Welcome

Jodi Harpstead
Commissioner
Department of Human Services

Jan Malcolm
Commissioner
Department of Health
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 a.m.</td>
<td>Welcome and agenda review</td>
</tr>
<tr>
<td>9:10 a.m.</td>
<td>One Minnesota Plan</td>
</tr>
<tr>
<td>9:25 a.m.</td>
<td>Follow-up topics from prior meetings</td>
</tr>
<tr>
<td>9:30 a.m.</td>
<td>Background presentation: MCO competitive price bidding and third-party liability</td>
</tr>
<tr>
<td>9:55 a.m.</td>
<td>Healthcare cost savings strategy presentation and discussion</td>
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<tr>
<td></td>
<td>• MCO competitive price bidding (initial submission #421)</td>
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<tr>
<td></td>
<td>• Improve compliance with third-party liability (initial submission #390)</td>
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<tr>
<td>11:10 a.m.</td>
<td>Break</td>
</tr>
<tr>
<td>11:20 a.m.</td>
<td>Public comment</td>
</tr>
<tr>
<td>12:00 p.m.</td>
<td>Background presentation: pharmaceutical spending</td>
</tr>
<tr>
<td>12:35 p.m.</td>
<td>Break to pick up lunch</td>
</tr>
<tr>
<td>12:45 p.m.</td>
<td>Healthcare cost savings strategy presentation and discussion</td>
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<td></td>
<td>• Uniform pharmacy benefit in public healthcare programs (initial submission #407)</td>
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<td></td>
<td>• Pharmacy pricing: Prescription drug purchasing council (initial submission #192)</td>
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<tr>
<td></td>
<td>• Pharmacy pricing: Establish Rx affordability commission (initial submission #205)</td>
</tr>
<tr>
<td>2:50 p.m.</td>
<td>Wrap-up and next meeting</td>
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One Minnesota Plan
Follow-up topics from previous meetings
Follow-up topics from previous meetings

• Commission staff are researching several requests made by Commission members during the January meeting. Research on these topics will be presented at an upcoming meeting.
  - Potential impact of extending DME strategies to MCOs (rate adjustment, carveout, payment terms requirement)
  - Additional services for potential volume purchasing and associated financial impact
• Based on input and in order to provide greater detail, The Improve Group has updated and is finalizing the public engagement work plan.
  - The revised plan will be sent to Commission members next week
  - The Improve Group will seek approval to move forward with the plan at the February 21st BRC meeting
Third-Party Liability and Competitive Price Bidding
Benefit recovery and cost avoidance
Blue Ribbon Commission

Geneva Finn | Manager, Special Recovery Unit
Medicaid is the payer of last resort

“A State plan for medical assistance must provide that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services available under the plan”

— Social Security Act
Health Care Integrity and Accountability division

Health Insurance Recovery Unit
Tort Recovery Unit
Special Recovery Unit
Health Insurance Recovery Unit

Discovers when other insurers (Medicare, COBRA, employer-sponsored insurance, other commercial insurance) should serve as the primary payer on claims rather than Medicaid
Recovers money in cases of:

- Workers’ compensation
- Settlements from no-fault, third-party auto, medical malpractice and homeowners insurance
- Restitution from criminal cases where a defendant’s actions resulted in the victim or victims receiving medical services
- Product liability class-action lawsuits
- High-dollar personal injury cases
Special Recovery Unit

- Supervises and trains local agencies in recoveries due to estate claims.
- Recovers assets:
  - Liens on real property
  - Trusts
Annual savings in millions

Health Insurance Recovery Unit
Tort Recovery Unit
Special Recovery Unit
Total

2017: $858
2018: $900
2019: $944

Savings breakdown:
- Health Insurance Recovery Unit: $4, $4, $3
- Tort Recovery Unit: $38, $38, $43
- Special Recovery Unit: $4, $3, $43
- Total: $903, $898, $944
Opportunities
Managed care procurement
Blue Ribbon Commission

Julie Marquardt | Deputy Assistant Commissioner of the Health Care Administration, Director of Purchasing and Service Delivery
What does managed care cover?

