INTERAGENCY PHARMACEUTICALS PURCHASING COUNCIL
Meeting November 12, 2020
Virtual Meeting - GoToMeeting
1:00 pm to 4:00 pm

1. CALL TO ORDER

Ken Ortiz, Director of the Interagency Pharmaceuticals Purchasing Council (IPPC), called the meeting to order at 1:04 p.m. via GoToMeeting. A quorum was established with roll call.

ROLL CALL

Designee, Department of Health, Dr. Thomas Massaro
Designee, Children, Youth, and Families Department, Terry Locke
Designee, Corrections Department, Wencelaus Asonganyi
Director, Risk Management Division, General Services Department, Mark Tyndall
Executive Director, Retiree Health Care Authority, David Archuleta
Designee, Albuquerque Public Schools, Valerie Atencio
Designee, University of New Mexico, Joey Evans
Executive Director, New Mexico Counties, Steve Kopelman

ABSENT/EXCUSED

Designee, Human Services Department, Dr. David Scrase
Executive Director, New Mexico Public Schools Insurance Authority, Richard Valerio

2. APPROVAL OF THE AGENDA

MOTION: Secretary Ortiz asked for a change to the Agenda to move agenda item number 4, "Update on House Bill 292: Prescription Drug Cost Sharing", to agenda item number 8 to accommodate a scheduling conflict for Superintendent Toal. Dr. Massaro moved to approve the agenda. The motion passed unanimously.

3. APPROVAL OF MINUTES

MOTION: Mr. Tyndall moved to approve the August 13, 2020 minutes with a second from Mr. Locke. The motion passed unanimously.

5. Update on Senate Bill 1: Wholesale Prescription Drug Importation Act

Presenters from the Department of Health, Aryan Showers, Policy Director and Dr. Massaro, Chief Medical Officer provided an update on the Senate Bill 1: Wholesale Prescription Drug Importation Act (presentation attached to the minutes).

Secretary Ortiz opened up for questions and comments from IPPC members and members of the public. There were no questions for presenters. Hearing no questions, Secretary Ortiz thanked the presenters.

6. NM Health Landscape and the Special Challenge of Unaffordable Prescription Drugs. One Solution: the Prescription Drug Affordability Board

Barbara Webber, Executive Director for Health Action New Mexico provided a presentation on the New Mexico Health Landscape and the Special Challenge of Unaffordable Prescription Drugs. One Solution: the Prescription Drug Affordability Board (presentation attached to the minutes). Jane

Horvath from Horvath Health Policy was also part of the presentation to help answer questions for committee members.

After the presentation, Mark Tyndall, Director of the Risk Management, General Services Department, thanked Ms. Webber for her presentation.

Secretary Ortiz opened up for questions and comments from IPPC members and members of the public. There were no questions for presenters. Hearing no questions, Secretary Ortiz thanked the presenters.

7. Updates on State Drug Pricing Strategies

Trish Riley, Executive Director for the National Academy for State Health Policy (NASHP) provided Updates on State Drug Pricing Strategies (presentation attached to the minutes).

After the presentation Mr. Tyndall thanked Ms. Riley and asked whether Ms. Riley knew whether review boards setting International Reference Rates need statutory authority to do so or whether the rates could be implemented administratively. Ms. Riley stated these are new initiatives and it depends on state to explore whether certain departments or boards within those states have the capacity to implement these initiatives or whether legislative authority in these states would be necessary. The models Ms. Riley presented assumed that legislative authority would be needed.

Mr. Tyndall asked Ms. Riley if she had come across states that have set upper limits on various types of medical spending but these limits were ignored by providers. Ms. Riley stated that NASHP is working with legal professionals on how to enforce states' medical pricing caps to ensure there are appropriate enforcement vehicles to hold providers accountable. But she warned that any enforcement method would be tested.

Superintendent Toal commented that he liked that Reference Rates are not set arbitrarily by an individual state, rather these rates are available for anyone in the country. He asked how often the Reference Rates are updated and the duration of these rates. Ms. Riley did not know the answer to the question but said she would get back to him with an answer. She also suggested that states could use the Medicare prescription rates as an index.

Louanne Cunico from the Presbyterian Health Plan noted that all the drugs presented on the ICER (Institute for Clinical and Economic Review) Analysis were generic or bio-similar and asked Ms. Webber when ICER planned to update its analysis of the cost and spending and the ratio of benefit versus pricing. Ms. Webber deferred the response to Ms. Horvath, who stated she did not know ICER's process for updating and asked for Ms. Riley's input. Both stated that ICER picks a "basket of drugs" each year to analyze.

Hearing no other questions, Secretary Ortiz thanked Ms. Riley for her presentation and said he would reach out to her to coordinate a call with Maine and New Hampshire to discuss their successes and experiences with Drug Affordability Boards.

4. UPDATE ON HOUSE BILL 292: Prescription Drug Cost Sharing

Superintendent Toal reminded attendees that House Bill (HB) 292 imposes a maximum of $25 per month out of pocket cost-sharing for preferred formulary insulin products. This provision goes into effect on January 1, 2021 and OSI has communicated this to New Mexico health plans with a reminder that all payers must recognize their obligation to this provision.

Mr. Toal stated that a second provision of HB 292 called for an advisory committee to study nine therapeutic drug categories to look at whether these medications warranted the same kind of patient cost sharing limitations as the insulin products.

The advisory committee reached out to licensed insurance companies in the state to provide information needed for analysis, engaged with an actuarial firm to work and guide the advisory committee, worked with insurers, and issued a report of the advisory committee on October 1, 2020 and shared with all New Mexico legislators.

Mr. Toal noted that this report, as well as the actuarial study, can be found at the Office of Superintendent website and in summary, the report noted that " … most of the current cost sharing for the drug categories in HB 292 is already relatively low with a high proportion of scripts being filled with generic drugs. However, the average cost sharing varies by insurer, plan, and drug category. Establishing cost-sharing limits could significantly lower out of pocket costs for a notable portion of members, but with some impact to overall insurer liability, which would need to be offset through higher premiums or higher cost sharing for other services or drugs".

Mr. Toal reported the OSI does not intend to bring legislation forward based on the report but he has heard feedback from some legislators that a similar HB 292 bill may be introduced to ensure that none of the nine therapeutic drugs impose more than a $25 co-pay.

Mr. Ortiz asked whether a public service announcement or communication campaign is underway to notify New Mexico citizens of this news. Mr. Toal said the OSI will communicate this news and pharmaceutical carriers will also issue communications.

