February 23, 2024

The Honorable Mike Prax, Chair
The Honorable Justin Ruffridge, Vice Chair
House Health & Social Services Committee
State Capitol
Juneau AK 99811

Re: HB 226 – Relating to Pharmacy Benefit Managers - OPPOSE

Dear Chair Prax and Vice Chair Ruffridge:

On behalf of the Pharmaceutical Care Management Association (PCMA), I respectfully submit our opposition to HB 226. HB 226 will result in higher costs for payers and patients, further exacerbating affordability and access to coverage for Alaskans.

Section 21.27.950 - Reimbursement Mandate
HB 226 essentially guarantees pharmacies make a profit on every drug dispensed. This would be an unprecedented step by the legislature intervening in the private market by guaranteeing one industry is 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 on behalf of plans. Mandating reimbursement levels under this provision will raise costs for patients. Although pharmacy profits may rise, it will come at the patients' detriment.

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 prescriptions 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. However, removing the ability of plans and PBMs to incentivize pharmacies to obtain drugs at the lowest possible cost and, instead, establishing 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”[1] for pharmacies, often through high dispensing

[1] Hyman, David. 2016. “The Adverse Consequences of Mandating Reimbursement of Pharmacies Based on Their Invoiced Drug Acquisition Costs.”

fees.[2] 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 regarding refills, as a dispensing fee is paid to the pharmacist regardless. Mandated dispensing fees are another way to increase pharmacy profits on the backs of consumers.

Subsection (b) 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 on the Alaska Care Plan as well as on small and large employers and unions.

Section 21.27.951 - 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 irrespective of whether the pharmacy meets quality metrics. It further prohibits 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.[3]

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 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 assertion. Specialty pharmacies usually focus on higher cost and high-touch medications for patients with complex health conditions. Specialty medications may require additional special handling, storage, administration, and specific training, given the higher risk for complications and side effects.

On behalf of health plans, PBMs only contact specialty pharmacies 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,

[2] Ippolito, Benedic, Joseph F. Levy, and Gerard Anderson. 2020. "Abandoning List Prices In Medicaid Drug Reimbursement Did Not Affect Spending.
[3] Federal Trade Commission, (March 7, 2014). Letter to the Centers for Medicare and Medicaid Services, Department of Health and Human Services.

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 section further prohibits health plans from taking advantage of cost savings provided by mail order pharmacies. Mail-order pharmacies are able to purchase drugs in smaller quantities, but independent pharmacies cannot. The savings generated from these bulk purchases are passed on to patients through lower premiums and/or copays. Imposing this restriction will increase costs for patients, not lower them.

A new provision related to clinician-administered drugs would eliminate a cost saving approach for patients by prohibiting PBMs from using a specialty pharmacy dispensing option for these medications. Clinician-administered drugs are generally higher priced and subject to significant markups above the acquisition cost. When clinically appropriate, by shipping the patient's medication directly to the provider until the patient is scheduled for treatment, the patient can see greater cost savings.

Sec. 21.27.952.- 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 significantly lower costs. Health plans rely on clinicians to administer drugs for patients 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 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 patient costs.

Sec. 39.30.091 – Expanded regulation of the self-insurance market
Several provisions of the bill will directly impact self-funded health plans, including union Taft-Hartley and government-sponsored health plans. This will result in higher costs for these plans and 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, firefighters, public safety officers, and other public and private sector employees who rely on self-funded plan sponsors.

Section 21.36.126 – A Ban on Cost Saving Tools
This section contains several concerning provisions, as outlined in more detail below. This section is similar to, but even more restrictive than 21.27.951, in that 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, incentivizing members to use the lowest cost, highest quality providers. Plans should be allowed to encourage their 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 of access to lower drug prices negotiated through these types of pharmacy networks. Plans pass on savings from these programs to their members through lower premiums and more flexible benefit designs.

21.36.126(a)(13) eliminates the ability for PBMs to properly screen and credential network pharmacies. Credentialing is a standard term and condition for participation in PBM networks. It is an important part of ensuring the quality and safety of networks, including verification that all 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 creating directories to ensure patients can 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 for 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.

21.36.126(a)(15) eliminates spread pricing, a financial model certain plans utilize 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 benefits. 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 be impacted by them.

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. Any prohibition on spread pricing does nothing to lower consumer costs; instead, it could 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 offer lower healthcare 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 will increase their costs, resulting in higher premiums for plan participants or a reduction in benefits.

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. These are services that 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. The specific transaction fee amount is in the parties' contract and identifiable as such on the pharmacies' remittances.

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 its members. Credentialing fees ensure a proper review and discourage wasteful and frivolous applications.

Conclusion
At a time when we are all experiencing higher prescription drug costs, we should not be considering policies that remove health plans' ability to manage their cost and provide beneficiaries access to lower-cost medicines in exchange for increasing profits for pharmacies. On behalf of the patients and payers that PBMs work with to lower costs, we oppose HB 226 because it will increase healthcare costs and negatively impact access to quality medications and coverage.

Sincerely,

Tonia Sorrell-Neal
Senior Director State Affairs