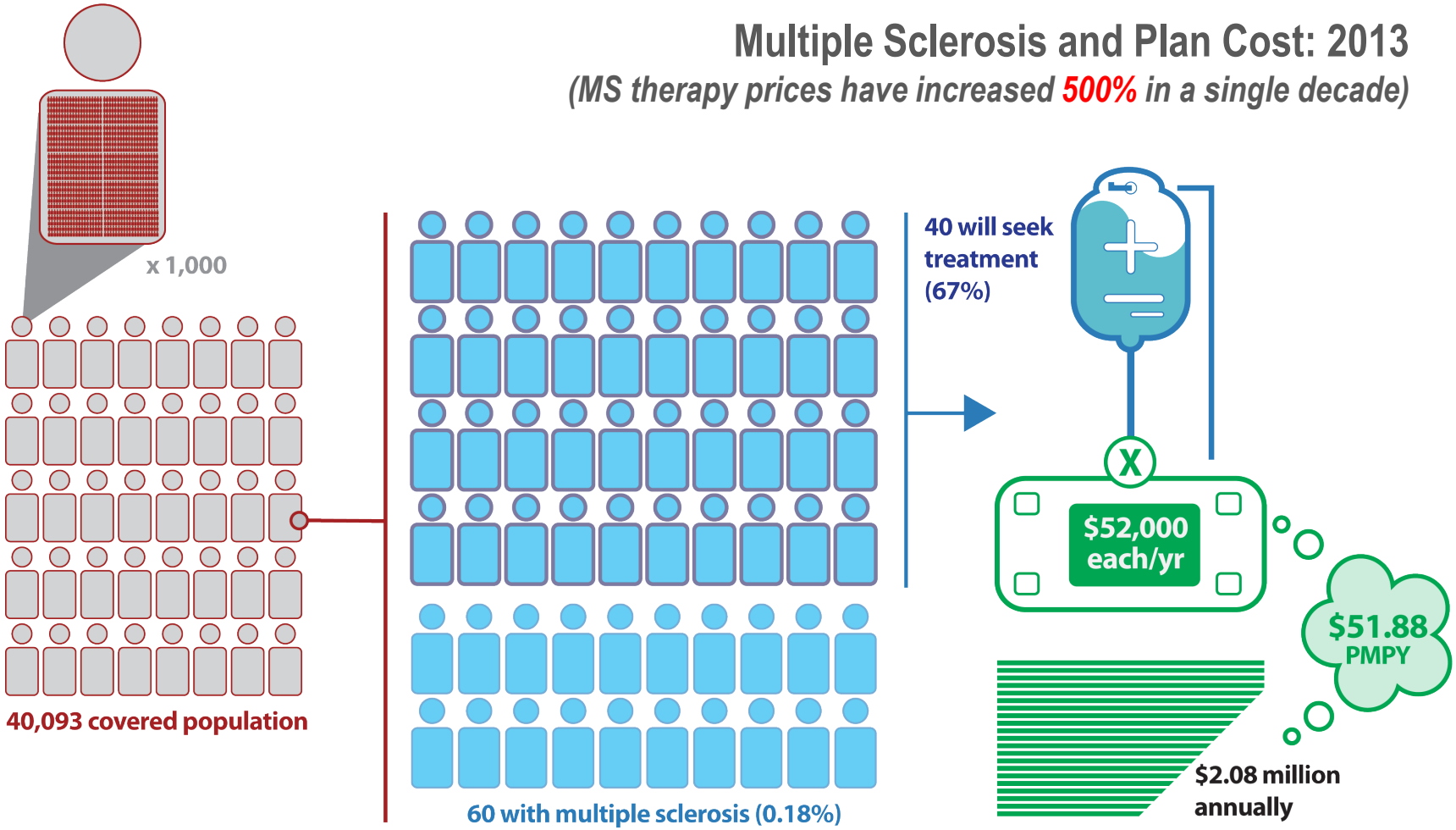
What they say: An illustration



Courtesy of Dr. Stephen Schondelmeyer

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From the Survey: Prescription Drug Copays for Most Popular Copay Plans

