Janet T. Mills
Governor

STATE OF MAINE
Maine Prescription Drug Affordability Board
61 State House Station
Augusta, ME 04333-0061

Dr. Noah Nesin
Chair

Maine Prescription Drug Affordability Board
Monday May 22, 2023 @ 10:30 am
Microsoft TEAMS Meeting
In Person Location: Burton M. Cross Building, Augusta, Maine - Room 600, 6th Floor, ME

Board Members in Attendance: Peter Hayes, Dr. Noah Nesin, Dr. Julia Redding, Rhonda Selvin, Dr. Susan Wehry
(Total = 5)

Board Members Absent: Heather Perreault, Jennifer Reck
Vacant Seat(s): 2

Others Present:
Advisory Council: Jennifer Kent, Anne-Marie Toderico, Shonna Poulin-Gutierrez, Jonathan French, Kristy Gould
Employee Health & Wellness: Devon French, Roberta DuPont, Emma-Lee St. Germain, Charles Luce
Program on Regulation, Therapeutics, and Law (PORTAL): Aaron Kesselheim, Adam Raymakers, Jerry Avorn, Catherine Hwang, Matthew Martin, Leah Rand, Benjamin Rome, Hussain Lalani
All Others: Meg Garratt-Reed, Representative Gary Merchant, Damian Walsh, Timothy McSherry, Patrick Comair, Rachel Cottle Latham, Kelly Ryan

Agenda Item:	Discussion:	Action/Next Steps:
I. Call to Order (10:33 am)	Dr. Noah Nesin called the meeting to order.	
II. Introductions		
III. Approval of the Minutes (January 17, 2023)		*Peter Hayes* made a motion to accept the meeting minutes; *Julia Redding* seconded the motion. Motion passed.
IV. Monthly Business		
a. Program on Regulation, Therapeutics, and Law (PORTAL) Presentation– *Catherine Hwang,*	Information contained in written reports; highlights and discussion noted below: • PORTAL Grant Funding: We do not receive funding from pharmaceutical companies. Arnold Ventures, the ElevanceHealth Public Policy Institute, the Kaiser Permanente Institute for Health	**Peter Hayes asks:** *Does PORTAL see any issues or solutions for the 340B issue when we're worried about patient and affordability where drugs that health systems and pharmacies are buying for $0.10 on the dollar, they're retailing to the patient at $10k or more? Is there anything we*

MD, and Benjamin Rome, MD, MPH	Policy, the Massachusetts Health Policy Commission, the Commonwealth Fund, the National Academy for State Health Policy. • <u>High Drug Prices Have Consequences</u>: Of the adults in the United States on average, 62% take one or more prescription medication while 25% take four or more, 26% have trouble affording their medications, 33% with serious health conditions, and 29% don't take medications as prescribed. • <u>The Lifecycle of New Drugs</u>: ○ **Period 1** – Drug Development: Drug development includes pre-clinical research, clinical trials, and FDA Review. FDA Review can take one year and during that time 14% of new drugs fail and do not make it to market. ○ **Period 2** – Period of Government Granted Monopoly: Brand-name market exclusivity state all new drugs are guaranteed for 6 years under the 1984 Hatch-Waxman Act and drugs protected by patents will each last 20 years. Market exclusivity for small-molecule drugs averages 12-17 years. ○ **Period 3** – Generic or Biosimilar Competition Leads to Lower Prices: Generic competition substantially lowers prescription drug prices. Biosimilar competition only modestly lowers drug prices and brand-name manufactures try to delay generic or biosimilar entry if possible. • <u>Trends in Prescription Drug Spending</u>: Annual drug spending totals $500B, with 1 in 7 being healthcare dollars, spending two times more than the Organization for Economic Co-operation and Development countries. • <u>Prescription Drug Spending in Maine</u>: In 2021, prescription drug spending in Maine reached $2.4 billion, or 25% of total health	*can do as a State to start pulling back some of the value for the patients?* **Aaron Kesselheim responds:** *This might require another full hour conversation.*

	care spending in the state. Manufacturer list prices increased by 9.9%, above the consumer price index (7.0% for 2021). • Prices for New Branded Drugs and Biologics: There has been a 20% per year increase in launch prices, and an 11% per year increase after adjusting for rebates and drug characteristics. The median new drug cost has increased from $2K in 2008 to $180K in 2021. • Generic Savings: Generics are a major source of savings and account for 90% of prescriptions and only 10% of spending. • Supply Chain Overview: Supply chain steps are as follows: o Drug manufacturers set the list price. o Health plans or Pharmacy Benefit Managers set the formulary and out-of-pocket costs. o Health plans/Pharmacy Benefit Managers negotiate rebates in exchange for formulary access and preferred position. o Drug manufacturers offer coupons to offset out-of-pocket costs charged by insurance. • Cash Flows in the Supply Chain: Manufacturers maintain a higher share of money spent on brand-name drugs. • Pharmacy Benefit Managers: Pharmacy Benefit Managers are hired by commercial and Medicare Part D plans. They encourage the use of generics and lower-cost brand-name drugs and negotiate rebates from manufacturers in exchange for offering preferred formulary position. Rebates do not always flow to patients. • The Widening Gap Between List and Net Price: Net prices are 50% lower than list prices due to rebates and other discounts. The costs to patients and payers are 33% higher than net prices due to supply chain, wholesaler, pharmacy, and more.	

