STATEMENT

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In Opposition to Prescription Drug Affordability Board and Upper Payment Limit in Minnesota Senate File 2744, Senate Commerce and Consumer Protection Omnibus Bill

Updated March 29, 2023

Position: PhRMA respectfully opposes the prescription drug affordability board and upper payment limit provisions in the Senate Commerce and Consumer Protection Omnibus Bill, Senate File 2744 (SF 2744). PhRMA believes that discussions about the affordability of medicines are important, but the intention of this bill is for the government to decide drug prices, which could limit the prescription options available to Minnesotans. SF 2744 shortsightedly targets drug spending in ways that likely will have long-term, harmful effects on innovation and the development of new, life-saving therapies.

Specifically, SF 2744 implements a government-appointed Board to review prescription drug costs and value with the goal of setting price limits by way of an "upper payment limit" (UPL) for the entire drug supply system. Regulating drug prices in-state could lead to a shortage of or limit access to medicines for patients. Specifically, if a pharmacy or provider cannot obtain a medicine at the government price, the medicine will not be available to Minnesota residents. Further, the legislation also requires onerous disclosure of pricing information which will not benefit patients and could jeopardize the competitive market. By disincentivizing the development of innovative treatments, this legislation could threaten the positive effect that the biopharmaceutical industry has on Minnesota's economy.

Price controls on brand medicines raise constitutional concerns.

Application of this price control to patented medicines raises constitutional concerns under the Supremacy Clause because it would restrict the goal of federal patent law, which is to provide pharmaceutical patent holders with the economic value of exclusivity during the life of a patent. Congress determined that this economic reward provides appropriate incentive for invention and Minnesota is not free to diminish the value of that economic reward. Specifically, in the case of *BIO v. District of Columbia, 496 F.3d 1362 (2007)*, the U.S. Court of Appeals for the Federal Circuit overturned a District of Columbia law imposing price controls on branded drugs, reasoning that the law at issue conflicted with the underlying objectives of the federal patent framework by undercutting a company's ability to set prices for its patented products. The bill raises due process concerns as it provides broad authority to the Attorney General and the Prescription Drug Affordability Board (PDAB), with very few standards or safeguards to ensure that authority is exercised in a consistent manner. The bill gives the PDAB the authority to determine which products will be subject to a cost review, and which products will ultimately have a UPL imposed on them, but provides no clear and consistent standard for how the Board will conduct price reviews or set UPLs. The bill also raises concerns under the Dormant Commerce Clause, which precludes the States from regulating commercial activity beyond their own borders. See Association for Affordable Medicines v. Frosh, 887 F.3d 664 (4th Cir. 2018). And, by allowing the board to take prices in Canada into account in setting the upper payment limit, the bill raises questions under the Foreign Commerce Clause.

The use of Medicare Maximum Fair Price (MFP) as the UPL is premature as the federal government is still in the stages of implementation.

For prescription drugs identified by the Board as "creating an affordability challenge" and subject to the Medicare MFP, SF 2744 requires the Board to set the UPL at the MFP. Medicare MFP is a price-setting mechanism recently enacted as part of the federal Inflation Reduction Act ("IRA"). Implementation of the IRA statute and the complex framework of its MFP provisions is at an early stage, and many operational and legal issues remain to be sorted out.[1] PhRMA believes it is premature to incorporate the MFP as the UPL because the Centers for Medicare and Medicaid Services (CMS) has not issued guidance or parameters describing how the MFP will be calculated. Including the MFP within the process for UPL determinations, in the absence of these important details, risks creating a UPL-setting process that will be influenced in a manner that the Board cannot have considered until CMS has completed MFP implementation, which could ultimately conflict with requirements in the statute. In light of the work that still needs to be done at the federal level to shape the IRA's MFP provisions, MFP should not be used as a consideration for the UPL.

The Minnesota Department of Health's (MDH) first prescription drug price transparency report notes significant limitations in the data used for cost reviews to set a UPL.

In 2020, the Minnesota Legislature passed the Minnesota Prescription Drug Price Transparency Act (Act), which required drug manufacturers to report specific information for new prescription drugs, newly acquired prescription drugs and prescription drug price increases that meet the criteria outlined in the Act. As part of the Act, the MDH is required to publish an annual report of findings from the data submitted by drug manufacturers. The first report was published on February 21, 2023.

The Prescription Drug Price Transparency Report from MDH on drug manufacturer data noted significant limitations of the data for use in analysis, including:

> *Unfortunately, in its current design, the Act's impact is limited because:*[2]
> - *The focus is on list prices instead of net prices, and therefore does not represent the actual income manufacturers earn from the sale of their products.*
> - *The focus is only on manufacturers rather than the full supply chain. Other downstream entities—like pharmacy benefit managers, wholesalers, pharmacies, and payers—also contribute to the final price paid by consumers.*
> - *Reporting requirements treat drug pricing as if there is one market functioning under a single set of practices, which does not reflect the complex factors—such as incentives, economic environments, and business arrangements—driving pricing and rebate practices.*

SF 2744 requires the Commissioner of Health provide the Board information reported by drug manufacturers under the Act for use in their duties of identifying prescription drug products for a cost review that can result in the establishment of a UPL. The limitations the MDH notes in the report raise concerns that the data being used to identify prescription drug products for costs reviews has significant flaws and should not be used for cost reviews or to set a UPL until the limitations of these data are addressed.

