# HB

# 240

<TARGET><BILL>HB 240</BILL><SUBJECT>HB
240</SUBJECT><COMM>HL&C30</COMM></TARGET>

*Session:*
*State Capitol*
*Juneau, Alaska 99801*
*(907) 465-4457 Office*
*(907) 465-3519 Fax*
*(800) 928-4457 Toll Free*

*Alaska House of Representatives*
*David Guttenberg*

*Interim:*
*1292 Sadler Way*
*Suite 304*
*Fairbanks, Alaska 99701-3171*
*(907) 456-8172*
*(907) 456-2490 Fax*

*District 4*

---

MEMORANDUM

TO: Rep. Sam Kito
House Labor and Commerce Committee

FROM: Rep. David Guttenberg

DATE: May 4, 2017

RE: HB 240 Hearing Request

Representative Kito,

I am requesting a hearing in the House Health & Social Services Committee for HB 240, "An Act relating to the registration and duties of pharmacy benefits managers; relating to procedures, guidelines, and enforcement mechanisms for pharmacy audits; relating to the cost of multi-source generic drugs and insurance reimbursement procedures; relating to the duties of the director of the division of insurance; and providing for an effective date." I appreciate your consideration and look forward to presenting this important piece of legislation to the Labor and Commerce Committee.

Best Regards,



GCC/IBT 722C

Session:
State Capitol
Juneau, Alaska 99801
(907) 465-4457 Office
(907) 465-3519 Fax
(800) 928-4457 Toll Free

# Alaska House of Representatives
# David Guttenberg

Interim:
1292 Sadler Way
Suite 304
Fairbanks, Alaska 99701-3171
(907) 456-8172
(907) 456-2490 Fax

District 4

MEMORANDUM

TO: Representative Sam Kito
House Labor and Commerce Committee

FROM: Representative David Guttenberg

DATE: January 17, 2018

RE: HB240 Hearing Request

Representative Kito,

I am requesting a hearing in the House Labor and Commerce Committee for HB240, PHARMACY BENEFIT MANAGERS. I appreciate your consideration and look forward to presenting this important piece of legislation to the Labor and Commerce Committee.

Best Regards,

David Guttenberg



GCC/IBT 722C

*Session:*
*State Capitol*
*Juneau, Alaska 99801*
*(907) 465-4457 Office*
*(907) 465-3519 Fax*
*(800) 928-4457 Toll Free*

*Alaska House of Representatives*
*David Guttenberg*

*Interim:*
*1292 Sadler Way*
*Suite 304*
*Fairbanks, Alaska 99701-3171*
*(907) 456-8172*
*(907) 456-2490 Fax*

*District 4*

**HB240: "An Act relating to the registration and duties of pharmacy benefits managers; relating to procedures, guidelines, and enforcement mechanisms for pharmacy audits; relating to the cost of multi-source generic drugs and insurance reimbursement procedures; relating to the duties of the director of the division of insurance; and providing for an effective date"**

30-LS0868\A

SPONSOR STATEMENT

If passed, House Bill 240, Pharmacy Benefits Managers, will establish procedures and guidelines for the auditing of pharmacy records so that all pharmacies are held to the same standards by their auditors. SB 38, the companion bill, was introduced in the Senate as a result of a request by the Alaska Pharmacists Association.

While the intent of this legislation is to help ensure that all pharmacies in the state would be subject to reasonable audits, it would especially help small-business pharmacies who, because of their smaller pool of assets, may face dire consequences as a result of an unreasonable audit. HB 240 would outline specific requirements for the auditing of pharmacy records by an insurer, a managed care company, a third-party payor, or a pharmacy benefits manager. In the event that disagreements should arise between an auditor and a pharmacy, the measure would allow for an appeal in the case.

Pharmacists acknowledge that audits are a good tool to protect the public and detect fraud or abuse, however, in some circumstances, audits can be unreasonable and used in a way to deprive pharmacies of fair reimbursement for their services. There may be times when pharmacies provide a customer the right drug in the right dose, but because of a clerical or typographical error in billing, they are penalized by receiving partial or no reimbursement on their cost for a drug. Additionally, this legislation will require timely updates of drug pricing changes, and provide pharmacies with an appeal process for when they are reimbursed below cost. House Bill 240 is aimed at protecting the public from potential abuse, while at the same time ensuring that pharmacists face reasonable and consistent audits and fair pricing practices.

I hope that you will join me in support of this common sense bill that will help your local, consumer-oriented pharmacy enjoy fair treatment by its prescription drug auditors.

*Session:*
*State Capitol*
*Juneau, Alaska 99801*
*(907) 465-4457 Office*
*(907) 465-3519 Fax*
*(800) 928-4457 Toll Free*

*Alaska House of Representatives*
*David Guttenberg*

*District 8*

*Interim:*
*1292 Sadler Way*
*Suite 304*
*Fairbanks, Alaska 99701-3171*
*(907) 456-8172*
*(907) 456-2490 Fax*

**HB240: "An Act relating to the registration and duties of pharmacy benefits managers; relating to procedures, guidelines, and enforcement mechanisms for pharmacy audits; relating to the cost of multi-source generic drugs and insurance reimbursement procedures; relating to the duties of the director of the division of insurance; and providing for an effective date"**

**30-LS0868\A**

## SPONSOR STATEMENT

House Bill 240, Pharmacy Benefits Managers, establishes procedures and guidelines for the auditing of pharmacy records so that all pharmacies are held to the same standards by their auditors.

HB240's intent is to ensure that pharmacies are subject to reasonable audits. The bill outlines specific requirements for the auditing of pharmacy records by an insurer, a managed care company, a third-party payor, or a pharmacy benefits manager. If disagreements arise between an auditor and a pharmacy, the measure allows for a meaningful appeal process.

Pharmacists acknowledge that audits are a good tool to protect the public and detect fraud or abuse. In some circumstances, audits can be unreasonable and used to deny pharmacies of fair reimbursement for their services. Pharmacies provide a customer the right drug in the right dose, but because of a clerical or typographical error in billing, they may be penalized by receiving partial or no reimbursement on their cost for a drug. HB240 also requires timely updates of drug pricing changes, and provide pharmacies with an appeal process when they are reimbursed below cost. HB240 is aimed at protecting the public from potential abuse, while at the same time ensuring that pharmacists face reasonable and consistent audits and fair pricing practices.


*Representative_David_Guttenberg@legis.state.ak.us*

*Session:*
*State Capitol*
*Juneau, Alaska 99801*
*(907) 465-4457 Office*
*(907) 465-3519 Fax*
*(800) 928-4457 Toll Free*

# *Alaska House of Representatives*
# *David Guttenberg*

*Interim:*
*1292 Sadler Way*
*Suite 304*
*Fairbanks, Alaska 99701-3171*
*(907) 456-8172*
*(907) 456-2490 Fax*

*District 4*

HB 240 Pharmacy Benefit Managers Sectional Analysis Version A

**<u>Bill section 1.</u>** Adds a new section concerning Pharmacy Benefits Managers.

**<u>Sec. 21.27.901.</u> Registry of pharmacy benefit managers; scope of business practice.** Requires that pharmacy benefits managers register as third party administrators under 21.27.630 and describes the parameters under which they may contract with an insurer or network pharmacies, set the cost of multi-source generic drugs and allows for appeals.

**<u>Sec. 21.27.905.</u> Renewal of registration.** Establishes a bi-annual renewal of a registration fee for a pharmacy benefits manager as set by the director.

**<u>Sec. 21.27.910.</u> Pharmacy audit procedural requirements.** Describes the procedural and time requirements required of the pharmacy benefits manager and defines who conduct an audit and what records can may be provided by the pharmacy.

**<u>Sec. 21.27.915.</u> Overpayment or underpayment.** Indicates that a pharmacy benefits manager shall base a finding of overpayment or underpayment on the actual payment and not a projection of patients served by similar circumstances. It also designates the dispensing fee limitations.

**<u>Sec. 21.27.920.</u> Recoupment.** Establishes how a pharmacy benefits manager shall base the recoupment of overpayments from a pharmacy.

