TPI Board Meeting

April 9, 2024

Summary:

The Texas Pharmaceutical Initiative (TPI) board held its 3rd meeting. Reminder that HB 4990 from the 88th legislative session created the TPI and tasked the board with developing a business plan for TPI to submit to the legislature for consideration next session.

We anticipate the next meeting in roughly a month from now. HHSC should have a contract executed with the search firm and scoring complete on the consulting firm for the business plan by the next meeting.

View the meeting agenda here.

TPI Board: Dr. Mike McKinney (chair), Dr. Goldina Erowele, Tony Schell

Key Discussions:

- Representatives from various state agencies shared data on high cost drugs and how the TPI could be beneficial to lowering prescription drug costs.
- New Type 2 diabetes/weight loss drugs were in focus as agencies cited these as the biggest drivers of spending and the various coverage and strategies they have for the drugs.
- State agencies answered questions about their procurement processes and explained how they are somewhat constrained in choosing a PBM that can manage the scale of their covered lives. They all suggested that joint procurement could lower costs.
- Medicaid drug coverage and a single statewide PBM was discussed and Board Chair, Dr. Mike McKinney, raised questions about the importance of both lower pricing but also managing utilization.

- Dr. McKinney noted that the “crux” of TPI is the question of building a statewide PBM for all employees or to procure one. The question of how Medicaid wraps into this appears to be a related but separate issue.
- UT’s Vice Chancellor for Health Affairs, Dr. John Zerwas, promoted the idea of a state established and run (not contracted) PBM and direct price negotiation.
- On question from Dr. McKinney, Dr. Zerwas said he was “skeptical” that increased rebates following patent expiration are passed on.

TPI Advisory Council (TPIAC) Agency Member Presentations on How Each Agency Will Utilize TPI

Employee Retirement System (ERS) of Texas: Blaise Duran from the ERS presented an overview of the Group Benefits Division at the Employees Retirement System of Texas (ERS). He discussed aspects such as plan coverage, vendor selection process through RFPs, and responsibilities under PBM contracts including drug formulary management and claims processing. Duran provided several insights and answered questions from TPI board members.

- Duran explained that Express Scripts became PBM for their commercial and medicare members January 1, 2024 and offered that under their contract, if they don’t meet rebate guarantees, the contract requires them to be made whole by the PBM through discounts.
- Duran explained that ERS keeps a data warehouse of drug plan claims back to September 1, 2008.
- Duran offered slides on specific drug spending at ERS and showed that Ozempic, Humira, Mounjaro are the most expensive drugs driving plan spending. $117 million for Ozempic, 107K for Humira, 82K for Mounjaro.
- Mr. Schell asked about the percentage of total spend for weight loss drugs.
- Duran explained that the total spend (before rebates) is 1.7 billion with roughly $400 million spent on the weight loss drugs. He added:
    - Atorvastatin is their most commonly prescribed drug with a total spend of just over 1 million.

- Ozempic is now in the top 10 most commonly prescribed.
- Roughly $1,000 per prescription.
- Ozempic is now in the top 10 for spending and prescribing.
- Stelara is the most expensive drug by cost per prescription.
- Antidiabetic medications as a category have more than doubled in 4 years for a total spend of $429 million.
- GLP-1s is the top shortage drug. Manufacturers can't keep up.
- ADHD medications have significant supply shortages.

- Duran explained that there are opportunities to create savings that go beyond ERS plans:
  - Acquire drugs at unit costs that beat out what they pay today,
  - negotiate with manufacturers directly,
  - manufacture and distribute pharmaceuticals,
  - contract with or create a single PBM for state agency buying power.
- Duran stated that the big 3 PBms were the only ones that responded to the RFP but in a previous RFP Medpac did respond.
- Dr. McKinney asked if there are requirements in the RFP around operational capacity that make it where only the big 3 PBMs could respond stating that it "Seemed to me that they were asking them to have a capacity that they would never use"
  - Duran responded that they do have capacity requirements and need someone that can handle half a million lives. He also noted they have requirements for financial stability as they are processing billions of dollars in claims.
- Dr. McKinney asked if there has been an increase in the incidence of type 2 diabetes and people diagnosed with type 2 that are starting on the more expensive drugs were metformin, for example, is an older and much cheaper drug.
  - Duran explained that the incidence rate of type 2 continues to grow, but more and more physicians are prescribing these new very expensive drugs vs. alternative therapies.
  - He added that ERS doesn't currently cover these drugs for weight loss, just type 2 and it's likely that because of advertising, celebrities, etc. patients are asking for them.

