March 11, 2021

The Honorable Bronna Kahle
Chair, House Health Committee
Lansing, Michigan

House Bill 4348 – Regarding Pharmacy Benefit Manager License

Dear Chairwoman Kahle, and Members of the House Health Committee:

On behalf of the Pharmaceutical Care Management Association (PCMA), I greatly appreciate the opportunity to work with members of the legislature to address the rising cost of prescription drugs, and provide information on how we provide high quality, cost effective prescription drug management programs. We respectfully request the committee to consider our comments in opposition to HB 4348.

PCMA is the national trade association representing America's Pharmacy Benefit Managers (PBMs), which administer outpatient prescription drug plans for more than 266 million Americans with health coverage provided through Fortune 500 large and small employers, labor unions and government programs. PBMs are projected to save payers over $34.7 billion through the next decade -- that's $962 per patient per year – thanks to tools such as negotiating price discounts with drug manufacturers, establishing and managing pharmacy networks, in addition to disease management and adherence programs for patients.

Section 15 – Retroactive Reimbursement Changes

The primary focus of PBMs is to create solutions for payers to improve the quality of patient care while managing ever-growing costs. Lines 4-18 prohibit PBMs in their private market contracts with pharmacies from reducing a payment paid to a pharmacy after adjudication. This section will prohibit a PBM from both contracting a pharmacy in a pay-for-performance model, or from using any aggregated reimbursement methods, both of which are common practices used nationwide.

Generic Effective Rate (GER) and Brand Effective Rate (BER) guarantees are a type of aggregated reimbursement paid by PBMs to pharmacies and are used to provide reimbursement predictability for pharmacies in dispensing drugs. Instead of focusing on an individual drug's reimbursement amount for a specific transaction, PBMs and pharmacies use GER/BER to manage to a predictable, aggregate reimbursement level for a group of a pharmacy's claims. By restricting the PBM's ability to make any of reduction in payment post adjudication, the bill could inadvertently create a circumstance whereby PBMs intentionally reimburse pharmacies lower than is their current practice on a claim by claim basis to ensure that any reconciliation that occurs afterward, would be guaranteed to have positive payment to pharmacies and not a recoupment. This scenario of lowered initial reimbursements would perhaps have the opposite effect of the bill's intent.

This section of the bill also takes health care a step backwards by prohibiting certain pay for performance programs between PBMs and pharmacies. Similar to how performance-based incentives for hospitals and doctors were initially used in Medicare, once proven as a tool that improves patient care and quality outcomes, the private market began looking at ways to use these same tools and demanded that their health plan and PBM be able to use both the carrot and the stick to ensure the highest quality care. The pharmaceutical industry is just starting to offer outcomes-based contracts for drugs. Unfortunately, since a PBM could not reduce reimbursements to a pharmacy except in the instance of an audit, this bill would prohibit pay-for-performance provisions that have downside risk to pharmacies and eliminate any opportunity to extend pay for performance to the pharmacy branch of healthcare. This type of prohibition is antithetical to the progress of the health care system and is a departure from the trend of payment for value.

Section 15 – Fees

Section 15 (7) PBMs maintain robust IT systems to allow them to administer benefits for their clients. Fees help support access to the PBM's IT systems that allow pharmacies to fill prescriptions from nearly any benefit plan. This system assists in streamlining the process for pharmacies that would otherwise have to contract with individual employers and plans in order to provide services to their beneficiaries. Fees also support maintaining help lines, benefit manuals, and other services provided to the pharmacy by the PBM.

Moreover, pharmacies agree to certain fees in their contractual arrangements with PBMs. These fees are not unlike those paid by retailers to credit card companies in exchange for the risk of consumer fraud and for immediate payment for purchases, or the fees that banks charge consumers for ready access to cash through ATMs. Pharmacies freely enter into contracts with PBMs, agreeing to pay these fees in return for access to PBM services that enhance their own business practices.

Section 17 – Spread Pricing

Section 17, line 29 of the bill would prohibit the use of spread pricing arrangements. PBMs offer payer clients a variety of contractual options to pay for PBM services and they choose the one that is best for them based on the services they need and their plan membership. Each employer and plan sponsor evaluates and determines the financial arrangement that meets their specific needs for PBM services.