• Most Medicaid benefits with certain exceptions
Managed care procurement process

• Managed care organizations (health plans and county-based purchasers) respond to a request for proposals issued by DHS

• DHS, the Department of Health and counties score the proposals to determine who will be offered a contract
  • Evaluate quality and service delivery
  • May include price components

• Final decision made by DHS commissioner as the single state Medicaid agency
Managed care RFPs

- Technical components
  - Quality of care and services
  - Network adequacy, e.g., access
  - Health care reform initiatives
  - State policy and program objectives
- County questions
- Data privacy
Competitive bidding in Minnesota

- **1985**: Minnesota begins using managed care
- **1995**: Federal waiver approved
- **2011**: Competitive price bidding begins in metro area
- **2014**: Competitive price bidding expands to 27 counties in Greater Minnesota
- **2015**: Statewide competitive price bid
Managed care cost savings

Medicaid average capitation rate for families and children: 2000-2017

Managed care reforms begin
Statewide competitive bid
Metro area competitive bid

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg. Capitation</th>
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<tbody>
<tr>
<td>2001</td>
<td>$231</td>
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<tr>
<td>2002</td>
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<td>2011</td>
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<td>2013</td>
<td>$392</td>
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<tr>
<td>2014</td>
<td>$379</td>
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<tr>
<td>2015</td>
<td>$364</td>
</tr>
<tr>
<td>2016</td>
<td>$327</td>
</tr>
<tr>
<td>2017 (Initial)</td>
<td>$338</td>
</tr>
</tbody>
</table>
Federal managed care regulations

- Promote quality of care
- Ensure appropriate enrollee protections
- Ensure accountability in capitation payment rates
- Enhance program integrity
- Strengthen efforts to reform delivery
- Highlight need for scoring free from conflicts of interest
- Highlight need for competitive procurement
- Apply to health plans and county-based purchasers
- Ensure appropriate enrollee protections
- Enhance program integrity

23
“We concluded that DHS followed existing legal standards for scoring competitive bids and accurately calculated the total bid scores and top rankings of the proposals that were submitted. We do not offer recommendations related to this aspect of the process.”

— Office of the Legislative Auditor
Questions?
Healthcare Cost Savings Strategy Presentation and Discussion
Strategy review guidelines

As a reminder, our objective for this portion of the meeting is for you to receive an explanation of the strategy, and then have an opportunity to:

- Ask questions
- Debate the merits of the strategy relative to the Commission’s charge

You will be asked to indicate your degree of support for the strategy. If there is strong support or opposition, we will so note. **You need not come to agreement today.** We will revisit these strategies in the spring.

As another reminder, the Commission’s charter indicates that:

- Inclusion of a specific strategy into the final Action Plan will be made by consensus without vote, unless a vote is requested.
- The complete Action Plan will require majority approval.
MCO Competitive Price Bidding (421) and Third-Party Liability (390)
Competitive price bidding (Slide 1 of 5)

I. Problem Statement

• Minnesota has contracted with MCOs for more than 25 years using an open, competitive process in accordance with federal regulations.
  • Incorporated price bids in three previous procurements, each time generating savings.
  • Improvements in annual MCO rate setting process have contributed to reducing annual cost trend of managed care contracts, particularly the Families and Children contract.
  • Current rates remain relatively lower and closer to lower boundary of actuarial soundness than in the more distant past.

• DHS has concern that year-over-year cost increases are still too high to sustain the program over time, and believes additional efficiencies and improvements could be achieved.
II. Recommended Strategy

• Continue competitive pricing bidding, but add an upper rate limit on rates paid to selected MCOs contracted to serve Families and Children populations. MCOs would have to explain how they would manage costs below the limit while meeting contract obligations.

• The upper rate limit would reflect a decrease in rates from the previous year.