**<u>Sec. 21.27.925.</u> Pharmacy audit reports.** Establishes time frames as to when preliminary and final audit reports shall be delivered to a pharmacy and the response time for any discrepancies found in the audits.

**<u>Sec. 21.27.930.</u> Pharmacy audit appeal; future repayment.** A written appeals process shall be established by a pharmacy benefits manager. It also states that future repayment of disputed funds or other penalties imposed on a pharmacy shall occur only when all appeals have been exhausted.

**<u>Sec. 21.27.935.</u> Fraudulent activity.** Defines what may not be considered fraud by the pharmacy benefits manager.

**<u>Sec. 21.27.940.</u> Pharmacy audits; restrictions.** Adopts restrictions on the requirements of the entire Section 1 when applied to an audit in which intentional or suspected fraud is demonstrated in a review of the claims data. In addition, the requirements do not apply to any claims paid for under the medical assistance program found in AS 47.07.



GCC/IBT 722C

**Sec. 21.27.945. Drug pricing list; procedural requirements.** The methodology and sources used to determine the drug pricing list will be provided to each network pharmacy at the beginning of their contract term and updated accordingly by the pharmacy benefits manager. Basic contact information shall also be provided.

**Sec. 21.27.950. Multi-source generic drug appeal.** Establishes a process by which a network pharmacy may appeal the reimbursement for a multi-source generic drug and procedures if their appeal is denied. It also sets the limitations on the pharmacy benefits manager and the insurance division director as to how many days they have to resolve an appeal or a request for review.

**Sec. 21.27.955. Definitions.** Defines all selective wording as used in Section 1.

**Bill section 2.** Adds a new section on Applicability as it applies to audits of pharmacies as conducted by pharmacy benefits managers.

**Bill section 3.** Adds a new section as to Transitional Provisions for adopting Regulations.

**Bill section 4.** Adds a new section stating the Revisor's Instructions.

**Bill section 5.** Effective date clause for Bill section 3.

**Bill section 6.** Effective date clause for this Act except as provided.

*Session:*
*State Capitol*
*Juneau, Alaska 99801*
*(907) 465-4457 Office*
*(907) 465-3519 Fax*
*(800) 928-4457 Toll Free*

*Alaska House of Representatives*
*David Guttenberg*

*Interim:*
*1292 Sadler Way*
*Suite 304*
*Fairbanks, Alaska 99701-3171*
*(907) 456-8172*
*(907) 456-2490 Fax*

*District 4*

HB 240 Pharmacy Benefit Managers Sectional Analysis Version A

**Bill section 1.** Adds a new section concerning Pharmacy Benefits Managers.

**Sec. 21.27.901. Registry of pharmacy benefit managers; scope of business practice.** Requires that pharmacy benefits managers register as third party administrators under 21.27.630 and describes the parameters under which they may contract with an insurer or network pharmacies, set the cost of multi-source generic drugs and allows for appeals.

**Sec. 21.27.905. Renewal of registration.** Establishes a bi-annual renewal of a registration fee for a pharmacy benefits manager as set by the director.

**Sec. 21.27.910. Pharmacy audit procedural requirements.** Describes the procedural and time requirements required of the pharmacy benefits manager and defines who conduct an audit and what records can may be provided by the pharmacy.

**Sec. 21.27.915. Overpayment or underpayment.** Indicates that a pharmacy benefits manager shall base a finding of overpayment or underpayment on the actual payment and not a projection of patients served by similar circumstances. It also designates the dispensing fee limitations.

**Sec. 21.27.920. Recoupment.** Establishes how a pharmacy benefits manager shall base the recoupment of overpayments from a pharmacy.

**Sec. 21.27.925. Pharmacy audit reports.** Establishes time frames as to when preliminary and final audit reports shall be delivered to a pharmacy and the response time for any discrepancies found in the audits.

**Sec. 21.27.930. Pharmacy audit appeal; future repayment.** A written appeals process shall be established by a pharmacy benefits manager. It also states that future repayment of disputed funds or other penalties imposed on a pharmacy shall occur only when all appeals have been exhausted.

**Sec. 21.27.935. Fraudulent activity.** Defines what may not be considered fraud by the pharmacy benefits manager.

**Sec. 21.27.940. Pharmacy audits; restrictions.** Adopts restrictions on the requirements of the entire Section 1 when applied to an audit in which intentional or suspected fraud is demonstrated in a review of the claims data. In addition, the requirements do not apply to any claims paid for under the medical assistance program found in AS 47.07.

**Sec. 21.27.945. Drug pricing list; procedural requirements.** The methodology and sources used to determine the drug pricing list will be provided to each network pharmacy at the beginning of their contract term and updated accordingly by the pharmacy benefits manager. Basic contact information shall also be provided.

**Sec. 21.27.950. Multi-source generic drug appeal.** Establishes a process by which a network pharmacy may appeal the reimbursement for a multi-source generic drug and procedures if their appeal is denied. It also sets the limitations on the pharmacy benefits manager and the insurance division director as to how many days they have to resolve an appeal or a request for review.

**Sec. 21.27.955. Definitions.** Defines all selective wording as used in Section 1.

**Bill section 2.** Adds a new section on Applicability as it applies to audits of pharmacies as conducted by pharmacy benefits managers.

**Bill section 3.** Adds a new section as to Transitional Provisions for adopting Regulations.

**Bill section 4.** Adds a new section stating the Revisor's Instructions.

**Bill section 5.** Effective date clause for Bill section 3.

**Bill section 6.** Effective date clause for this Act except as provided.

# The PBM Story

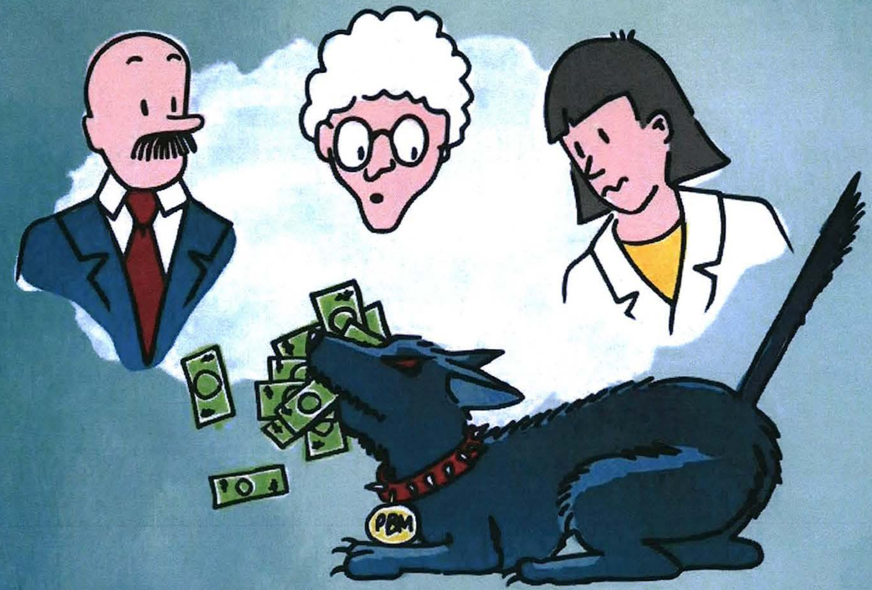
Decades ago, insurance companies expanded their coverage to include prescription drugs. They turned to a new kind of company, a sort of middleman, to process prescription drug claims.

For just a small fee per claim, these processors took care of all those prescription claims, not only for insurers, but also for self-insured employers and even certain state and federal government agencies—"plan sponsors" for short.

**Everyone was happy: Plan sponsors had someone else to administer all those prescription claims, the claims processors made money providing the service, and patients had easy access to their medications at their neighborhood pharmacies.**

As time passed, the middlemen began to exert more and more control over the consumer's prescription drug benefits. They developed formularies and told doctors and pharmacists which drugs they were allowed to give consumers and under what circumstances. They had morphed from something good and useful into large corporations intent on pursuing profits at the expense of quality patient care. They began to concentrate their power. Many smaller PBMs were gobbled up by larger ones. Others were purchased by plan sponsors themselves, or even by large drugstore chains.