One option for clients is to elect a pass-through pricing arrangement for pharmacy reimbursement. Under a pass-through contract, the reimbursement negotiated with the retail pharmacies is passed along to the client to pay and the PBM collects fees from the client to pay for the entirety of the services it performs for the client. In this case, there would be no difference between what the client pays the PBM and what the pharmacy is reimbursed by the PBM. This approach may involve more variation in cost along with drug price fluctuation due to drug shortages, patent expirations, and other market pressures.

Another option for clients is spread pricing. In spread pricing, clients choose a financial arrangement for pharmacy reimbursement where the price paid to the pharmacy by the PBM may not equal the price billed to them. In this case, the difference in the amount paid by the client to the PBM and the amount the PBM reimburses a pharmacy is how the PBM is paid for the services it provides to the client. Many clients choose a spread pricing arrangement because it achieves a

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pricing level guarantee to the client. It provides clients with more certainty in their pharmacy costs and allows them to budget in a more predictable manner. Employers and plan sponsors often want to maintain this option in the marketplace because they do not want to have to pay per member or per claim fees for the services provided by the PBM. Reducing contracting options will ultimately reduce employer and health plan flexibility to contract in the best way to meet their needs.

Section 19 – Steering & Affiliated Pharmacies

This section eliminates the ability of plan sponsors to elect plan designs with pharmacies that demonstrably lower costs for their members, and restricts communications to members that would inform them about lower cost pharmacies. As consumers and payers search for ways to reduce out of pocket costs and the overall cost of healthcare, this legislation runs contrary to these goals and does not help Michigan plan sponsors who are trying to control costs for their members and removes several tools they elect to use to design a robust and cost effective pharmacy benefit.

In September 2018, when the U.S. Department of Justice approved the merger of health care corporations that operate in the PBM and insurance markets, the Antitrust Division said that one merger "is unlikely to result in harm to competition or consumers[1]." In October 2018, the Antitrust Division said that another merger would "allow for the creation of an integrated pharmacy and health benefits company that has the potential to generate benefits by improving the quality and lowering the costs of the healthcare services that American consumers can obtain."[2]

In the run-up to the implementation of Medicare Part D, Congress asked the Federal Trade Commission (FTC) to study if PBM-owned mail order pharmacies would pose a conflict of interest.[3] The FTC produced a voluminous study concluding that no such conflict existed.

Moreover, concerns about plan-pharmacy negotiations and ownership interests are unwarranted. The Federal Trade Commission found accusations of "self-dealing" that might arise when PBMs both administer a pharmacy benefit and ship drugs via their own mail-order pharmacy are "without merit."

One of the many tools that employers and other PBM clients use to provide significant cost savings and convenience for their enrollees are mail-service pharmacies. Mail-service pharmacies can contain the increasing cost of prescription drugs due to their unmatched efficiency and lower overhead costs compared to retail pharmacies.

Between 2015-2024, mail-service pharmacies are expected to save Michigan employers and other payers $1.12 Billion.[4] Health plans and PBMs often incentivize patients to use mail-service pharmacies by providing lower copayment options for 90-day supplies of maintenance medications, like those prescribed for asthma, for example.

[1] U.S. Department of Justice. "Statement of the Department of Justice Antitrust Division on the Closing of Its Investigation of the Cigna–Express Scripts Merger." September 17, 2018. Available at: https://www.justice.gov/atr/closing-statement

[2] U.S. Department of Justice. "Justice Department Requires CVS and Aetna to Divest Aetna's Medicare Individual Part D Prescription Drug Plan

[3] Federal Trade Commission. (August 2005). Pharmacy Benefit Managers: Ownership of Mail order Pharmacies.

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This legislation will eliminate a health plan's ability to use mail-order programs removes the lowest cost pharmacy option available. Retailers are not offering to lower copays to patients to provide price parity – instead this legislation mandates that mail order pharmacies raise prices.

When an employer or health plan contracts with a PBM to administer their pharmacy benefit, the employer maintains authority over the terms and benefit plan design. The employer or plan – not the PBM – makes decisions regarding cost-sharing requirements, mail-service, formulary, etc. This bill removes the option for the employer or health plan to use mail order and specialty pharmacy mail-order as cost savings tools.