• DHS would incorporate price bid into these upcoming procurements:
  • Families and Children contract for CY 2022 in Greater Minnesota
  • CY 2023 for seven-county Metro area
III. Anticipated Benefits

- Savings estimated to fall in the $1M-$10M range.
- Reduction in managed care base rates.

IV. Supporting Evidence

- State has successfully utilized price bids on three previous occasions, each time helping to reduce overall costs.

V. Administrative Implications

- Resource requirements include a relatively small increase in actuarial costs, staff time, and time and resources for MCOs to respond.
VI. Equity Review Considerations

• Establish equitable contractual mechanisms that concentrate on social determinants as a risk factor to coverage.

• Implement a framework of equitable metrics that address concerns of those who disproportionately rely on managed care for their coverage.

• How will this strategy advance equitable health outcomes related to care management and quality of care?

• Does the strategy make provisions for accountability?

• How will the strategy assess community and stakeholder impact?

• Embed equitable standards in the contract design, RFP, and selection process.
VII. Anticipated Challenges

• MCOs may not be able to fully achieve proposed efficiencies and improvements, which could impact MCO revenue, provider payments, or enrollee access.

• The legislature could create exceptions for certain MCOs, thus reducing the savings that would be achieved.
I. Problem Statement

• DHS undertakes a variety of activities to ensure Medical Assistance is the payer of last resort. DHS relies on:
  • County-based prosecutors to enforce statutes related to estate recovery and subrogation, and
  • Personal injury and trial attorneys to litigate recovery cases involving personal injury or casualty.

• County-based prosecutors currently lack the training and education to ensure consistent, equitable and legally sound application of TPL statutes.

• Personal injury attorneys do not properly adhere to all notification requirements related to accidents and injuries.
II. **Recommended Strategy**

• Authorize and fund DHS to create educational resources related to: the Medicaid program, recovery from probate and non-probate assets, and DHS’s process for seeking recovery or subrogation and its approach to resolution of these cases.

• Specifically, DHS proposes to:
  • Produce training materials and offer trainings, including with a web presence
  • Publish litigation support materials for county attorneys
  • Complete and record trainings for attorneys

• DHS will work with county-based prosecutors, Minnesota County Attorney Association, elder/estate planning bar and Minnesota Association for Justice.
III. Anticipated Benefits

• Savings roughly estimated at approximately $1M.

• Consistent enforcement of Medicaid laws, higher rates of proper payments, and increased cost avoidance accountability.

IV. Supporting Evidence

• County-based survey identified an opportunity for education.

• Minnesota Association for Justice and attorneys in personal injury and workers’ compensation bar have expressed interest in better understanding of the Medicaid program and DHS’s role in recovering benefits.
V. Administrative Implications

• DHS staff time and some financial resources to complete.

VI. Equity Review Considerations

• The strategy considers equity implications by addressing opportunities for counties and personal injury attorneys to ensure a consistent practice across Medicaid programs.

• Further equity considerations:
  • Embed cultural awareness into training
  • Establish an equity lens into the training that focuses on intent vs. impact (benefit and burden)
  • Embed awareness of sovereign nations who are not subject to recovery
VII. Anticipated Challenges

- DHS staff time and financial resources.
- Time and resources of attorneys to attend trainings.
- Geographic and resource challenges of county attorneys.
Break
Public Comment
Pharmaceutical Spending
Minnesota spending on prescription drugs
  - Why are prescription drugs getting so much attention?
  - Drug spending in context