Amber Espinosa-Trujillo from the General Services Department's Employee Benefits Bureau asked if Mr. Toal would look at the drug, Advair Diskus because she has been getting calls from state health plan members using this medication that the price has gone from $17 for a 3-month supply to $530. Mr. Toal thanked Ms. Trujillo for bringing this issue forward.

Mr. Ortiz asked Superintendent Toal to inform him if he needed any additional information from the General Services Department.

8. IPPC SUBCOMMITTEE'S WORK PROGRESS

Rx PAYER SUBCOMMITTEE WORK PROGRESS

Mr. Tyndall reminded IPPC members that at the last IPPC meeting he prepared and presented a PBM Contract Comparison from the five payers on the subcommittee, which showed many similarities between the contracts.

Today, Mr. Tyndall provided a comparison of cost trends for the Interagency Benefits Advisory Council's (IBAC) entities, excluding the Retiree entity (presentation attached to the minutes).

Rx PURCHASER SUBCOMMITTEE WORK PROGRESS

Department of Corrections, Mr. Asonganyi, Health Services Administrator, presented steps the Purchaser subcommittee will be taking to move the Purchaser subcommittee forward (presentation attached to the minutes).

Secretary Ortiz opened up for questions and comments from IPPC members and members of the public. There were no questions. Hearing no questions, Secretary Ortiz thanked the presenters.

9. PUBLIC COMMENT

There were no public comments.

10. NEXT STEPS FOR IPPC

Mr. Ortiz stated the next meeting will be February 11, 2021, noting that we will follow the Open Meeting Act and provide required notification on the IPPC meeting venue as well as whether any Special Meetings will be held before the regularly scheduled meeting date.

11. ADJOURN

MOTION: With all business conducted, Dr. Massaro moved to adjourn at 3:12 p.m. with a second from Mr. Archuleta. The motion passed unanimously.

Ken Ortiz, Director

5/14/21
Date

SB 1: Prescription Drug Importation Program Update

Interagency Pharmaceutical Purchasing Council

Aryan Showers, Policy Director, NMDOH

Thomas Massaro, Chief Medical Officer, NMDOH

November 12, 2020

Goals of Senate Bill 1

"Wholesale Drug Importation Act"

- Provide a state pathway to safe, effective, more affordable medications by importing them from countries that have lower-priced drugs
  - Reduce consumer costs, reduce state costs

Types of medications

- High cost medications, but not biologics or controlled substances

Safety and Effectiveness Safeguards

- State must meet FDA safety/efficacy standards
- State must comply with federal law on tracking and tracing
- Regular audits on program compliance

Partner countries

- Canada
- Other countries if authorized by the FDA

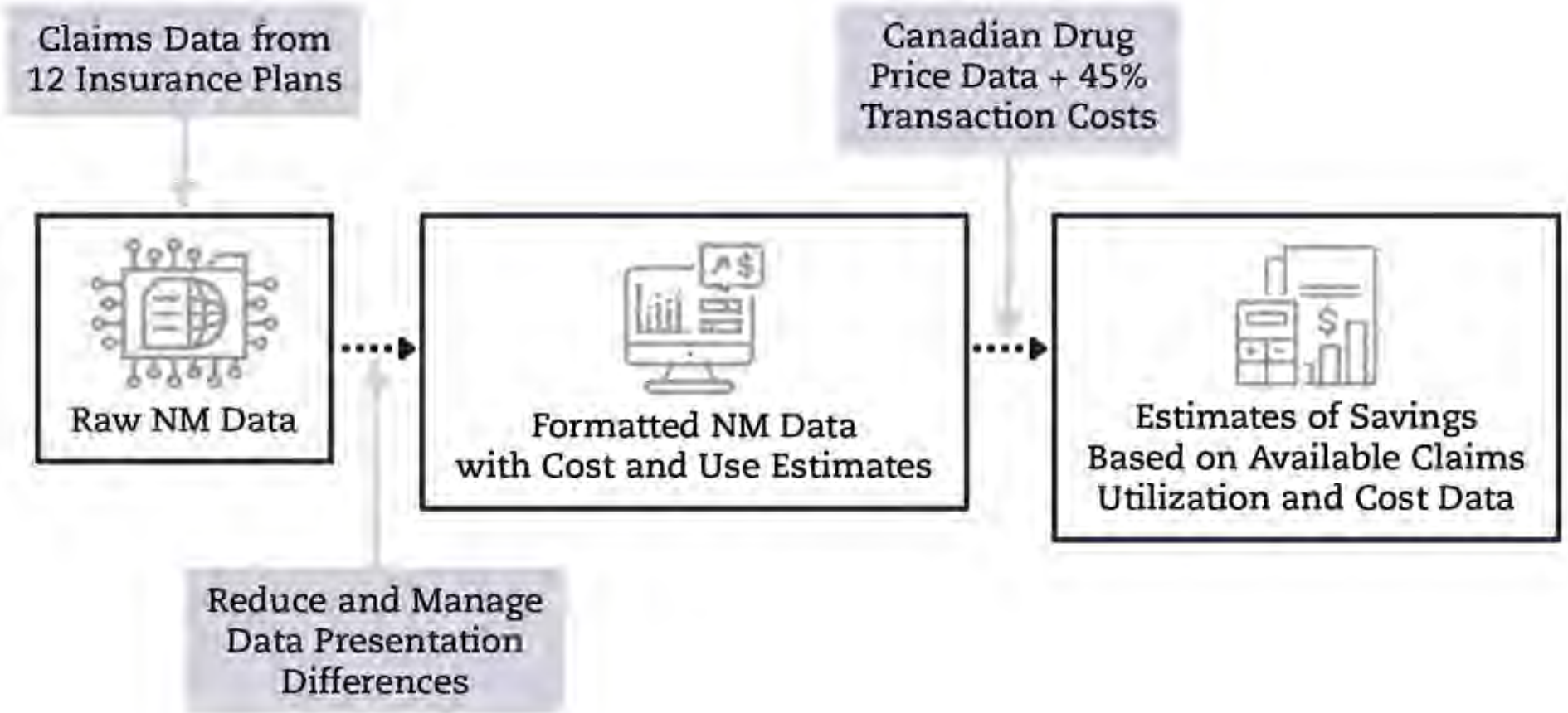
Populations who may benefit

- Individuals with private insurance
- State employees and institutional purchasers
- Taxpayers
- The Uninsured

