Advisory Task Force on Lowering Pharmaceutical Drug Prices
Past and Current Legislative Regulatory and Law Enforcement Strategies Group
August 21, 2019; 5:00 – 7:00 p.m.
Minnesota Board of Pharmacy, Conference Room A

Members Attending: Cody Wiberg, Chair (CW); Nicole Smith Holt (NSH); Senator Matt Little via conference call (ML); Shirlynn LaChapelle (SL)

Also Attending: Rep. Robert Bierman (RB); Donovan Hurd from Faegre Baker Daniels; Shawna Audette (SA); Jennifer Reck from NASHP via conference call (JR)

Group Discussion:
Review of previous meeting minutes.

Questions prepared for tonight's speaker:

- (CW) Several states tried to enact price controls, such as Maine (2003), and possibly Oregon and Minnesota. Does AG staff have information on that? (SA) Will ask for information.
- (CW) Should states put pressure on manufacturers?
- (CW) Should states put pressure on Congress?
- (RB) Pricing board on wholesale cost, importation even at a state level, and negotiation on all state (govt entities) purchases for all state departments.
- (CW) Congress passed laws that are still on the books, allowed importation of drugs from Canada and EU. Catch was if FDA approved safety, Clinton and Bush said no, but Trump is looking at allowing states to propose, plus pharmacies and drug wholesalers. Manufacturers respond to actions of state governments, if legislation is passed. HealthCanada would not be able to support mass importation of drugs from Canada to USA.
- (CW) Parallel importation would allow importation from multiple countries.
- (NSH) Pricing importation

Speaker Presentation: Jennifer Reck, NASHP
(Speaker is JR unless otherwise noted below)

NASHP is nonpartisan forum for development and implementation of health policies.

NASHP tracks state level legislative activity. Overall number of bills have been with increasing recent years: there were 100 bills in 2017, there are now 272 bills in 2019 and still counting.

Laws being passed:

1. Legislation regulating PBM (which includes MN) 120 bills with 23 laws passed. States are gag clauses, requirements of state licensures, mandated reporting, attempt to prohibit pricing across a spread.

2. Prescription drug price transparency: 52 bills with 5 new laws this year joining 5 new laws last year. Transparency laws require reporting by manufacturers to justify price increase. Also increase transparency across entire drug chain.

3. Canadian importation: 30 bills introduced with 3 new laws this year (FL, CO, Maine), VT passed at only the wholesale level 2018. NASHP working with states in implementing laws to gain federal approval for their program design to demonstrate that consumers would not be exposed to any safety concerns. State importation action plans.

4. Drug affordability review boards: builds off of a public utility commission idea. Not for all drugs, but for high cost drugs, unaffordable, etc. would establish a review board to look at what drives the prices of the drugs and set an upper limit. Session saw 14 bills with laws in 2 states Maryland following the NASHP model. Maine is different, doesn't set upper payment limit, but instead sets spending targets, to work across payers.

5. DE and NM to create intra agency pharmacy model to lower drug costs.

6. New model for public option prescription drug plan, the Rx drug benefit would allow employees a buy in model for non-state employees, so state could leverage paying power and expand to other persons.

Work happening for states outside of legislation: alternative payment models, Medicaid changes, outcome based contracts directly with manufacturers for payment parameters based on agreed upon outcomes.

Questions for the speaker:

(RB) Price transparency boards, are there boards that are effective yet, or are they new? (JR) 2 laws passed (Maryland and Maine) are very new in implementation, and board members are being appointed.

(ML) What is working? (JR) Many ideas are in early stages of implementation. Target the high cost drugs more so. Drug price transparency is in a number of states: CA and NV were passed in 2017, and are further along. Required reporting has been in for awhile. Transparency is not just a means to an end, but also gives useful information for next steps, such as implementing a price review board or develop a list of targets for importation or bulk purchasing. NV is unique in that is focuses on essential diabetes medication only, and now moving to asthma drugs as well.

(JR) Canadian import laws: states are responsible to ensure safety of medications being imported. No states are taking on a regulatory role, but relying on what FDA has established. Sometimes new packaging and labeling needs to happen. (CW) Many are drugs that were already approved by FDA. At a minimum, drugs need to be confirmed as Health Canada drugs, and not illicit sources.

(SL) Many countries purchase from drugs from pharmacies around the globe. (JR) To a large degree, yes, that happens. The reason Canada is singled out, is that is what Canada does. (CW)

Drugs that are approved by Health Canada. Example: Lipitor in early 2000s was made in either Puerto Rico or Dublin, Ireland, for all across the globe. Drugs now can be from most anywhere. Health regulatory agencies across the globe work together so that medications are regulated similarly.

(ML) What is most effective? (JR) Not there yet. Most effective is collective pressure across states and continuous work to explore multiple options. A lot of PBM legislation has passed and is worthwhile to look at, but not the whole problem. Manufacturer prices and high list prices should be addressed as well. Building state action on federal bill would move the agenda.

Jennifer Reck agreed to send additional information to the group, and offered to be available for further questions if they arise. (JR left the conference call)

Workgroup Recommendation Discussion:

(RB) Nevada focused their transparency law on only essential medications.

(CW) Concerted pressure from all states. Other states have been active in at least six legislative areas, look at what works, and try all of it.

(SL) Changing US healthcare to a single payer: billing coding would be eliminated, and systematic costs would come down for managing single payer system.

(ML) Transparency would help. Review board would help address excessive prices. The easiest way to lower the price is to lower the price. Single payer seems political, and may not in the scope of the AG staff. (SA) Unknown if the idea is within AGO scope, but added to the list of ideas.

(NSH) what about physicians who make more based on what they prescribe or physician administered? (CW) Marketing the spread: purchasing the competitor at AWP may be cheaper, but purchasing a "premium" product would give higher reimbursement.

(NSH) reclassify "essential" medications, tier level 3 versus tier level 1 price points. Is there a way to reorg PBM classification.

(NSH) Coupons/ Rebates. (CW) A criticism of coupons is that it is generally for expensive drugs only. Also at some point, the coupon or rebate program runs out. (NSH) Oftentimes patients are unaware that the coupon program is over, and suddenly cannot afford their meds.

--------Main Points for Recommendations-----

(RB) Pricing review board; parallel importation; transparency laws on essential medications (possibly based on WHO recommendations); negotiation of state government costs across state agencies.

(CW) tighten up the gift ban statute (tighten up what is NOT considered gifts, such as speaker fees, and reasonable honoraria)

(CW) PBM regulation monitoring and follow through

Plan for Recommendations:
List of what other states have done, and then what the group suggests for recommendations.

Next Meeting:
TBD. Will check with Sadaf if above list needs additional information.