April 8, 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 2669 – Senate Health and Human Services Omnibus Budget Bill**
PCMA Testimony in Opposition to A-6 Amendment of Article 5, Section 1 – [62Q.83] Formulary Changes AND Concerns with A-6 Amendment of Article 2, Section 12 – Subd. 13. (5) - PBM Prescription Drug Substantial Public Interest Reporting

Dear Chair Wiklund and Members of the 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 289 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 testimony to the A-6 amendment to SF 2669 the Senate Health and Human Services Omnibus Budget bill. Our primary concerns with SF 2669 are outlined below:

■ Opposition to A-6 Amendment of Article 5, Section 1 – [62Q.83] Formulary Changes

PCMA appreciates the sponsor's numerous exceptions made to the language on formulary changes which we have discussed in various iterations for the last few years. However, at this time PCMA is opposed.

While an exception is allowed if the drug's safety changes, there is no exception that allows for formulary changes related to drug shortages for backorders. When plan formularies are updated to address a drug shortage or backorder, the available drug may not be available at the same cost or lower than the drug on backorder. Additionally, formulary changes due to drug shortages or backorders need to be made promptly to limit impacts to members. The restrictions in this bill will negatively impact the plan's ability to quickly respond to market changes.

SF 2669 restricts changes that result in a lower net cost to the plan sponsor. Plans need to be able to make changes at various times during the plan year to the formulary when pharmaceutical manufacturers increase their prices. As an alternative, we would suggest an

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amendment that would require pharmaceutical manufacturers to “freeze” their prices for the calendar year.

Finally, the effective date of January 1, 2026, does not allow plans enough time to update their contracts for the upcoming plan year, create new processes to meet the bill's requirements or update the systems to effectuate the changes. We ask the committee to consider the feasibility of such a short effective date.

For your information, the following is background information about what a prescription drug formulary is and why they exist.

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 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.

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

■ Concerns with A-6 Amendment of Article 2, Section 12 – Subd. 13. (5) - PBM Prescription Drug Substantial Public Interest Reporting

The language in Article 2, Section 12, Subd. 13, (5) requires "the total administrative fee amount accrued and receivable from payers for **pricing units** of the drug product filled during the reporting period specified in the notification to report." However, it is not always possible to tie an administrative fee to a drug pricing unit. Therefore, we respectfully request that the language "drug pricing unit" either be removed or if that is not possible, to include the language "if available" after "drug pricing unit."

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

Sincerely,

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