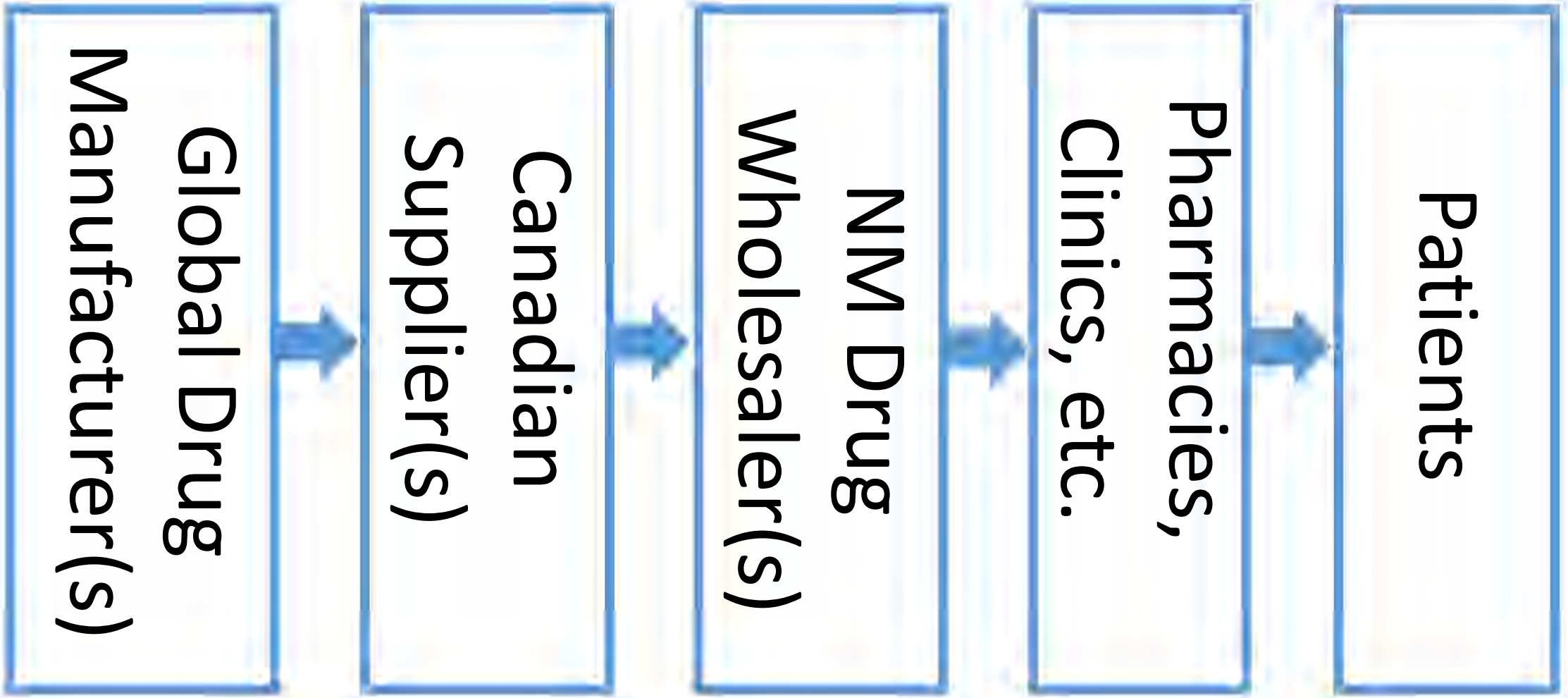
State agencies involved

- DOH
- Advisory Committee: DOH, OSI, HSD, GSD, Board of Pharmacy

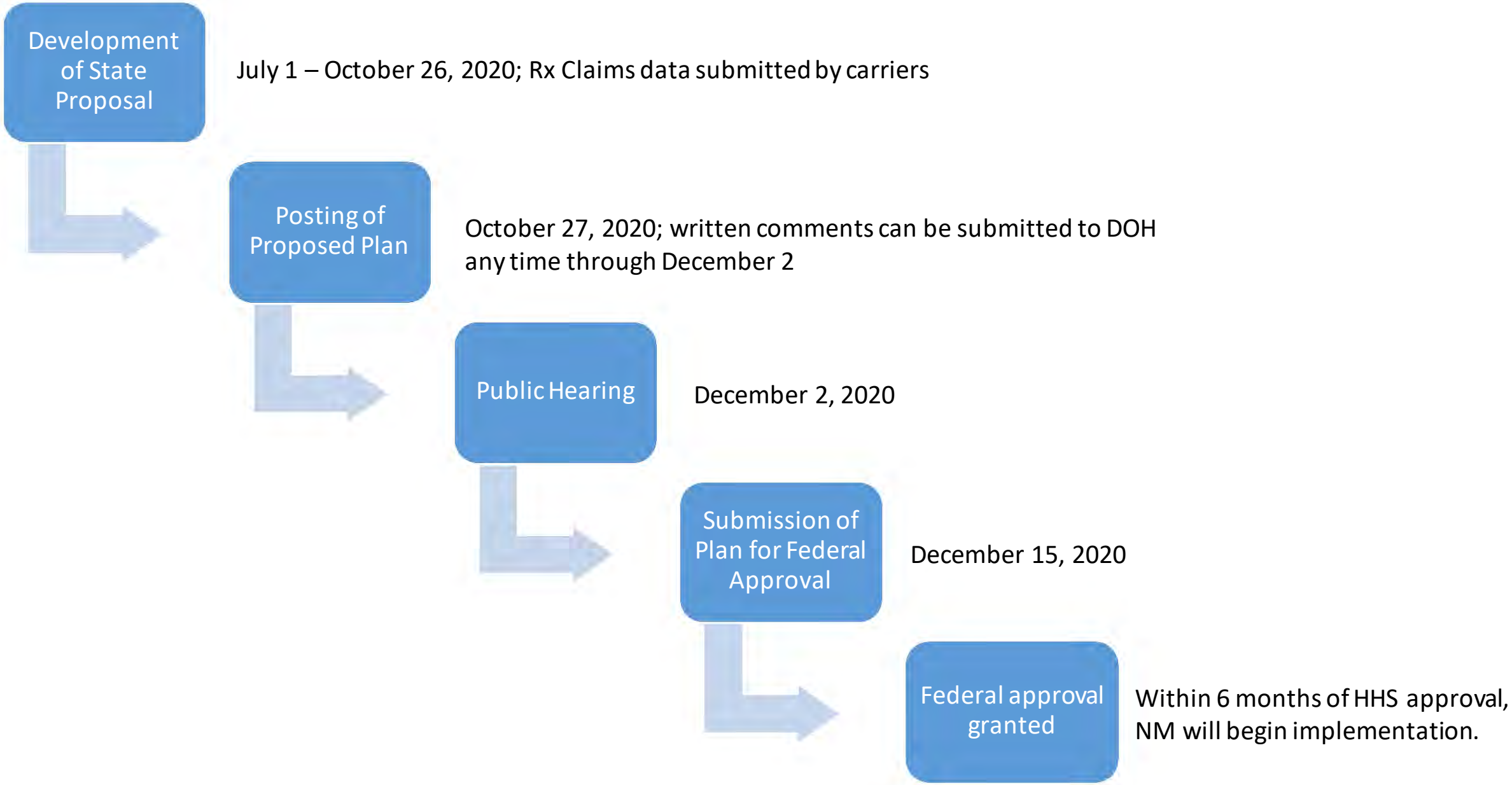
Flow Diagram of Importation Cost-Savings Analysis