[1] See Establishment of the Medicare Drug Rebate and Negotiations Group Within the Center for Medicare (CM), 87 Fed. Reg. 62433, 62433 (Oct. 14, 2022) ("The work required to implement and administer these new programs will be novel and differ significantly from the Medicare functions that CMS performs today ... Moreover, the scope and complexity of these new programs ... require that a new, dedicated organization be established to ensure that CMS is able to implement these programs successfully and on time.").

[2] Minnesota Department of Health. Minnesota Prescription Drug Price Transparency Report to the Minnesota Legislature. February 2023.

This legislation ignores that there are meaningful policies for addressing affordability without utilizing government price setting that could reduce treatment options.

PhRMA is increasingly concerned that the substantial rebates and discounts paid by pharmaceutical manufacturers, approximately $236 billion in 2021,[3] do not make their way to offsetting patient costs at the pharmacy counter. Patients need concrete reforms that will help lower the price they pay for medicines at the pharmacy, such as making monthly costs more predictable, making cost-sharing assistance count toward a plan's out-of-pocket spending requirements, and sharing negotiated savings on medicines with patients. These policies can be done without utilizing international price setting, which can reduce the options available to treat patients.

This legislation does not account for insurance benefit design issues that prevent discounts from flowing to patients, and SF 2744 assumes incorrectly that the price a patient pays is determined solely by drug manufacturers.

This legislation singles out the biopharmaceutical industry and ignores the variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy benefit managers (PBMs), wholesalers, and the government. The important role that these entities play in determining drug coverage and patient out-of-pocket costs is overlooked by the requirements of this legislation. For example, PBMs and payers—which dictate the terms of coverage for medicines and the amount a patient ultimately pays—negotiate substantial rebates and discounts.

According to research from the Berkeley Research Group (BRG), rebates, discounts, and fees account for an increasing share of spending for brand medicines each year, while the share received by manufacturers has decreased over time. In 2020 manufacturers retained only 49.5% of brand medicine spending while members of the supply chain retained 50.5%.[4] Increased rebates and discounts have largely offset the modest increases in list prices and reflect the competitive market for brand medicines.

The growth of net price prices, which reflects rebates and discounts, has been in line with or below inflation for the past five years. Specifically, brand medicine net prices increased 1.0% in 2021.[5] This, of course, does not necessarily reconcile with what patients are feeling at the pharmacy counter, which is why looking at the whole system is so important. For example, despite manufacturers' rebates and discounts negotiated by health plans, nearly half of commercially insured patients' out-of-pocket spending for brand medicines is based on the medicine's list price rather than the negotiated price that health plans receive.[6]

In FFY2020, only 3.6% of Minnesota's Medicaid budget was spent on prescription drugs, including both brands and generics. Specifically, in FFY2020, pharmaceutical manufacturers paid more than $632 million in brand and generic rebates, which is 55% of the total Medicaid spending on drugs, on Minnesota's Medicaid drug utilization alone.[7]

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[3] Fein, A. "The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute. March 2022.
[4] BRG: The Pharmaceutical Supply Chain 2013-2020. January 2022.
[5] IQVIA Institute for Human Data Science. The Use of Medicines in the U.S. 2022. Published April 2022. Accessed January 2023. https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2022
[6] IQVIA Institute for Human Data Science. Medicine spending and affordability in the United States. Published August 2020. Accessed August 2020. https://www.iqvia.com/insights/theiqvia-institute/reports/medicine-spending-and-affordabilityin-the-us
[7] Menges Group analysis of FFY2020 CMS Financial Management Reports (FMR) and State Drug Utilization (SDU) data files. Brand/generic expenditure totals net of rebates. Data predominantly derived from CMS FMRs. Brand/generic prescription drug costs derived through tabulations performed by Menges. Pre-rebate expenditures tabulated using FFY2020 CMS SDU data files and CMS brand/generic indicators for each NDC. Statutory rebates and fee-for-service supplemental rebate information obtained from CMS FMRs. MCO supplemental rebates available in FMRs for several states and estimated in remaining states at similar percentages as the published FMR data indicate. Generic rebates assumed to always be at the statutory 13% level –no supplemental rebates assumed. Total brand rebates are therefore derived as the difference between total rebates and the generic statutory rebates. Post-rebate expenditures derived through Menges tabulations using above information.

The biopharmaceutical industry is heavily regulated and discloses significant information to the public.

The biopharmaceutical industry is one of the most heavily regulated industries in the United States. Companies already report extensive information to the federal government about costs, sales, clinical trials, and total research and development (R&D) expenditures. SF 2744 goes further and focuses on the costs of approved medicines while ignoring a large portion of the drug discovery and development process—failure. Specifically, requiring information on production and distribution costs for individual products may not be feasible, as R&D is a long-term process, and manufacturers pursue research efforts that include many failures before the development of one FDA-approved drug. Accounting for these related discovery costs could be nearly impossible.