Pharmacists, patient groups, and policymakers expressed concern that all that consolidation and vertical integration was reducing competition and limiting patient choices. And they were right....

**Today**

PBMs control the pharmacy benefits of more than **253 MILLION Americans.**

*After numerous acquisitions* ***and consolidations,***

**Just 3 PBMs now CONTROL 78%** ***of prescription drug benefit*** *transactions in the U.S.*[1]

[1] Health Strategies Group, "Research Agenda 2015: Pharmacy Benefit Managers," http://www.healthstrategies.com/sites.default.files:PBM_Research_Agenda_PBM_RA101513.pdf. Similar figures come from "Prescription Medicines: Costs in Context," August 2016, available at http://phrma-docs.phrma.org/sites/default/files/pdf/prescription-medicines-costs-in-context-extended.pdf.

These days, PBMs market themselves as the guard dogs of cost in the supply chain. That's their story.

**But that's all it is... a story, a fable.** Drug expenditures keep going up. Plan sponsors and patients are paying more. And those middlemen, the PBMs—well, they've not only gotten powerful, they've also gotten rich. Very, *very* rich. And they've done it at the expense of plan sponsors and consumers.

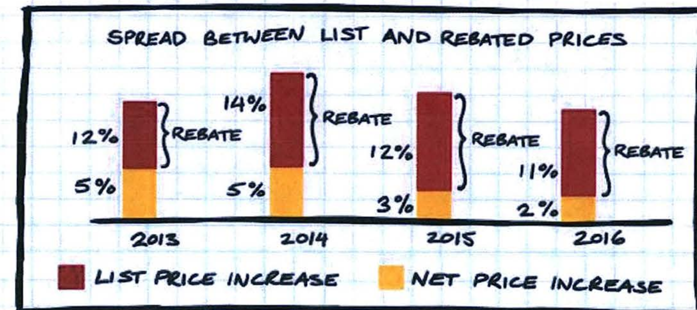


# Here's how they make money.

The main ways PBMs extract their profits is via rebates, administrative fees, and spread.

A **rebate** is a discount on a medication a drug *manufacturer* gives a PBM in return for the PBM agreeing to cover the drug manufacturer's product. Sometimes that means eliminating a less expensive, comparable medication from the formulary. Usually, only a portion of those rebates are shared with the plan sponsor. The PBM pockets the rest.

In recent years, rebates have exploded in magnitude. Today, roughly a third of the net price paid for medications is attributable to those rebates.[2] **In other words, a consumer's prescription may cost a good third more than it should due to rebates alone.**




**Source:** IMS Health, National Sales Perspectives. Mar 2016

> *"The problem is that our current system provides incentives for companies to push list prices higher, only to rebate the money later on the back end. Yet the rebates don't benefit consumers equally and they don't necessarily help offset the costs paid by those who need a particular drug."*
>
> – FDA COMMISSIONER-DESIGNATE SCOTT GOTTLIEB IN OCTOBER 2016 TESTIMONY TO THE SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

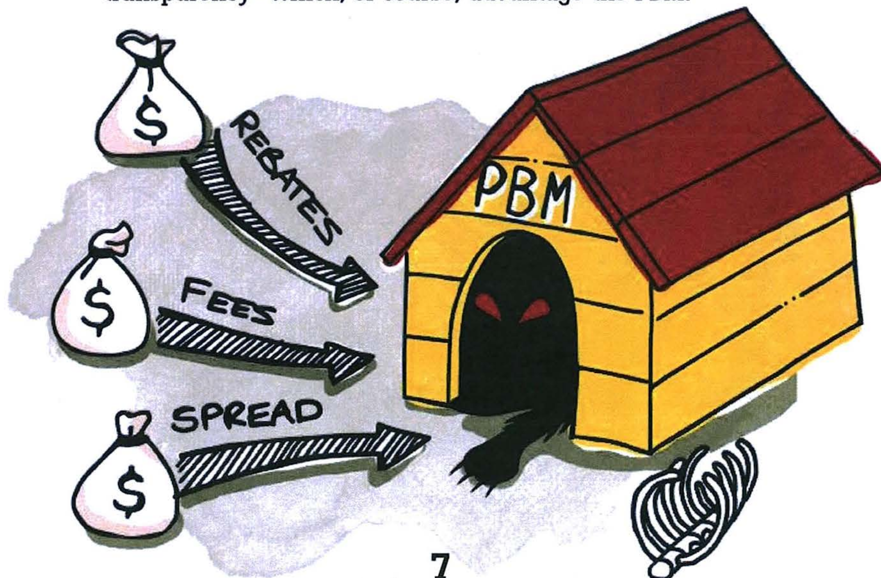
[2] Derived from IMS Institute for Healthcare Informatics' April 2016 Report, "Medicines Use and Spending in the U.S. – A Review of 2015 and Outlook to 2020."

> *"I have never met, in this entire experience, a PBM or a payer outside of the Medicaid segment that preferred a price of $50,000 over $75,000 and a rebate back to them."*
>
> ~ EXECUTIVE WITH PHARMA MANUFACTURER GILEAD SCIENCES, INC, AS QUOTED IN *BLOOMBERG NEWS*, MARCH 3, 2017

Rebates aren't the only charges PBMs extract. Often, they charge manufacturers and plan sponsors additional **fees and payments** that the PBM keeps for itself. Without full transparency, drug pricing is so complex that even the savviest of plan sponsors may not know all of the charges buried in their contracts. Those fees work to further drive up drug prices, too.

PBMs also make money on what's called **"the spread."** That's the practice of reimbursing the pharmacy one amount for a medication, charging the plan sponsor a higher price for the same drug, and pocketing the difference.

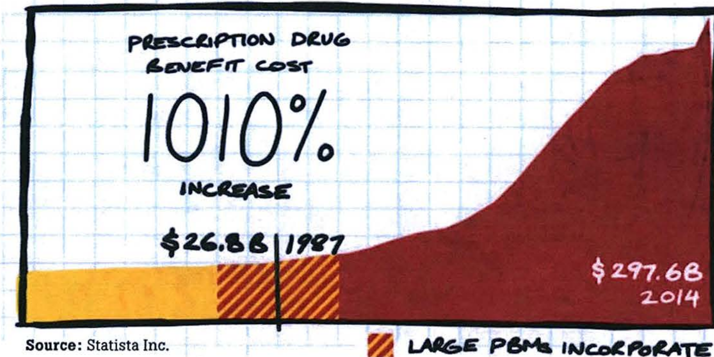
Often, plan sponsors don't know exactly how much more they are being billed for a drug than the pharmacy was reimbursed for it. They don't know this because of the complexity of pharmacy pricing and the lack of appropriate transparency—which, of course, advantage the PBM.





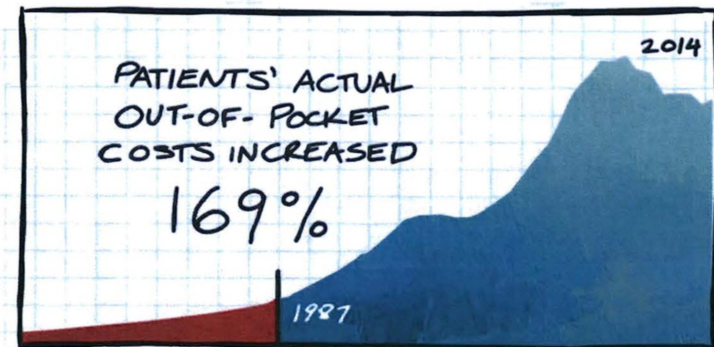

# Here are some real numbers.

Today's largest PBMs say they lower prescription drug benefit costs for plan sponsors. Yet, since 1987, total spending on prescription drugs in the U.S. has increased 1,010 percent, from $26.8B to $297.6B. Overall price inflation in the U.S. only grew 125.9 percent in that same period.




Source: Statista Inc.

