WILKE, FLEURY, HOFFELT, GOULD & BIRNEY, LLP
TWENTY-SECOND FLOOR
400 CAPITOL MALL
SACRAMENTO, CALIFORNIA 95814

TELEPHONE (916) 441-2430
TELECOPIER (916) 442-6664

PHILIP R. BIRNEY*
SCOTT L. GASSAWAY
ERNEST JAMES KRTIL
ROBERT R. MIRKIN
MATTHEW W. POWELL
STEPHEN K. MARMADUKE
DAVID A. FRENZNICK
JOHN R. VALENCIA
KELLI M. KENNADAY
ANTHONY J. DeCRISTOFORO
ROBERT F. TYLER
MICHAEL G. POLIS
DANIEL L. EGAN
DANIELLE M. GUARD

*PROFESSIONAL CORPORATIONS

WILLIAM A. GOULD, JR.*
KIM JOHNSTON
DANIEL L. BAXTER
MEGAN A. LEWIS
ERIN E. WEBER
PAUL ASTERLIN
ANTHONY R. EATON
CRAIG A. CARNES

OF COUNSEL

RICHARD H. HOFFELT
GENE E. PENDERGAST, JR.
THOMAS G. REDMON
RONALD R. LAMB

SHERMAN C. WILKE
(1914-2002)
GORDON A. FLEURY
(1916-1987)

MEMORANDUM

VIA E-MAIL NONPROFITREGS@CIRM.CA.GOV

TO: Intellectual Property Task Force
Independent Citizens Oversight Committee (ICOC)

FROM: John R. Valencia
on behalf of
California Healthcare Institute (CHI)

DATE: November 5, 2006

RE: CIRM-Proposed "Requirements for Licensing of CIRM-Funded Patented Inventions to Third Parties" - Title 17 of California Code of Regulations, Section 100306(d), as Proposed to be Revised: Largely Redundant and in Need of Clarification to Determine Which, If Any, California State or Political Subdivision Purchasers May Benefit

Summary of Analysis

1. State and political subdivision purchasers, using a myriad of federal-source funds to purchase outpatient prescription medicines resulting from CIRM-funded research, already enjoy federal law, or combined federal/state law, acquisition price preferences for such products.

2. For undefined "therapies and diagnostics" which are not the subject of federal Medicaid law at 42 USC 1396r-8 et seq., the proposed regulations provide little guidance and introduce general uncertainty as to what "cost" such therapies and diagnostics must be provided to certain California purchasers other than the statutory reference price of 15.1 percent of Average Manufacturers Price (AMP), if, as defined, that term is applicable to, or can be calculated for, such sales.

3. The apparent objective of the proposed regulation – to provide California purchasers with preferred product acquisition pricing for "therapies and diagnostics" resulting from CIRM-funded research -- lacks adequate certainty and definiteness to meet the general purpose of state agency regulatory adoptions to define, clarify, interpret and implement statutory enactments. Outpatient prescription drugs which result from CIRM-funded research will be readily available to virtually every state and local agency purchaser, at preferred product acquisition cost levels guaranteed by federal or state law, or the designed combination of the two. The proposal

requires further detail in relation to key elements (i.e., definitions for key operational elements of the proposed regulation, such as "therapies," "diagnostics," "California funds," and "political subdivision") in order to avoid failure upon review by the state Office of Administrative Law (OAL) for lack of clarity.

1. Title 17 of California Code of Regulations, Section 100306(d), as Proposed to be Revised

As published for discussion on November 9, 2006, the CIRM Proposed Policy relating to cost containment of "therapies and diagnostics" requires that "licensees will agree to provide to patients whose therapies and diagnostics will be purchased in California by public funds the therapies and diagnostics at a cost not to exceed the federal Medicaid price."

As we understand this to be proposed for revision, the language would be converted to require that "…licensees will agree to provide to patients whose therapies and diagnostics will be purchased in California with *California funds or fund of any political subdivision of the state* the therapies and diagnostics at *a cost equal to that resulting from the provisions of Title 42, United States Code section 1396r-8, subdivisions (c)(1)(A)-(B) and subdivision (c)(2).*"

The signficance of absent or adequate definitions of key operational elements of this requirement will be evident throughout the succeeding discussion.

2. The Medicaid Drug Rebate Law (42 USC 1396r-8(a) et seq.)

The Omnibus Reconciliation Act of 1990 declared that "In order for [federal Medicaid Program] payment to be available…for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement… with, ultimately, the Centers for Medicaid and Medicare Services (CMS). This obligation extends, by federal law, solely to outpatient prescription drugs.