All	Generic	Preferred	Non-Preferred	Brand	Specialty
2019 Average Copay	$12	$34	$64	$49	$145
2018 Average Copay	$12	$32	$58	$46	$116
General Industry	**Generic**	**Preferred**	**Non-Preferred**	**Brand**	**Specialty**
2019 Average Copay	$11	$38	$69	$56	$169
Cities, Counties & School Districts	**Generic**	**Preferred**	**Non-Preferred**	**Brand**	**Specialty**
2019 Average Copay	$14	$29	$54	$44	$101

As we've seen in the trend to shift costs to employees, copay levels are up slightly over last year, with the exceptions of generics. Like most plan design components, GI has higher copays than CCS.

Variation in year-to-year results will be partially due to changes in survey participants year-over-year. Please note when making comparisons on a year-over-year basis.

See appendix for Rx plan design detail by employer (de-identified).

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What specialty pharmacy drug tactics do you use or plan to use to control specialty prescription drug costs and utilization?

Use Rank	Category	Currently Using	Implementing	Contemplating	Not Interested	Effectiveness (1-5)	Last Year Use Rank
1	Prior authorization for specific drugs from PBM	68%	0%	14%	13%	3.1	2
2	Prior authorization for specific drugs from health plan	62%	0%	22%	12%	3.1	1
3	Medication Therapy Management	61%	3%	14%	13%	3.3	5
4	Step therapy for specific drugs from health plan	61%	0%	19%	17%	3.1	7
5	Step therapy for specific drugs from PBM	61%	0%	10%	20%	3.3	4
6	Limit supply/partial fill programs	51%	3%	13%	26%	3.5	3
7	Analyze costs by condition, by provider, including medical and prescription specialty drugs	45%	4%	30%	16%	3.2	6
8	Delay or not cover newly approved drugs	33%	4%	22%	32%	3.6	8
9	Limit provider network for diseases with high specialty drug costs	33%	1%	13%	45%	3.3	10
10	Narrow retail pharmacy networks	29%	0%	22%	43%	3.3	11
11	Require health plan to report costs of medical specialty services and drugs by site of care and NDC	28%	3%	39%	22%	3.0	12
12	Specialty pharmacy carve out (direct contract) from PBM	22%	0%	25%	51%	3.5	13
13	Require employer authorization to add drugs to specialty pharmacy distribution list	16%	0%	25%	57%	3.3	18
14	Require employer authorization to change formulary	16%	0%	17%	62%	3.5	15
15	Use of PBA (Pharmacy Benefits Administrator)	16%	0%	17%	59%	3.6	9
16	Require employer authorization to cover newly approved drugs	13%	0%	22%	61%	3.8	16
17	Require employer authorization to change prior authorization or step therapy criteria	13%	0%	20%	61%	3.5	14
18	Purchase stop-loss insurance for specialty pharmacy costs	12%	0%	20%	58%	3.3	17

= “Currently Using” > 50% | “Contemplating” > 20% | “Effectiveness” > 3.5 | Jump 5 spots

Specialty pharmacy carved out from PBM vendors: Acredo (3), Walgreens (2), Fairview (2), Allina, BCBS of MN, CVS, ESI, HP, Prime Therapeutics (4), Rx Mgmt. & Benefit Design Specialists, Thrifty White, captive.

Analyze drugs costs vendors: Prime Therapeutics (5), BCBS of MN (2), ESI (2), HP (2), Medica (2), Fairview, MCPBS, MMA, PreferredOne, Springbuk, OptumRx, captive.

See appendix for breakout by General Industry and Cities, Counties & School Districts.

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Inaction is not an option

Employers pay the bills without knowing exactly what they're paying for.

Higher drug costs are driving up employer, employee, individual, senior, taxpayer costs.

Costs affect Minnesota city, county, state budgets, global competitiveness, and overall vitality of the state and U.S. economy.

