Alaska Pharmacists Association

March 21, 2018

Good Afternoon, Chair Foster:

Thank you for allowing the Finance Committee to continue to work on HB 240-Pharmacy Benefits Managers sponsored by Rep. Guttenberg.

Please accept this document as a response from the Alaska Pharmacists Association to points made in a letter you received dated March 2nd from the Pharmaceutical Care Management Association (PCMA).

So far we do not see any true compelling reasons presented by PCMA to keep HB 240 from moving forward. The Pharmacy profession in the State supports HB 240 and asks you to move it from committee.

Our comments follow sections of the PCMA letter and are in blue. Please let us know if you need further information.

Sincerely,

Barry Christensen, RPh
Dirk White, RPh

Co-Chairs, AKPhA Legislative Committee

E-mail: akphrmcy@alaska.net
203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

PCMA
March 2, 2018
The Honorable Neal Foster Chair
House Finance Committee
Alaska State Legislature
Juneau AK 99801

Re: Concerns re: HB 240 - Pharmacy Benefit Managers

Dear Chairman Foster:
On behalf of the Pharmaceutical Care Management Association (PCMA), I am writing to you regarding HB 240. PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through large and small employers, health insurance plans, labor unions, state and federal employee benefit plans, and government programs. As requested by the Committee during the February 14th hearing on HB 240, I am writing to share our concerns with HB 240.

I. PBM Registration Provisions: SS 21.27.901 - 905 Are Unnecessary
The registration requirements in sections 21.27.901 - 905 are unnecessary because the Division of Insurance already has jurisdiction 'over the pharmacy benefits of insured plans and the ability to enforce those requirements on the plans providing those benefits in Alaska. PBMs, through their contracts with health plans, cannot do anything that would bring the client out of compliance with Alaska law. Thus, PBMs are required to comply with the same consumer protections governing utilization review, prior approval, and dispute resolution systems, among others.

Response
The last sentence states that PBMs are required to comply with consumer protections. While true, Pharmacists and pharmacies are not consumers (those are our patients) but providers of services, and there is nothing forcing compliance to any provider protections.

The Division of Insurance has indicated that they currently have no jurisdiction over PBMs since they are not currently required to register with the Division.

Other states adopting similar legislation have found it necessary to require PBM registration in order for their respective Divisions of Insurance to be able to take action when PBMs are out of compliance with the state's laws.

We would remind you that Alaska is one of only four states (Nevada, Idaho and Illinois being the other three) that is without any statutory regulation of PBMs. If HB 240 passes, Alaska would join 21 other states and the District of Columbia that have PBM registration, MAC Pricing parameters, and audit regulation. The other states have combinations of these protections in place for pharmacies.

II. Pharmacy Audit Provisions: SS 21.27.910- 940 May Encourage Fraudulent Activity
Sections 21 .27.910 - 21.27.940 may have the unintended consequence of opening the door to fraud, abuse, and wasteful spending in health care. Health plans and employers that choose to use PBMs for pharmacy benefits rely on audits of network pharmacies to recoup monies incorrectly paid for claims with improper quantity, days' supply, and coding; duplicative claims: and other irregularities. The State of Alaska's own RFP for PBM services specifically requires a "robust process for tracking and monitoring fraud/abuse." Audits also have a patient safety aspect in that they verify if pharmacies are complying with board of pharmacy rules such as the proper storage of prescription drugs and posting of required signs. Specifically:

Response
HB 240 will in no way prevent audits, waste, fraud, or abuse, such audits are specifically allowed. The bill simply sets common sense guidelines that all PBM's and pharmacy will be expected to follow. The language in this bill is similar or identical to legislation that has been passed in nearly every other state.

The question that really needs asking is what is the current total, in millions of dollars, that PBMs have recouped from pharmacies and consumers because of the lack of current protocols, and transparency of precious healthcare dollars. (See PMB Watch Lawsuit Summary)

a. Section 21.27.91 O (b) requires entities to provide pharmacies with an advanced written notice 10 business days before an audit. This would give individuals ample time to hide evidence of fraudulent activities or evade authorities altogether.

Response
The pharmacy audit trail is basically a paper trail. If any of the trails looks suspicious PBM's can contact patients and prescribers to verify that the information is valid.

The IRS gives notice of an audit-usually much greater than 10 days. This time period merely allow pharmacies to have adequate staff available during the on-site audit to not only assist the auditor but also to continue serving patients during the business day.