Much of the information that SF 2744 requires to be disclosed is considered proprietary and confidential trade secret information, which is protected by state and federal law. The Federal Trade Commission (FTC) has repeatedly acknowledged that disclosure of competitively sensitive information could undermine beneficial market forces within the pharmaceutical industry.[8] In a letter to the New York legislature in 2009, the FTC's Office of Policy and Planning, Bureau of Competition and Bureau of Economics cautioned that disclosure of information similar to what is requested in SF 2744 could jeopardize the competitive market by impacting incentives to provide discounts and additional rebates, which "…may increase pharmaceutical prices."[9]

This legislation could harm Minnesota's economy.

On average, it takes more than 10 years and $2.6 billion to research and develop a new medicine. Just 12% of drug candidates that enter clinical testing are approved for use by patients. Efforts to impart price controls on innovative manufacturers could chill the research and development of new medicines by taking away the incentives that allow manufacturers to invent new medicines. Price controls also could severely reduce Minnesota patients' access to medicines, as is seen abroad.

The biopharmaceutical sector is committed to bringing new treatments and cures to patients. This commitment to innovation supports high-quality jobs and is a vital part of Minnesota's economy and its economic competitiveness. The biopharmaceutical sector directly accounted for 11,733 jobs in Minnesota in 2020 and supported another 50,036 jobs in Minnesota for a total of 61,769 jobs. These jobs generated over $1.1 billion in state and federal tax revenue for in 2020. This bill could place these jobs, and tax revenue, in jeopardy.

PhRMA recognizes the access challenges faced by patients in Minnesota with serious diseases. We stand ready to work with the Minnesota legislature to develop market-based solutions that help patients better afford their medicines at the pharmacy counter. We believe this bill would not help patients better access breakthrough, innovative medicines and respectfully oppose the passage of SF 2744.

We urge you to vote no for SF 2744 for these reasons.

[8] FTC Letter to Terry G. Kilgore, Member, Virginia House of Delegates, re: H.B. 945 (Oct. 2, 2006); FTC Letter to Representative Patrick McHenry, re: North Carolina Bill 1374 (July 15, 2005); FTC Letter to California Assembly Member Greg Aghazarian, re: AB 1960 (Sept. 7, 2004). FTC Letter to The Honorable Mark Formby, Mississippi House of Representatives, re: SB 2445 (March 22, 2011).
[9] FTC Letter to Senator Seward, re: SB 58 (March 31, 2009).

POLICIES TO HELP PATIENTS PAY LESS FOR THEIR MEDICINES

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America's biopharmaceutical companies agree that, for too many Americans, the health care system is not working and needs to change. While medical innovation has made the United States a world leader in the discovery of new medicines, these treatments won't benefit patients who can't get them.

There are no easy solutions, but patients need real leadership from everyone involved in our health care system to make it work better. That's why our companies are calling for everyone in the health care system to join us in supporting common-sense reforms to make insurance work like insurance and ensure that patients can access and afford the medicines their doctors prescribe.

We believe the following policies are the best way to achieve these goals and make sure that *patients pay less* for their medicines.

1 Share the Savings

On average, nearly half of spending on brand medicines goes to health insurers, PBMs, the government and others, not the manufacturer that researched and developed the medicine. However, patients often do not benefit from these significant discounts in the form of lower out-of-pocket costs for their medicines. That's not right, and it needs to change. If insurance companies and middlemen don't pay the full price for medicines, patients shouldn't have to either. These rebates and discounts must be directly shared with patients at the pharmacy counter.

2 Make Coupons Count

In some cases, health insurance companies are not allowing the coupons manufacturers provide to patients to count towards deductibles or other cost sharing requirements, meaning patients could be paying thousands more at the pharmacy than they should be. We need to end this practice so that patients are getting the full benefit of programs meant to help them access their medicines.

3 Offer Lower, More Predictable Cost Sharing Options

Actual spending on medicines is growing at the slowest rate in years. Unfortunately, it doesn't feel that way for patients. Insurers are increasingly using high deductibles and coinsurance that result in patients paying more for certain medicines out of pocket. Patients should have more choices when it comes to their medicine coverage. Every state should require health insurers to offer at least some health plan options that exclude medicines from the deductible and offer set copay amounts instead of forcing patients to pay an amount based on the full list price of their medicines.

4 Cover Medicines from Day One

Insurers increasingly require patients to pay high deductibles before receiving coverage of their medicines. This can lead to patients rationing or not taking their medicines, which can result in devastating consequences to their health. Policymakers can help patients from day one by requiring all plans to cover certain medications used to treat chronic conditions with no deductible. Additionally, insurers should be mandated to offer some plans that cover all medicines from day one.

5 Cap Patient Cost Sharing

Many commercially insured patients are being exposed to high out-of-pocket costs due to increasing use of deductibles and coinsurance. High cost sharing is a barrier to prescription medicine access, especially for patients with chronic, disabling or life-threatening conditions, who shoulder the largest share of the burden. Cost sharing should not be so burdensome that it prevents patients with insurance from accessing necessary prescription medicines.

DID YOU KNOW?