The Centers for Medicare and Medicaid Services (CMS) studied drug costs and mail-service pharmacies. The CMS study showed that drug costs were 16% lower at mail-service pharmacies compared to brick-and-mortar drug stores.[6] Mail-service pharmacies not only deliver monetary savings, but actually increase adherence to a prescription's regimen, resulting in improved health outcomes for patients who are able to lead healthier lives.[7]

Section 27 – National Average Drug Acquisition Costs

When employers and other plan sponsors are required to reimburse pharmacies at whatever cost the pharmacy purchases a drug or using a specific cost-based methodology, an important cost and quality restraint is removed from the drug supply chain. These kinds of "guaranteed profit" requirements impose a "blank check" approach to reimbursement and undermine affordability for patients.[4] Pharmacy reimbursement requirements promote use of off-invoice discounting, which decreases transparency of drug prices and further hamstrings pricing competition. If the goal is to understand exactly how much drugs cost, it is necessary to consider all discounts and rebates associated with pharmacies' actual purchase price – whether they appear on an invoice or are recorded elsewhere. Survey-based reimbursement methodologies or reliance on pharmacy invoices cannot do that. Rather, they can lead to cost inflation, guaranteed profits for certain drug supply chain actors, and reduced transparency –
all at the expense of patients.

Because pharmacies purchase different drugs at different times and in different volumes, the price of a particular drug can vary significantly among pharmacies—even within a specific drug class or type. If patients can fill their prescription at lower-cost pharmacy locations, they, and, if they are insured, their health plans, can spend less. Employers and other plan sponsors, with their PBMs, contract with pharmacies for a set price for the same reason.6 These pharmacies, which typically form a plan's pharmacy network, are incented to purchase the drugs that they dispense efficiently and based on competitive market rates.

Reimbursement requirements discourage pharmacies from joining plans' preferred pharmacy networks, which undermines value for patients. In addition to lowering total drug spending and patients' out-of-pocket costs, preferred networks improve health outcomes, promote high-quality care, and advance the transformation to value-based care by incorporating risk sharing with preferred pharmacies to encourage higher use of cost effective generics and other evidence-

[4] The inflationary consequences of similar cost-based reimbursement systems are well known. For many years, the federal government relied heavily on cost-based procurement for defense contracts, only to discover that this approach resulted in large cost over-runs, because defense contractors knew their costs would be reimbursed, however much they were.

based health promotion strategies, including pharmacists in teams that integrate care for high-risk patients, and incentivizing pharmacies to provide patient care services and supports as part of accountable care arrangements and other ways to further health outcomes.

Section 29 – Accreditation

Lines 10-13 would limit Michigan employers' and health plans' ability to provide their beneficiaries with high quality, affordable care by prohibiting the use of accreditation and recertification standards for network pharmacies that helps ensure quality and safety. Certification standards are the foundational requirements that health plans, employers, and their PBMs use to validate pharmacy providers prior to enrollment and network contracting. State licensure evaluations by the Board of Pharmacy do not include measures to validate a pharmacy's ability to comply with contractual provisions and regulatory requirements, such as inventory control for claim payment audits, quality management, liability, patient compliance and adherence, safety, and clinical programs, etc. HB 4348 would restrict the ability of health plans and employers to ensure that pharmacies are meeting such critical requirements through their network contracts.

Additionally, the Board of Pharmacy is charged with overseeing pharmacy practice and does not have expertise or visibility in managing a pharmacy benefit or creating provider networks. Certification of pharmacies is an important part of establishing a high-quality pharmacy network and necessarily goes beyond a standard pharmacy license requirement.

Regarding specialty pharmacy, this legislation would allow any pharmacy to dispense specialty medications to patients without being required to meet the accreditation and certification standards used to ensure quality and patient safety. Accreditation and recertification are designations that demonstrate a pharmacy's commitment to safety by adhering to required, proper patient care standards that must be met to ensure appropriate dispensing of highly complex specialty drugs. Its important to note that accreditation standards are not set by PBMs, but instead by independent standard setting organizations recognized for establishing high quality standards, as many other providers in the healthcare system are responsible for achieving, as well.

Allowing any pharmacy to dispense highly complex specialty medications would not only lead to patient safety issues that would result in increased costs, but it would also interfere with the use of pharmacy networks comprised of pharmacies with the necessary expertise and service level, which health plans and employers use to help lower costs while providing a robust pharmacy benefit.

I appreciate the opportunity to weigh in and am happy to answer any questions you may have.

Sincerely,

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