Significantly, for California, which enacted a state Medi-Cal Drug Rebate Program a half-year ahead of the federal government, the U.S. Secretary of Health and Human Services was expressly empowered to "…authorize a State to enter directly into agreements with a manufacturer...," provided those state contracts met specified financial and operational conditions. Recognition and authorization for California's program was "grandfathered" into this later-enacted federal law. The federal act created key product cost reference points and terminology, such as Average Manufacturer Price (AMP) and Best Price, for use in the Medicaid program to calculate outpatient prescription drug rebates payable from manufacturers to the federal government.

In exchange for guaranteeing payment of the federal share of cost for outpatient prescription drugs provided to Medicaid-eligible patients throughout the country, the federal government requires manufacturers of outpatient prescription drugs to remit to the federal government either (a) a statutorily specified minimum rebate of 15.1 percent of AMP or (b) a manufacturer's Best Price to a U.S. purchaser whose purchases are not otherwise excluded from the computations of this preferred pricing.

Average Manufacturers Price "…means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts." (Emphasis added)

Best price "means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding--…" prices made available to:

- the Indian Health Service
- the Department of Veterans Affairs
- a State veterans' home
- the Department of Defense
- the Public Health Service
- prices charged under the Federal Supply Schedule of the General Services Administration
- any prices used under a State pharmaceutical assistance program (SPAP), of which there are at least three (3) in California
- any depot prices and single award contract of any agency of the Federal Government
- the prices negotiated from drug manufacturers for covered discount card drugs endorsed by the federal government
- any prices negotiated by a prescription drug plan under Medicare Parts A through D

and, prices made available to:

- Federally-qualified health centers
- Federally-funded family planning projects
- Entities receiving federal grants for outpatient early intervention services for HIV disease
- State-operated AIDS drug purchasing assistance programs (ADAPs)
- Black lung clinic
- Comprehensive hemophilia diagnostic treatment centers
- Native Hawaiian Health Centers
- Urban Indian Health Care Improvement organizations
- Any federally funded entities treating sexually transmitted Diseases
- Federally-certified tuberculosis treatment programs
- Hospitals owned or operated by a unit of State or local government, as a public or private non-profit corporation formally granted governmental powers by a unit of State or local

government, or is a private non-profit hospital which has a contract with a State or local government to provide health care services to low income individuals who are not entitled to Aged, Blind and Disabled benefits

- Disproportionate share hospitals
- Hospitals obtaining covered outpatient drugs through a group purchasing organization (GPO) or other group purchasing arrangement.

This litany of federal exclusions recognizes numerous areas of federal law in which preferential pricing for purchase of outpatient prescription medications meets or *exceeds* the levels established in the Medicaid Drug Rebate Law (42 USC 1396r-8(a) et seq., without the corresponding "best price" obligation to accord that same, preferred product pricing to the federal Medicaid Program serving in excess of 60 millions patients in the U.S.

A. Notwithstanding that the proposed regulatory terms, "California funds" or "fund of any political subdivision of the state" are not defined in the proposed regulation, this much is clear: California state or political subdivision purchasers of outpatient prescription medications making such purchases with funding from, and under the *aegis* of, any of the above programs will not likely benefit from the proposed regulatory mandate. The funds made available to California state or political sudivision purchasers from these sources already enjoy preferred pricing. This has the effect of rendering the state-level product pricing mandates proceeding from a state agency, such as CIRM, largely redundant.

B. Potentially, unequivocal preferred product acquisition pricing under the cited provisions of federal law (42 USC 1996r-8 (c)(1)(A)-(B), (c) (2)) in the proposed CIRM regulations will extend solely to outpatient prescription drugs since that is the limit of the reach of the Medicaid drug pricing provisions. If the source(s) of funding for outpatient prescription drug purchases by state or political subdivision purchasers are either (a) not already advantaged by federal law, or (b) by a state program for preferred product acquisition pricing (discussed extensively below), then those purchases can be made at the better of either 15.1 percent of AMP, or a "best price" beyond that level, should one exist.

The proposed preferred product acquisition pricing does not extend, currently, to products other than outpatient prescription drugs. Generally, then, for "therapies and diagnostics" other than outpatient prescription drugs, there may be no identifiable "…cost equal to that resulting from the provisions of Title 42, United States Code section 1396r-8, subdivisions (c)(1)(A)-(B) and subdivision (c)(2)." This results from the fact that AMP has a specific definition proceeding from the business of distribution of outpatient prescription drugs that may not, and likely does not, apply to eventual "therapies or diagnostics" developed from CIRM-funded research.

To reiterate: Average Manufacturers Price "…means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts."