PBMs, Plans and Wholesalers Continually Rank Higher on Fortune 500 Lists than Biopharmaceutical Companies

THE TOP 10

2022
Fortune 500 Rankings

1. Walmart
2. Amazon
3. Apple
4. CVS Health
5. UnitedHealth Group
6. Exxon Mobil
7. Berkshire Hathaway
8. Alphabet
9. McKesson
10. AmerisourceBergen

Health Plan, PBM, Pharmacy
Health Plan, PBM
Wholesale Distributor

FORTUNE

https://fortune.com/ranking/fortune500/2022/search/

PBMs, Plans and Wholesalers Continually Rank Higher on Fortune 500 Lists than Biopharmaceutical Companies

TOP RANKED PBMS AND PLANS

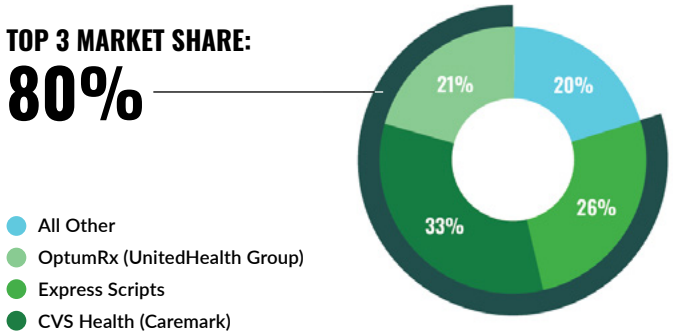
4. CVS Health (Caremark and Aetna)
5. UnitedHealth Group (OptumRx)
12. Cigna (Express Scripts)

TOP RANKED BIOPHARMA COMPANIES

37. Johnson & Johnson
43. Pfizer
63. AbbVie

Insurers and PBMs Control Access to Pharmacies and Leverage for Medicine Costs

TOP 3 MARKET SHARE:
80%



INSURERS DETERMINE:

FORMULARY
if a medicine is covered

TIER PLACEMENT
patient cost sharing

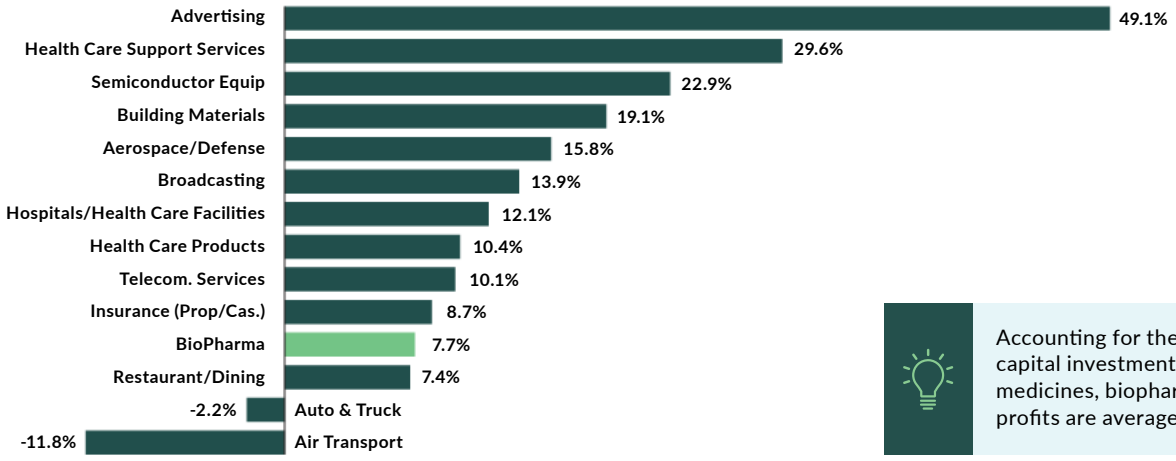
ACCESSIBILITY
utilization management through prior authorization or fail first

PROVIDER INCENTIVES
preferred treatment guidelines and pathways

HOW DOES THE BIOPHARMACEUTICAL INDUSTRY COMPARE TO OTHER INDUSTRIES?

Biopharmaceutical Profits Are in Line With Those of Other Industries

AVERAGE ECONOMIC PROFIT FOR SELECTED INDUSTRIES, 2019-2021*



Accounting for the significant risk and capital investments required to develop medicines, biopharmaceutical industry profits are average among industries.

*Economic profits are accounting profits minus capital expenses.

†Represents the weighted average of pharmaceuticals (8.2%) and biotechnology (2.2%), which are listed as separate industries in the source data.

Source: Adapted from R. Manning and A. Subramaniam, Intensity, LLC. Economic Profitability of the Biopharmaceutical Industry, 2022. https://intensity.com/news/economic-profitability-of-the-biopharmaceutical-industry-2022

[The Use of Medicines in the U.S. 2022: Usage and Spending Trends and Outlook to 2026]