- Dr. McKinney asked if there was cost savings associated with having the same company offer both pharmaceutical and medical coverage services vs. a "carve out" where PBM services are separately awarded.
  - Duran explained that they have had a carve out strategy since he's been there and isn't aware of a study that looks at this, however, historically, "you get better deals with a carve out." He offered to look more into this.
- Dr. McKinney asked Duran to also provide what percentage of the premium is from pharmaceutical spending.
- Dr. Erowele asked if shortages on GLP-1 agonists have impacted utilization and if there has been any utilization review to make sure this is actually being used for diabetes.
  - Duran explained that he saw some shift to Trulicity because of shortages of Ozempic and Mounjaro and that they do require prior authorization to make sure its actual people with type 2 diabetes getting these drugs by requiring medical history. He added that they saw a growing number of prescriptions before going to people that could not provide a type 2 medical history and hopes that these new measures in place will address that.
- Dr. Erowele asked if they've seen the impact of that PA requirement?
  - Duran said he believes so, and hopes to see it in the data in the next few months.
- Dr. Erowele asked what has the PBM done to reduce costs and is there anything stopping ERS from negotiating directly with the manufacturers?
  - Duran said that he doesn't have experience with directly negotiating but mentioned some states have done this for example with hepatitis C medications. mentions hep C where some states negotiated it directly.
- Dr. Erowele stated that we need to understand if there's anything in place in the current PBM contract that would prevent them from negotiating directly.
  - Duran said he was not aware of any issues but direct negotiation for some drugs would probably require them to renegotiate the rebate agreement with their PBM.
- Dr. Erowele asked for Duran to elaborate on state manufacturing?
  - Duran explained that there are some generics that tend to have a high markup vs. acquisition costs and the state could identify drugs that are more

widely used on the generic side and then create manufacturing and directly distribute those drugs..

- Dr. Erowele - asked about leveraging biosimilars, Stelara, Skyrizi.
  - Duran stated that they are in preliminary discussions but don't have an estimate on what that could be and success would depend on uptake.
  - Dr. Erowele added that several of the top cost drugs for ERS have biosimilars and encouraged that this needs to be on the table. She stated there are 30 biosimilars on the market now and the FDA is set to approve much more.
- Schell added that he's thinking about how GLP-1s are 20% of the ERS spend and said he would be curious to see all the categories over time to understand what classes of drugs are the biggest cost and if there are proactive health interventions that should be considered.
- Dr. Erowele added that she would like to see the top 10 drugs by spending in each class.

Teachers Retirement System of Texas: Katrina Daniel, Chief Health Care Officer of TRS provided an overview of TRS's approach to providing insurance products for public educators and retirees in Texas. She highlighted TRS's size, expenditure on drug costs before rebates, and its procurement strategies.

- Daniel's opening presentation did not include specific spend details alongside the top drugs listed in categories but she stated that this could be provided. She went on to add:
  - TRS & ERS are very similar and TRS has 700K lives and spends 1.3 billion on drug costs per year, before rebates.
  - Her recommendations included: carve out generic medications from current PBMs to be purchased from other lower cost suppliers, consolidate purchases of high cost medications across agencies, narrow therapeutic options for certain medical conditions, shift medication from medical side to pharmacy side, and foreign importation.
  - Daniel added that they self fund benefits (except for Medicare Advantage) and they sometimes see significant costs from state and federal legislative actions.
  - TRS also uses Express Scripts.

    - She explained that because of their size it does create challenges for procurement and in the latest round of procurement TRS tried to lower minimum requirements to try to attract some of the smaller PBMs as well as looked at possibly carving out specialty drugs and clinical management.
    - She added that they don't just look at pricing but also the pharmacy network.
    - Mounjaro is the most expensive drug to the plan, and the only GLP-1 they cover.
    - TRS also requires a diabetes diagnosis for coverage and does not cover GLP-1 for weight loss.
- Schell asked if we know definitively that these GLP-1s don't have loopholes where they are being prescribed for non-diabetic treatments.
    - Daniel stated that they ask for medical documentation but of course in any industry you do see fraud and abuse and couldn't "say with 100% assurance that there isn't some gaming."
    - Dr. Erowele recommended a retrospective review of a sample of claims to learn more and stated that she likes the strategy of just having one GLP-1 to drive economies of scale and get a lower cost.
- Daniel discussed drug shortages on Mounjaro and Adderall XR as well as other drugs. She added that TRS has data in the warehouse back to 2018.
- Dr. McKinney asked for insight into the rebates using the phrase "black box".
    - Daniel explained that rebates are a significant component of PBMs and the "black box is locked pretty hard around rebates".
    - She added that TRS relies on rebates to keep the plan affordable. They get between 30-40% rebates that go to lower TRS spend from $1.3 billion to under $700 million per year. TRS asks for a rebate guarantee and tries to build in as much transparency as possible into the contracts asking for everything that is manufacturer sources of revenue and auditing rebates.
    - She also included that they put in as many safeguards as possible but are constantly improving.
    - Daniel talked specifically about Mounjaro, saying that there are drugs that come out that are really life changing, but they don't want to pay for drugs like GLP-1s for vanity. TRS took the strategy to get the best possible price and then layer on PAs to make sure they are going to the people that need it.
- Dr. McKinney asked "If I have a $100 drug and get a $30 rebate, why can't I just buy the drug for $70 dollars?"