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Learning Networks: Investing in knowledge

16 employers and 22 key informants

2,000+ hours and 20+ months

More than 50 potential action items

2 comprehensive Purchaser's Guides

1 international expert advisor *(THANK YOU, Dr. Schondelmeyer!)*

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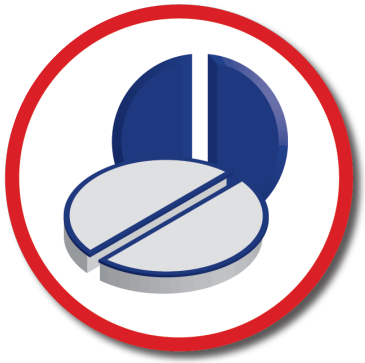
The 5 rights at a high level



Right
DRUG

Right
PRICE

Right
PLACE

Right
PATIENT SUPPORT

Right
DATA

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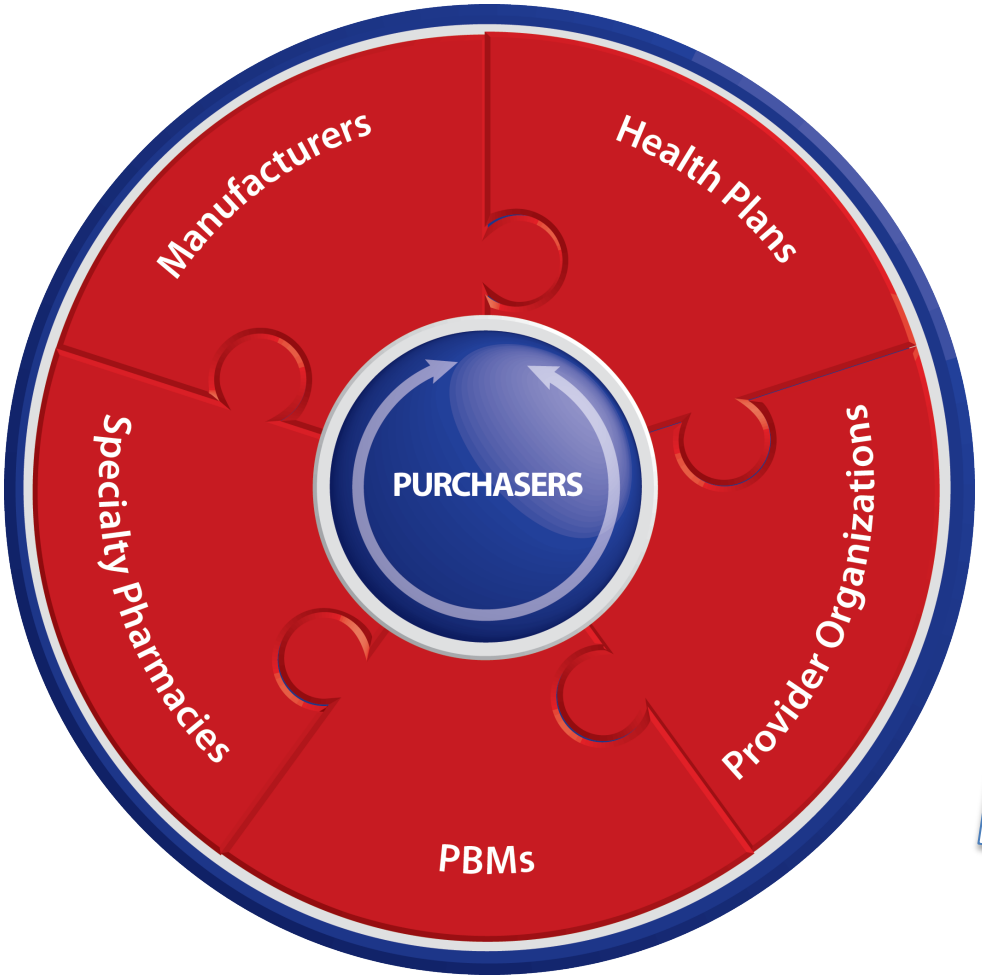
Better together: We're all part of the solution

Our ultimate goal: All stakeholders develop solutions together, holding one another accountable for getting the 5 rights, right.