If such "therapies or diagnostics" are not the subject of (a) payment by a wholesaler to a manufacturer, for (b) distribution to the retail pharmacy class of trade, or for which there is no (c) customary prompt pay discount, the notion of AMP may be entirely inapplicable to the transactions involving the eventual "therapies or diagnostics."

There may, in fact, be no method for product licensees to calculate a "cost equal to that resulting from…" provisions of federal law that do not describe, let alone contemplate, transactions that do not involve the elements of AMP.

This brings into focus an obvious task that should be completed as part of this regulatory proceeding. An alternative cost reference, or equivalency goal, should be identified that more would, in fact, work with alternative discoveries. Bringing a sharper definition of "therapies and diagnostics," other than outpatient prescription drugs, before the panel for study and deliberation, will have the effect of putting potential licensees on notice as to exactly what conditions they are accepting when agreeing to commericalize products resulting from CIRM-funding. Otherwise, this element of the regulatory effort is susceptible to failure when scrutinized by the OAL.

Assuming successful enactment as currently proposed, and assuming no other conditions or provisions barring, limiting or otherwise complicating the state or political subdivision purchase of CIRM-funded therapies and diagnostics, as those come to be known or defined, one challenge clearly emerges from the proposed language: finding a mechanism to ensure that CIRM-funded therapies and diagnostics would be provided at a cost <u>equal to</u> the financial equivalent of a minimum of 15.1 percent of Average Manufacturers Price as that term is defined in federal law, <u>or</u> a different (and presumably greater) pricing preference resulting from the enabling statutes for the listed, exempt programs and purchasers.

C. Significantly, and critically, the CIRM is <u>not</u> an exempt agency or program specified or recognized, *per se*, under federal law. Thus, as to eventual <u>outpatient prescription drug products</u> funded by Proposition 71-generated funds, CIRM product pricing mandates upon fund recipients and, in turn, on other third parties as conditions of acceptance of Proposition 71-generated funds would clearly implicate and, potentially, trigger the effects of this federal statutory scheme.

The absent clarification of what is meant by "California funds or funds of any political subdivision" as the triggering mechanism for imposition of the proposed CIRM mandate make it impossible to determine exactly when this would occur. Obviously, if purchases are made under the *aegis* of either Medicaid or one of the specified exempt programs, there is unlikely to be any added benefit from the proposed CIRM mandate, as preferred pricing is already guaranteed for those purchases.

Only those California state agency, or political subdivisions of the state - generally counties, cities, and special districts such as municipal utility and/or water districts – purchases of CIRM-funded therapies or diagnostics with funds outside the *aegis* of Medicaid or one of the

specified exempt programs, may benefit from the proposed CIRM mandate. In the next section of this memorandum, however, we review various and extensive state preferential price purchasing programs. Given their sheer number, and variety, we assess the benefit from this proposed mandate in relation to outpatient prescription drugs as virtually nil. To be of identifiable financial value in relation to purchases of other products (i.e., therapies and diagnostics), work to overcome the identified deficiencies in the proposal must be completed.

3. Comprehensive State Law Generating Preferential Pricing for Publicly Funded Purchases of Prescription Medications Complements, and Extends, Federal Law, Likely Mooting the Need for Express CIRM Pricing Mandates

In California, there are numerous state statutory enactments that have resulted in, or shortly will result in, preferential pricing for outpatient prescription medications that at least meet, or, as authorized, exceed, product pricing thresholds guaranteed by federal law. In virtually every instance, the proposed regulation is of questionable value until greater certainty is provided regarding the cost guarantee that will attend to CIRM-funded discoveries other than eventual outpatient prescription drugs.

A. Medi-Cal: Since 1990, the state's Medi-Cal program, serving almost 6.5 million Californians, has been expressly authorized to negotiate discounts and rebates with pharmaceutical manufacturers that are supplemental to, and exceed, the thresholds set in the provisions of federal law relied upon in the proposed regulations. Authorized Medi-Cal contracting on behalf of its fee-for-service population (historically, approximately 3.25 million patients), produces hundreds of millions of dollars in rebate revenue to this major state program.

As a consequence of their status as independent, at-risk contractors to the State of California, Medi-Cal managed care entities responsible for the balance of Medi-Cal enrollees in the state are not imbued with the same status as the State of California in the form of the Medi-Cal Program. Thus, they are strictly limited to the pricing caps set forth in federal Medicaid law.

In either instance, the proposed regulation is of no identifiable financial benefit to the Medi-Cal Program given (a) the statutory capacity of the fee-for-service program to substantially exceed Medicaid pricing limitations, and given (b) the strict statutory limitations on Medi-Cal managed care contractors.

