March 31, 2023

The Honorable Melissa Wicklund, Chair, Health and Human Services Committee
Minnesota Senate Health and Human Services Committee Members
Minnesota Senate
Room 1100 Minnesota Senate Building
St. Paul, MN 55155

Re: **SF 2995 – Senate Health and Human Services Omnibus Bill**
**PCMA Comments in Opposition to SF 2995**
**Article 2 Sections 9 and 10– [62J.497] NCPDP Real-Time Prescription Benefit Standard**
**Article 2 Section 21 – [62Q.83] Prescription Drug Benefit Transparency and Management**

Dear Chair Wicklund and Members of Health and Human Services Committee:

My name is Michelle Mack and I represent the Pharmaceutical Care Management Association, commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

PCMA appreciates the opportunity to submit written comments on the A2 amendment to SF 2995 which is the Health and Human Services Omnibus Bill. PCMA respectfully opposes/ expresses areas of concern in Article 2, Sections 9, 10, and 21. The language in these Sections will increase costs and we are concerned about the intended and unintended consequences as well as being able to comply. We have outlined our issues below.

**❍ ARTICLE 2 SECTIONS 9 AND 10– [62J.497] NCPDP REAL-TIME PRESCRIPTION BENEFIT STANDARD**

Our industry has concerns relative to the language in these Sections. At this time, there is **no** NCPDP Real-Time Prescription Benefit (RTPB) standard. PBMs comply with all other set NCDPD standards around ePrescribing, formulary, etc., but given there is no standard, we would be unable to comply.

**❍ Article 2 SECTION 21 – [62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

Our industry has significant concerns relative to the language in this Section which we refer to as “frozen formulary”. We do acknowledge that language is included which would allow

health plans to update their formulary quarterly, for those enrollees not already taking a drug affected by the change. However, this will still restrict our ability to put downward pressure on pharmaceutical manufacturers to limit the increase of prescription drug costs and work with our clients to effectively manage formularies on their behalf.

A report by Milliman shows that **this type of policy would cost Minnesota health care payers $75 million over five-years and the state's own analysis of a similar bill this year substantiates this**. PBMs help employers, insurers, and public health programs provide their members access to safe, effective, and affordable medications, but pricing in the drug market is volatile, and there are very few tools to incent drug manufacturers to reduce prices. Formulary placement and financial incentives (i.e., lower cost sharing) to use lower-cost generics and brand alternatives are among those tools. This section threatens these cost saving mechanisms. If specific drugs are mandated to be covered, brand drug manufacturers have no incentive to provide price concessions on their drugs to make them more affordable for patients.

Significant market forces to drive down the cost of drugs will be eliminated under this section. For example, imagine that a new generic alternative or competing brand medication were introduced to the market. Under this language, even if these medications offered fewer side effects, a lower risk profile, or came at a lower cost for consumers, PBMs would be unable to encourage patients to use the new medication; favoring the more expensive brand medication and driving up costs for consumers. When hepatitis C drugs Sovaldi, Harvoni, and other competitors came to market, health insurers and PBMs would not have had the leverage to negotiate the deep discounts—around 40% off the list price—on these very expensive drugs in exchange for placement on the formulary as the preferred drug.

Currently, there are appeals processes which health plans and PBMs have in place for patients to access a non-formulary drug. The health plan or PBM works with a patient and his or her provider to provide access to non-formulary dugs where medically necessary and/or likely to create the best clinical outcome. We believe our appeals processes are fair and responsive. If the exception is allowed to drive the rule, then costs will go up, not down.

Finally, the language in Subd. 4. Not severable., needs to be updated so that it reads as follows:

> Subd. 4. Not severable. The provisions of this section shall not be severable from article. ~~1~~ 2, sections 1, 9, 10, 12-16 of this act. If any provision of article ~~1~~ 2, sections 1, 9, 10, 12-16 of this act or its application to any individual, entity, or circumstance is found to be void for any reason, this section shall be void also.

PCMA believes this Section will raise prescription drug costs for consumers, employers, and health plans. It removes important tools that PBMs use to deliver high quality services to health plans. Rather than protecting patients, 'frozen formulary' bills primarily increase costs.

Thank you for your time and consideration and please contact me should you have any questions.

Sincerely,

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