Causes and Contributors Working Group
AG Lowering Pharmaceutical Prices Task Force
June 26, 2019

Present: Rose Roach, Chair (RR); Dr. Stephen Shondelmeyer (SS); Dr. Leonard Snellman (LS); Christy Kuehn (CK); Representative Lesch

Guest speakers: Sara Turnbow, Senior Pharmacist at MN Multistate Contracting Alliance for Pharmacy (ST); Rick Bruzek, former HealthPartners Pharmacy Administration Director (RB)

AGO staffers in attendance: Sadaf Rahmani, Willow Fortunoff, Ben Velzen, Brian Lebens

-RR: Discussed working group's charge

- They've determined that there's no root cause but many (granted monopolies, patent abuses, coupons and patient assistance programs)

-RB: Gave presentation (everything below was said by him unless noted otherwise)

- His background: Health Licensing Investigator under Skip Humphrey, US Public Health Service, PharmD degree, DHS, BlueCross BlueShield, started Prime Therapeutics, spent 20 years at HealthPartners
- In 1970s, most people didn't have a PBM and could go to any pharmacy they wanted
    - Sent receipt to insurance company and they'd pay 80% - no monitoring of pharmacy or drug
    - Fewer and less expensive prescription drugs
    - Market consolidation has occurred since he's been in the industry
- Managed care: came up with formularies that determined which drugs are most effective, made recommendations, negotiated with pharmacies, and introduced clinical programs that added a safety component.
- Early 1980s, PBMs come in and things became more formalized
    - Increased online capabilities were a benefit, allowed for safety monitoring
    - PBMs started getting greedy off of rebates from manufacturers, didn't return them
    - PBM would charge client AWP-15 and would pay AWP-16 or 17 so they'd make the spread price
    - Co-pays : started with flat-tier, now we're up to 8 tier (formulary, non-formulary, brand, generic, etc.)
    - Employers are struggling with cost of health care – high deductible programs, over half of his members were in deductible plans
        - Ex: insulin went from $30 copay to $600 full cost

- Rebates:
    - They should go to the party that pays the majority of drug
        - In copay plans, rebates should go to employer
        - In high deductible plans, they should go to the patient.
    - LS: What is the value added by having rebates?
        - They have no value, the drug price should just be decreased

    - Managed Care has done so much to keep drug prices down, yet manufacturers have found ways (rebates, coupons, other loopholes) to make money
    - At one point, rebates were returned to members at point of service and manufacturers came back and said that rebate information was confidential so they had to use average rebate costs.
    - Medicare should directly negotiate rebates with inflation factors built in.
        - Medicaid rebate program is excellent

- Coupons:
    - "Formulary busting activity" – if there was a product not on formulary, manufacturers gave coupon to patient
    - Employer picks up balance of drug costs, so it's still increasing cost of care –takes away consumer involvement in drug affordability
    - MA tried to eliminate coupons but they had to re-instigate it
    - Patient has some responsibility of care but coupons put it all on employer

- Orphan drugs (affect less than 200,000 people)
    - Special status grants manufacturers incentives such as tax credits (25%) and extended years of market exclusivity (no competition for 7 years)
    - Leads to large abuses from manufacturers
        - Ex: Humira was approved as orphan drug (less than 10% of use) so they can charge more –despite the fact that intended use is arthritis (90% of use)
    - Top orphan drugs cost $147,000
    - Suggestion at Federal level: Remodel Orphan Drug Act
    - Potential price regulation after patent expires

- Generics
    - Saved more money in drug costs than any other intervention that they've tried (showed graph demonstrating increasing cost in brand drugs overtime with flat-line generic drug price)

- Specialty drugs (less than 1% of our prescriptions) around 30% of costs - by 2020, 50% of costs
    - Industry has created standards to protect these drugs

- In 2016, the average specialty prescription cost was $5,000/month or $60,000/year – the median household income was $54,000

- Pharmacists have to make a living too; it's time for manufacturers to step up
    - Over 10x HealthPartners' profit margin
- Doesn't believe that they have to charge high prices for R&D – British Medical Journal 2012 says for every $1 they spend on R&D, $19 are spent on marketing & promotion

- FDA needs to include value-pricing: assign values for factors such as extending life, quality of life, safety, efficacy

    - Prices are currently based on what market could bare, but someone has to determine if there's an increase in value.
    - Approval shouldn't be compared to placebo, that's not enough
        - Ex: Cancer therapies would increase price by 90 days, yet wipe out family with cost
    - We need to allow health plans to assess the value of drugs, find ways to evaluate long term efficacy – especially of drugs prescribed for lifetimes

- Drug importation from Canada won't work, can't steal their drugs when they've legislatively achieved lower drug prices
    - Not feasible due to differences in population and drug needs
    - RR: Pharmaceuticals are only covered if you're "In" patient not "out" in Canada but it looks like nurses are passing national pharmacare program.

- We need oversight of price increases – either state or federal
    - Tie prices to CPI or medical CPI
        - Ex: can't be priced at more than 5xCPI

- Better drug stability studies, expiration should be continued or you should receive a new prescription if your current one expires without being used
    - Ex: EpiPen has 2 year shelf life, yet 95% potency 2 years after expiration

- DTC advertising: waste of resources for advertisers, why don't they just decrease the price of their drugs? Price transparency is good, but what's the price?