Again, if fraudulent behavior has occurred it can still be uncovered by an audit. Also if fraud is suspected then the requirements of this legislation do not apply (see section 21.27.940).

b. Section 21 .27.91 O(c)(3) limits the number of prescriptions available to audit to 250, which is simply not a large enough sample size to do an effective audit. Auditors look for errors, irregularities, and suspicious patterns over time, and compare claims with historical information and with similarly situated pharmacies. Substantial changes in claim volume or the dollar amounts from pharmacies can indicate fraudulent activity.

Response
The last sentence references claim volumes. PBMs can look at all the pharmacy claims to check for fraudulent activity at any time. It may be that such checks are how they develop reasons to audit a pharmacy.

Since PBMs are **our payer** they see every prescription filled by us. It doesn't make sense to say that this clause will hamper them from any audit information.

Additionally, all states that have enacted fair audit legislation have set maximum number of prescriptions per audit. However, again if fraud is suspected then the requirements of this legislation do not apply.

c. Section 21 .27.910 (d)(1) and (2) require a pharmacist licensed in AK to conduct the audit. Since this could limit the ability to conduct full and fair audits, we recommend requiring an audit be conducted (1) by a licensed pharmacist or (2) in consultation with a licensed pharmacist.

Response
We disagree. Licensure in Alaska would not limit the ability to conduct full and fair audits. It is a very simple thing for a pharmacist to become licensed in the state of Alaska. If they are not licensed here how will they truly know the **AK statutes and regulations** that we practice under every day?

This requirement applies only to an on-site audit, not the desk audits that PBMs conduct on a regular basis.

d. Section 21.27.920 {b){2) and {b){3) prohibit recoupments of mailed payments as well as payments based on a percentage.

Response
Alaska has a significant population of rural residents who rely on mail order or "bush plane" delivery of medications. Currently some PBM's prohibit Alaskan pharmacies from providing this type of service simply because they operate **their own** out-of-state mail order pharmacy **in competition** with in-state Alaskan operated pharmacies.

Patient protection is significantly enhanced when patient utilizes **one pharmacy for all their needs**, both in-person and via mail (or bush plane). Since different pharmacies are not currently connected with patient information, it is very important that the patient utilizes one pharmacy for their prescription and over-the-counter health care needs.

e. Section 21 .27.935 states that when conducting an audit, clerical or computer errors must be intentional. However, section 21 .27.940 states that activities under sections 21 .27.907-955 do not apply in cases of suspected fraud.

Response
This provision merely says if the pharmacy is suspected of committing fraud then all potential errors can be reviewed. These are two separate sections of the bill and are not linked.

f. Section 21.27.940 should clarify that the requirements of AS 21 .27.901 - 21.27.955 do not apply to federal programs or payers. Audit procedures are contained in PBM-pharmacy contracts and PBMs supply pharmacies with provider manuals that contain information about audits and examples of fraud, waste, and abuse. Additionally, some PBMs also distribute provider tip sheets quarterly, which may contain additional information related specifically to what audits entail. These protections are sufficient.

Response

Section (2) of this section specifically spells out that Medicaid assistance programs do not apply to these auditing standards.

We do not see the referenced materials as sufficient. PBMs can and do change those audit procedures whenever they want and the contracted pharmacy cannot contest or refuse the change to the contract when it happens.

If we try to protest the change or ask that the PBM honor the old contract we are told that this is the contract now take it or leave it if you want to continue to serve your patients that are covered by this contract.

Ill. Payment for Generic Drugs: §§ 21.27.945- 950 Create a State-Mandated Pricing Scheme
Sections 21 .27.945 - 955 would create a pricing scheme that would limit or delay the ability of plan sponsors and consumers to benefit from the dramatic cost savings associated with the use of generic drugs. Maximum allowable cost (MAC) is the PBM or plan payment for the unit ingredient costs for generic drugs, and a MAC list creates a standard reimbursement amount for identical products. A MAC list is a common cost management tool that is developed from a proprietary survey of wholesale prices existing in the marketplace, taking into

account market share, existing inventory, expected inventories, reasonable profits margins, and other factors. The purpose of the MAC list is to ensure that the pharmacy and/or their buying groups are always motivated to seek generic drugs at the lowest possible price. The MAC list ensures that the PBM, on behalf of their clients (primarily employers), are paying a fair price for widely available generic drugs. States adopted MAC lists for their Medicaid programs after audits showed that Medicaid reimbursements for generic drugs far exceeded a pharmacy's acquisition costs. Employers have similar concerns and goals to protect against overpaying for generic drugs.

Response
We contend that the MAC system of pricing worked for years prior to the PBM's reaching Fortune 500 status and institution of MAC prices which benefited the stockholders of the PBM at the expense of pharmacies.

This bill simply allows a process whereby the pharmacy (and plan sponsor) can verify that the PBM is actually using a reimbursement price that is representative of the marketplace that serves pharmacies in the State of Alaska.