	• Manufacturer Coupons: Manufacturer coupons are offered by brand-name drug makers to offset high out-of-pocket costs set by payers and pharmacy benefit managers. They are only available for patients with private insurance and are now used on 15-20% fills by eligible patients for certain brand-name drugs. • States with Overall Health Care Cost-Growth Targets: States with overall health care cost-growth targets include Massachusetts, Rhode Island, Connecticut, New Jersey, Delaware, Washington, Oregon, Nevada, and California. • Responses to Healthcare Spending Targets: Favorable responses to healthcare spending targets include decreasing low-value care, lowering prices, improving efficiency, while unfavorable responses include decreasing high-value care, and the cost shifting to patients. • Accounting for Rebates: The price change when compared to data from 2007 show an increase in list price of 9.1% before rebates, with net prices increasing by 4.5% after rebates. • Costs by State-Funded Health Plans: To set spending targets, the State must be able to accurately measure spending by state-funded health plans. Total spending includes spending by insurance plans on retail prescription drugs and clinician administered drugs, plus administrative costs paid to insurers and Pharmacy Benefit Managers, minus rebates and discounts paid back the payers and PBMs by the manufacturers and pharmacies. • Cost by Beneficiaries: It is also important to measure and assess beneficiary spending, particularly to avoid shifting costs from insurers to beneficiaries. Total beneficiary spending includes health insurance premiums for prescription drug coverage and medical coverage of clinician-administered drugs, plus patient out-of-pocket costs on retail prescription drugs and clinician-	

	administered drugs, minus discounts from manufacturer-funded coupons and patient assistance programs.
	
	• The Maine Prescription Drug Affordability Board Statutory Authority: The Prescription Drug Affordability Board is tasked with the following to address state drug spending:
	  ○ Setting annual spending targets for drugs purchased by public payors.
	  ○ Setting spending targets for specific drugs that may cause affordability challenges for plan enrollees.
	  ○ Determining which public payors are likely to exceed set spending targets.
	  ○ Determining methods for public payors to meet spending targets and reduce costs to individual purchasers.
	To do so, the Prescription Drug Affordability Board may consider data compiled by the Maine Health Data Organization (MHDO) and spending data submitted by public payors (e.g., expenditures & utilization, formulary placement, Pharmacy Benefit Manager services, enrollee cost-sharing).
	
	• Goals of Spending Growth Targets: The goals of spending growth targets include preventing prescription drug spending from growing faster than other services, incentivizing public purchasers to actively negotiate better deals, and garner support for legislation to support efforts in lowering prescription drug prices.
	
	• Spending Targets Alone Can Lead to Favorable and Unfavorable Outcomes: Spending targets alone can lead to favorable and unfavorable. Favorable outcomes include decreasing low-value care, lowering prices, and improving efficiency and unfavorable outcomes include decreasing high-value care, and cost shifting to patients.
	
	• Additional Considerations When Setting a Spending Target: Additional Considerations When Setting Spending Targets include -
	  ○ Spending on brand-name verses generic drugs.	

	○ Spending on clinician-administered verses pharmacy-dispensed drugs. ○ Spending on biologics verses small molecule products. ○ Spending on oncologic therapies and gene therapies. ○ Spending by specific state plans if individuals within the state are covered by different types of state insurance plans. ○ Spending on specific drugs. (e.g., The top 10 drugs with the highest total annual spending, and the top 10 drugs with the largest annual growth in spending from the previous year.)	
b. Advocacy – *Dr. Noah Nesin*	Information contained in written reports; highlights and discussion noted below: • Our board members are aware that I submitted testimony in support of the transparency 340B bill for hospital systems which were LD1395, and for Medicare referencing and Canadian price rights, LD1816 & LD1829 1:34	
V. Other Business		
a. Open Discussion	Discussion highlights below: *Meg Garratt-Reed* – • The Office of Affordable Healthcare: The reference-based pricing bills, regarding Medicare negotiated prices, I did submit testimony in opposition to those bills. It is not about the principal of the concept, which I am fully in agreement with, but I have some concerns about implementation and some unanswered questions about how these programs would work in practice. • Spending Targets: Having given thought to the requirement to establish spending targets – I would welcome a more in-depth conversation with the PORTAL team regarding some of these elements.	**Meg Garratt-Reed states:** *I can send the letter of testimony out to the committee*. **Meg Garratt-Reed states:** *An area I would like to understand more is our State employee plans current experience with drug purchasing, and any work they are already doing to control drug prices.* **Dr. Noah Nesin Responds:** *We did hear from the State plan a long time ago and I think a reset on that might be a really good idea. Maybe you and I can connect around that.*

VI. Adjourn (12:03pm)		*Dr. Susan Wehry* made a motion to adjourn; *Rhonda Selvin*, seconded the motion. The motion passed. Meeting adjourned.

Next meeting: September 25, 2023