PBMs point out that patients' out-of-pocket expenses (copays, etc.) as a *percentage* of total prescription drug spend have been falling for decades. That's misleading, because total drug spend in *dollars* has risen precipitously in the same period. And in fact, the amount of money consumers themselves are paying for prescriptions has grown, not fallen. Indeed, actual *patient out-of-pocket costs have increased 169 percent* since 1987!



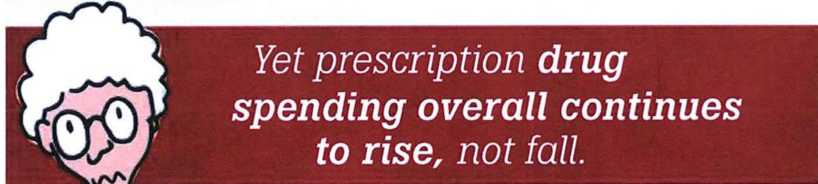

**Source:** Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

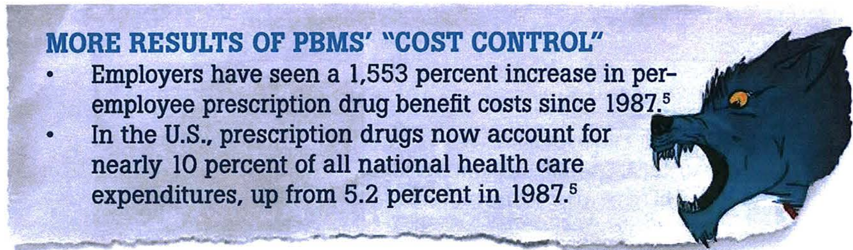
# There's more.

Per-patient spending on prescription drugs has *continued* to rise dramatically—especially since 2014, when costly specialty drugs sky-rocketed and high-deductible insurance plans took off. Oddly, PBMs have been unable to control specialty drug spending, even while the two largest specialty pharmacies are owned by—you guessed it—PBMs. They fill specialty prescriptions at those PBM-owned pharmacies, and often *require* patients to use those pharmacies. The PBM-owned specialty pharmacy comes out all right in that transaction. But the plan sponsor and the patient? Not so much.

Generic medications saved **$1.68 TRILLION** from 2005-2014.[3]

**TODAY generics account for 88%** of prescriptions dispensed,[3] up **from 56% in 2005**[4]



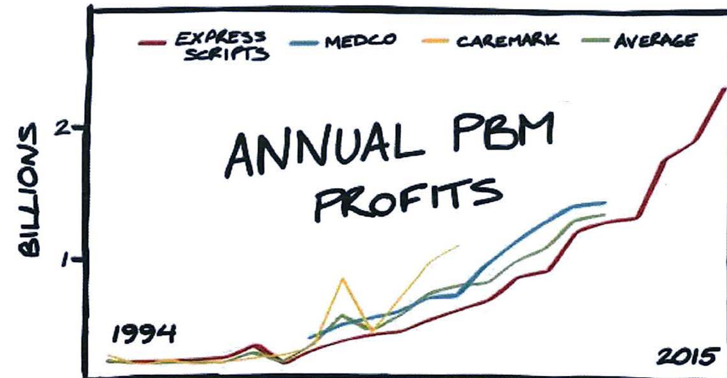

[3] Generic Pharmaceutical Association. 2015 Annual Report.
[4] 2006 *NCPA Digest.*
[5] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.



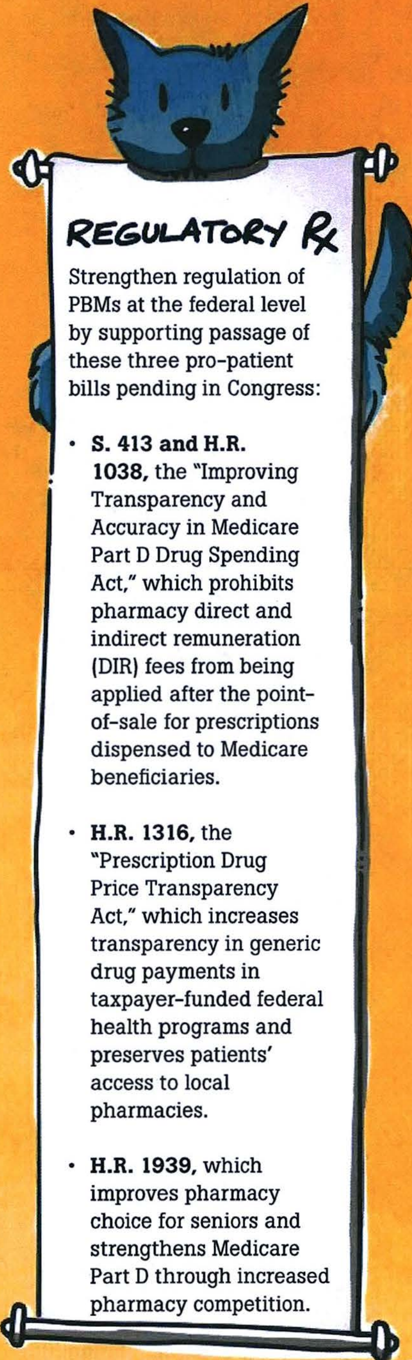
*The largest PBM experienced an increase in net income of 70 percent in just two years, while the Bureau of Economic Analysis shows that after-tax corporate profits by other U.S. businesses remained virtually unchanged. According to one estimate, PBMs fail to pass $120 billion back to consumers, and retain another $30 billion in additional out-of-pocket costs.*

~ "YOU CAN BLAME PHARMACY BENEFIT MANAGERS FOR HIGHER DRUG PRICES," *REAL CLEAR HEALTH*, MARCH 28, 2017

And the most damning fact of all: Thanks to the massive savings in newly available generic drugs, thanks to enormous increases in manufacturer rebates, and thanks to increased plan costs to employers and consumers, **PBM profits have increased exponentially.** The profits PBMs extract from the prescription drug supply chain actually *increase* prescription drug costs—*just the opposite of what PBMs claim.*




**Source:** Medco was owned by Merck from 1994-2003 and purchased by Express Scripts in 2012. Publicly available income statements are reported from 2001-2011. Caremark was purchased by CVS in 2006. Net income from publicly reported statements are reported from 1994-2006. Reported net income excludes negative values from discontinued operations reported on 10-K forms from 1995-2000. Express Scripts has been the sole independent major PBM with publicly available income statements since 2012.



### REGULATORY Rx

Strengthen regulation of PBMs at the federal level by supporting passage of these three pro-patient bills pending in Congress:

- **S. 413 and H.R. 1038,** the "Improving Transparency and Accuracy in Medicare Part D Drug Spending Act," which prohibits pharmacy direct and indirect remuneration (DIR) fees from being applied after the point-of-sale for prescriptions dispensed to Medicare beneficiaries.
- **H.R. 1316,** the "Prescription Drug Price Transparency Act," which increases transparency in generic drug payments in taxpayer-funded federal health programs and preserves patients' access to local pharmacies.
- **H.R. 1939,** which improves pharmacy choice for seniors and strengthens Medicare Part D through increased pharmacy competition.

# Here's a better story.

Think of it as a handful of prescriptions for what's ailing prescription health care costs in the U.S.

**DEMAND TRANSPARENCY...**

Sunlight, as they say, is the best disinfectant. In the short run, plan sponsors—employers, unions, and federal and state governments—deserve better cost control. They must require complete transparency from PBMs when it comes to direct and indirect revenues that the PBMs receive for administering that plan sponsor's prescription benefit plan.

**CHANGE THE MODEL...**

Another option for plan sponsors is to look at changing the model entirely: paying PBMs a simple flat fee (in total or per prescription) to administer the plan sponsor's chosen services. Properly structured, that model would eliminate hidden costs for plan sponsors and patients—costs that are at the heart of the continuing increases in prescription benefit spending. Another route some large self-insured employers have taken—Caterpillar, Inc., for instance—is for the company to act as its own prescription coordinator. Caterpillar has cut its annual prescription drug spend by tens of millions of dollars using this approach.