In other states where this language has been implemented, there has been no indication that pricing changes cannot be made instantly, **which includes both increases in drug pricing, as well as decreases.**

HB 240 will not limit use of generic drugs in any way, and we will always use them when available unless otherwise instructed by the prescriber.

Midway through the paragraph the term "reasonable profits" is used. Why are they supposed to determine what a reasonable profit should be for our services? How are they determining what is reasonable? Alaskan pharmacies are largely reimbursed for MAC lists based on "Lower 48 prices". Most everyone recognizing there is a higher cost of doing business in Alaska and in this case Alaskan pharmacies pay additional charges for shipping that lower 48 pharmacies don't.

Not a single PBM has a business license, employees, and/or a brick and mortar location in the state of Alaska, so how would they know what it costs Alaskan pharmacies to heat, light, and staff our pharmacies, let alone know the true costs of the various shipping logistics of each and every individual pharmacy in the state?

Currently Alaskan pharmacies are losing significant revenues due to MAC pricing systems that do not represent true costs. We are concerned about our ability to survive without passage of legislation such as HB 240.

a. Section 21 .27.945(1) requires PBMs to provide proprietary information to pharmacies. Section 21 .27.945(1) requires PBMs to provide the "methodology and sources used to determine the drug pricing list" (emphasis added). While providing sources gives the pharmacies insight into where the PBM is gathering the market data to create the list, each PBM has its own confidential methodology in creating a MAC list. These methodologies are one way PBMs compete and should not be exposed.

Response
This goes toward transparency. When a PBM pays a pharmacy below cost, we want the PBM to tell us where we can buy that medication for that price. Pharmacies would be on the phone in the next minute buying the medication for that price and saving everyone money.

When it is stated that the seller is proprietary information or that the PBM really doesn't know where the medication can be bought for that price then it appears to us that this alleged wholesale price is a fabrication and PBMs are hiding behind proprietary information.

It doesn't make sense that on the one hand they would say a medication could be bought less expensively and on the other hand say they don't know where it could be bought less expensively.

b. Section 21.27.945(b)(2) limits drugs allowed on a MAC list. Section 21.27.945(b)(2) in coordination with the definition of "multi-source generic drug" in Section 21 .27.955 (6) limits the generic drugs that can be included on a MAC list to only drugs that have two or more "multi-source generic drugs" available in the marketplace. By prohibiting the use of MAC reimbursement for drugs during the generic exclusivity period (right after the brand counterpart goes off patent), the number of drugs that can be dispensed at discounted generic drug rates significantly decreases. Thus, pharmacies would be allowed to purchase these drugs at a competitive rate (the price of the exclusive generic as opposed to the price of the brand name drug), but payers would be forced to reimburse pharmacies at excessive brand prices, benefitting pharmacies at the expense of consumers.

Response
HB 240 doesn't require pharmacies to dispense brand name drugs when generically available drugs are available; nor does it assume that we would. And that is the key to this section. If PBMs are not able to provide a drug price as a true multisource generic drug then there should not be a generic MAC price for it!

c. Section 21.27.950 guarantees profits for pharmacies. Section 21 .27.950(c), stating that PBMs "shall grant an appeal" in specified circumstances prescribes specific pharmacy reimbursement terms by requiring that pharmacies are reimbursed at the "cost" of the drugs to the pharmacy, even if the cost was inflated or not truly reflected on the invoice-ensuring pharmacy profit at the expense of consumers. MAC provides an incentive for the pharmacy to shop for the lowest price of a generic drug. The risk that a pharmacy may be reimbursed at something less than it paid its supplier places an incentive on the pharmacy to manage its inventory efficiently and leverage buying power to result in the lowest possible acquisition cost. Poor purchasing practices, negligence in research, and inadequate management of inventory can cause pharmacies to fail to acquire a drug at a price less than or equal to the MAC list price. These inefficient practices should not be rewarded. Academics have opined that there are dangers in reimbursing pharmacies based on their invoiced drug acquisition cost. 1 Dr. Hyman reports that this type of cost-based reimbursement system will "effectively function as a 'guaranteed profits' term," because the pharmacies will be "guaranteed they will be paid at least that amount, and likely more. And because of rebates and discounts [that pharmacies receive from their suppliers], invoiced prices may not reflect actual drug acquisition costs-further inflating the guaranteed profits."2 In addition, he indicates that legislation mandating cost-based reimbursement is likely to cause:

• Increased spending on pharmaceuticals and the cost of pharmaceutical coverage

• Reduced competition at the wholesaler and manufacturer level;

• Increased use of off-invoice discounting

• Guaranteed profits for pharmacies, irrespective of their actual efficiency

• Reduced consumer welfare.