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Getting the 5 Rights, Right
Right drug, right price, right place, right support, right data

Health Plans

- Require submission of Drug Codes (NDCs), in addition to Healthcare Common Procedure Codes (HCPCs), units, quantity and day's supply by all providers, in all settings; use NDCs for prior authorization, utilization management, payment, collection or rebates, claim-level reporting, data analysis, provider contracts, and patient outcomes.
- Contract with providers to assure cost parity of all sites of care for the same drugs and services.
- Align total cost of care (TCOC) and accountable care organization (ACO) provider contracts so prescribers select and/or administer high-value drugs.
- Involve employers in key decisions* that affect their overall health care costs.

From 2012-2020, spending on specialty drugs is expected to increase 361%.
Source: PwC Health Research Institute: Behind the Numbers 2015 and analysis of CVS Caremark Data.

Provider Organizations

- Include actual NDCs (in addition to HCPCs), units, quantity and day's supply by all providers in all settings; use NDCs for prior authorization, utilization management, payment, collection of rebates, claim-level reporting, data analysis, provider contracts, and patient outcomes.
- Include cost parity across all sites of care for the same drugs and services in all contracts.
- Align TCOC/ACO contract incentives to include drugs so practitioners select and/or administer high-value drugs.
- Ensure practitioners know drug prices (what employers and consumers pay) at the point of care to support use of high-value drugs.

Specialty drug costs affect Minnesota city, county, state budgets, global competitiveness, and overall vitality of the state and U.S. economy.

Pharmacy Benefit Managers (PBMs)

- Accept fiduciary responsibility (ERISA definition).
- Ensure a level of financial transparency, so purchasers know exactly how their money is being spent.
- Provide complete claim-level reporting, including all data fields, for employer ad hoc analysis.
- Involve employers in key decisions that affect their overall health costs.

*Additions to the specialty drug list, pre-FDA approval pipeline management, dramatic drug price increases (for under-the-radar drugs), excluded drugs, UM/PA criteria, formulary designation, etc.

Normally, prices go down as more competitors enter the market. What happened when multiple therapies became available for multiple sclerosis patients? The annual cost increased 500% in just 10 years.
Source: The cost of multiple sclerosis drugs in the U.S. and the pharmaceutical industry: Too big to fail? Neurology, 84 May 26, 2015, pp.1-8

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Guiding Coalition: Articulating a path forward