**LEAVE THE MIDDLEMAN, TAKE THE PHARMACIST...**

Some companies are negotiating directly with pharmacy networks for prescription dispensing, as well as for patient care services. Working with community pharmacists to provide medication therapy and chronic disease management and wellness coaching, plan sponsors have seen extraordinary results in:

- Reducing emergency room visits
- Reducing hospital readmissions
- Evaluating for cost-effective options to lower patient prescription costs
- Identifying and preventing adverse drug interactions and side effects
- Increasing patients' medication adherence

Such plan sponsor-pharmacy partnerships are a two-fer. They've been proven to reduce not only the plan sponsor's prescription drug spend, but its overall health care costs as well.

*"One of the most evidence-based decisions to improve the health system is to maximize the expertise and scope of pharmacists and minimize expansion barriers of an already existing and successful health care delivery model."*

– THE 2011 REPORT TO THE US SURGEON GENERAL FROM THE OFFICE OF THE CHIEF PHARMACIST

**One community pharmacy in Iowa saved an insurer $2.4 million over 12 months for the care of just 600 patients.**

A 2010 systemic review of 298 studies found that pharmacist-provided services positively impacted patient outcomes and reduced health care spending across health care setting and disease states.

Pharmacists decreased total direct medical costs by $1,200 to $1,872 per patient per year for employees of the city of Asheville with chronic diseases.

*"Caterpillar's move away from benefit managers started when it suspected that as much as a quarter of its $150 million drug spending was wasted. The company devised its own list of drugs to offer its U.S. health-plan members and negotiated deals with pharmacies. It promoted generics and discouraged use of expensive heartburn and cholesterol medicines. The changes have saved the company $5 million to $10 million per year on cholesterol-lowering statins alone.... Drug spending at Caterpillar... has dropped per patient and per prescription since the company started the program."*

~ "DRUG COSTS TOO HIGH? FIRE THE MIDDLEMAN," *BLOOMBERG NEWS*, MARCH 3, 2017

When it comes to prescription drug prices, there's a better story than the one America has been told—and sold—by PBMs over the past quarter century.

By embracing appropriate transparency and new payment and patient care models, we can rewrite the story—so we can all live happier—and healthier—ever after.

NCPA®
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

100 DAINGERFIELD ROAD, ALEXANDRIA, VA 22314 · 800.544.7447 · WWW.NCPANET.ORG
(C) NCPA 2017. ALL RIGHTS RESERVED.

# Pharmacy Benefit Managers

***And the need for fair and reasonable standards over the practice of auditing pharmacies***

## HB 240

***Establishes Procedures & Guidelines for the Auditing of Pharmacy Records***

***Requires Timely, Price Updates of Pricing Changes***
***&***
***an Appeals Process***

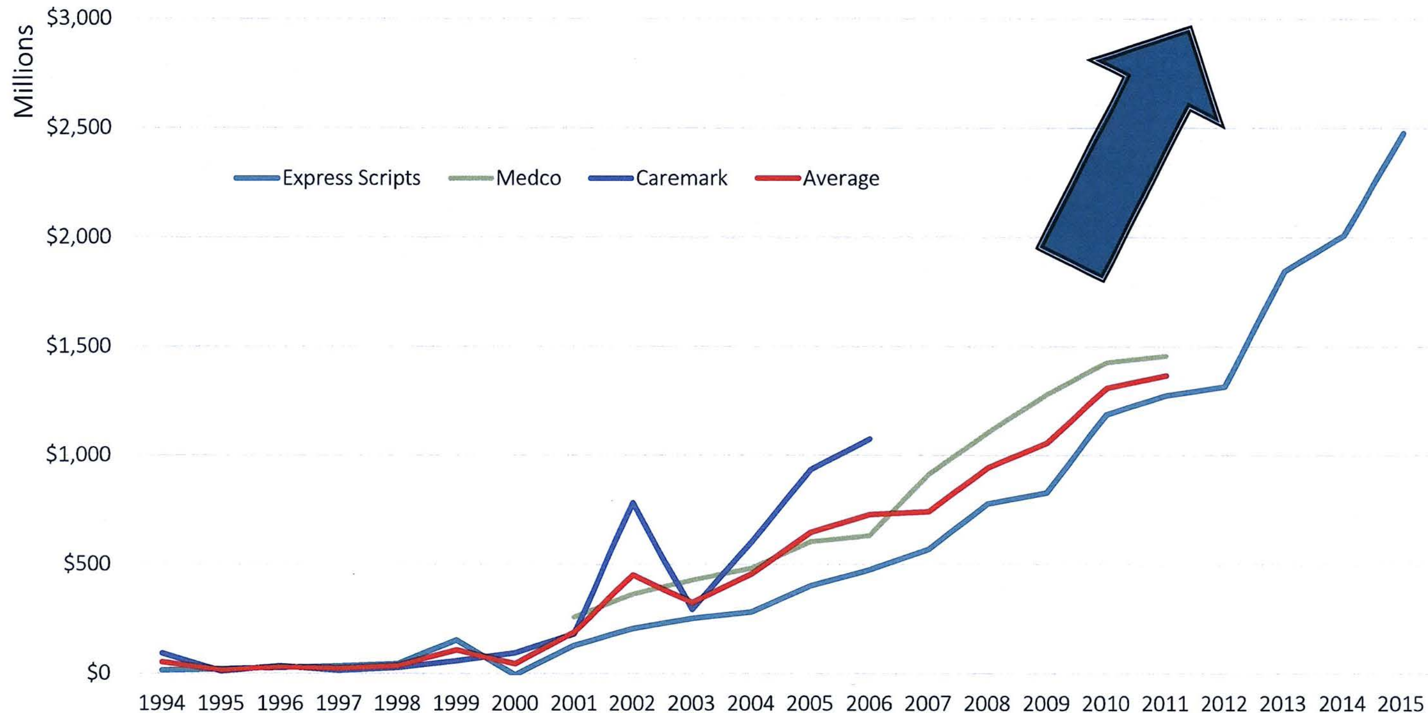
# PBM 101 – What's a PBM?

- PBMs are multi-billion dollar middlemen
- Started in1970 as claims processers and have since become intertwined in almost every aspect of the pharmaceutical/pharmacy supply chain
- Virtually unregulated at either the state or federal levels – including in Alaska
- Today, the top PBMs represent some of the largest companies in the nation

# PBM 101 – cont.
# Examples of PBM's Market Power/Influence

- **CVS/Caremark (AK State Plan Pharmacy Benefit Manager)**
  1. 12th largest US company as identified by Fortune 500
  2. 2013 Revenue: $127 billion
  3. CEO Compensation: $20 million
- **Express Scripts (ESI)**
  1. ESI generated $94 billion in revenue in 2015
  2. ESI's profits have grown from $250 million a decade ago to $1.8 billion
  1. ESI CEO Compensation: $12.8 million and $22 million in stock
- **ESI, CVS Caremark, and OptumRX control approx. 70% of all US scripts**

# Annual PBM Profits ($)




Medco was owned by Merck from 1994-2003 and purchased by Express Scripts in 2012. Publicly available income statements are reported from 2001-2011.
Caremark was purchased by CVS in 2006. Net income from publicly reported statements are reported from 1994-2006. Reported net income excludes negative values from discontinued operations reported on 10-K forms from 1995-2000.
Express Scripts has been the sole independent major PBM with publicly available income statements since 2012

# State of Alaska Health Care Plan

**AK State Plan Pharmacy Benefit Manager - CVS/Caremark**

# PBM 101- cont.

## PBMs are designed to:

- reduce administrative costs for insurers
- validate patient eligibility
- administer plan benefits
- negotiate costs between pharmacies and health plans
- audit pharmacies for fraud

## PBM 101 – cont.

# PBM's Impact on Pharmacy & Patients

- PBMs develop pharmacy provider networks.
- Pharmacies must accept a PBM contract.
- Contracts truly are **"take it or leave it."**
- PBMs influence what drugs are ultimately dispensed regardless of what a physician prescribes (a list of approved drugs known as formularies).
- PBMs collect money from drug manufacturers for putting their drugs on a given formulary (rebates).
- PBMs restrict pharmacies on how many pills they can dispense at a given time based on plan design.