    - Katrina explained that they use rebates to buy down premiums and put that money back into the plan.
    - Dr. McKinney said "I just don't understand why the rebate is better than buying the drug for cheaper."
    - Daniel added that there was a discussion about point of sale rebates last session but there are trade offs.
- Dr. McKinney asked if there are savings in bulk purchasing.
    - Daniel stated that as big as Texas is there are essentially 3 PBMs that bid on their contract. She added that "there's a notion that because of who we are, Texas, there are some things we could be doing, but there are consultants that have a bird's eye view around the country and we know we get really good deals. Could we build it better in Texas? It's worth exploring but it's hard to say."
- Dr. Erowele asked for her to elaborate on policy issues and opportunities.
    - Daniel stated that the state could decide it was going to get behind a certain strategy on GLP-1s with all payers.

Health and Human Services Commission: MacGregor Stephenson, Director of Strategic Operations provided an overview of programs under HHSC's umbrella including Medicaid, CHIP (Children's Health Insurance Program), state supported living centers, and mental health hospitals operated by DSHS (Department of State Health Services).

- MacGregor's comments included:
    - The biggest benefit to HHSC would be through a more holistic purchasing program but noted that federal rebate requirements in Medicaid may create challenges.
    - Cetirizine is the most prescribed drug and Humira is the most expensive.
    - He provided significantly less detail than ERS & TRS.
    - He explained that they have 7 years of Medicaid/CHIP data available on drugs.
- Dr. McKinney commented that PBMs own the health plans and the health plans own the PBMs and said he "would think that HHSC would have the unique ability to give us a feel for the percentage of the premium by category that is in fact pharmaceutical spend." He added that they should be able to "understand the MCO concern about utilization as well as price" as "they have insight into the physician

prescribing." He added "if you carve out you get cheaper prices" but he's "trying to be convinced that you get better utilization management."
  - MacGregor stated that he will take that back to their actuaries.
- Dr. Erowele added that she wants to see trend data similar to what ERS provided.
- Dr. McKinney asked if state hospitals get 340B pricing. (Goldina says yes)

Texas A&M University System: Sheri Meyer provided an overview of Texas A&M University System's structure, including its universities, agencies spread across counties statewide, employee count exceeding 32,000 individuals along with retirees totaling over 59,000 members.

- Meyer explained that they use Express Scripts also, since 2011, and offered several comments and detailed data:
  - TPI could create economies of scale and would also benefit from learning how these other programs use their PBM and set pricing.
  - A&M had Capitol Rx bid on the last RFP in addition to the bigger PBMs. Their response wasn't so focused on rebate guarantees, more on rebate pass through, and it was very hard for actuaries to analyze that vs. a guaranteed rebate.
  - The most prescribed drug is Atorvastatin. Humira was the highest cost drug for FY 2023, and now Ozempic is the highest cost drug for FY 2024. The GLP-1s makeup 14.5% of A&M's overall spending on drugs. In FY 2023, A&M spent $169 million overall with $22 million spent on GLP-1s.
  - They are also putting programs in place to help curtail the spending, as well as programs with their PBM to make sure they get actual medical data and newer stuff that will look at fraudulence in both prescribers and pharmacies.
  - There are programs in place for weight loss drugs that have certain BMI requirements as well as a new program that requires participation in a weight loss management program. The goal is to try to make sure people aren't on these drugs permanently.
- Meyer noted that the most common shortages are the GLP-1s and the ADHD medications, and they have drug spending data going back to 2011.
- Dr. McKinney noted that all four agencies use Express Scripts and asked if they do joint procurement.

- Meyer said there is some legislation that would allow them to use another agency's contracting, but they do not do that.