SB 1 Supply Chain To Mimic Existing Flow



Timetable


Development of State Proposal
July 1 – October 26, 2020; Rx Claims data submitted by carriers
Posting of Proposed Plan
October 27, 2020; written comments can be submitted to DOH any time through December 2
Public Hearing
December 2, 2020
Submission of Plan for Federal Approval
December 15, 2020
Federal approval granted
Within 6 months of HHS approval, NM will begin implementation.

Implementation

- Within 6 months of HHS approval, NM DOH must begin implementation.
- SB 1 outlines the requirements that must be addressed on implementation.
- The Wholesale Prescription Drug Importation Fund will be created as a non-reverting fund in the state treasury.
- DOH must submit an annual report to the Governor and Legislature about the operation and impact of the program.

Importation: Federal Law

- **In general**, importing Rx into the US is not legal except under the control of the original manufacturer, except as follows:
  - **Personal:** The FDA does not enforce the law for importation of drugs for individuals when quantity ≤ 90 pills
  - **Wholesale:** With Federal DHHS Secretarial approval, allows importation of wholesale quantities of drugs from Canada by wholesalers or pharmacies if safe and consumer savings are guaranteed
    - Biologics (including insulin and vaccines) excluded from importation by law
    - Imports only from Canada allowed
- In general, ~70% of US Rx supply is imported already by manufacturers. Federal law and regulation establish a safe, transparent, global supply chain that state wholesale import programs would use. Proposed regulation tries to add more requirements to wholesale importation that are not needed and make state importation very difficult on several levels.

Importation: Final Regulation

- Federal Proposed Rule, 12/2019, Final Rule 9/24/2020.
  - Rule establishes requirements for federal approval of an import program
    - Program must be overseen by a state government – we are working with the BOP on a co-sponsored program
      - Two year approval periods
      - Program terminated for any infraction – no corrective action
    - Pharmaceuticals *licensed and labeled* for Canadian market
    - Foreign Seller (~Canadian wholesaler) registered with FDA
      - Only 1 foreign seller per state
    - Import packaged products (not bulk quantities)
    - Batch testing after purchase and before labeling for US market, on US soil, by lab with FDA testing history
    - Phased federal application approval –Foreign seller vendor can be identified within 6 months of conditional application approval. State application must name rest of supply chain
    - Program requires manufacturers to provide certain data and records to the State
    - Flexibility to calculate consumer savings

The Basics of State Wholesale Importation

- Price through the supply chain based on imported price
- Imported price is publicly available
  - Consumers know what price to expect
  - Carriers know what to pay
- Import price should be basis of claims payment
- Import price should be basis of insured's cost sharing or out of pocket if uninsured
- Only prescription drugs with Canadian price that produce net savings should be imported

The Basics

- Imports tested prior to distribution in NM
- Imports relabeled to FDA specifications
  - including NDC for billing and payment purposes
  - State will be the manufacturer/labeler of record
- Imports stay in NM for safety assurance
- There are no US manufacturer rebates on imported products

Take- Away…

- Despite having developed a Drug Importation Program, we interpret the final rule to limit the implementation of these programs for states
- There is much uncertainty given the eventual shift in administrations and policy priorities
- We have joined several states in passing legislation to reduce the cost of prescriptions in light of the federal government taking no action. This momentum is valuable
- We have learned a great deal about our New Mexico population and ways to deliver these savings
- This a valuable and foundational step for any future proposals seeking to limit the cost of these drugs to NM consumers

NM PRESCRIPTION DRUG AFFORDABILITY BOARD

Health Action New Mexico

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NMCAP
NEW MEXICO CONSUMERS FOR AFFORDABLE PRESCRIPTIONS

EASY ENROLLMENT – LEVERAGING TAX FILING TO ENROLL ELIGIBLE NEW MEXICANS

PRESERVING MEDICAID IN A BUDGET SHORTFALL.

INCREASING HEALTH COVERAGE AFFORDABILITY FOR LOW INCOME NEW MEXICANS

Some NM Health Policy Issues for 2021

In addition to reducing prescription drug prices in NM.

Medical Debt Protection

Emergency Medicaid (EMSA) treatment for undocumented immigrants who get Covid

Covid Relief for those in need, business, healthcare

Oral Health elevation at state and federal level

US Healthcare Spending

The biopharmaceutical sector facts

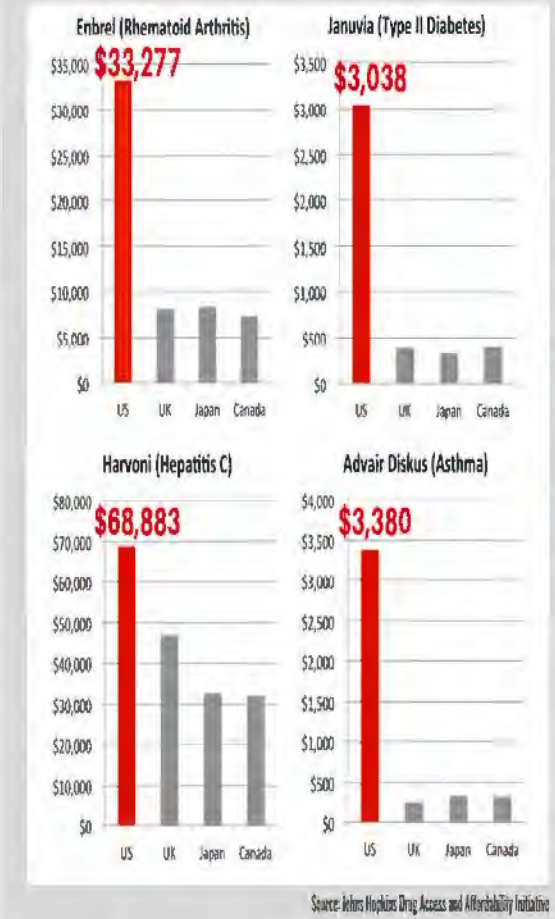
- **US spends equal to 18% of its GNP on healthcare – twice the amount of the 9 other developed countries - with poorer health outcomes. (**Papanicolas, Woskie, and Jha 2018). **We are now 25th in the world for life expectancy.**

- **In perspective, the savings of what the next highest GNP country spends on healthcare – 7 percentage points less - would pay for all US public primary and secondary education system** (Natl Academy of Sciences 2019)

The Washington Post, Big Pharmaceutical Companies are Spending Far More on Marketing than Research; February 11, 2015

The biggest driver of prescription drug costs is price increases on existing medications, not new drugs entering the market.