Financial and health impacts of drug costs

MN and other state activity to address drug costs
Why The Attention on Prescription Drugs?
<table>
<thead>
<tr>
<th>Category</th>
<th>Total Spending</th>
<th>Spending (in Billions)</th>
<th>Growth from 2016</th>
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<tbody>
<tr>
<td>Hospital Care</td>
<td>$50.3 Billion</td>
<td>$16.8</td>
<td>▲ 6.9%</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td>$9.3</td>
<td>▲ 2.7%</td>
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<tr>
<td>Other Spending</td>
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<td>$8.2</td>
<td>▲ 6.8%</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td></td>
<td>$7.9</td>
<td>▲ 6.0%</td>
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<tr>
<td>Retail Prescription Drugs</td>
<td></td>
<td>$5.1</td>
<td>▲ 1.3%</td>
</tr>
<tr>
<td>Dental Services</td>
<td></td>
<td>$1.7</td>
<td>▲ 8.4%</td>
</tr>
<tr>
<td>Other Professional Services</td>
<td></td>
<td>$1.2</td>
<td>▲ 2.6%</td>
</tr>
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</table>

Source: MDH, Health Economics Program, forthcoming,
Rx Account for an Increasing Share of Total Spending, Medical Rx Costs Are an Increasing Source of Growth

Source: MDH Health Economics Program. Retail prescription drug spending is net of rebates. Prescription drug spending occurring in medical settings is not net of rebates, which may reduce spending if rebates are collected by providers (estimated potential impact in 2017 may be as much as $360 million). However, the trajectory of total prescription drug spending and prescription drug spending as a share of total spending remains similar.
In 2016, total health care spending was $47.1 billion and estimated to reach $94.2 billion by 2026.

This is the equivalent of annual growth of 7.4 percent each year.

Why The Attention on Prescription Drugs?

- Astonishing brand prices at market entry & regular increases
- Industry practices focused on maintaining revenue (e.g., biologics, generic competition)
- Health care market that is dysfunctional across many dimension:
  - No transparency in price setting and in arrangements across supply chain – perverse incentives abound
  - Generics are not always reducing price
  - Return on innovation is confusing
  - Little or no competition in some therapeutic classes and for drugs made from living organisms (biologics)
Why The Attention on Prescription Drugs, cont’d.

- Populations benefiting from prescription drug therapies are growing
- More expensive therapies are coming
  - Orphan drugs
  - Biologics
  - Specialty drugs
- Stalled congressional and federal action
- And then there is genetic therapy: a new dimension of opportunity ... and bankruptcy
Drivers of Rx Spending are Complex – Not Many Simple Solutions

Seniors and the Chronically Ill Face the Highest Burden (2016)

Average Annual Out-of-Pocket Spending for Prescription Drugs

- Children: $51
- Working-Age Adults: $149
- Seniors: $462
- Commercially Insured: $170
- Medicare: $452
- MHCPs: $27
- One or More Chronic Conditions: $314
- No Chronic Conditions: $88

MN Average: $170

Source: MDH/Health Economics Program analysis of the MN APCD spending in 2016, January 2019
Uninsured, Young Adults, Lower Income, and Some Minority Groups More Likely to Forego Filling an Rx Script Due to Cost (2017)

These are the rates of Minnesotans who reported they did not fill a prescription, broken down by demographic categories. The lines indicate the rate of Minnesotans who did not fill a prescription statewide (9%) and by whether they had a chronic condition (16%) or not (5%).

The statewide rate equals about 500,000 Minnesotans who have reported not filling a prescription. About 330,000 of these have a chronic condition and about 170,000 did not report a chronic condition.

*Indicates a statistically significant difference from the overall statewide rate (9%) at the 95% level.

Public Attention to High Drug Costs Has Been Increasing

The $6 Million Drug Claim
The New York Times

Big Pharma’s Go-To Defense of Soaring Drug Prices Doesn’t Add Up
The Atlantic

We Either Buy Insulin or We Die
The high (and rising) cost of insulin is forcing diabetics to risk their lives to get the drug.

