Advisory Task Force on Lowering Pharmaceutical Drug Prices
Minutes of Third Meeting
July 23rd, 2019

The Attorney General's Advisory Task Force on Lowering Pharmaceutical Drug Prices met for the third time on Tuesday, July 23rd, 2019 from 4:00 to 8:00 p.m. The meeting was held at the Minnesota State Capitol, 75 Rev. Dr. Martin Luther King Jr. Blvd., St. Paul, MN 55155, Senate Committee Room G3.

The following members were present: Rose Roach, Christy Kuehn, Phu Huynh, Michaela Muza for Sen. Matt Little, Stephen Schondelmeyer, Sen. Scott Jensen (co-chair), Nicole Smith-Holt (co-chair), Shirlynn LaChapelle, Jessica Braun, Rep. John Lesch.

Members joined via phone: Nazie Eftekhari, Rep. Rod Hamilton.

Members that were absent: Dr. Leonard Snellman, Elo Alston, Dr. Cody Wiberg

AGO staffers in attendance: Sadaf Rahmani, Willow Fortunoff, Jason Pleggenkuehle, Allison Hustedt, Ben Velzen, Rachel Bell-Munger, Shawna Audette.

Meeting Agenda:

Task force voted to approve the proposed agenda.

Presentation from Speakers:

Task force opened the floor to the following speakers:

Minnesota Department of Health - Stefan Gildemeister and Jan Malcolm

- Discussed how current legislation across the country is looking to bring new information to states - both legislatures and the public.
- Highlighted the need for more research, as we don't really understand what's behind spikes in retail pharmacy pricing.
    - We lack data on when Minnesotans face staggering deductibles that hinder them from receiving insurance benefits.
    - We don't have a systematic way of assessing clinical and economic value of drugs.
- MDH is working with Department of Commerce to collect info to regulate new PBM bill.
- Discussed the value based insurance design: coverage levels are based on the importance of therapy, high value interventions have lower cautionaries.
- Wants to encourage/require carriers to share the cost of coverage.
- Suggests the use marketplace incentives such as group purchasing.

- Sen. Jensen noted that MDH and the task force should partner and combine efforts.

- Dr. Schondelmeyer asked if there is a state inventory of all agencies that pay for drugs directly and indirectly (pharmacy claims, medical claims, etc.). He guesses that state buys at least 60% of all drugs, and hopes to use this as leveraging power.
- Commissioner Malcom stated that MDH does not accurately count every way that the state pays for drug but this is an excellent purchasing strategy.
- MDH and the task force can work together to build out inventory, then sit down with lawyers to see how to defend purchasing program.
- Sen. Jensen asked Commissioner Malcolm about drug importation; she responded that she hasn't studied issue in enough depth but that it seems like an available tool that could make sense.

MMCAP Infuse - James Babbit, Sara Turnbow, Renata Vaschevici

- MMCAP is the largest government operated group purchasing organization and they pool volume from all 50 states.
- They function on the non-acute side and work for cities, counties, and states and contract directly with manufacturers.
- They aggregate purchasing volume to negotiate discounts and are operated by the Office of State Procurement.
- Offer no rebates, all up-front pricing and have one base price for all members.
- There are no requirements that manufacturers contract with MMCAP but this could change.
- Challenges:
    - They face class of trade limitations, manufacturers are more inclined to give discounts to certain groups than others.
        - Classes of trade: corrections (services are 100% covered by state so there's no duplicate discounting and is therefore a clear area for larger discounts), in-patient mental health facilities (per diem basis), county health pharmacies, fire and police departments, student health centers.
    - They can't compete with the private sector.
    - Manufacturers don't want to work with MMCAP because MMCAP is a state agency and subject to freedom of information requests.
    - Some agencies cannot use MMCAP because of regulation.
    - A number of states prohibit agencies from using MMCAP.
- Recommendation: look into 340B Federal Drug Discount Program.

Paul Nolette - author and professor

- Discussed the importance of litigation in achieving structural change, utilizing the case study of pharmaceutical lawsuits in the '90s and '00s that changed pricing benchmark from AWP (average whole price) to ASP (average sale price).
    - In the '80s and '90s, Congress tried to pass proposals to drive down prices yet nearly all failed due to partisan gridlock and lobbyists - action moved away from the legislature and to the legal arena.
- Task force should examine tobacco litigation as a template.
- AWP was the key pricing benchmark that was supposed to reflect the average price yet was actually set by drug companies (similar to sticker price for cars).