Americans pay more for their prescription drugs than any other developed country in the world.



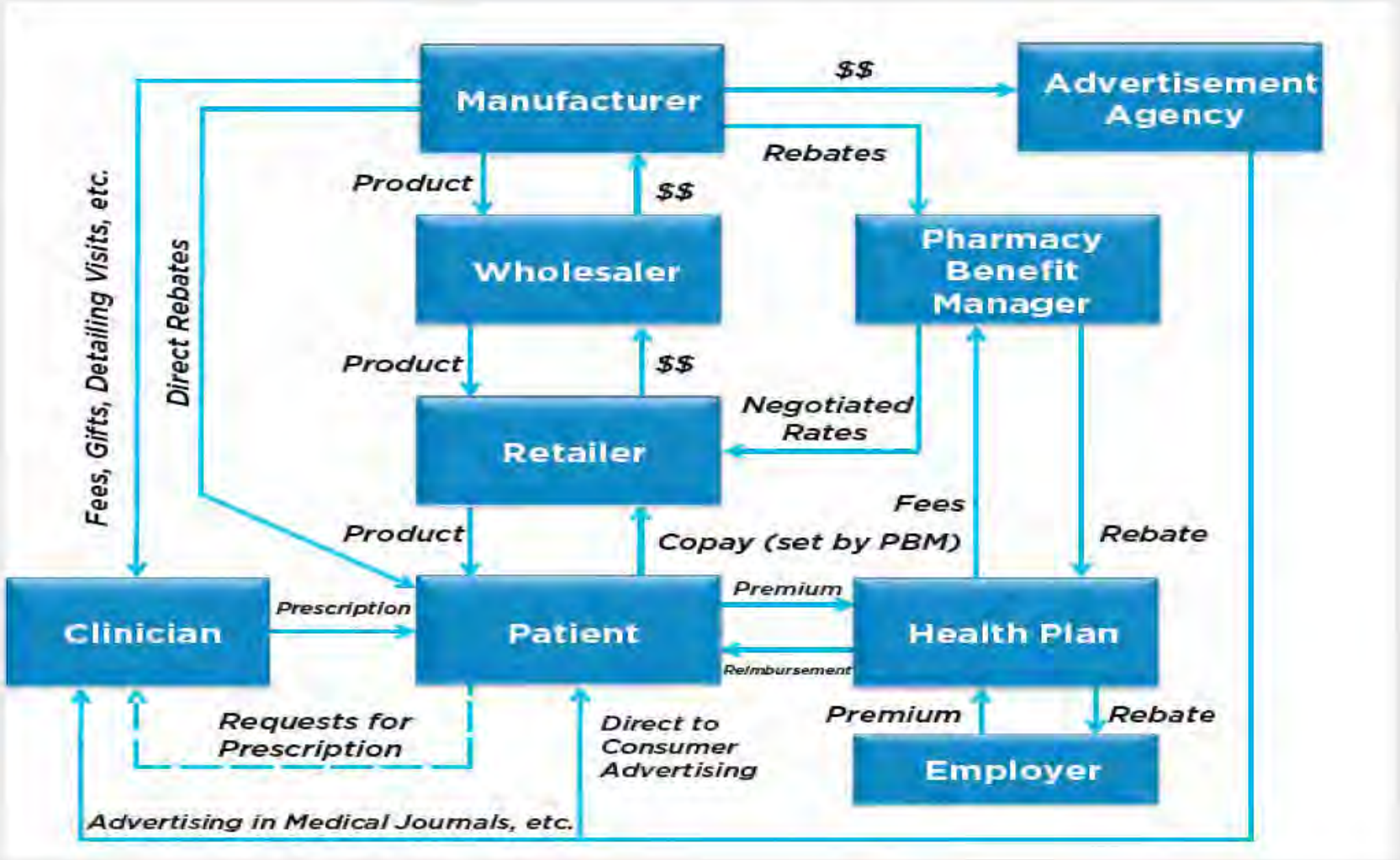
WE'RE ASKING: WHY DO AMERICANS PAY MORE FOR THE SAME PRESCRIPTION DRUGS?

Biopharmaceutical sector

Quick Facts

- Annual expenditures on biopharmaceuticals is nearly 17% at half a trillion dollars of the US health care bill.
-
- The pharmaceutical industry ranks 2nd in 18 industries according to OpenSecrets.com in lobbying expenditures.
- A study by the Institute of New Economic Thinking revealed that over a 10 year period drug companies expended 11% more on share repurchases and dividends than on R&D.
- Industry with greatest profit margins: Branded pharmaceuticals with 28% and generics ranked 4th at 26% (Sood et al., 2017)

Complexity of the retail market for RX drugs



Price

74% of for all drug patents between 2005 and 2015 were for existing drugs many using evergreening or minor changes of no significance

In 2019, 4,311 prescription drugs experienced a price hike, with the average increase hovering around 21%, according to data compiled by Rx Savings Solutions, a consulting group.

- **A Gallup Survey n June 2020 found 90% of Americans worry that drug companies will take advantage of the pandemic to raise drug prices. In addition to the January 2020 average 6.8% increase, in June prices increase 3.5%.**

Looking at consumer picture in NM

In October 2020, GBAO Polling firm conducted **statewide polling in NM** on medication issues.

Some key findings:

- NM Consumers regardless of race, ethnicity or party affiliation rated the cost of drugs **in their top 4 concerns: 1. Cost of Health Care. 2. Level of Poverty in NM. 3. Lack of good jobs.** 4. **Cost of RX. These concerns were higher than crime, school quality and funding, coronavirus, & taxes.**

- **44% of New Mexicans answered that they had not filled a prescription or skipped taking medications because of cost concern.**

- **78% favored a Prescription Drug Affordability Board and after hearing oppositional messaging, those favoring a Prescription Drug Affordability remained high at 71%.**

Patient stories
Mr. Valentin Anaya - Socorro

- Mr. Anaya lives in Socorro with his wife and two high school age children. His son has autism so he has been staying at home with him. They are on his wife's insurance where they pay $800 a month. His insulin is costing him $400 a month. An injection for a back injury cost him $500 and are slowly paying that off. They are putting of his required surgery until they can save up for the cost of the surgery.