## PBM 101 – cont.

# PBM's Impact on Pharmacy & Patients

- PBMs dictate how much pharmacies will be paid for the drugs they dispense regardless of the pharmacies' acquisition costs.
- PBMs have free reign to dictate what pharmacies are permitted to do in a given network thereby driving patients to particular pharmacy options.
- PBMs operate their own mail-order pharmacies and can incentivize or mandate that beneficiaries obtain their medications only through the mail-order option.
- PBMs audit pharmacies and in most cases there are no defined rules or regulations over what can be considered a recoupable offense.

# How It Works

Step 1

Insurer hires PBM to manage drug costs.

PBM acts as go-between for both insurers/manufacturers and insurers/pharmacies

Step 2

PBM negotiates prices with manufacturers

Manufacturers agree to prices and pay rebates to PBM for preferred placement on insurer's formulary

PBM splits rebate between self and insurer

Step 3

Pharmacy negotiates costs with manufacturers/wholesalers **(how much pharmacies will have to pay to get the drugs)**

Step 4

PBM negotiates insurer reimbursement for drugs and dispensing fees with pharmacies **(how much pharmacies will earn for dispensing the drugs)**

# HB 240 – What Does a Fair Audit Bill Do?

- Brings fairness to the unregulated and expanding practice of pharmacy audits
- Does not allow audits during the first seven calendar days of each month because of the high patient volume, unless the pharmacy and auditor agree otherwise
- Is designed to prevent the targeting of minor clerical or administrative errors where no fraud, patient harm, or financial loss has occurred
- Establishes submission of data/medical record standards to allow for clarification where discrepancies are identified
- Establishes a reasonable time frame for the announcement of an audit to allow proper retrieval of records under review

# What Does a Fair Audit Bill Do? – cont.

- Establishes an audit appeals process for pharmacies
- Establishes guidelines for PBMs (Pharmacy Benefit Managers) to follow regarding patient confidentiality
- Prohibits Extrapolation in assessing fees/penalties
- Alaska pharmacists would not be penalized for providing mail-order service to their customers.
- Local mail-order service keeps Alaska dollars in Alaska.
- Legislation **does not** prevent the recoupment of funds where fraud, waste, and abuse exist.

# What Does a Fair Audit Bill Do? – cont.

- 37 states have enacted fair audit legislation
- 32 states have enacted Maximum Allowable Cost (MAC) transparency legislation

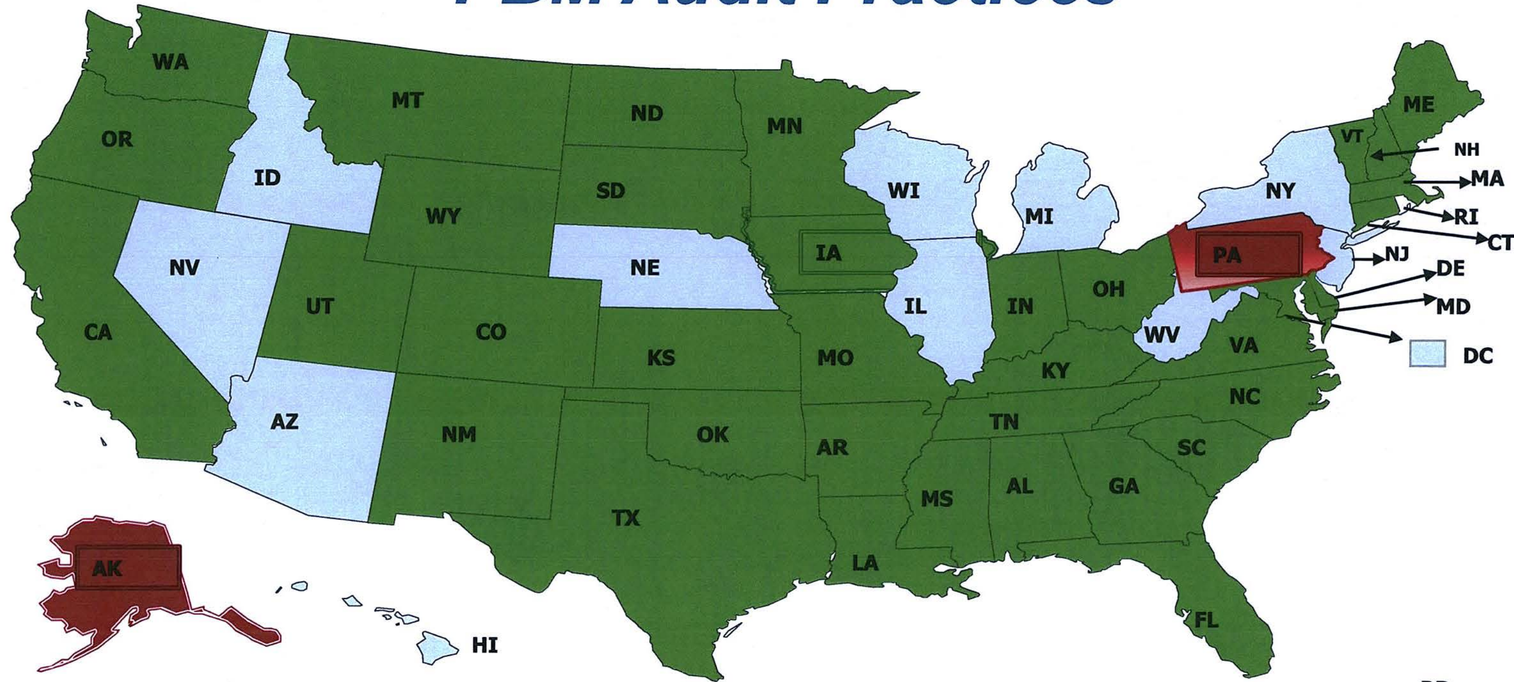
**Bill will also include:**

- Registration of PBMs with the State of Alaska Division of Insurance
- Set-up guidelines for generic drug maximum allowable cost (MAC) pricing by PBMs
- Establish a mechanism for a pharmacy to appeal MAC pricing

**Bottom-line: Don't audit local pharmacists out of business.**

**Keep these jobs in Alaska.**

# PBM Audit Practices




| 37 | Legislation passed regarding PBM Audit Practices |
|---|---|
| 2 | Legislation introduced - still in session |
| 14 | No legislation |

Last Updated – March 2017

# Maximum Allowable Cost (MAC) Legislation

WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
NM
ND
SD
NE
KS
OK
TX
MN
IA
MO
AR
LA
WI
IL
MI
IN
OH
KY
TN
MS
AL
GA
FL
SC
NC
VA
WV
PA
NY
VT
ME
NH
MA
RI
CT
NJ
DE
MD
DC
AK
HI
PR

| | |
|---|---|
| 32 | Legislation passed requiring MAC Transparency |
| 1 | Legislation passed, litigation ongoing |
| 2 | Legislation introduced – state is still in session or awaiting Governor's signature |
| 19 | No legislation passed |

Last Updated - March 2017

NASPA
NATIONAL ALLIANCE OF STATE PHARMACY ASSOCIATIONS

# Alaska Example 1

- "In August 2012- two auditors arrived at our store and I spent the entire day answering their questions, pulling files, and finding documentation.
- They were not very knowledgeable in pharmacy practices so it took quite a long time.
- I was told we would be receiving a final report in a few weeks.
- The report arrived and I was very pleased when I read the first few pages. Out of over $103,000 in claims reviewed - we had only $89 in errors according to the auditors."

# Alaska Example 1 – cont.

- “However, when I got to the last page – using the "one-sided confidence extrapolation method” (PBM’s name for this) - they said
- I owed over $7,300!
- I called the auditors to no avail. I hired a lawyer to help in disputing this claim. Most companies only use extrapolation when the error rate is over 5%. Ours was less than 0.1%!
- Being told to repay over $7,300 is just not right!”