B. Deficit Reduction Act of 2005:

Commencing January 1, 2007, the federal Deficit Reduction Act (DRA) of 2005 will expand savings generated by existing rebate and discount requirements first enacted in 1990. The DRA will require state Medicaid programs to collect rebates from drug manufacturers on certain drugs administered by physicians, will expand the definition of the "best price" -- which HHS uses in calculating the rebate that manufacturers of brand-name drugs must pay to Medicaid -- to include the prices of authorized generics, and will allow children's hospitals to purchase prescription drugs at discounted prices (under section 340B of the Public Health Service Act).

C. CalRx Discounted Drug Program for California's Uninsured/Underinsured:

Governor Schwarzenegger has signed into law AB 2911/SB 1702 which take effect on January 1, 2007. These measures enact the California Discount Prescription Drug Program (CalRx) for a broad range of eligible Californians "to make prescription drugs more affordable for qualified California residents, thereby increasing the overall health of California residents, promoting healthy communities, and protecting the public health and welfare."

This new health care benefit extends to eligible uninsured or underinsured Californians, estimated at approximately 6.5 million persons, who are:

- Residents of the state who-

(1) Have total unreimbursed medical expenses equal to at least 10 percent of his or her family's income where the family's income does not exceed the state median family income, or

(2) Are enrolled in the Medicare Program, but whose prescription drugs are not covered by the Medicare Program, or

(3) Have a family income that does not exceed 300 percent of the federal poverty guidelines and who do not have outpatient prescription drug coverage paid for by: Medi-Cal, the California Healthy Families Program or other programs funded by the state, or (A) In whole by the Medi-Cal program, by the California Healthy Families Program or other programs funded by the state, or by any other third-party payer, for which the annual limit on prescription drug coverage has not been reached.

prescription drugs under the program at a volume weighted average discount equal to any one of the following benchmark prices:

(1) Eighty-five percent of the average manufacturer price for a drug, as published by the Centers for Medicare and Medicaid Services, or

(2) The lowest price provided to any nonpublic entity in the state, or

(3) The Medicaid best price.

With respect to this population, and the public funds to be expended on their behalf as to outpatient prescription medications, the proposed regulation duplicates the discount ranges accorded to this major policy advance for the provision of prescription drugs to the state's uninsured and underinsured. Given these precise parameters, the proposed regulation appears to be of little or no identifiable financial benefit to the CalRx Program.

D. The Healthy Families Program

The Healthy Families Program is low cost insurance that provides health, dental and vision coverage to children who do not have insurance and do not qualify for no-cost Medi-Cal. Current enrollment is approximately 500,000.

Healthy Families offers low-cost health, dental and vision care through contracts with selected insurance plans. Each county in California has different plans to choose from. The benefits in all Healthy Families' insurance plans are similar. The benefits may be administered differently. Enrolled children are eligible for all covered services that are medically necessary.

Insurers under contract with the The Healthy Families Program, which is administered by the state's Managed Risk Medical Insurance Board (MRMIB), negotiate the cost of benefits with vendors and providers, to managed within fully capitated, at-risk contracts for care delivery. These negotiations are either direct with vendors/manufacturers, or are managed by a pharmaceutical benefits management firm under subcontract to one or more of the primary contractors.

E. AIDS Drug Assistance Program (ADAP) - A State Pharmaceutical Assistance Program (SPAP)

State and federal funds are annually appropriated in the state Budget Act to provide drug treatments to persons with HIV or AIDS. This program serves approximately 29,000 Californians.

Manufacturers of the drugs funded by DHS are required to pay the department rebates equal to the rebate applicable to the drug under 42 U.S.C. 1396r-8(c), plus a Supplemental Rebate negotiated with each manufacturer. To avoid "double dipping" or contradiction with other preferred pricing drug purchasing programs, no rebates are available on drugs which have been provided to patients under the Medi-Cal Program for whch DHS has received a rebate, nor on drugs that have been purchased on behalf of county health departments or other eligible entities at discount prices made available under the breadth of preferred pricing programs described aboved.

Express recognition as an SPAP has been accorded by to the ADAP by the federal government.

F. Genetically Handicapped Persons' Program (GHPP) - A State Pharmaceutical Assistance Program (SPAP)

Serving approximately 2,500 Californians, California DHS administers a program for the medical care of persons with genetically handicapping conditions, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, Friedreich's Ataxia, Joseph's disease, Von Hippel-Landau syndrome, and hereditary metabolic disorders: phenylketonuria, homocystinuria, branched chain amino acidurias, disorders of propionate and methylmalonate metabolism, urea

cycle disorders, hereditary orotic aciduria, Wilson's Disease, galactosemia, disorders of lactate and pyruvate metabolism, tyrosinemia, hyperornithinemia, and other genetic organic acidemias that require specialized treatment or service available from only a limited number of sources.