IQIVA • April 21, 2022

Key Findings

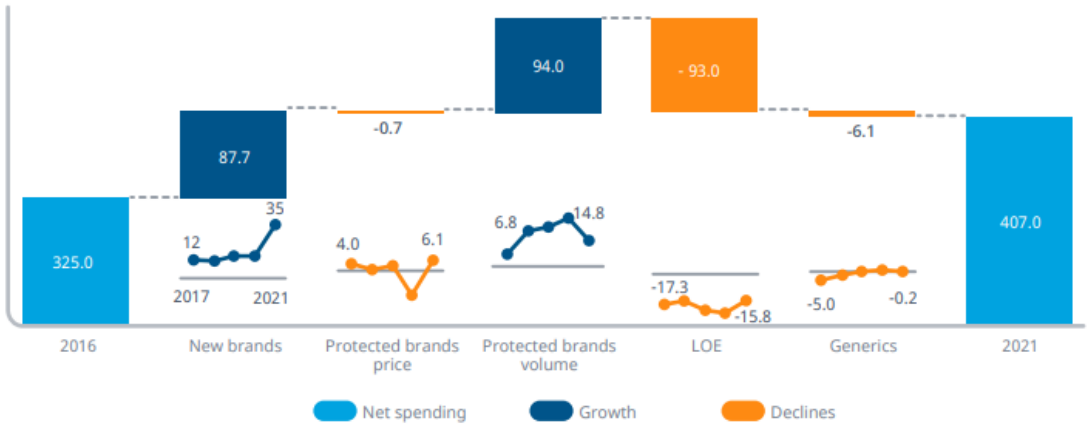
- Net prices for brand medicines increased 1.0% in 2021, below the rate of inflation for the fifth year in a row. Looking ahead, net price growth is projected to be 0% to -3% per year through 2026.
- Overall net spending on medicines (net manufacturer revenue) increased 12.1% in 2021, driven by the "unprecedented contribution" of the COVID-19 vaccine and treatments. Excluding spending on COVID-19 vaccines and treatment, spending on medicines increased just 4.9% in 2021.
- Excluding spending on COVID-19 vaccines and treatment, net per capita spending on medicines *declined* by 1% in 2021.
- Looking ahead, net spending growth is projected to return to pre-pandemic trends, increasing 1% to 4% per year, on average, through 2026.
- Brand medicine net prices are, on average, 49% lower than their list price.
- Savings from loss of exclusivity (LOE) totaled $93 billion between 2016 and 2021, more than offsetting the $87 billion spent on newly launched brand medicines over this period.

Full Summary

Medicine Spending

- Total net manufacturer revenue on medicines increased 12.1% in 2021, driven by the "unprecedented contribution" of the COVID-19 vaccine and treatments, reaching $407 billion.
    - Excluding spending on COVID-19 vaccines and treatment, spending on medicines increased 4.9% in 2021.
- Total net manufacturer revenue on medicines is projected to increase 1-4% per year, on average, through 2026.
- Real per capita net medicine spending (net manufacturer revenue) grew by 5.8% in 2021 when factoring in COVID-19 spending.
    - Excluding spending on COVID-19 vaccines and treatment, real per capital net medicine spending would have *declined* by 1% in 2021.
    - Medicine spending per capita has increased just $204 since 2011, a 1.8% compound annual growth rate, from $1,028 to $1,232.
- Total net spending on medicines increased by $82 billion from 2016 to 2021, driven by new products and increased utilization
    - COVID-19 vaccines and treatments accounted for $29 billion of this growth
    - Savings from loss of exclusivity (LOE) totaled $93 billion between 2016 and 2021, more than offsetting the $87 billion spent on newly launched brand medicines
    - Between 2016 and 2021, changes in brand medicine prices *reduced* total spending on medicines by $700 million.

Exhibit 22: Spending and growth at estimated net manufacturer prices 2015–2020, all channels, US$Bn



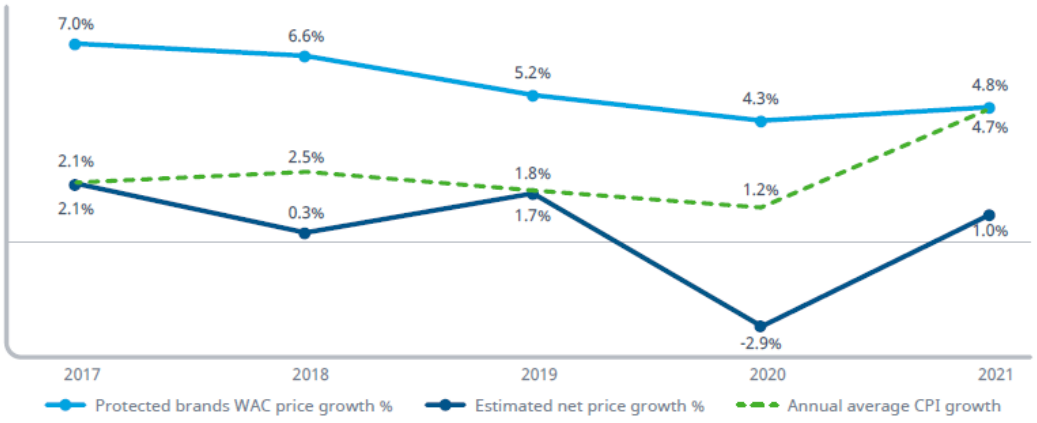
Source: IQVIA Institute, Mar 2022.

- Specialty medicines accounted for 55% of total medicine spending in 2021 but accounted for 3% of total prescription volume.

Medicine Prices

- Net prices for brand medicines increased 1.0% in 2021, below the rate of inflation for the fifth year in a row. Looking ahead, net price growth is projected to be 0% to -3% per year through 2026.
- Brand medicine net prices are, on average, 49% lower than their list price.
- List prices for brand medicines increased 4.8% in 2021, below the rate of inflation.