A new drug costs $2.1 million for children with a muscle-wasting disease
USA TODAY
### 2019 State Legislatures' Actions to Curb Drug Spending

<table>
<thead>
<tr>
<th>Type of State Bills/Laws in 2019</th>
<th>Bills</th>
<th>Laws</th>
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<tbody>
<tr>
<td>Pharmacy Benefit Manager</td>
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<td>Drug Price Transparency</td>
<td>51</td>
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<tr>
<td>Importation</td>
<td>33</td>
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<tr>
<td>Drug Affordability Review</td>
<td>14</td>
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<td>Volume Purchasing</td>
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<tr>
<td>Study</td>
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<tr>
<td>Coupons</td>
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<td>Price Gouging</td>
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<td>0</td>
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<tr>
<td>Other</td>
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<td>4</td>
</tr>
</tbody>
</table>

Areas of significant attention nationally have largely overlapped with policies Minnesota has passed or is exploring.

- Licensing PBMs
- Strengthening transparency
- Assessing affordability of prescription drug costs

Source: Adapted from National Academy for State Health Policy (NASHP), October 2019: [the National Academy for State Health Policy](https://nashp.org/policy/prescription-drug-pricing/newly-enacted-laws/); and [NASHP's Legislative Tracker](https://nashp.org/rx-legislative-tracker-2019/).
Actions of Policy Makers Have the Potential to Reach More Than 50% of Minnesotans

<table>
<thead>
<tr>
<th>Private</th>
<th>Public</th>
<th>Public with Federal Constraints</th>
<th>Uninsured</th>
<th>Not Under State Influence</th>
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<tbody>
<tr>
<td>16%</td>
<td>16%</td>
<td>16%</td>
<td>6%</td>
<td>46%</td>
</tr>
</tbody>
</table>

0% 50% 100%

Source: Minnesota Management and Budget/State Employee Group Insurance Plan. 2017 enrollment are estimates. We assume a growth rate similar to the Minnesota Department of Employment and Economic Development QCEW 2016 to 2017. The 2017 membership are estimated by MDH at 2.5 times employment. Employment data is from Minnesota Department of Employment and Economic Development, data for 2017 (QCEW Results); number of people covered by health insurance through local government estimated by MDH at 2.5 times employment (same as state government). Population estimates are based on adult and juvenile population as of July 1, 2017. Minnesota Department of Corrections: Adult Prison Population Summary and Juvenile Resident Population Summary, the MN Department of Corrections at https://mn.gov/doc/data-publications/offender-statistics/historical-population-summary-reports/. Monthly average enrollment (estimated net enrollment) during calendar years 2017 and 2018. Fully Insured, small group and individual market estimates from Health Economics Program, based on health plan reporting. Most uninsured are eligible for public programs, or could enroll in the individual market (in 2017 and 2018). Number of uninsured from the Minnesota Department of Health/Minnesota Health Access Survey.
Initiatives on Prescription Drugs in Minnesota

**Governor’s Subcabinet Working Group**
- Identify opportunities for greater collaboration on prescription drug budget and other challenges
- Inventory public direct and indirect prescription drug spending

**AG Ellison: Task Force on Lowering Pharmaceutical Drug Prices**
- Charged with compiling data to better understand causes of high drug prices and develop recommendations to lower prices

**MN Medicaid Program**
- Various administrative and policy changes

**MN Legislature:**
- Deliberating pathway for providing emergency and longer-term insulin security for diabetics
- Considering Rx transparency
- Passed PBM licensure legislation

**MDH: Data Analysis and Public Use Files**
- Prescription drug analyses on spending, trends, and prescribing patterns
- Public use files in development ranking drugs by multiple criteria

**MDH/DHS: Blue Ribbon Commission**
- Three high-priority proposals under consideration
Thank You!

Health Economics Program: www.health.state.mn.us/healtheconomics
MN All Payer Claims Data: www.health.state.mn.us/data/apcd/publications.html
Health Care Market Statistics: www.health.state.mn.us/data/economics/chartbook/
The Health Care Spending Dilemma (Video): https://youtu.be/aitOKUtAgrs
Contact: Stefan.Gildemeister@state.mn.us | 651.201.3550
Break
Healthcare Cost Savings Strategy Presentation and Discussion
Pharmacy pricing: Uniform pharmacy benefit (407)
I. Problem Statement

• Spending on prescription drugs in Minnesota is rising at a rate much higher than growth in the number of prescriptions, according to Minnesota’s All Payer Claims Database (APCD).
  