- The difference between AWP and actual price is called the spread - created perverse incentives.
- Basic case from state and federal investigators: when drug companies marketed the spread, it represented legal fraud under the False Claims Act.
    - Unique interpretation of False Claims Act which hadn't been widely used beforehand.
- After 4 years of gathering data, state and federal investigators entered settlement with Bayer Pharma and later Tap Pharma in 2001.
    - Provisions included oversight of corporate practices and introduced ASP (defined term, set by actual market practices and intended to diminish spread).
- NAAG got involved in 2002.
- IN 2003, the Medicare Modernization Act replaced AWP with ASP – this change was a direct result of the lawsuits against Bayer and Tap Pharma.
- Overall lessons from case study:
    - AGs and federal investigators have powerful tools at their disposal which can be used to set new precedent.
    - Litigation should be done in conjunction with other branches, and organized as a true campaign instead of single settlements.
    - Pharmaceutical litigation has been very bipartisan, which is remarkable considering that healthcare is one of the most partisan issues.

- Dr. Schondelmeyer mentioned that litigation can be a tool, but has also blocked many states efforts' via Dormant Commerce Clause.
- Nolette noted that legislators should address these holes and make sure that their laws can face legal challenges.
- Nolette suggested that future settlements have stronger corporate oversight provisions from AG offices, as the state AG position could be the ideal watchdog over company overseers.

Health Partners - Linda Davis and Carolyn Pare

- Discussed how employers are "flying blind" as they have no idea what they're paying for.
- In other countries, they compare pharmaceuticals to each other and pay more for more efficient drugs.
- Employers need alignment with state and federal policy actions as they face a number of obstacles.
- More action is needed on PBM practices, Part B practices, and regulating pharmacies who own PBMs (conflicts of interest).
- Can't solve the problem if you can't define the problem, so transparency should be addressed first.
- Some PBMs are working hard to increase transparency but can't provide large rebates and therefore aren't as popular.
- Self-insured employers can decide what they want to cover, yet baseline is state mandates.
    - Good employers cover essential benefits.

    - Mandates aren't driving up costs on self-insured programs, they're typically already paying for the baseline.
- LaChapelle suggested a social media campaign with all large employers to increase transparency.

AARP - Leigh Purvis

- Described AARP's commitment to tackling high prescription drug prices as older adults are more vulnerable to these high prices.
    - AARP Stop Rx Greed Campaign
- Discussed current political landscape:
    - Trump Administration has been talking a lot about high prescription drugs but not much movement.
    - Congress has been very active - many hearings and proposals on refinancing, Medicare Part D, and implementing hard caps.
    - States are also very active - at least 30 bills in 18 states addressing price gouging, importation, Affordability Review Boards, PBM regulation.
- Discussed merits of importation:
    - Usually has two different connotations.
        1. Implies importation of actual drugs
        2. Importation of prices
    - Fits with larger narratives of "fairness."
    - Supported by 72% of the public.
    - FDA has said that 80% of active pharmaceutical ingredients come from overseas.
- Discussed value based purchasing:
    - Pay based on value of drug, not based on what the market will bear.
    - "Value" is very hard to define so this should be a long term goal.
    - We need to figure out how to implement arrangements that work for a wide variety of drugs.
- Discussed "nuclear" options:
    - Revise how patents and exclusivity are granted.
    - A few years ago this was a taboo subject to address but that is shifting more and more
- Drug companies propose to expand use of biosimilars.
- Manufacturers don't seem to be responding to threats from politicians.
- We need a long-term, multi-pronged strategy that involves multiple stake-holders that agree on proposed strategies.
- 75% of patents are for re-existing or repurposed drugs.
    - In other words, nothing new is being created
- Approximately 75% of R&D comes from taxpayer research.
    - There are laws that could be pushed to retain control of University research.
- Recommends that the task force consider Drug Review Boards as they address transparency and add a regulatory element.

General Discussion and Debrief: Sen. Jensen opened up the conversation to the community members who were present.

- Nicole Smith Holt brought up the Colorado bill which caps copays at $100, yet doesn't benefit enough people. We need to critically examine laws that people think are good for everyone.
- Dr. Schondelmeyer added that, by themselves, copay caps are probably more harmful than helpful so they need to be combined with something else.
- Sen. Jensen mentioned that any successful bill has to have eligibility, sustainability, and a pharmacy network.
- Dr. Schondelmeyer agreed, noting that we have pharmacies in every county of MN and should utilize this existing network. Additionally, rural pharmacies are under pressure due to high costs.

Public Testimonies:

- A.J.- Registered nurse from Health Care for All MN who spent 25 years in the field. She advocates for a single payer plan, as this would lead to a decrease in drug prices and would offer healthcare security.
- D.T. - With Health Care for All MN. Has MS and is on a drug with a price that is $92,000.
- P.T. - With Health Care for All MN. Believes that pharmaceutical lobbyists are at the heart of the problem.
- D.F. - Metastatic breast care patient. She's on a fb page for cancer patients where they share drugs, yet no one knows how it affects everyone else.
- N.E. - Metastatic breast care patient who has been terminal for 14 years. She wants to focus on the actual price of drugs, not the cost that individuals pay. She's on a drug with a price of $660,000 per year, yet that astronomical amount isn't being addressed as consumers only understand what's coming out of their bank account.