the PACIFIC HEALTH COALITION

February 27, 2024

The Honorable Jesse Bjorkman, Chair
The Honorable Click Bishop, Vice Chair
Senate Labor & Commerce Committee
State Capitol
Juneau, AK 99811

RE: Pacific Health Coalition's Opposition to SB 121 – Relating to Pharmacy Benefit Managers

Dear Chair Bjorkman and Vice Chair Bishop:

On behalf of the Pacific Health Coalition (PHC), I respectfully submit our opposition to SB 121. Our opposition stems from the significant financial impact this legislation would have on Alaskans by increasing costs to all Health Plans. PHC represents 49 member groups, including Public Sector as well as multi-employer Taft-Hartley, self-insured, Trust Funds, covering approximately 125,000 Alaskans.

Reimbursement Mandate

SB 121 essentially guarantees pharmacies make a profit on every drug dispensed. This would be the result of the State intervening in the private market and guaranteeing pharmacies are profitable, even at the expense of patients. Independent pharmacies are often represented by Pharmacy Service Administrative Organizations (PSAOs) in negotiating contracts with PBMs and participating in pharmacy networks. By representing multiple pharmacies, PSAOs negotiate contract terms with PBMs. By mandating reimbursement levels, this provision will increase costs for patients. While pharmacy profits may increase, it will be 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 rely on PBMs to contract with pharmacies for a set price for the drugs they dispense. In turn, pharmacies are incented to purchase the drugs that they dispense efficiently and based on competitive market rates. If pharmacies purchase a higher-priced product, they may not make as much profit or, in limited instances, may lose money on that specific drug. Alternatively, if they purchase drugs at a more favorable price available in the marketplace, pharmacies will make a higher profit. Market-based reimbursement models play an important role in keeping incentives aligned for payers and pharmacies.

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However, removing the ability of plans and PBMs to incent pharmacies to obtain drugs at the lowest possible cost and, instead, establish minimum reimbursement rates lines pharmacy pockets by taking money out of consumer pockets.

Requiring PBMs to reimburse pharmacies at mandated levels will cause spending on prescription drugs to soar. Studies have found that reimbursement mandates do not save states money, because they act as "guaranteed profits" for pharmacies, often through high dispensing fees. Dispensing fees are in addition to ingredient fees paid to pharmacies. Dispensing fees are negotiated between the PBM and the pharmacy, or the PSAO on the pharmacies' behalf. It is supposed to include any counseling provided by the pharmacist to the patient. While such counseling is often necessary and important, it is not always needed, particularly with respect to refills, However, a dispensing fee is paid to the pharmacist regardless. Mandated dispensing fees are another way to increase pharmacy profits on the backs of consumers. This will also increase costs by requiring the pharmacy dispensing fee to be no lower than the Medicaid dispensing fee. Mandated dispensing fees will have a significant impact to the Alaska Care Plan as well as small and large employers and unions.

Any Willing Pharmacy (AWP) - Disruption to Pharmacy Networks

This section requires a health plan to pay any pharmacy that dispenses a prescription to a covered individual, regardless of whether or not the pharmacy is in-network and regardless of whether the pharmacy meets quality metrics. It further prohibits the use of mandatory mail order, which results in improved access and cost savings to both payers and patients.

Health plans contract with PBMs to create a network of pharmacies that compete on cost and quality, providing patients with access to a range of high-quality pharmacies while providing savings for payers and patients. According to the Federal Trade Commission (FTC), networks and selective contracting generate significant savings that are passed on to consumers in the form of lower premiums, lower out-of-pocket costs, and better services, while any willing pharmacy (AWP) laws lead to higher drug prices because:

- When a retail pharmacy "faces no threat of sales losses if it fails to bid aggressively for inclusion in the payers networks," it has no incentive to offer its most competitive terms; and
- Opening networks to any willing provider reduces the volume of sales for all network participants, ultimately resulting in smaller discounts.

Imposing an AWP mandate would also potentially expose patients to pharmacies that lack quality standards or, worse, have been sanctioned by the Board of Pharmacy or have been banned by Medicare or Medicaid. Furthermore, the bill would also allow any pharmacy to presume to meet the requirements of a "specialty pharmacy" upon its own assertion. Specialty pharmacies focus on higher cost and high touch medications usually for patients with complex health conditions. Specialty medications may require additional special handling, storage and administration and require specific training given higher risk for complications and side effects. On behalf of health plans, PBMs only contract with specialty pharmacies that that have been accredited by national, independent organizations such as The Joint Commission and URAC. Accreditation provides an important layer of patient safety by ensuring a specialty pharmacy is handling, storing, dispensing, and shipping drugs appropriately. Given the sensitive nature of these medications, patient safety must be paramount. Unfortunately, not all clinics and hospital pharmacies are independently accredited.

This proposed bill further prohibits health plans from taking advantage of cost savings provided by mail order pharmacies. Mail order pharmacies are able to purchases drugs in quantities smaller, independent pharmacies

cannot. The savings generated from these bulk purchases are passed on to patients in the form of lower premiums and/or copays. Imposing this restriction will increase costs for patients, not lower them.

Increased costs of specialty drugs

This section requires health plans to reimburse clinicians for drugs at the cost charged despite the availability of the same medications at significant lower costs. Health plans rely on clinicians to administer drugs for patients that they cannot administer themselves (e.g., many cancer drugs). However, health plans should not be forced to pay exorbitant prices for the drugs administered. The higher drug prices charged by hospitals and clinics is what forced health plans to consider alternative methods. Licensed specialty pharmacies purchase medicines requiring clinician administration from the very same sources clinics and hospitals do. In fact, they are every bit as safe, reliable, and effective. Just at a much more reasonable cost to the health plans. Requiring health plans to pay the high prices charged by clinics and hospitals will ultimately result in higher costs for patients.