NM Patient Stories

- Kristina C., Albuquerque, NM

For the past 28 years, I've taken various $300,000 per-year drugs to treat my Gaucher's disease. Like other patients, I appreciate the innovative breakthroughs for new treatments, but I can't help but wonder if the price tag has reached the point of being absurd. These drug companies are earning unreasonable amounts, and they're earning all of this profit off of people's misfortune. Americans pay more for their prescription drugs than anyone else in the world. Patients like me deserve leadership that works for affordable drugs.

Cecilia and Susana Las Cruces

Ceciia's daughter has a life threatening seizure disorder. Her critical meds were paid until she turned 19 to go off of Medicaid., As a working college student she often struggles to make the medication payments and her mother helps out. Her Mom has been diagnosed with a serious digestive disorder. She has spent a year appealing with her insurance company because she cannot afford the monthly out of pocket costs for her specialty drug. So her illness remains untreated.

Cost of Prescription Drugs

- Patients
- Premiums
- Public Health
- Health Equity

Basic premise for state action on affordable medications

- **Consumer access to effective and affordable medicines is imperative for public health, social equity and economic development and this imperative is not served by the biopharmaceutical enterprise as it exists today. Simply stated, the current system is not sustainable.**
  - Making Medicines Affordable, The National Academy of Sciences 2018

PDAB – a state solution being pursued in 15 states and passed in two states

Intent of PDAB

- **Set a maximum amount purchasers and health insurers pay for the costliest drugs**, which reduces costs and increases access for consumers and payers.
- **PDABs regulate Instate costs** for particular drugs among state licensed health care entities

Sets an upper payment limit. PDABs do not control prices

- **Does not regulate manufacturer list prices.**
- **Upper payment limits** – common in the industry – limits what insurers wills reimburse.
- **All residents get the benefit** of the statewide upper payment limit regardless of their health plan or lack of coverage

What is a Prescription Drug Affordability Board?

Prescription Drug Affordability Board

A Prescription Drug Affordability Board is an independent body with the authority to evaluate high cost drugs and set upper payment limits on what state residents will pay. This is similar to existing state practices for utilities and insurance premiums. Upper payment limits apply to the entire supply chain, ensuring lower costs benefit consumers.

Five Member Board

Stakeholder Council

Full-Time Staff

Evaluate Expensive Drugs

- New drugs: $30,000
- Existing brand name: $3,000 increase
- Pose any affordability challenge

Entire Supply Chain

- Manufacturers
- Wholesalers/PBMs
- Insurers/Pharmacies

Upper Payment Limits

- Set fair, affordable rates
- Consider barriers
- Apply to all purchasers and payor reimbursements

DRUGS DON'T WORK IF PEOPLE CAN'T AFFORD THEM.

Health Action New Mexico

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NEW MEXICO CONSUMERS FOR AFFORDABLE PRESCRIPTIONS

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New Mexico Interagency Pharmaceuticals Purchasing Council (IPPC) Meeting
Nov. 12, 2020

State Action Achieving Rx Cost-Savings

Trish Riley - Executive Director
National Academy for State Health Policy
triley@nashp.org

Supported by Arnold Ventures

Setting the Stage: State Legislative Action

Drug Pricing Laws 2017-2020					
Year	**2017**	**2018**	**2019**	**2020**	**Total**
Number of States Enacting Laws	13	28	37	17	48
Total Laws Enacted	18	45	62	35*	160*
PBM	8	32	33	19	92
Transparency	3	4	7	4	18
Importation	0	1	3	2	6
Affordability Review**	1	0	3	1	5
Volume Purchasing	0	0	2	0	2
Coupons/Cost Sharing	1	0	4	9	14
Study	0	1	5	1	7
Other	5	7	5	0	17

**Totals laws enacted are lower than column totals because a New Hampshire law contains multiple provisions.*
*** Includes New York's Medicaid drug cap and Massachusetts' enhanced negotiating authority.*

- Since 2017, legislation to address prescription drug costs has been **introduced** in all 50 states.
- Since 2017, 48 states have **enacted** 160 laws to address prescription drug costs.

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Medicaid: Rx Carve-outs / PBM Contracts

West Virginia:

- 2018 - $54.5 mil in savings from Rx carve-out (550,000 enrollees)

Ohio:

- 2018 – DoH report: PBMs serving Medicaid MCOs retained $224 mil in profits from spread pricing
- 2019 – required MCOs to have transparent, pass-through (no spread) contracts with PBMs
- 2020 – Rx carve-out from MCOs; single PBM contract for Ohio Medicaid (3 mil enrollees)

California:

- Jan. 2021 - Medi-Cal Rx carve-out; Single PBM contract for Rx benefit for Medi-Cal, state employees, corrections, and counties
- Estimated net savings of $100s of millions annually

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Medicaid: Single PDL

Washington:

- Jan 2018: Health Care Authority (HCA) began instituting a single Medicaid PDL across all MCOs/FFS
- Phased in all drug classes over two years
- Evidence-based PDL determined by:
  - P&T Committee / Drug Utilization Review Board review of clinical effectiveness
  - Opportunities to maximize supplemental rebates
- HCA estimated $22 mil in savings over the biennium

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Medicaid: Drug Caps & Enhanced Negotiating

New York (2017)

- Medicaid has authority to negotiate with drug companies for supplemental rebates if spending is projected to exceed an annual spending limit. If unable to reach an agreement, drugs are referred to its Drug Utilization Review Board for a value assessment
  - Results as of Aug 2019:
    - Achieved $85 mil statutory savings target
    - Negotiated over 20 supplemental rebate contracts
    - In SFY 19, net drug spend increased 1% over SFY 18 – a significantly lower growth rate as compared to projections and prior year actuals.