***~ Tom Hodel – former owner, Soldotna Professional Pharmacy***

***After years of frustration and no relief, Tom sold his pharmacy to an outside company***

# Alaska Example 2

- “This past summer we received a large desk audit from a PBM which generated over 100 pages of documentation.
- Our two choices from the PBM for material transmission was either unsecured email or FAX. Naturally, we chose FAX.
- Our FAX machine will only hold/send 50 pages at a time, so we had to send two separate FAXES which were so noted on cover letters and also in an email to the auditor.
- Imagine our surprise when we received our audit results which showed we didn’t include half the claim’s documentation.”

# Alaska Example 2 – cont.

- "When we contacted the auditor she claimed they never received the second FAX (even though we had confirmation that the FAX went through!).
- They eventually allowed us to resend it, but only allowed a five-day period on the final audit findings for an appeal.
- This included a $400 claim for an RX that wasn't even present in the original list of audited prescriptions claims that were sent to us.
- The auditor claimed that they randomly select claims to send to prescribers to verify.
- In this case, we checked with the prescriber's office and they had no documentation asking to verify the prescription."

# Alaska Example 2 – cont.

- "We received the final audit findings document from the PBM on a Thursday afternoon and were told any additional documentation needed to reach their office in the Midwest by the following Tuesday via USPS MAIL.
- This gave us less than 24 hours to get our documents (and the letter from the prescriber mentioned above) in the mail so it would reach them in time.
- We do not believe that was a fair submission turn-around time and quite frankly it was a miracle we were able to make the deadline."

**~Barry Christensen, RPH – Island Pharmacy**

**(family-owned business for 41 years) – Ketchikan, Alaska**

# Maximum Allowable Cost (MAC) - 101

## What is MAC?

- A "maximum allowable cost" or "MAC" list refers to a payer or PBM - generated list of products that includes the upper limit or *maximum* amount that a plan will pay for generic drugs and brand-name drugs that have generic versions available ("multi-source brands").
- Essentially, no two MAC lists are alike and each PBM has free reign to pick and choose products for their MAC lists.

# MAC 101 – cont.

## PBM Use of MAC as Revenue Stream:

- Because of this lack of clarity, many PBMs use their MAC lists to generate significant revenue.
- Typically, they utilize an aggressively low MAC price list to reimburse their contracted pharmacies and a different, higher list of prices when they sell to their clients or plan sponsors.
- Essentially, the PBMs reimburse low and charge high with their MAC price lists, pocketing the significant spread between the two prices.
- **Most plan sponsors are unaware that multiple MAC lists are being used and have no real concept of how much revenue the PBM retains.**

# MAC 101 - cont.

- When the PBMs fail to update MAC lists in a timely manner, pharmacies are forced to dispense at a loss, sometimes as high as $100 or more, or not dispense at all.
- When prices increase, PBMs often wait weeks or even months before updating MAC lists and rarely, if ever, reimburse pharmacies retroactively, yet the PBMs act swiftly to update MAC cost when drug costs decrease.
- This significantly jeopardizes financial viability of community pharmacies.
- In fact, 84% of pharmacists said the acquisition price spike/lagging reimbursement trend is a **"very significant" impact on their ability to remain in business and to continue serving patients**.

# MAC 101 – cont.

MAC legislation is designed to reasonably address the above concerns by:

- Providing clarity to plan sponsors and pharmacies with/regard to how MAC pricing is determined and updates and establishrd an appeals process in which a dispensing provider can contest a listed MAC price.
- Providing standardization for how products are selected for inclusion on a MAC list.

*The MAC process provides no transparency for plan sponsors or contracted retail network pharmacies.*

*They are required to blindly agree to contracts.*

# MAC 101- cont.

- Retail pharmacies are not informed about how products are added or removed from a MAC list or the methodology that determines how reimbursement is ultimately calculated.
- However, pharmacies must contract with PBMs to provide services and participate in plans without having this critical information.
- **In other words, pharmacies are required to sign contacts not knowing how they will be paid.**

**It is equivalent to agreeing to the services of a home builder, not knowing how you will be paid or what materials will be utilized in the home's construction.**

# HB 240: What Does A MAC Transparency Bill Do?

## A MAC Transparency Bill:

- Sets reasonable standards on what can be MAC'ed
- Requires regular reporting of MACs to a pharmacy in a useable format
- Provides for a defined MAC appeals process

## A MAC Transparency Bill Does Not:

- Mandate that a PBM reimburse a pharmacy at a higher amount
- Represent an administrative burden on the PBM
- Mandate that a PBM approve a pharmacy's MAC appeal
- Result in increased costs to the healthcare system

# Alaska MAC Example 1

- “During the last 2 weeks of February 2016 we had approximately 150 RX claims (excluding Medicaid claims) for generic drugs that were paid to us below invoice cost by the PBMs.
- These amounted to over $1,500.
- Under the terms of our contract we are required to submit these claims.
- Yes, we can and do submit pricing appeals, but rarely do we receive a positive result.
- Obviously, any business cannot operate long under a payment system that reimburses below cost.”

**~ Barry Christensen, RPH – Island Pharmacy (Family own business for 41 years) – Ketchikan, AK**

# Alaska MAC Example 2

- "I just sent off 4 MAC appeals to 3 different PBMs -- CVS Caremark, Alaska Medicaid and Med Impact.
- Out of the 39 MAC appeals we have sent off in the last 6 months--with proof showing our invoices and cost, we have received only 2 positive rulings.
- We just lost over $50 dollars on a prescription that we were told is available less expensively…maybe, but not thru our wholesaler and not available to us in Sitka."

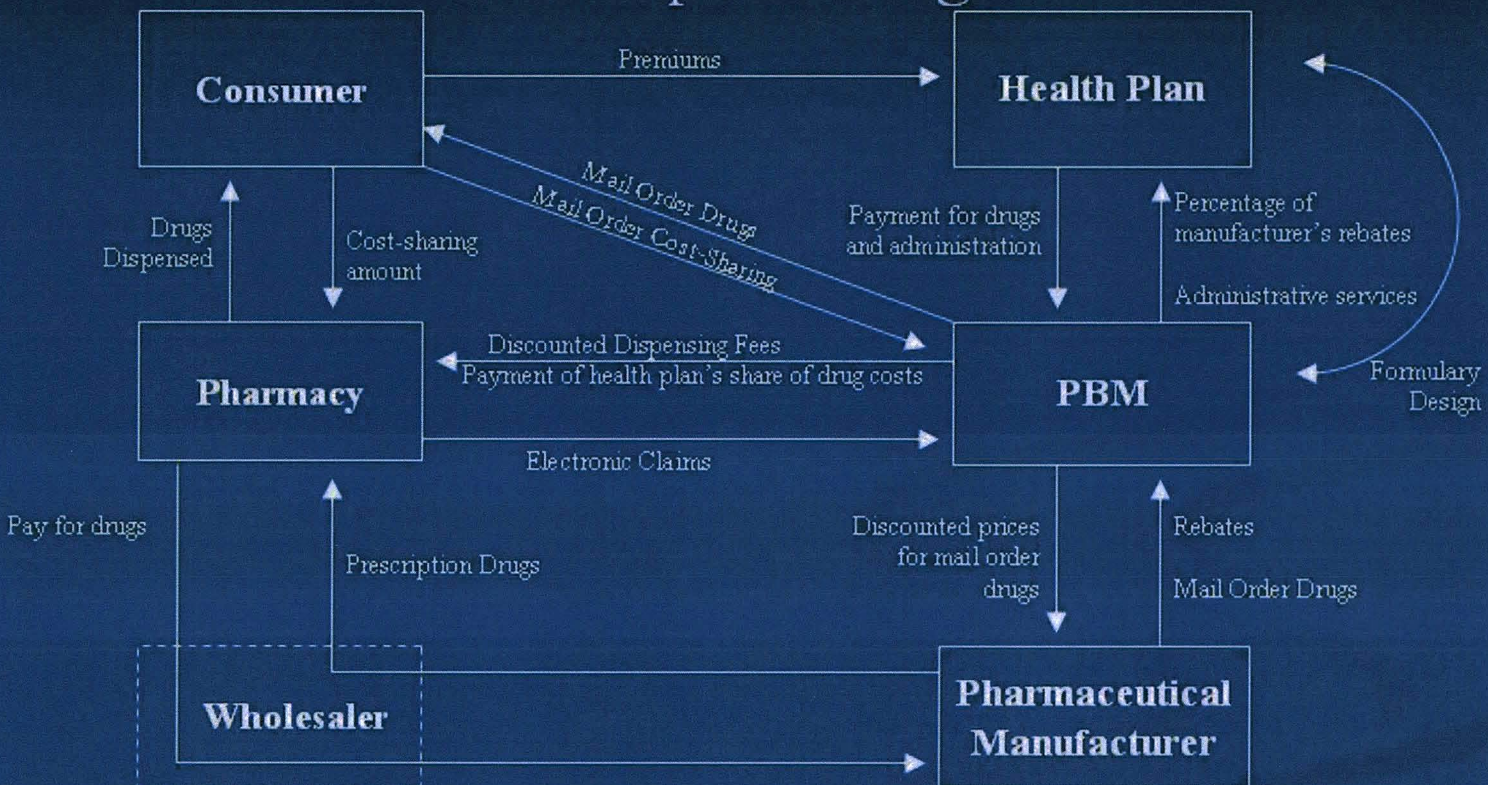
**~ Trish & Dirk White, RPH – White's and Harry Race Pharmacies**