  • Prescription drug spending rose 20.6%, between 2009 and 2013.
  
  • In Medical Assistance, pharmacy service spending per enrollee increased by 56.6% between 2012 and 2016.
  
  • Increases have been significantly more rapid in managed care pharmacy benefit than for the FFS benefit.
II. Recommended Strategy

• DHS administers the pharmacy benefit for Medical Assistance beginning January 2022.
  
  • Currently, pharmacy benefits are administered either by DHS or by the MCOs through their Pharmacy Benefit Managers.

• By moving management of the pharmacy benefit to DHS, the State will reduce cost of providing pharmacy benefits and improve visibility and transparency into pricing and operations.

• A uniform pharmacy benefit will rely on the State’s preferred drug list process, which is established and maintained transparently with consumer and provider input.
III. Anticipated Benefits

• Savings to be determined by DHS staff. Will vary based on whether the State can start prior to January 2022.

• Implementing this strategy will result in reduced cost and increased transparency for Medical Assistance without significant impact on consumers.

IV. Supporting Evidence

• West Virginia recently implemented this strategy and experienced significant savings ($54M – state and federal shares combined)

• Additional states have recently implemented, or are in process of implementing, this strategy (California and North Dakota).
V. Administrative Implications

• Additional funding will be necessary to account for increased prior authorization volume that would have been handled by MCOs but will shift to DHS.
V. Equity Review Considerations

• What are the unintended consequences?
• How does the strategy impact Medicaid beneficiaries?
• How will the strategy assess community conditions and geographic impact?
• How will this strategy reduce poor health outcomes?
• Does the strategy pose a potential impact in access to pharmacy service benefits?
• Further equity consideration: embed an equitable process for utilization management.
VII. Anticipated Challenges

• Added administrative to manage increased prior authorization volume.

• Ensuring continuity of patient experience where prior authorizations are already in place.
Pharmacy Pricing: Prescription drug purchasing council (192)
I. Problem Statement

• All payers of health care benefits have experienced increasing pressure in their budgets from the high and rising cost of prescription drugs.

• The market for pharmaceutical products fails to operate effectively and transparently.

• Intermediaries benefit from this opaqueness, and from payers operating in isolation, when establishing formularies or preferred drug lists, negotiating rebates and other financial components in contracts.
II. **Recommended Strategy**

- Establish a legislatively chartered group comprised of officials from across applicable state agencies, counties, cities and other public entities to:
  
  - Conduct a comprehensive inventory of prescription drug spending in the state;
  
  - Identify opportunities for, and boundaries to, greater collaboration on purchasing of prescription drugs; and
  
  - Support the development and implementation of strategies to increase leverage of prescription drug benefit purchasing within existing statutory authorities, as well as the development of legislative proposals to address statutory barriers.
III. Anticipated Benefits

- More Minnesotans may experience lower-than-projected increases in their premiums or cost-sharing related to increasing prescription drug prices.
- Public purchasers (non-DHS purchasers likely, initially) may gain increased power in negotiation of prescription drug benefits and prices with drug manufacturers and PBMs.

IV. Supporting Evidence

- Delaware and New Mexico each passed similar legislation to create an interagency group tasked with identifying steps to increase the leverage of state purchasing of prescription drugs; no data on results are available yet.
V. Administrative Implications

- Resources to operate the council, including technical expertise and resources to develop and run financial models to assess the impact of various potential strategies.
V. Equity Review Considerations

• Which specific populations could experience unintended consequences?
  • Will this strategy impact existing programs?
  • What could be the equity implications when adapting this strategy to Minnesota?
• How will this strategy equitably develop the council, considering racial/ethnic and geographic access that is representative of Minnesota, as well as applicable public entities?
• How will this strategy ensure collaboration?
• How will the strategy make provisions to reduce administrative challenges?
VII. Anticipated Challenges

• Statutes or existing contract provisions that prevent greater collaboration in purchasing and data sharing.