40+ members from 20+ organizations;
16 Action Group members

10 half-day meetings over 2 years

20 specific goals for key stakeholders

1 comprehensive Employer Playbook

1 international expert advisor *(THANK YOU again, Dr. Schondelmeyer!)*

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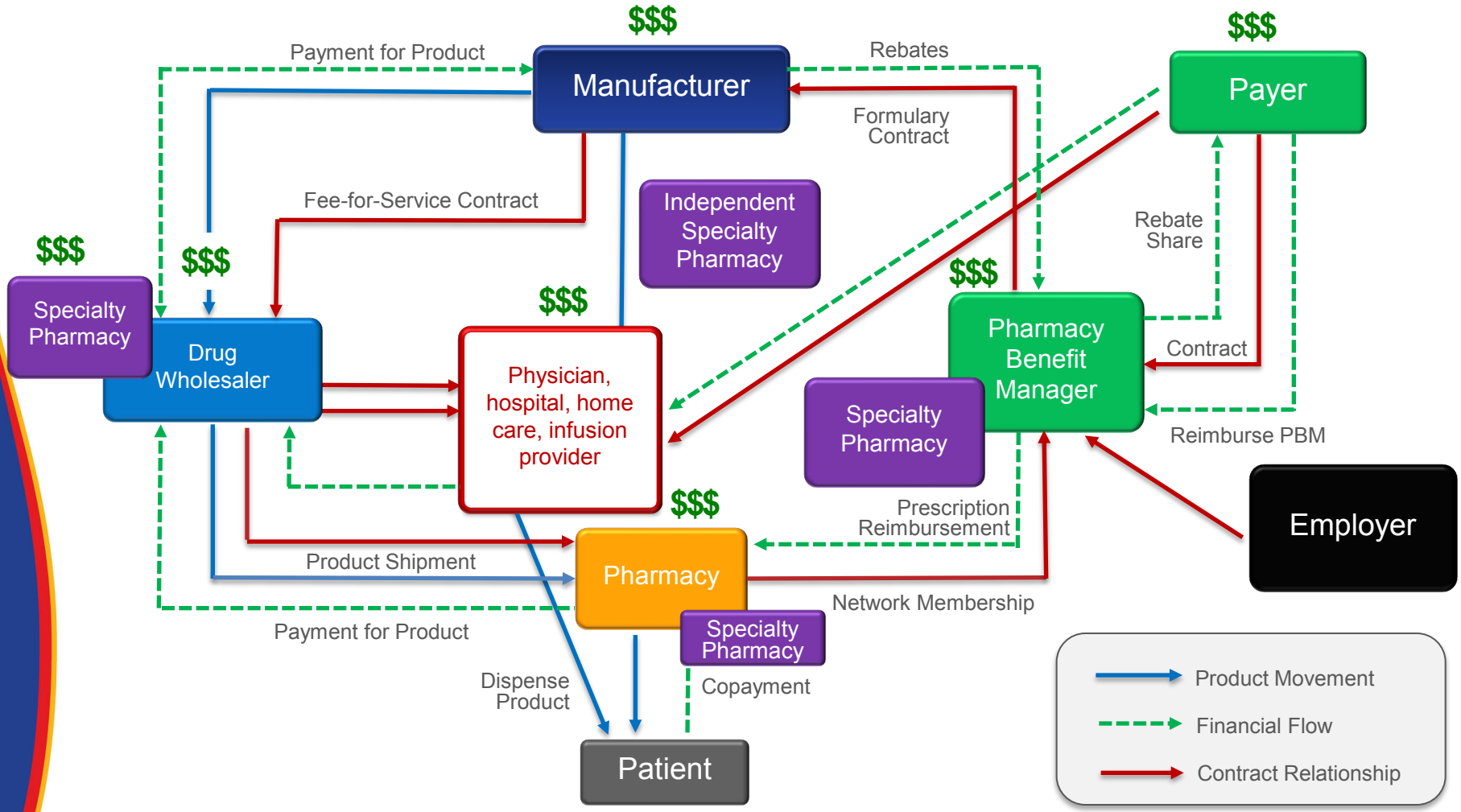
Manufacturer pricing is part of a powerful, complex, consolidating supply chain of "middlemen"



Pembroke 2013-14 Economic Report on Retail, Mail, and Specialty Pharmacies; Drug Channels Institute

