Advisory Task Force on Lowering Pharmaceutical Drug Prices
Causes and Contributors Working Group
July 10th, 2019

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

AGO staffers in attendance: Sadaf Rahmani, Willow Fortunoff, Ben Velzen (BV)

Also in attendance: Sara Turnbow, Senior Pharmacist at MN Multistate Contracting Alliance for Pharmacy (ST)

-RR shared article by Amy Kapczynski with federal recommendations for drug pricing reform

-RR shared list of potential recommendations that the working group had discussed in previous meetings. For the rest of the meeting, the group briefly discussed each recommendation.

-JL: Volume purchasing agreements have run into trade obstacles (NAFTA, TPP)
-Several court cases in recent years stymied state drug purchasing plans
-SS can check out the status of this federally, there are some provisions that limit volume purchasing but he can look around it and will bring information to next meeting
-Ways that pharmaceutical companies can limit volume purchasing: utilizing rules about intellectual property rights, advocating for extended patents (some language in trade agreements calls for all signatories to adopt the length of longest patent)

-SS: State as a prudent purchaser in two ways:
-Direct: someone at the state level takes possession of drugs and distributes them
-Indirect: someone at the state level pays for drug through layered health plans (school districts, retirees, etc.)
-Recommendation: create an inventory of all direct and indirect purchasers involved with the state (members of multistate purchasing plan, eligible entities who aren't members, county and city organizations, etc.)
-Catalog and contact them with a brief survey: how much do you pay for drugs per year, where do these drugs go?
-Learn how to leverage purchasing volume, inventory could allow us to recommend that direct purchasers are brought together to make their purchasing more efficient
-Avoid double counting data
-ST: Include jails, public health departments

-CK: This doesn't address initial drug price at manufacturer level
-SS: True, but this is the first step at developing leverage and we can then discuss how to utilize it
-If we don't know how much we're spending, it's difficult to make recommendations
-If state has a significant percentage of drug costs, we should be able to get a good rebate

-JL: Keep in mind the strength of pharma lobby

-ST: Are you thinking of a statewide formulary?
-SS: Not initially, first step is obtaining data to fully understand the state's role

-RR: How would this research be completed?
-MMCAP can start initial list of purchasers for inventory, Secretary of State has information as well
- AGO will figure out what next steps are necessary

-SS: Jensen proposed the Prescription Drug Affordability Act that would set price levels based on percentage increase (SF 353, HF 1668 - didn't get hearings)
-ST: CA implemented a similar commission but lacks leverage
-SS: We would need to determine price levels and enforcement mechanisms
-JL will look into these proposed bills
-RR: ME just adopted similar program that sets drug spending targets and monitors how effectively public payers meet them
-Allows small businesses to buy into program

-SS: State laws that mandate coverage of certain drugs often lead to highest price increases
- "Blank check process"
-Accountability/Affordability Commission could investigate these cases (Example: EpiPen)
-AGO will look into feasibility of investigations

-SS: MA had a law aimed at limiting co-pay coupon that faced pushback from biotech industry
-RR: Can we use existing federal coupon regulations from Medicare to apply to MN?
-Existing research demonstrates that coupons may not actually benefit patients
-Look at studies used in federal regulations and MA law
-ST: EpiPen had a co-pay coupon

-JL: Task Force should include recommendations for executive action

-SS: EpiPen, Naloxone, Insulin, 8-10 others will be included in report as examples of drugs that weren't adequately regulated by market

-RR: Rebates can be abused by PBMs and pharmaceutical industry
-SS: Safe harbor regulations make rebates legal instead of being categorized as kickbacks
-Safe harbor permits rebates that are passed on to end user, that's not happening at the moment - or even if it is, administrative fees for operating rebates aren't passed on
-It may be possible to be more restrictive
-JL: We may run into issues with the dormant commerce clause
-SS: There are drug companies that support eliminating rebates
-SS: Solely eliminating rebates doesn't lower prices, we need companion provision

-BV: Right now, drug companies compete to be put on drug formularies with highest rebates not actual price - so eliminating rebates might force them to actually lower prices

-ST: MMCAP is funded by safe harbor administrative fee (letter J: group purchasing organizations) but they have a 3% cap

-They use about 30% of this for operational costs but return the rest

-3% is in federal safe harbor law, they can collect more but have to report explanation

-They have one rebate program, the rest is up front pricing

-RR: Remodel Orphan Drug Law
-SS: We should prioritize what we can do at the state level as we don't have sufficient leverage for federal recommendations

-SS: Canada's Patent Medicine Price Review Board (PMPRB) could be model agency for our recommendations

-AGO will send annual report to group

-Board only deals with patents while US board would need to focus on generics as well

-RR: If drug isn't statistically better than placebo, it shouldn't be marketed
-SS: This is the marginal value, some drugs barely extend life for exorbitant costs
-SS: Should the state be paying for this?
-Difficult ethical component, choosing "x" number of diabetes patients vs cancer patient

-SS: Discuss drug companies' language, the way they frame the problem to shift blame without addressing or lowering price

-RR: We need to discuss end-of-life quality

-Group discussed recent ruling that Trump administration can't force pharmaceutical companies to disclose the list price of drugs in ads.

-SS: We can identify drugs that have highest DTC advertising spend and publish names and prices of top ~25 in report index

-New lawsuit doesn't stop us from publishing info

-RR: Most DTC advertising is for drugs not yet on formularies

-RR: Could information on expired drugs fall under "purchaser education" section of report?
-SS: Instead recommend that FDA review their expiration dates with more scientifically accurate time periods, many drugs are still effective long after their expiration date
-SS: If we consider recommending that patients receive new prescription if theirs expires unused, we have to find funding

-Discussed importance of pharmacy review process in which pharmacists review patient's prescribed drugs
-SS: this is part of many health plans

-ST: 60 day notice of price increases would be very helpful to purchasing groups like MMCAP

-Transparency legislation would be welcome

-They have the volume of 50 states yet still can't negotiate as well as they'd like to , this issue won't be solved by just increasing purchasing volume

-RR: What purchasing entity will ever be large enough to take on pharmaceutical industry?

-ST: Insulin recommendation - everyone in state is covered and drug companies receive payment up front (capitated payment per person per month)

-Louisiana "Netflix" model

-BV: That's how DHS currently contracts with health plans

-SS: How would the value of that contract be determined?

-Managed Care financing wasn't success, wary of capitated payment model

-We could identify shortlist of drugs that are included in this capitated payment plan

-LS: Publish searchable database

-SS: Look at FL Medicaid model, reach out to Cody Wiberg about previous MN Medicaid model

-Next meetings: August 7th instead of July 24th and August 21st