• Limited legal, business, and operational expertise.

• Risk aversion among partners to substantial change, reinforced by labor contracts.

• Gaining access to reliable data to model procurement alternatives.

• Designing possible narrower pharmacy benefit or formulary designs that address the needs of populations with certain conditions and needs for specific drug therapies.

• Avoiding time and administrative barriers to accessing high-cost drugs as a result of preferred drug lists, step therapy, or other forms of utilization management.
Pharmacy Pricing: Establish Rx affordability commission (205)
I. Problem Statement

• In 2013, over 130,000 Minnesotans paid $1,000 or more out-of-pocket for prescription drugs; nearly 3,000 people paid $5,000 or more.

• High and increasing prescription prices contribute to increased premiums for all beneficiaries.

• Rates of Minnesotans foregoing filling a prescription due to cost are on the rise and stand at levels last observed during the economic recession 13 years ago (9.1% in 2017).

• Foregoing filling a prescription is associated with worse health outcomes—an additional 4.4 mentally unhealthy days per month and an additional 3.9 physically unhealthy days per month among Minnesotans with a chronic condition.
II. Recommended Strategy

• To establish a Prescription Drug Affordability Commission that will:
  • Assess, for certain drugs, whether the wholesale acquisition cost (WAC) would lead to affordability challenges for the state health care system or high out-of-pocket costs for patients;
  • Establish an upper reimbursement limit to apply, as permitted, to all purchases and payer reimbursement for drugs dispensed or administered to individuals in the state;
  • Identify potential instances of price gouging for referral to the Minnesota Attorney General, and
  • Perform certain activities related to ensuring compliance with requirements for upper reimbursement limits.
III. Anticipated Benefits

• Spending on prescription drugs by individuals and health plan payers will, over time, decline or stabilize.

• Manufacturers may establish reimbursement levels more consistent with likely outcomes of a review while also producing useful public information on cost and therapeutic effectiveness.
III. Supporting Evidence

• Nationally, it remains too early to assess the impact of state-level action to set upper price limits on selected, high-cost prescription drugs, as similar legislation was only recently passed in Maryland and Maine in 2019.

• Internationally, there is substantial evidence that the use of centralized, national reimbursement limits, or centralized negotiation with drug manufacturers, results in lower pharmaceutical prices.
V. Administrative Implications

• Resources to fund operations of the Commission, including:
  • hiring staff;
  • acquiring pricing information/data systems/technical expertise, and
  • overseeing compliance with manufacturer reporting and reimbursement limits.
Establish Rx affordability commission
(Slide 6 of 8)

V. Equity Review Considerations

• How will the strategy establish an equitable mechanism for the development of the commission, selection of prescription drugs for review, and the reduction institutional and structural barriers to greater public engagement?

• Does the strategy consider the impact on populations that experience high costs associated with prescription drugs?

• What could be the equity implications of this strategy, and how will the commission identify and reduce inequities?
VII. Anticipated Challenges

• Past criticisms of approaches like affordability commissions have argued that such approaches risk reducing access to selected prescription drugs.

• Yet, even at lower reimbursement levels than they receive in the U.S., manufacturers continue to sell drugs in other countries, as these lower rates remain above manufacturers’ expenses from research and development, production, and marketing.
VII. Anticipated Challenges (Continued)

- **Scope and Capacity** – An estimated 1,000 drugs per year would fall within the purview of the commission based on current affordability review thresholds. The commission would need to select a manageable number to review within available resources.

- **Litigation** - Similar legislation has been met with vigorous legal challenges from manufacturers.

- **Compliance and Enforcement** – Determining how the State will monitor for and address noncompliance.

- **Assignment of Responsibilities** – While third-party entities that perform cost-effectiveness research could be of use to this strategy, the commission will need to find ways to assess the rigor of such analysis, as well as consider patient testimony on access, affordability, and preferences.
Wrap-up
Thank you!

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