-RL: Several unsuccessful attempts at audits, how would we get price? Is AWP "real"?

- SS: People pay a discount price, but AWP is a good marker and can give you a sense of the magnitude of a drug's price

-RR: "Health isn't a consumable good"

- DTC transparency is good as a pressure point, yet doesn't change things if patient just wants to survive –they don't care what the price is

-SS: Oregon program driven by consumer panels, citizen preferences for drugs – they had a certain budget and choose which drugs to purchase

- Discontinued, many ethical dilemmas

-Promote the value of pharmacy services: quality=outcomes+ wellbeing+return on investment+total cost of care

- Pharmacists can do more than safe dispensing, they should advise patients
- MN should pass in insurance laws that pharmacists manage prescriptions holistically, private consultations (this is what's done in Medicare)

-RL: that's certainly something we could do in state government

- Potential hurdle is increased cost

- Today, pharmacists can do generic substitution directly to patients or therapeutic substitution via doctor's recommendation

-KC: how does that work with mail-order medications?

- It doesn't work as well, better to have a local pharmacy

-RR: We should look at what Medicare is doing and see if it can be replicated at state level

-ST: Gave presentation (everything below was said by her unless noted otherwise)

- MMCAP is an aggregator/buying group
    - Aggregate volume for MN and across states, and through that volume they negotiate contracts with manufacturers for discounts
    - Primarily serve corrections, mental health, student and public health facilities
- Current contract requires clients to have pharmacy although some contracts serve groups without (corrections)
- Other entities could use them such as cities and counties
    - City that provides employee benefits or runs employee health clinic for vaccines can purchase through them
- They have bigger operation in other states, primarily just serve corrections in MN
- They don't maintain formularies, they put contract in place with base price yet there are opportunities below base price
- They have contracts for insulin, but cost depends on who you are
    - Hospitals and patients get lowest charge
- 1.4 billion is dollar buy-in per year (5-6 million in MN)
- MMCAP is set up as one contract for everyone. States could pass laws to overpass procurement laws, but they don't.
    - SS: We could propose state legislation.

-Suggestion: try to access 340B – federal discount drug program

- Many entities are eligible, try to have more patients seen and get them access to lower prices
- SS: lots of turmoil in Washington about potentially eliminating 340B
- LS: At Regents, they get 340B due to high indigent care and their employees can access 340B pricing
- Eligibility is with respect to providers, not patients
    - Middle-income family could go to 340B facility if drug is participating
- Facility gets 340B to buy drug, they could still sell it at regular retail price
    - RB: Outpatient hospital facilities make a margin on 340B that isn't always passed on
- Dept. of Corrections will access 340B as of July 1st
- 340B price is set in federal statute, formula based on drug prices that can't be negotiated
    - Lower prices than Medicaid, similar to VA prices
- 340B prices aren't public, only available to manufacturers and eligible entities
- RR: the more attention that's brought to these discounts, the more they'll be jeopardized
- SS: Patients' pharmacy has to be eligible, all participating facilities available online

- Walgreens and CVS do 340B contracting
- MMCAP pricing is much higher than 340B pricing, pricing based on WAC
    - 8-10% discount on average for brand, 90% for generic

-SS: some states have state operated wholesale stores (for liquor, example) what would you think if all of MN bought through you? All pharmacies in MN has access to your buying group?

- Contracts are currently written for city, county, state, nonprofit (state statute which could be changed)
- MMCAP is watching other states – some are combining contracts everywhere state pays for pharmaceuticals (employees, public health, corrections) to get a better deal
    - She thinks this is insane
    - They're all so different, and each is good at negotiating for their own needs
        - Ex: Medicaid is good at negotiation supplemental rebates

-SS: Everyone is getting discounts off ever-increasing top-line list prices that grow faster than discounts, would the increased volume of state power change this paradigm?

- There's nothing that requires manufacturers to hold prices
- State could refuse to use a drug
    - Effective on manufacturers, but difficult politically

-RL: We're familiar with this fight in legislature (pensions)

-RL: His bill created list of essential, life-saving drugs which were watched by AGO to see if there's an unconscionable increase

- Likely will be threatened by the Dormant Commerce Clause

-CK: member called her, only "real" pharmacy in town closed and they now have to pay higher prices at a farther pharmacy and they lack transportation – we should address rural access side

- Sadaf: rural pharmacists have reached out to AGO, we could potentially contact Land Stewardship Project, CK could reach out to patients as potential testifiers to WG#2
- Cody Wiberg has access to licensed pharmacies across state

Future meetings and speakers:

- SS has former graduate student who knows 340B well, AGO will reach out
- Phu Huynh also knows 340B very well
- Group wants to hear from manufacturers
- CEO of Riley Children's Hospital, CEO of U of Michigan
- Someone from state plans, AGO can connect
- No speaker on 24th meeting, just debrief
- In the next few weeks, all members will look at speaker list and decide who they want to speak
- Next meeting: August 21st from 5:00-7:00