Exhibit 24: Wholesaler Acquisition Cost (WAC) growth and net price growth for protected brands

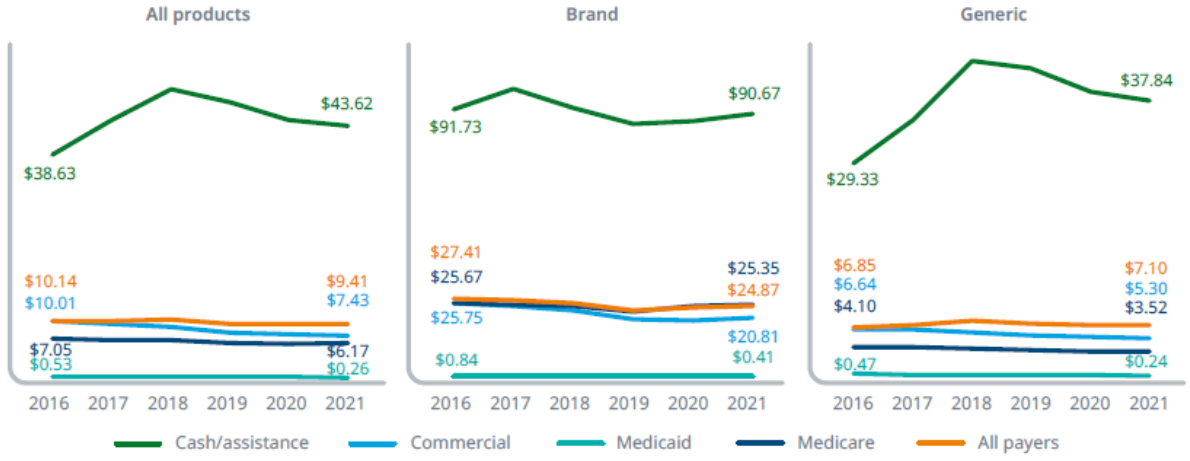


Source: IQVIA Institute, National Sales Perspectives, Dec 2021; Bureau of Labor Statistics, Annual Average Monthly CPI Growth, Dec 2021.

Patient Out-of-pocket (OOP) Spending

- The average OOP cost per retail prescription was $9.41 in 2021 (down from $10.14 in 2016)
- The average OOP cost per brand retail prescription was $24.87 in 2021 (down from $27.41 in 2016)

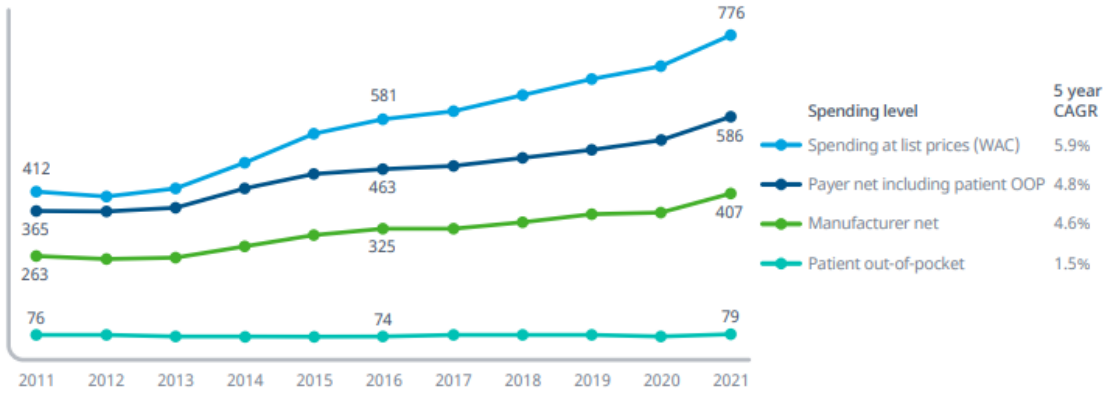
Exhibit 31: Average final out-of-pocket cost per retail prescription by product type and method of payment, 2016–2021



Source: IQVIA LAAD Sample Claims Data, Dec 2021.

- Across all patients, 29% had no annual medicine OOP costs, 8% reached annual OOP costs above $500, and 2.1% paid more than $1,500 OOP in 2021.
    - Among Medicare beneficiaries, 22% had no annual medicine OOP costs, 16% reached annual OOP costs above $500, and 4% paid more than $1,500 OOP.
    - Among commercially insured patients, 23% had no annual medicine OOP costs, 7.3% reached annual OOP costs above $500, and 1.6% paid more than $1,500 OOP.
- Over 92% of total prescriptions (brand and generic) had a final OOP cost below $20 in 2021, while 0.9% (totaling 64 million prescriptions) had a final OOP cost above $125.
- 73% of brand prescriptions had a final OOP cost below $20 in 2021, while 4% had a final OOP cost above $125.
- Coupons and debit cards provided by brand manufacturers totaled $12 billion in 2021.
- Total patient OOP spending increased by an average of 1.5% per year over the past five years, slower than the growth rate of payer spending on medicines, manufacturer net revenue growth, and spending at list price.

Exhibit 17: Medicine spending at selected reporting levels, US$Bn



Source: IQVIA Institute, Mar 2022; CMS National Health Expenditures (NHE), Dec 2020.

