8-20-19 WG#3 Meeting

- started at 4:14

Present:

- Dr. Jensen, Elo Alston, Jessica Braun, Nazie Eftekhari, Ben Velzen (AGO), Maria Shaw (Health Ez), Donovan (Faegre), Josh Shrawner (Health Ez), Matt (Health Ez), Dr. Stephen Schondelmeyer

Absent:

- Phu Huynh

- Nazie: we should think about "value based pricing" where we pay for efficacy – so the better the drug the more the drug company can charged, but if it does not improve much on the current treatment, you cannot charge as much
  -Jensen agrees

- Germany and Italy just worked out a deal for value based pricing on a particular drug

- Minnesota could be a leader on value based pricing, and MN could be that leader

- Nazie "someone has to be first" on new pricing practices and methods

- Nazie said employers and re-insurers will likely back such pricing

- Nazie: would this violate ERISA in some manner?

- Only pay for usage on an incremental basis; buy drugs and medical care on a "lease to own" type system

- Dr. Schondelmeyer arrived at 4:23

- Is there any precedent in the U.S. where the AG has taken on the role of a "prescription drug affordability" commission within the AG office

- Maryland had a law to do something against this, per Dr. S

    - It only applied to generic drugs and only for dramatic price increases, so it could have been a better law, per Dr. S
    - Nazie: if AG narrows the scope to cover only state employees could we regulate prices only on state employees through SEGIP
        - so do it incrementally like this, according to Nazie

- Dr. S: this will only work with drugs where there is competition; it won't work for single source drugs
- Dr. S: the way you fix the drug market is let it function, but within certain guardrails, through a drug pricing commission
    - So, for example, if the commission does not approve a drug then it costs patient more or is not covered at all (like a formulary)
- Dr. J: his bill should set a ceiling, above which no more could be charged; review his bill with the group
- Jessica: would this require legislation, or could the AG do this already?
- Nazie: there is an agreement to allow uninsured to pay the lowest drug prices could you expand on the 340B program?
- Dr. S: the state can't expand on the program, only try harder to meet its criteria
- Dr. J: setting ceiling prices per a drug commission; possible importation; but what can you tell us Dr. S about how the AG's Office could help with the problem
- Dr. S: you can identify mechanisms to use, but enforcement is the toughest issue
- Dr. S: we already have authority to import drugs if the FDA declares them safe and effective, but they are now getting pressure to do this
    - but importation from Canada will be tough because Canada does not have capacity
- Dr. J: could we implement an executive order to accomplish a pricing importation for select drugs for SEGIP, thereby getting around the legislature?
- Dr. S: FDA may even sign off on this
- Dr. J: there is power if the AG's Office and Governor's Office teamed up on this
- Dr. J: we are going to do this for insulin, narcon, and epi-pen ("strike three plan")
- Can we have the State of Minnesota buy in bulk from a legitimate Canadian wholesaler and make this available to retail pharmacies in Minnesota – does this take legislation or can it be done via executive order
- Nazie: for these three drugs we have set up a mass importation channel and make these available through SEGIP
- Then let other private employees buy a membership for these three drugs through SEGIP
- Dr. J: these drugs make up just a few percent of the market, gets the foot in the door, and then we can expand it later
- Dr. S: we should try to expand the 340B program, which is a function of the drug, patient, doctor, and ___; could we expand it
- Could we define additional class of persons as 340B eligible, based on newly expansive interpretation of the federal rules
- Or change how state and county health programs work/operate to make them fit within the confines of 340B
- Dr. S: has a former student independent who could tell us about the 340B and how to maximize it
- Dr. S: Acthrel drug example of extreme price increases
- Dr. S: or deriprim is another example
- Look at state-run liquor stores in determining whether state's can run pharmacies, too
- Dr. J: is there mechanisms through ERISA modeled after the "CPAP thing" where they only pay an allotment as long as it is being used, but if it is not no more payments

- Dr. J: we need to look at this with respect to medical device
- Jessica: could we do this with insulin
    - Dr. J: you only get a larger price if the patient outcome from insulin is acceptable, or else you get a lesser price
    - Dr. S: only pay drug companies after a drug works, not before
- Eric Philcker: has the date for 121 million patient live
- Eric: there should be risk sharing agreements for high price payments; but it depends on who takes the risk – the drug manufacturer or the provider?
- Eric: German health care system used to be similar to U.S., but now uses "reference pricing"; then it implemented something called "therapeutic reference pricing", but Germany only had three payers in Germany, unlike U.S.
- Pfizer initial pulled out after it was subject to reference pricing for a "class" of drugs that involved Lipitor, but then came back
- Eric: you could do risk sharing for high priced drugs
- Eric: you could go to employer groups that have wellness programs with both negative and positive re-enforcements
- Kaiser Family Health plan has more information
- Dr. S: what are vendors to ERISA plans (PBMs) obligations to those plans under ERISA?
- Could be a good law review paper
- Could AG do test cases against SEGIP's PBM CVS?
- MFN prices for SEGIP enrollees
- Eric: we need more purchasing power, though
- Ben: should we talk about reforming rebate practices
- Eric: Humira's $14 billion in rebates are 40% of the total
- Dr. S: could we address rebates outside of federal legislation?
- Eric: Truveris, which advises employers and payors how to set up the both rebate structure
- Final suggestions:
    - Pricing commission that is set up as a result of the DPTF that would at least identify drug price gouging and define the metrics to establish when this occurs
    - Strike three importation program for insulin, Epi-pen, and narcon
    - 340B program expansion