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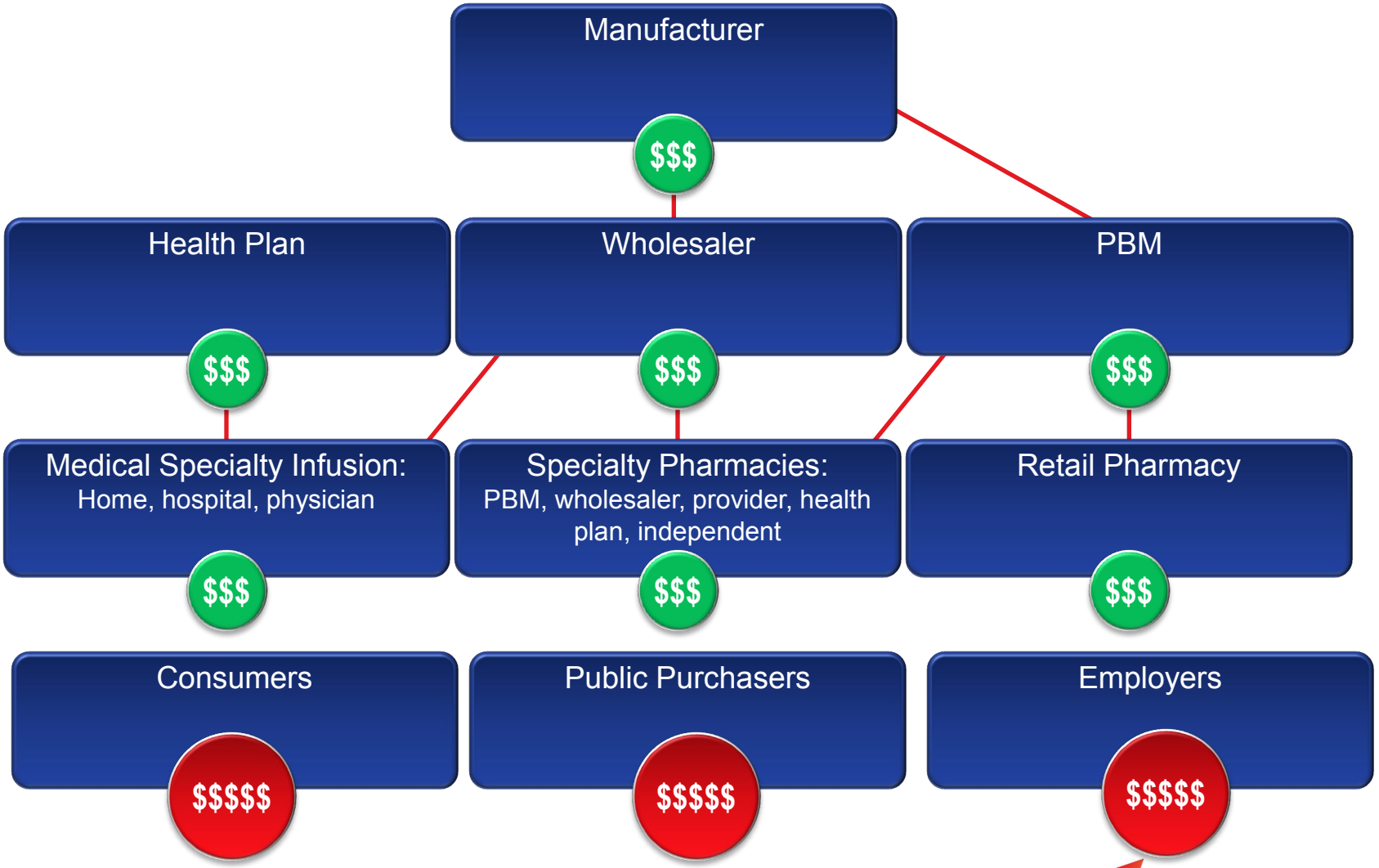
One person's profit is another's loss