Massachusetts (2019)

- HHS has authority to negotiate supplemental rebate agreements directly with manufacturers. If unable to reach an agreement and the drug meets exceeds cost thresholds, the drug is referred to the Health Policy Commission (HPC) for further review and the HPC may determine if the drug's price is reasonable based on its value

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Medicaid: Supplemental Rebate Agreements

- 46 states negotiate supplemental rebate agreements (SRAs)
- SRAs can reduce Medicaid Rx spending by 35%
- 30 states leverage their SRA negotiating power through multi-state pools:
  - The National Medicaid Pooling Initiative (11 states)
  - The Sovereign States Drug Consortium (10 states)
  - The TOP Dollar Program (9 states)

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Public Employees: Waste-Free Formularies

- Wasteful drugs cost more but offer no additional benefits. Examples include:
  - high-priced brand-name drugs with a generic equivalent
  - combination drugs when the combined product is more than the component parts purchased individually
    - Duexis, a Rx combination of ibuprofen (Motrin) and famotidine (Pepcid) =$1,500/month vs $20/month for the 2 drugs OTC)
  - Rx drugs with an OTC equivalent
  - new drugs that have been slightly tweaked (different strength/dosage/extended release)

- Self-Insured Schools of California (260,000 members)
  - Excluded 600 drugs that did not provide value
  - PMPM drug costs decreased from $87.31 in 2013 to $78.65 in 2019

- NJ State Health Benefits Program and School Employees' Health Benefits program (800,000 members)
  - Excluded high-cost brands/generics when a therapeutically equivalent, lower-cost generic available
  - $12.8m in savings/year
  - Excluding drugs that have OTC equivalents is projected to save $12.6 million/year

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Public Employees: Reverse Auctions

- Reverse auction model allows public plans to reduce costs by negotiating higher-value contracts with PBMs without reducing drug benefits:
  - Requires all participating PBMs to offer the same contract terms and to compete on price only, - with consecutive rounds of competitive bidding against the lowest offer

New Jersey:

- First state to successfully implement a reverse auction process for its 800,000 public employees
  - $2.5-$3.05 billion projected savings between 2017 and 2022 resulting from lower PBM contract costs
  - $45.9 million in additional savings from using reverse auction platform for PBM oversight to identify claim processing issues over an 18-month period

- 2020: Maryland & New Hampshire passed leg. enabling reverse auctions
  - NH estimates it could save between $42.5 million and $53.1 million on its next 3-year PBM contract

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Bulk Purchasing Groups

MMCAP Infuse (1985)

- Group purchasing organization that combines state agencies, counties, cities, school districts, and clinics in 49 states
- Contracts are competitively bid following state procurement guidelines
- Combined negotiation power results in lower prices for purchasers
- An evaluation conducted by Florida found MMCAP prices were 2.8-4.4 percent lower than other group purchasing orgs and were roughly equivalent to Medicaid best price

Northwest Prescription Drug Consortium (2006)

- Combination of the Oregon and Washington Prescription Drug Programs (~1 million lives)
- Administered by Moda Health: transparent pricing / no spread /pass-through of manu. rebates / fixed admin. fees / audits
- Open to state agencies, local government, private sector businesses, labor organizations
- Offers a discount card program for underinsured or uninsured individuals: savings of 42% off retail; up to 60% for generics
- 2017: estimated savings of $130 mil in drug costs

Civica Rx for generics (2018)

- Non-profit drug manufacturer that produces affordable, sustainable supplies of certain generic drugs for health systems/hospitals
- 2020: partnered with Blue Cross Blue Shield health plans to expand access to outpatient setting
- State purchasers can join the Civica Rx/BCBS partnership, - open to all health plans, employers & retailers
- Expanding list of available generic products

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ME and NH Prescription Drug Affordability Boards

PDABs in ME and NH have tasks similar to NM's IPPC:

- Determine annual spending targets for prescription drugs purchased by public payors and for specific drugs that may cause affordability challenges to enrollees in a public payor health plan
- Consider methods for public payors to meet spending targets, including negotiating specific rebate amounts for costly drugs, establishing a common formulary, purchasing drugs in bulk, and others

- Boards were delayed in their initial meeting/reporting due to COVID-19 but are convening again
- NASHP could virtually convene ME/NH PDABs and IPPC to share strategies

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International Reference Rates

- Why:
  - Foreign countries pay a fraction of what Americans pay for prescription drugs
  - Rate setting is a common approach in the health care sector – one that can be extended to setting rates for prescription drugs
  - International prices offer a fair, easy-to-implement approach to rate setting
- What:
  - The Superintendent of Insurance works with the SEHP and BOP to develop a list of the 250 drugs costing the state the most
  - The state references Canadian prices for the four most populous provinces (available online)
  - The lowest price becomes the international reference rate for payers in the state
- Impact: This model act can greatly lower prescription drug spending in a state - without running afoul of patent law through price setting.

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International Reference Rates

Drug Name & Dosage Source: National Average Drug Acquisition Cost (NADAC) data	US Price (NADAC)	Canadian Reference Rate*	Price Difference	Savings off US Prices
Humira syringe (40 mg/0.8 ml) (arthritis, psoriasis, Crohn's)	$2,706.38	$541.29	$2,165.09	80%
1 ml of Enbrel (50 mg/ml syringe) (arthritis, psoriasis, Crohn's)	$1,353.94	$272.28	$1,081.66	80%
1 ml of Stelara (90 mg/1 ml syringe) (arthritis, psoriasis, Crohn's)	$21,331.28	$3,267.64	$18,063.64	85%
1 ml of Victoza (2-pak of 18 mg/3 ml pen)* (diabetes)	$103.44	$17.30	$86.14	83%
Truvada tablet (200 mg/300 mg) (PrEP for HIV)	$59.71	$19.78	$39.93	67%
Xeljanz tablet (5 mg) (rheumatoid arthritis)	$76.07	$17.50	$58.57	77%
Eplcusa tablet (400 mg/100 mg) (hepatitis C)	$869.05	$541.32	$327.73	38%
Zytiga tablet (250 mg) (cancer)	$87.63	21.47	$66.16	75%
		Average discount based on 8 top selling drugs in 2018		73%

*Converted based on $1 CAN = $0.76 USD
Canadian price per ml of Victoza established based on $136.98 price for 2-pak of 3 ml pens - 6 mg/ml

Penalizing Unsupported Price Increase

- Background:
  - The Institute for Clinical and Economic Review (ICER) produces an annual report identifying the drugs with unsupported price increases outpacing 2x medical inflation that are the greatest drivers of net spending
  - Unsupported price increases = unjustified by new clinical data

- What:
  - State tax authority is used to assess penalties on manufacturers identified in annual ICER report as having a drug with an unsupported price increase
  - Penalties = 80% of excess revenues (i.e., revenue from unsupported portion of price increase)
  - Manufacturers must report information on total sales revenue in the state to the Tax Assessor to determine the penalty owed