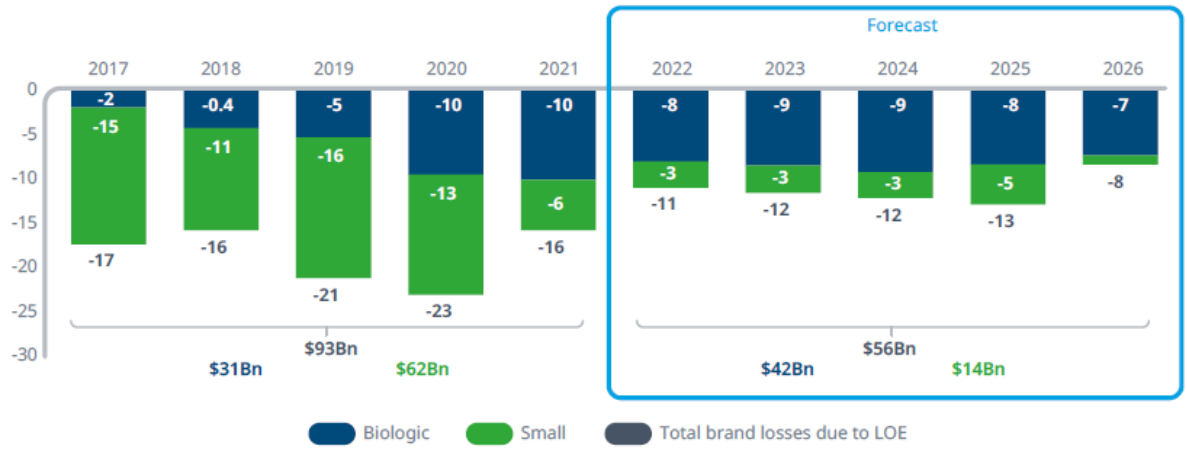
Abandonment

- Patients starting a new therapy abandoned 81 million prescriptions in total at the pharmacy in 2021.
- 61% of patients did not fill their new prescription when OOP costs exceeded $250, while just 7% of patients abandoned their prescriptions when OOP costs were less than $10.
- Abandonment of medicines to treat chronic conditions resulted in 5.3 billion fewer patient days of therapy in 2021.

Market Dynamics

- There were 72 novel active substances (NAS) launched in 2021, including emergency use authorizations (EUA) for COVID-19.
- Over the next five years, a projected 250–275 NAS will enter the market but are anticipated to represent an average 6–7% of brand spending compared to 11% in the past five years.
- LOE reduced net spending on brand medicines by $93 billion over the past five years, with a $62 billion savings from small molecules and $31 billion savings from biologics
- LOE is expected to lower brand spending by $56 billion from 2022 to 2026, with $41.6 billion from reduced spending on biologics.

Exhibit 42: U.S. impact of brand losses of exclusivity 2017–2026, US$Bn



Source: IQVIA Market Prognosis, Sep 2021; IQVIA Institute, Mar 2022.

Medicine Use

- Medicine utilization, measured by days of therapy, grew by 3.3% in 2021
- In total, dispensed prescriptions increased by an average of 2.1% per year over the past five years, driven mainly by the aging population.
- Retail drugs currently represent 86% of medicine use (by days of therapy), with non-retail accounting for the remaining 14%.