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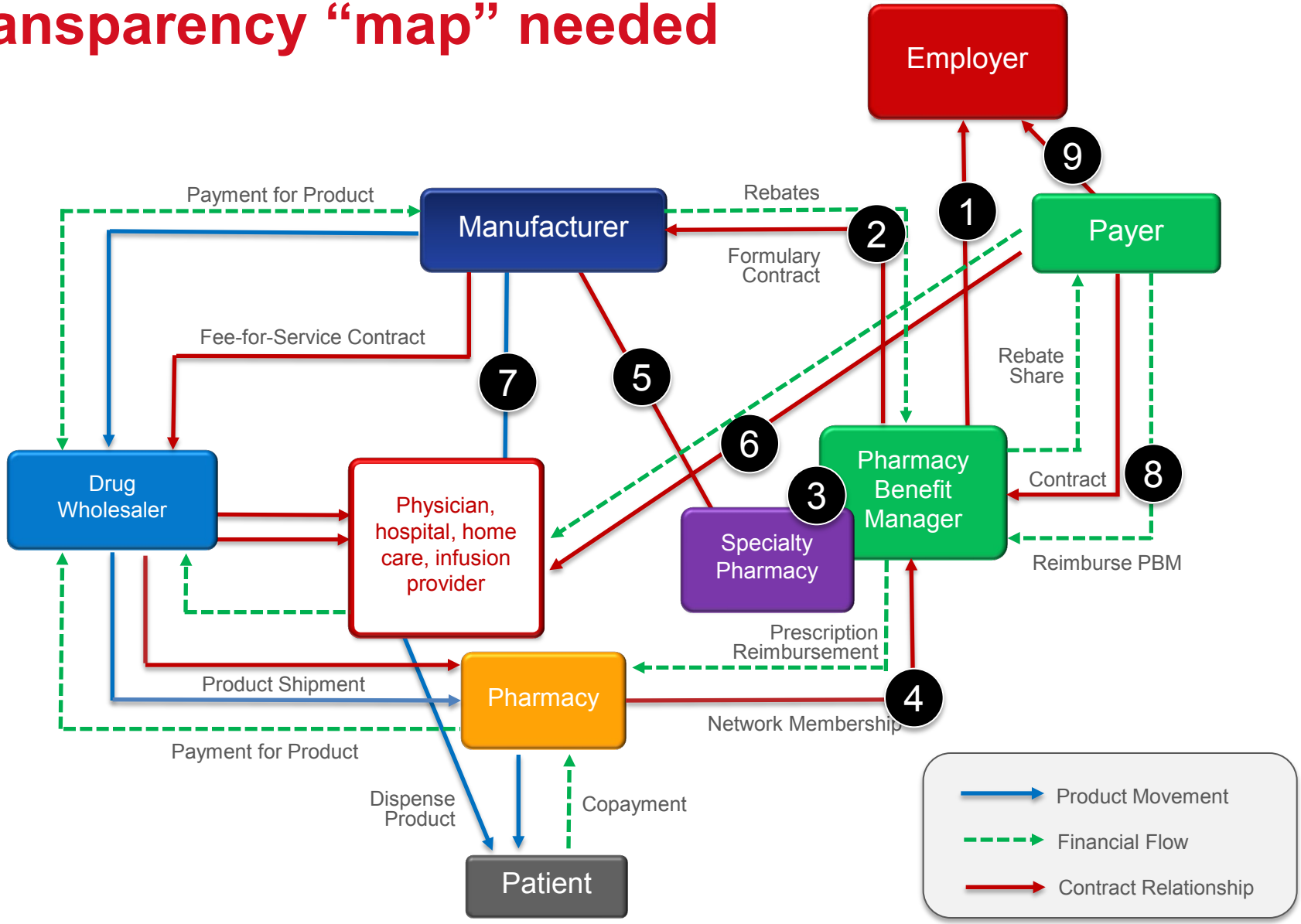
Transparency "map" needed



Adapted from Pembroke 2013-14 Economic Report on Retail, Mail, and Specialty Pharmacies; Drug Channels Institute

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Aspects of Transparency

- What you mean by *"transparency"* may not be what I mean; we need to be more specific
- Misaligned incentives and conflicts of interest in the entire supply chain create the need for transparency; includes PBMs, health plans, provider systems, consultants…
- Rebates are a distraction from value; they obfuscate, complicate, delay pricing and payment
- Consumer price transparency is the tip of the iceberg; need total price paid by purchaser
- Need specifics (NDCs) on medical specialty drug claims
- Manufacturer coupons circumvent employers' intentions, insert inequities into benefit plans (why cover drugs but not services?)
- What is comparative drug effectiveness and pricing?

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Transparency Requirements

PBM	Revenue sources and terms, agreements with manufacturers related to formulary placement, excluded drugs, UM/PA criteria
Provider Organization	Margin from infused drugs, 340B discounts, prescriber payment models, incentives in health plan contracts related to drug costs, site of care practices
Specialty Pharmacy	Revenue sources, spread, financial independence and relationship to parent organization (if applicable)
Non-owned Retail Pharmacy	Payments to PBMs including Direct and Indirect remuneration fees, prescription transfers to PBM owned pharmacies
Payer/Health Plan	Health plan incentives and payment terms with providers and systems using medical specialty drugs
Manufacturer	Drug launch prices, increases over time, copay/coupon practices, value-based pricing practices, cost and comparative effectiveness compared to prices

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Employers need alignment with state and federal policy actions