- Dr. McKinney said the crux of the whole TPI is the question of whether it's better for them to build a statewide PBM for all state employees or to procure a single one.
  - Meyer said they would still want some "autonomy" to pick what their plan looks like, for example, they cover for weight loss, others don't. She also said drugs are lower hanging fruit than the medical side. They all look different based on where people are, networks, what's available, and what they need for their populations.
  - Meyer noted that they all use Rudd & Wisdom so it may be helpful to get some data from them.

University of Texas System: Dr. John Zerwas, Exec. Vice Chancellor for Health Affairs, UT System

- UT did not provide a powerpoint presentation, but Dr. Zerwas provided the following comments:
  - Dr. Zerwas noted that the UT system is a provider of prescription drugs and operates pharmacies and specialty pharmacies.
  - He said that pharmacy costs are the "pain point" for their plan totaling about 25% of their costs with 25% of the premium that is passed on to the people in their plan.
  - He mentioned it was critical to address the role that PBMs play and that TPI may be well positioned to do so, laying out three main paths that TPI could explore.
    - First path is what he called a "status quo" contracting with one of the three big PBMs (Express Scripts, CVS Caremark, and OptumRx) that collectively serve nearly the entire market. He believes savings under this plan would be relatively minimal in that nothing about the system would change, with the same issues regarding transparency, rebates , etc, all continuing. The fundamental mechanics would stay the same.
    - The second path would be to seek to contract with a new "transparent" model PBM, the so-called "disruptors" in the market. He believes that could start to bring some significant savings through pass through savings models like transparent PBMs. However, the transition would likely be "pretty rocky" as these PBMs gradually come to scale.

        - The third path would be for Texas to create its own statewide PBM and negotiate pricing.
- Zerwas says that apart from the PBM issue, the UT system and the state could build prescription drug manufacturing capacity locally to produce drugs that are essential for patient care but are subject to artificial, predatory and anti competitive monopolistic pricing or continuous supply chain constraints. He also says we should invest more in data analytics and drug research.
- UT uses the PBM Express Scripts, and it is chosen based on servicing parameters and pricing.
- Last year, UT eliminated coverage of Wegovy because of cost.
- Dr. McKinney says the legislature has asked about a "state specific acquisition cost" and says Alabama is doing this. He also asks about importing drugs from Canada. And if there is any feel for when drugs go off patent life and rebates go up, "is that passed on?"
    - Dr. Zerwas said he's "skeptical" that this is passed on. He talked about generics being reformulated, epi pen, etc to renew patents. He said he wasn't sure about authority for importation of prescription drugs (note this was allowed via HB 25 last session). He defended pharmaceutical companies' costs saying the U.S. pays for all the R&D and noted that he has "a lot of respect for the whole pharmaceutical industry, biosciences industry and so forth in terms of states being able to leverage their size and go to market". In terms of states being able to leverage their size, Dr. Zerwas explains that they did have some conversations with the University of California on how they are working with the state government in California. HHSC coordinated this call, and they are using more of a "targeted approach" on how California was looking into manufacturing insulin on their own dime and looking into other opportunities to manufacture drugs. Dr. Zerwas notes that we could look at our own capability of doing some drug manufacturing.
- Dr. McKinney asked about mail order pharmacy.
    - Dr. Zerwas said they have mail order but could be doing more and are talking with Aon about that.

<u>Status update on TPI-related procurements:</u>

- Contract has not been completed with the executive search firm but very close and hopefully can have the contractor at the next meeting.

- They also do not have a contractor to develop the business plan.
- Dr. McKinney addressed the timeline and raised concerns about not being able to get a contract with a firm for 3 months and they are facing an October deadline for a business plan.
- Also still waiting for LBB approval to post staff positions.

Further Discussion and Closing Thoughts

- Goldina says that data will drive decision making and make notes on contracting with PBMs. Talked about Oregon state run PBM and want to understand the impact of that. Wants to further explore leveraging biosimilars, says they save 25-30%. But recognized that this does impact rebates. Iquva(?) slide deck she is going to share on the impact of biosimilars and uptake. Said you don't see as big of an uptake on some very expensive drugs.
- Tony provided an accounting perspective involving the desire to see data trends and what can be considered beyond the renegotiation of a PBM. It looks like GLP-1s, something that sparks Goldina's concerns, are an enormous amount of what is being spent. He was also concerned about the market of drug companies.
- Dr. McKinney says that it's one thing to have access to a drug and another thing to have everyone else pay for it. He also thinks that the Amazon Pharmacy was efficient and impressive. He will be traveling to College Station next week to see their drone facility that delivers prescriptions.
- MCOs are subject to a profit cap. If what they are leaving with their PBMs rebates, however, Dr. McKinney thinks that's not subject to scrutiny.