March 24, 2025

The Honorable Melissa Wiklund, 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 1876 – Pharmacy benefit managers and health carriers inclusion of lower-cost drugs in formularies requirement provision and lowest out-of-pocket-cost drug to patient formulary tiering preference provision**

PCMA Testimony - Concerns with SF 1876

Dear Chair Wiklund and Members of the Health and Human Services Committee:

The Pharmaceutical Care Management Association, commonly referred to as PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 289 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans, and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

PCMA appreciates the opportunity to provide written testimony on SF 1876 outlining our concerns but we wanted to provide you with a bit of background first.

What is a prescription drug formulary?

A plan's formulary (or drug list) is a list of prescription drugs approved for coverage by plan sponsors. In coordination with independent clinical experts on a pharmacy and

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therapeutics (P&T) committee, PBMs typically develop a recommended formulary for plan sponsors, who may customize it. P&T committee experts analyze all available data for a drug and other treatment options for the same condition or disease and develop a scientifically informed recommendation about which drugs should be included on the formulary and which could be included at the plan sponsor's discretion. Plan sponsors may accept the recommended formulary or change it but it needs to be noted that they always make the final decision on the structure of the formulary.

Why do formularies exist?

PBMs encourage use of the safest, most effective and affordable drugs for patients when designing formularies to recommend to plan sponsors. Prescription drug formularies give patients financial incentives to use the most efficacious and cost effective drugs. Formularies also serve to elicit discounts from drug companies. Due in large part to these efforts by PBMs, 90% of prescriptions are filled with generics and biosimilars.[1] PBMs often support uptake of biosimilars by placing these drugs on preferable tiers and also supporting policy proposals that bolster proliferation.

Sometimes, a brand name drug with a higher list price can maintain market share by offering deep discounts that place its overall cost below that of a lower list price drug with no rebates. This is a strategy brand name drug manufacturers typically use to undercut the first generic manufacturers they are forced to compete against. And while the shift in market share may be delayed, the reduction in plan liability demonstrates that the introduction of competition among manufacturers effectively lowers costs even in these circumstances.

PCMA Concerns and Questions

PBMs have always encouraged the use of generic drugs. Years ago, the PBM's were instrumental in supporting the Federal law that was enacted to grant the Food and Drug Administration the ability to create a framework under which biosimilars are approved.

[1] AAM. 2024. 2024 U.S. Generic and Biosimilar Medicines Savings Report. https://accessiblemeds.org/resources/blog/2024-savings-report.

It is our understanding that the intended goal is to require PBMs to include the lowest price generic/biosimilar drug on their formularies and to tier formularies based on the lowest net cost to the patient. While we applaud this goal, we have the following questions:

- We are wondering who this bill applies to and does it include Medical Assistance, the Minnesota State Employee Group Insurance Program (SEGIP), and self-insured plans.
- In subd. 2, there is use of the term, "wholesale acquisition cost (WAC)." It should be noted this term "does not represent the price paid by any entity within the drug channel, because it excludes rebates and such other reductions as distribution fees, product returns, discounts to hospitals, price reductions from the 340B Drug Pricing Program, and other purchase discounts."[2] Given this, there are times when WAC is higher than the negotiated rebate (also known as "net price.") This is particularly true when a new generic enters the market. Therefore, we have concerns with the use of WAC as a reference term.
- Subd. 2, lines 2.14 and 2.20 the language requires the "WAC of any other equivalent generic drug". We are wondering if the term, "any other" is pertaining to the same therapeutic class, or multi-source generics.
- Subd. 3, lines 3.6 and 3.12: the language states, "…PBM or health carrier must immediately make the newly approved [generic drug/biosimiar] available on its formulary."
    - We have concerns as this does not allow time for our any additions to go through a PBM's P&T Committee for review, placing clinical criteria first.
    - It also does not allow a PBM's clients to decide how to proceed.
    - In addition, many clients want to provide notice to clients of such a change and this does not allow time for that.
    - Finally, there are bills circulating in the legislature that require a certain number of days where written notice is required and this conflicts with them.
- Subd. 4 states prior authorization or step therapy cannot be imposed. This appears to state that any drug on the formulary cannot have prior authorization or step therapy. Is that what the language intends to do?
- Current statute, 62W.075 states that "a [PBM] or health carrier must not require, or demonstrate a preference for, a pharmacy to dispense a therapeutically

[2] Fein, Adam J., Four Crucial Questions about the Humira Biosimilar Price War, Drug Channels Institute, July 18, 2023. https://www.drugchannels.net/2023/07/four-crucial-questions-about-humira.html

equivalent or therapeutically alternative drug that costs the enrollee more out-of-pocket than the prescribed drug, unless the substitution is made for medical reasons that benefit the patient." We are curious as to if the current bill is redundant.

SF 1876 appears to *expressly limit PBM tools* (such as formulary development and management) —effectively hamstringing PBMs and plans where these tools are needed most. The biosimilar and interchangeable biosimilar markets are still emerging markets – the existing incentive structure will drive them to get more efficient in their manufacturing capabilities and thus allow them to compete on price, just as happened with generics over the previous decades.

Thank you for your time and please feel free to contact me should you have any questions.

Sincerely,

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