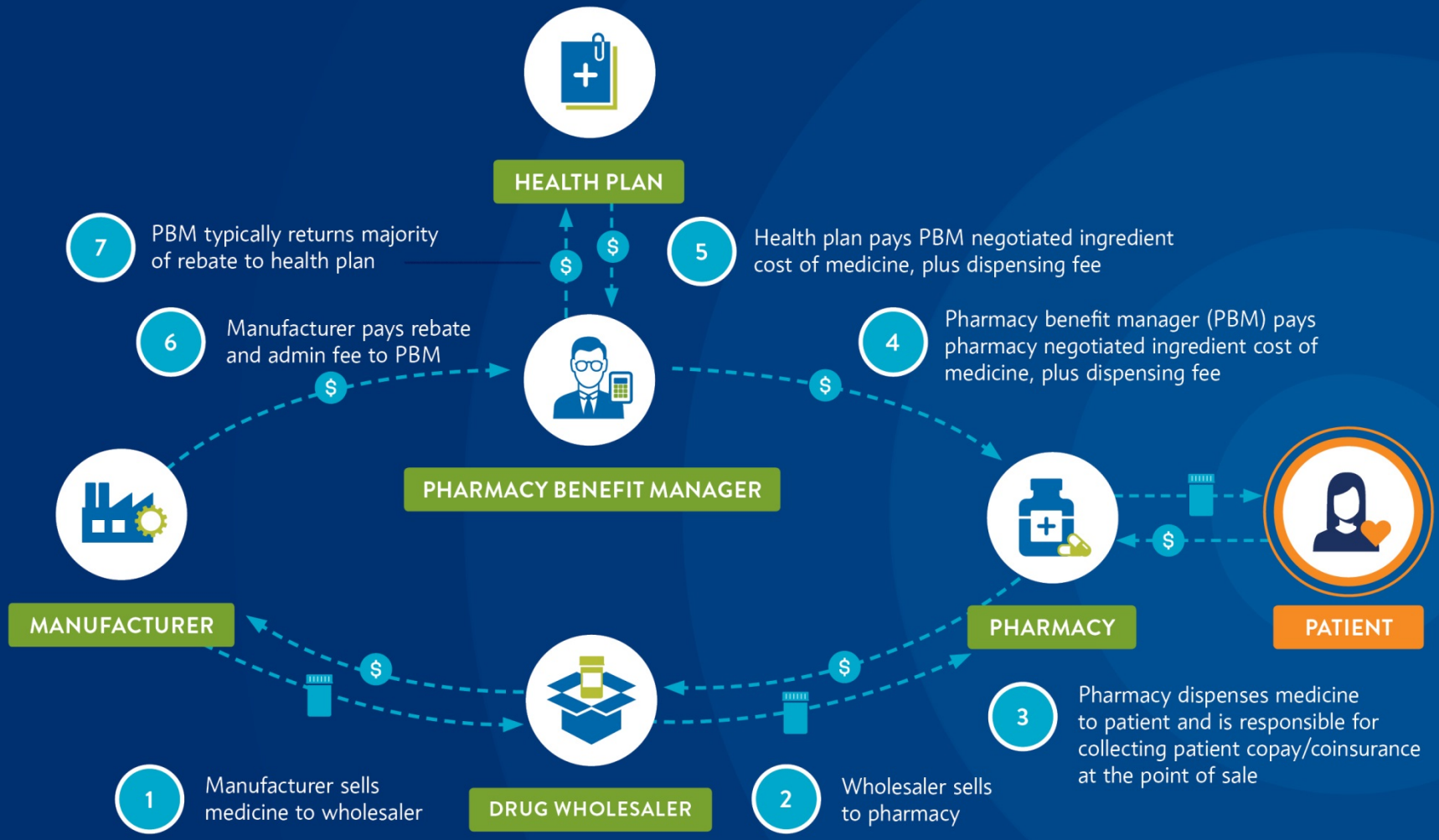
Condition Specific Findings

- Oncology
  - Oncology spending is projected to exceed $113 billion by 2026, with annual growth slowing to 9% due to competitive pressure from biosimilars
  - Net prices for brand oncology products are, on average, 7% lower than the list price.
- Cell, Gene, or RNA Therapies
  - There are currently 33 cell, gene or RNA-based therapies launched globally to-date, with 18 currently marketed in the U.S.
  - An additional 55–65 new therapies are expected to launch globally by 2026
  - “Even considering the large numbers of these products, they will not be more than 20% of all new drugs expected to be launched in the next five years and less than 10% of the spending on new drugs in the same period.”
  - Spending on these treatments is projected to reach $11 billion by 2026, estimates range under different assumptions ($7 to $20 billion).
- Diabetes
  - Net prices for brand diabetes products are, on average, 78% lower than the list price.
  - Total OOP costs paid by patients with insulin prescriptions amounted to $1.27 billion in 2021
    - 44% of this total is from the 20% of prescriptions that cost patients more than $35
  - Insulin OOP costs have declined by $500 million since 2018

        - If insulin OOP costs were capped at $35, patient spending would have been further decline by $555 million.
    - Net spending (manufacturer revenue) on diabetes medicines is projected to decline 12% through 2026, while list prices are estimated to grow 10-13% annually
- Autoimmune
    - Net prices for brand autoimmune products are, on average, 49% lower than the list price.
    - Net spending on autoimmune disorder treatments is expected to exceed $70 billion by 2026, slowing after 2022 due to key biosimilars

Distribution and Financial Flow

FOR RETAIL BRAND DRUGS



Source: Adapted from Pembroke Consulting

Vertical Business Relationships Among Insurers, PBMs, Specialty Pharmacies, and Providers, 2022

1. In September 2022, CVS Health announced its acquisition of Signify Health. The transaction is expected to close in 2023.
2. Since January 2021, Prime's Blue Cross and Blue Shield plans have had the option to use Express Scripts or AllianceRx Walgreens Prime for mail and specialty pharmacy services. On Dec. 31, 2021, Walgreens purchased Prime Therapeutics' 45% ownership interest in AllianceRx Walgreens Prime, so this business has no PBM ownership in 2022. Effective June 2022, the company has been known as AllianceRx Walgreens Pharmacy.
3. In 2021, Centene has announced its intention to consolidate of all PBM operations onto a single platform and outsource its PBM operations to an external company.
4. In 2021, Centene sold a majority stake in its U.S. Medical Management to a group of private equity firms.
5. Since 2020, Prime has sourced formulary rebates via Ascent Health Services. In 2021, Humana began sourcing formulary rebates via Ascent Health Services for its commercial plans.
6. Cigna also partners with providers via its Cigna Collaborative Care program.
7. In 2022, Humana announced an agreement to divest its majority interest in Kindred at Home's Hospice and Personal Care Divisions to Clayton, Dubilier & Rice. In 2022, Kindred at Home was rebranded as CenterWell Home Health.

Source: *The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Exhibit 212. Companies are listed alphabetically by insurer name. Published on *Drug Channels* (www.DrugChannels.net) on October 13, 2022.

DRUG CHANNELS INSTITUTE