DHS is empowered to contract with manufacturers of factor replacement therapies to obtain the full range of available therapies and services for clients with hematological disorders at the most favorable price and to enable the department, notwithstanding any other provision of state law, to obtain discounts, rebates, or refunds from the manufacturers based upon the large quantities purchased under the program. Additionally, DHS is also empowered to contract with manufacturers, distributors, dispensers, or suppliers of pharmaceuticals, appliances, durable medical equipment, medical supplies, and other product-type health care services and laboratories to obtain the most favorable prices to the state. This authority extends to multisource prescribed products, and suppliers of outpatient clinical laboratory services.

Express recognition as an SPAP has been accorded by to the GHPP by the federal government.

G. California Childrens' Services Program (CCS) - A State Pharmaceutical Assistance Program (SPAP)

Administered through a network of county offices, CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. DHS manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

The program is open to California residents under 21 years old, with a covered medical condition, a family income of $40,000 or less, or out-of-pocket medical expenses for a child of more than 20 percent of family income, or the child has Healthy Families coverage.

Among the broad categories of medical conditions covered are congential heart conditions, neoplasms, blood disorders, endocrine, nutritional, and metabolic diseases, genito-urinary system disorders, gastrointestinal system disorders, serious birth defects, sense organs disorders, nervous system disorders, musculoskeletal system and connective tissues disorders, severe immune system disorders, disabling conditions or poisonings requiring intensive care or rehabilitation such as severe head, brain, or spinal cord injuries, or severe burns.

DHS is empowered to contract with manufacturers of factor replacement therapies to obtain the full range of available therapies and services for clients with hematological disorders at the most favorable price and to enable the department, notwithstanding any other provision of state law, to obtain discounts, rebates, or refunds from the manufacturers based upon the large quantities purchased under the program. Additionally, DHS is also empowered to contract with manufacturers, distributors, dispensers, or suppliers of pharmaceuticals, appliances, durable medical equipment, medical supplies, and other product-type health care services and

laboratories to obtain the most favorable prices to the state. This authority extends to multisource prescribed products, and suppliers of outpatient clinical laboratory services.

Express recognition as an SPAP has been accorded to the CCS by the federal government.

H. Department of General Services (DGS) Pharmaceutical Program

DGS administers the State of California Prescription Drug Bulk Purchasing Program in accordance with Government Code mandates. California state institutions purchase about $185 million in pharmaceuticals through this program.

The DGS is responsible for procuring drugs for California Department of Corrections, Department of Mental Health, Department of Developmental Services, California Youth Authority, and the California State University's student health centers. The DGS contracts with a vendor, AmeriSourceBergen Drug Corporation, to process departmental drug orders. AmeriSourceBergan is responsible for filling and then distributing those drug orders to the departments. AmeriSourceBergan acquires the drugs through (1) competitively procured state contracts for generic drugs, (2) negotiated state contracts for brand-name drugs, or (3) the Massachusetts Alliance, a GPO consisting of both public and private agencies. For drugs that are not available through these methods (i.e., noncontract purchasing), AmeriSourceBergan acquires the drugs at discounted prices.

I. Public Employee Retirement System (PERS)

State employees and many local government employees receive health insurance benefits through PERS. PERS offers health maintenance organization (HMO) plans and self-insured preferred provider organization (PPO) plans. The HMOs either manage their own prescription drug programs and offer this coverage as a part of their overall health insurance packages, or contract with a pharmacy benefits manager (PBM) to administer a prescription drug program. Similarly, PERS contracts with a PBM to provide prescription drug services for the PPO plans. The PERS annually negotiates rates with HMOs and sets PPO premiums. The costs of drug coverage are included in these annual rate negotiations.

J. University of California (UC)

The UC purchases drugs for its medical centers and student health clinics. As part of a nationwide network of academic medical centers, each UC facility purchases drugs through a group purchasing organization (GPO). A GPO is a drug volume purchasing entity. These drugs are delivered directly to the campus sites by a pharmaceutical distribution company. State law does not require UC to purchase drugs through DGS. All of the UC medical centers (Davis, Irvine, San Francisco, Los Angeles, and San Diego) are 340B hospitals and, therefore, are eligible for the federal drug program discounts. In addition, the UC medical centers provide services to some Medi-Cal patients. 255547.2