Expanded regulation of self-insurance market

Several provisions of the bill will have a direct impact on self-funded health plans, including union Taft-Hartley and government-sponsored health plans. This will result in higher costs for these plans and, ultimately, their plan participants. At a time when we are all searching for ways to expand access to more affordable prescription drugs, this bill instead puts more financial burden on the backs of teachers, fire fighters, public safety officers and other public and private sector employees who rely on self-funded plan sponsors.

A Ban on Cost Saving Tools

This proposed bill contains a number of concerning provisions. The provisions completely deprive plans of any ability to establish a pharmacy network benefit design. It prohibits plans from utilizing limited, preferred, or exclusive pharmacy networks that incentivize members to use the lowest cost, highest quality providers. Plans should be allowed to encourage its members to choose lower cost, higher quality options and reward them for doing so with favorable out-of-pocket costs. This bill would deprive patients access to lower drug prices negotiated through these types of pharmacy networks. Plans pass on savings from these programs to its members through lower premiums and more flexible benefit designs. Recent action taken by states is limiting choice plan sponsors have to drive patients to the highest value healthcare.

Furthermore, the proposed bill eliminates the ability for PBMs to properly screen and credential network pharmacies. Credentialing is a standard term and condition for participation in PBM networks and is an important part of ensuring the quality and safety of networks, including verification that all of providers are

properly licensed and are in good standing. Failing credentialing generally means that a pharmacy does not meet qualitative standards sufficient to be included in any network to dispense medications to a plan participant. Limiting denials of admission related to credentialing or re-credentialing findings could have significant health and safety consequences for plan participants as credentialing is the primary way PBMs screen for pharmacies likely to engage in fraud, waste, and abuse. Additionally, the credentialing process provides an opportunity to capture pertinent demographic data and practice-specific details about a pharmacy. This information is used in the creation of directories to ensure patients are able to identify a pharmacy that will meet their specific needs, while also allowing PBMs to evaluate pharmacies within their respective lines of business (i.e. specialty and mail order). Credentialing ensures pharmacies meet the highest standards of care necessary to safety and effectively dispense medications for more focused practice types. PBMs' ability to enforce certain credentialing requirements is a critical component in maintaining network integrity while mitigating financial risk to plans and is typically a requirement of the PBM-client agreement.

The proposed bill eliminates spread pricing, which is a financial model utilized by certain plans to fund their prescription drug benefit. When spread pricing is eliminated, it deprives plans of the option of having cost certainty by letting the PBM assume more of the financial risk. Eliminating spread pricing as a financial lever reduces creativity and competitive forces within the industry, and limits PBMs ability to design affordable, high quality prescription drug benefit. Spread pricing contracts do not involve or impact pharmacies. Third parties should not be allowed to determine the terms of contracts they are not a party to, let alone not even impacted by. Given the diverse needs of health plans, PBMs offer multiple financial models from which clients may choose which best meets their specific needs. While pharmacists may push for a prohibition of spread pricing because they believe it results in lower reimbursement for themselves, this is not the case; the pharmacy is reimbursed the same, regardless of how the client elects to fund its prescription drug benefit. The fact is, any prohibition on spread pricing does nothing to lower costs for consumers, rather it could actually increase costs. Many clients choose a spread pricing arrangement to provide certainty and predictability in their pharmacy spend. With the PBM sharing the risk in this type of arrangement, this option can provide lower health care costs for clients and their members. For clients that choose spread pricing, there are typically no administrative fees. Depriving health plans of the ability to choose a particular financial model is certain to increase their costs, which will result in higher premiums for plan participants or a reduction in benefits.

The proposed bill restricts charging pharmacies any type of fee. PBMs contractually negotiate with pharmacies to pay a transaction fee per paid claim. The exact amount of the per claim transaction fee is negotiable between the parties.

PBMs provide claims processing and pharmacy transaction services to pharmacies participating in pharmacy networks under a bundled arrangement to support pharmacy network providers. The bundle of services contained within PBM services includes: (1) real-time POS adjudication; (2) help desk/IT/telecom services; (3) concurrent drug utilization review (i.e., online, real-time drug utilization analysis at the point of prescription dispensing to prevent drug-related adverse events); (4) automated prior authorization process to reduce calls to pharmacy; and (5) maintenance of industry standards (e.g., NCPDP). These services are typically performed on behalf of the network pharmacy provider to support a client's health plan members' access to prescription

drug benefits. In providing these services and facilitating this connection between the client, the member, and the pharmacy in accordance with the applicable specifications of each client, PBMs must provide various component items and services, including those identified above. Transaction fees are used to offset the cost of these services. Services which every pharmacy relies on to conduct its business.

Notably, these fees are not based on pharmacy performance and do not retroactively reduce a pharmacy's reimbursement. On the contrary, these fees are negotiated as part of the parties' written contractual arrangement and the specific transaction fee amount is clearly provided for in the parties' contract and identifiable as such on remittances that the pharmacies receive.

This mandate would also prohibit credentialing fees. Credentialing necessarily involves a comprehensive expert review. PBM fees are used to engage staff with appropriate knowledge and experience to review the applications to ensure that the pharmacy can safely and effectively meet the needs of the members it serves. Credentialing fees ensure an appropriate review and discourage wasteful and frivolous applications.

It is important to note that the Pacific Health Coalition fully supports transparency. We are however, opposed to State legislation that increases cost to both members and the Plans themselves. We urge legislators to refuse passage and conduct key stakeholder meetings giving careful consideration to existing alternatives and/or the unintended negative consequences that may arise.

Respectfully submitted, On Behalf of the Pacific Health Coalition,

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