- Impact: Because ICER's analysis targets drugs with the greatest impact on net spending, penalties can result in millions in revenue for a state -- revenue that the Model Act specifies must be used to offset costs to consumers

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY

2019 ICER Analysis: Results

	Q4 2016 to Q4 2018 Wholesale Acquisition Cost (WAC) Increase	Q4 2016 to Q4 2018 Estimated Average Net Price Increase	US Spending Impact of Net Price Increases in 2017 and 2018 (in Millions)
Humira	19.1%	15.9%	$1,857
Lyrica	28.3%	22.2%	$688
Truvada	14.3%	23.1%	$550
Rituxan	17.0%	13.8%	$549
Neulasta	14.6%	13.4%	$489
Cialis	26.2%	32.5%	$403
Tecfidera	16.7%	9.8%	$313

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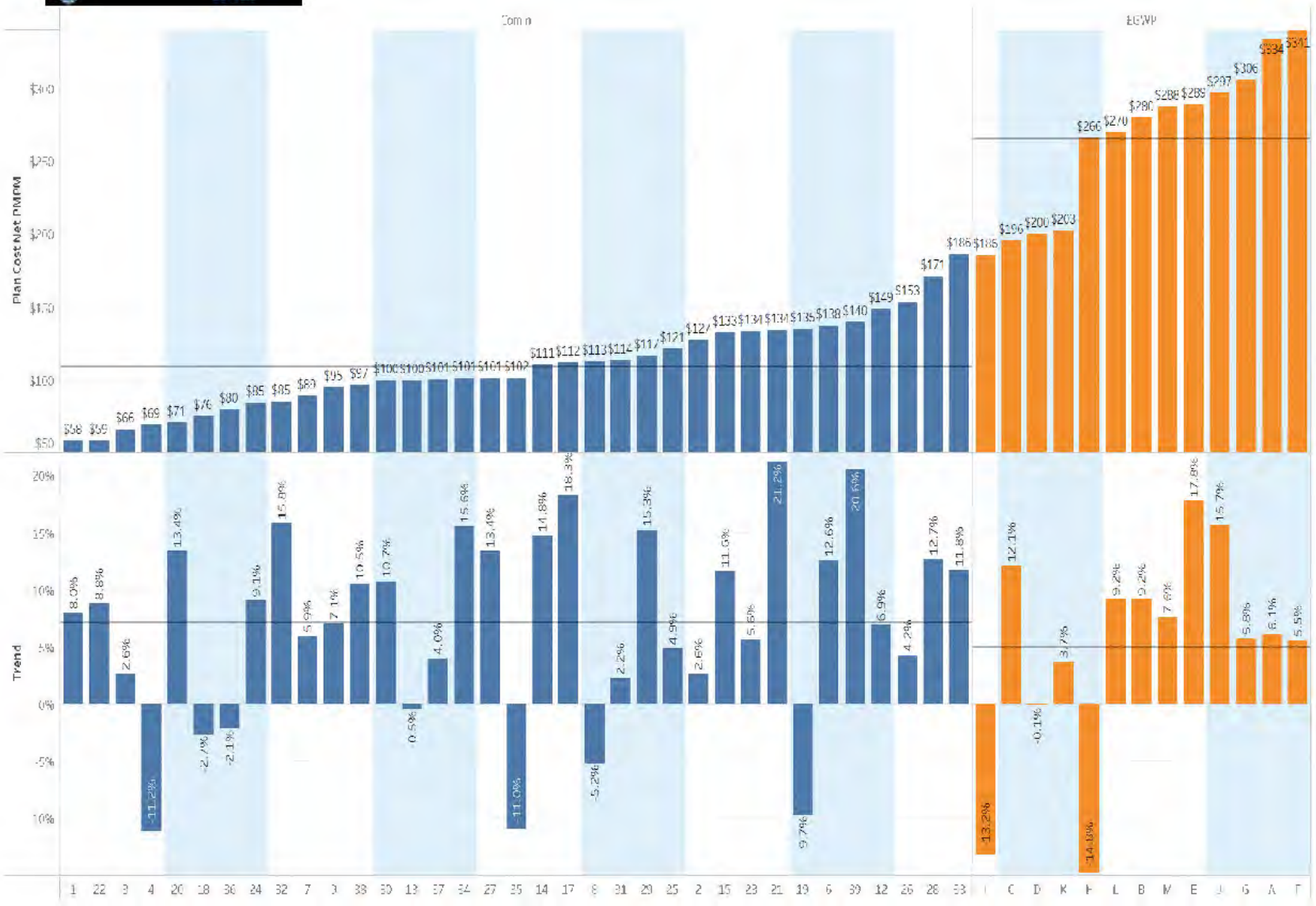
IBAC Payer Update

	Previous 3 Years Trend	FY19 Net PMPM	FY20 Net PMPM	% Increase
Group20	2.4%	$59.88	$67.46	12.7%
Group1	1.2%	$54.61	$58.51	7.1%
Group22	0.7%	$53.39	$60.77	13.8%
Average	1.4%	$55.96	$62.25	11.2%

GOVERNMENT ADVISORY PANEL



IPPC's
Rx Purchaser Subcommittee work Progress report
Nov 12, 2020

Wence Asonganyi
Health Services Administrator, NM Corrections Department

Committee members are:

- Dept of Health – Dr. Massaro
- CYFD – Janet Berry-Beltz
- UNM – Joey Evans
- NM Counties – Kamie Denton
- Corrections Dept – Wence Asonganyi

Update on activities

- October 2020

- Meeting with current subcommittee leader – Mr Evans facilitated by Ms Trujillo

- Background information and update on subcommittee activities shared

- Corrections Department was invited to take on leadership role for subcommittee

Update on activities

- November 2020

- All subcommittee members were sent available purchaser agreements

  - Agreements shared included:

    - Corrections Department: BosWell

    - DOH: Cardinal Health

      PharMerica Long-Term Care LLC

    - CYFD: Diamond drugs Inc

    - NM Association of Counties: Equian LLC

Update on activities

November 2020

- A proposed framework to be used to analyze the purchaser agreements developed
- Validation of framework slated for Nov 16th 2020
- Integration of findings

Update on activities

- Dec 2020/ Jan 2021

- Establish key characteristics and components of reviewed agreements

- Findings will inform:

1. Identifying any opportunities to consolidate purchasing among 2 or more agencies
2. Identifying any opportunities for pooling risk among 2 or more agencies
3. Exploring the possibility of establishing a single purchaser agreement for all constituent agencies' pharmaceuticals and pharmacy benefits