The State of Washington considered a pharmacy "reimbursement at cost" requirement for PBMs, and found that the fiscal impact would be between a 1 percent increase and 10 percent increase in pharmacy costs paid for by the State-up to $113 million annually. The state's Office of Financial Management fiscal analysis done on the

original version of the bill it analyzed indicated that "if PBMs pay more for pharmaceuticals, the inventory management for pharmacies may also change. Removing price limits, such as those created by MAC lists, reduce the incentive for pharmacies to purchase pharmaceuticals at the lowest cost possible; demand for lower cost pharmaceuticals may be reduced."3

Response
This implies that pharmacies shouldn't be reimbursed for at least the cost of the medication. Pharmacies must not only be reimbursed the cost of the drug but make a profit to survive.

What the letter does not state it that the State of Washington did pass a MAC reimbursement/transparency law! Again we are only asking for what the majority of other state legislators have already provided.

The only way the consumer will be impacted is if this legislation does not pass and we have independent pharmacies go out of business reducing critical access to health care in our small communities with only one or two pharmacies.

The last paragraph of the above mentioned analysis talks about how Academics have opined on the dangers of this type of legislation. The one "academic" referenced is a professor of medicine and law having an MD and JD degrees and has been hired many times by PBMs to testify as an expert on their behalf in legal matters/trials. He has no economics background other than his work for the Federal Trade Commission.

d. Section 21 .27.950(d)(2) requires PBMs to provide information they do not have. Section 21.2.950(d)(2) requires PBMs, upon denial of an appeal, to identify a drug "that has been purchased" by a network pharmacy at a particular price. Although PBMs have information about average prices in the marketplace and through MAC reimbursement methodology, encourage pharmacies to purchase efficiently, PBMs do not know where a specific pharmacy has purchased a drug at a particular price. This section is unworkable because of these issues.

Response
Again when PBM's were using MAC prices that were truly indicative of pharmacy acquisition prices then pharmacies were made whole. If they truly don't know what a pharmacy pays for a drug then how can they really set a MAC price? Again, historically the PBM's used to set prices that were reasonable but we don't see that now.

e. Section 21.27.950(d)(3) is unclear. This section requires a PBM, upon denial of an appeal, to provide the name of a wholesaler "who operates in the state in which the drug may be purchased." This is unclear drafting. If it means that PBMs must provide the name of a wholesaler from which a drug may be purchased at a particular price, it is inappropriate for PBMs to direct pharmacies to specific suppliers of drugs.

Response
If the PBM, through MAC pricing, is "motivating" us to buy at that price then the action of telling us which wholesalers have stock and are willing to sell that medication at that price then it does become an appropriate activity.

f. Section 21 .27.950 authorizes director to interfere in private contracts. Sections 21 .27.950(e) and (f) would give the Division Director the ability to supersede any arbitration agreements between PBMs and pharmacies. Arbitration agreements are used regularly in contracting because they provide an alternative forum for resolving disputes outside of the courtroom, and they are widely used in the healthcare industry. Parties negotiate contracts in good faith, anticipating potential disagreements and drafting terms that outline the rights and

responsibilities of each party in the event of conflict. These arbitration agreements sometimes provide for appeal rights to the court system, in the event resolution by arbitration fails. This section appears to authorize the Director's Office to render binding judgment on the parties, inserting itself in the midst of an agreed-upon process-something that is unheard of for other health care entities. This is unnecessary and a government overreach into private contracting.

Response

The Cambridge English Dictionary defines arbitration as "the formal process of having an outside person, chosen by both sides to a disagreement, end the disagreement".

Under this definition we have never had an outside person be an arbiter. Under this legislation the Director of Insurance will be that person.

Unfortunately this will not be chosen by both sides, but since recently this process has been one-sided, it seems fair that the arbiter is chosen via legislation.

The Cambridge English Dictionary defines negotiate as "to have formal discussions with someone in order to reach an agreement" and "the process of discussing something with someone in order to reach an agreement, or the discussions themselves".

The third sentence in this paragraph states "Parties negotiate contracts in good faith". Under the definitions presented from the Cambridge English Dictionary pharmacies have testified that they are not able to negotiate specific language terms in a PBM contract.

Our members have stated over and over that PBM's have told them that "You have the contract and if you wish to continue to serve your patients then sign the contract as it is, this is not a negotiation".

We greatly appreciate the opportunity to provide the Committee with our perspectives and look forward to further discussion. Please let me know if you have any questions about our concerns. Thank you.

Sincerely,

April C. Alexander
Assistant Vice President, State Affairs Pharmaceutical