Most public policy action focuses on manufacturer pricing and remedies for public purchasers, patients	More action needed on PBM practices and pricing	More action needed on provider systems' Part B (outpatient hospital) drug pricing and practices	More action needed on pharmacies owned by PBMs	More action needed to accelerate health plan movement to value-based payment related to drugs
Public policy actions often shift cost to private sector, commercial plans, and employers *Employers then manage increased costs by increasing patient cost sharing*	*Public policy actions focus on transparency of rebates, need financial trans-parency on all revenue sources, formulary placement* *Disclose conflicts of interest when PBMs own pharmacies*	*Transparency of margin made from drugs* *Price parity of all sites of care, e.g., physician office, home, outpatient* *Include prescriber incentives to choose high-value drugs*	*Eliminate conflicts of interest with PBM owned pharmacies where profits increase with increased drug costs* *Compare performance to non-owned pharmacies*	*Require health plans to accelerate movement to provider contracts with prescriber incentives to choose high-value drugs*

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MN Health Action Group Specialty Pharmacy Action Network
Policy Actions – December 2, 2015

	Topic	Explanation
1	Comparative effectiveness research (CER) & pricing	Establish an independent entity and/or process to assess comparative effectiveness and relative value of drugs, recommend reasonable prices based, update CER with new evidence over time; authorize public and private purchasers to establish coverage based on reasonable prices
2*	Price justification	Require manufacturers to disclose drug prices including prices in other countries; report development costs including R&D, marketing, and other costs, profits, and sales information
3*	Price disclosure	Manufacturers and PBMs must disclose prices & economic transactions to payers and public
4	Bio-similar access and interchangeability	Advocate FDA regulations and policies that support accelerated approval of appropriate and economical bio-similar products; limit exclusivity period to 5-8 years rather than 12 years
5	Fast track generic drug approval	Appropriately fund the FDA's office of generic drugs to reduce approval time for Abbreviated New Drug Applications and facilitate, in other ways, the rapid approval of generic drug applications
6	Prohibit pay for delay*	Prohibit anti-competitive arrangements between brand and generic drug makers where brand name drug manufacturer pays generic manufacturer to delay bringing their generic alternative to market.
7	Remove importation barriers; parallel trade*	Allow importation of high quality drugs from multiple countries including Canada, the European Union, and Australia through legitimate channels (not internet)
8	Medicare negotiations*	Require CMS to negotiate drug prices on behalf of Medicare Part D programs or require Medicaid level rebates be applied to Part D
9	Find and join other aligned organizations & coalitions	Support and coordinate with other organizations with similar positions, e.g., AARP, AHIP, NCHC, grass roots consumer groups, et. al., on establishing sustainable drug market
10	Meet with MN Congressional delegation	Educate and advocate on payer, employer, and consumer perspectives related to specialty medications, bio-similar interchange, and other policies
11	Importation from Canada	Single country importation may create artificial pricing & shortages
12	Individual out-of-pocket spending caps	Limiting individual spending will not address overall pricing issues; in fact may exacerbate irrational pricing and continue to increase insurance premiums
	Priority Minnesota Policy Actions	
1	Prior Authorization (PA)	Support actions that reduce administrative burden and improve PA efficiency; do not limit ability to use PAs as an appropriate utilization management tool; increase benefit transparency; explore alternative models to PA that ensure appropriate utilization of drugs
2	Bio-similar interchange	Enable appropriate, economically effective, interchange of FDA approved bio-similar drugs in MN
3	NDC coding	Require health plans to utilize NDC codes (and require submission by providers) on all medical claims that include prescription drugs
4	Meet with MN legislators	Educate and advocate on payer, employer, and consumer perspectives related to specialty medications, bio-similar interchange, and other policies

For more information

- https://mnhealthactiongroup.org/taking-action/collaboration/specialtydrug/specialty-drug/

- Carolyn Pare, President and CEO
  cpare@mnhealthactiongroup.org

- Linda Davis, Consultant, Project Manager
  lindad222@gmail.com

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Thank you!

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