**(Family owned business for 32 years) Sitka, Alaska**

Thank you!

PLEASE SUPPORT HB 240

Questions?


The Role of PBMs in the Flow of Money and Prescription Drugs
Consumer
Health Plan
Premiums
Mail Order Drugs
Mail Order Cost-Sharing
Payment for drugs and administration
Percentage of manufacturer's rebates
Administrative services
Formulary Design
Drugs Dispensed
Cost-sharing amount
Pharmacy
PBM
Discounted Dispensing Fees
Payment of health plan's share of drug costs
Electronic Claims
Pay for drugs
Prescription Drugs
Discounted prices for mail order drugs
Rebates
Mail Order Drugs
Wholesaler
Pharmaceutical Manufacturer
Note: PBMs negotiate prices and administer claims, they do not buy drugs (except MO)
Sources: CBO, GAO, other

# Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: HB 240
Fiscal Note Number:
() Publish Date:

Identifier: HB240-DOA-DRB-05-15-17
Title: PHARMACY BENEFITS MANAGERS
Sponsor: GUTTENBERG
Requester: House Labor & Commerce

Department: Department of Administration
Appropriation: Centralized Administrative Services
Allocation: Retirement and Benefits
OMB Component Number: 64

**Expenditures/Revenues**
Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

| | FY2018 Appropriation Requested | Included in Governor's FY2018 Request | Out-Year Cost Estimates | | | | |
|---|---|---|---|---|---|---|---|
| **OPERATING EXPENDITURES** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2020** | **FY 2021** | **FY 2022** | **FY 2023** |
| Personal Services | *** | | *** | *** | *** | *** | *** |
| Travel | | | | | | | |
| Services | | | | | | | |
| Commodities | | | | | | | |
| Capital Outlay | | | | | | | |
| Grants & Benefits | | | | | | | |
| Miscellaneous | | | | | | | |
| **Total Operating** | *** | **0.0** | *** | *** | *** | *** | *** |

**Fund Source (Operating Only)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| None | | | | | | | |
| **Total** | *** | **0.0** | *** | *** | *** | *** | *** |

**Positions**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Full-time | | | | | | | |
| Part-time | | | | | | | |
| Temporary | | | | | | | |

**Change in Revenues**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| None | | | | | | | |
| **Total** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Estimated SUPPLEMENTAL (FY2017) cost:** 0.0 *(separate supplemental appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2018) cost:** 0.0 *(separate capital appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**
Does the bill direct, or will the bill result in, regulation changes adopted by your agency? no
If yes, by what date are the regulations to be adopted, amended or repealed?

**Why this fiscal note differs from previous version:**

Not applicable, initial version.

Prepared By: Emiliy Ricci, Chief Health Policy Administrator Phone: (907)465-8245
Division: Retirement and Benefits Date: 05/15/2017 02:25 PM
Approved By: Sheldon Fisher, Commissioner Date: 05/15/17
Agency: Department of Administration

## FISCAL NOTE ANALYSIS

**STATE OF ALASKA**
**2017 LEGISLATIVE SESSION**

**BILL NO.** HB 240

### Analysis

The fiscal note is indeterminate until an actuarial analysis can be conducted. There are a few potential areas of fiscal impact as outlined below.

The bill requires the Pharmacy Benefits Manager (PBM) to register with and pay a fee to the Division of Insurance. The bill also provides the Director of the Division of Insurance the ability to determine binding judgment on contractually negotiated contractual appeal processes, rather than the court. It further requires the PBM to pay the Division of Insurance a fee to allow for this function to be self-supporting. These costs would likely be passed on in terms of administrative fees payable from AlaskaCare to the PBM.

Should the audit procedures restrict the ability of PBMs to identify waste, fraud or abuse patterns, the AlaskaCare plans may pay for unnecessary or fraudulent prescriptions.

Should the audit procedures restrict the ability of PBMs to recoup overpayments, this is money that is unable to be recovered by the AlaskaCare health plans.

The bill requires that prescriptions for multi-source generic drugs be reimbursed at certain levels. This may delay or limit the ability of AlaskaCare and other plans to benefit from cost savings associated with generic competition with brand names that have lost their patent.

The requirement to increase the maximum allowable reimbursement in certain circumstances is anticipated to increase the AlaskaCare plan generic drug spend by 10%. In 2016, $51.3M of the $217.9M in drug spend in the AlaskaCare Retiree Plan was paid for generic medications. Similarly in 2016, $3.7M of the $17.5M in drug spend in the AlaskaCare Employee Plan was paid for generic medications. Taking into account that approximately 40% of AlaskaCare retirees reside outside of Alaska while this bill impacts only generics dispensed in Alaska, we have adjusted our retiree generic spend to an estimated $30.7. 10% of this amount combined with the employee spend, would be approximately $3.7M in the first year.

# Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: HB 240
Fiscal Note Number:
() Publish Date:

Identifier: HB240-DCCED-DOI-05-11-17
Title: PHARMACY BENEFITS MANAGERS
Sponsor: GUTTENBERG
Requester: House Labor and Commerce

Department: Department of Commerce, Community and Economic Development
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

| | FY2018 Appropriation Requested | Included in Governor's FY2018 Request | Out-Year Cost Estimates | | | | |
|---|---|---|---|---|---|---|---|
| **OPERATING EXPENDITURES** | **FY 2018** | **FY 2018** | **FY 2019** | **FY 2020** | **FY 2021** | **FY 2022** | **FY 2023** |
| Personal Services | | | | | | | |
| Travel | | | | | | | |
| Services | | | | | | | |
| Commodities | | | | | | | |
| Capital Outlay | | | | | | | |
| Grants & Benefits | | | | | | | |
| Miscellaneous | | | | | | | |
| **Total Operating** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Fund Source (Operating Only)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| None | | | | | | | |
| **Total** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Positions**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Full-time | | | | | | | |
| Part-time | | | | | | | |
| Temporary | | | | | | | |

**Change in Revenues**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| None | | | | | | | |
| **Total** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Estimated SUPPLEMENTAL (FY2017) cost:** 0.0 *(separate supplemental appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**Estimated CAPITAL (FY2018) cost:** 0.0 *(separate capital appropriation required)*
*(discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

**Why this fiscal note differs from previous version:**

Not applicable, initial version.

Prepared By: Lori Wing-Heier Phone: (907)465-2560
Division: Director, Division of Insurance Date: 05/11/2017 07:00 PM
Approved By: Catherine Reardon, Director Date: 05/11/17
Agency: Division of Administrative Services, DCCED

**FISCAL NOTE ANALYSIS**

**STATE OF ALASKA**
**2017 LEGISLATIVE SESSION**

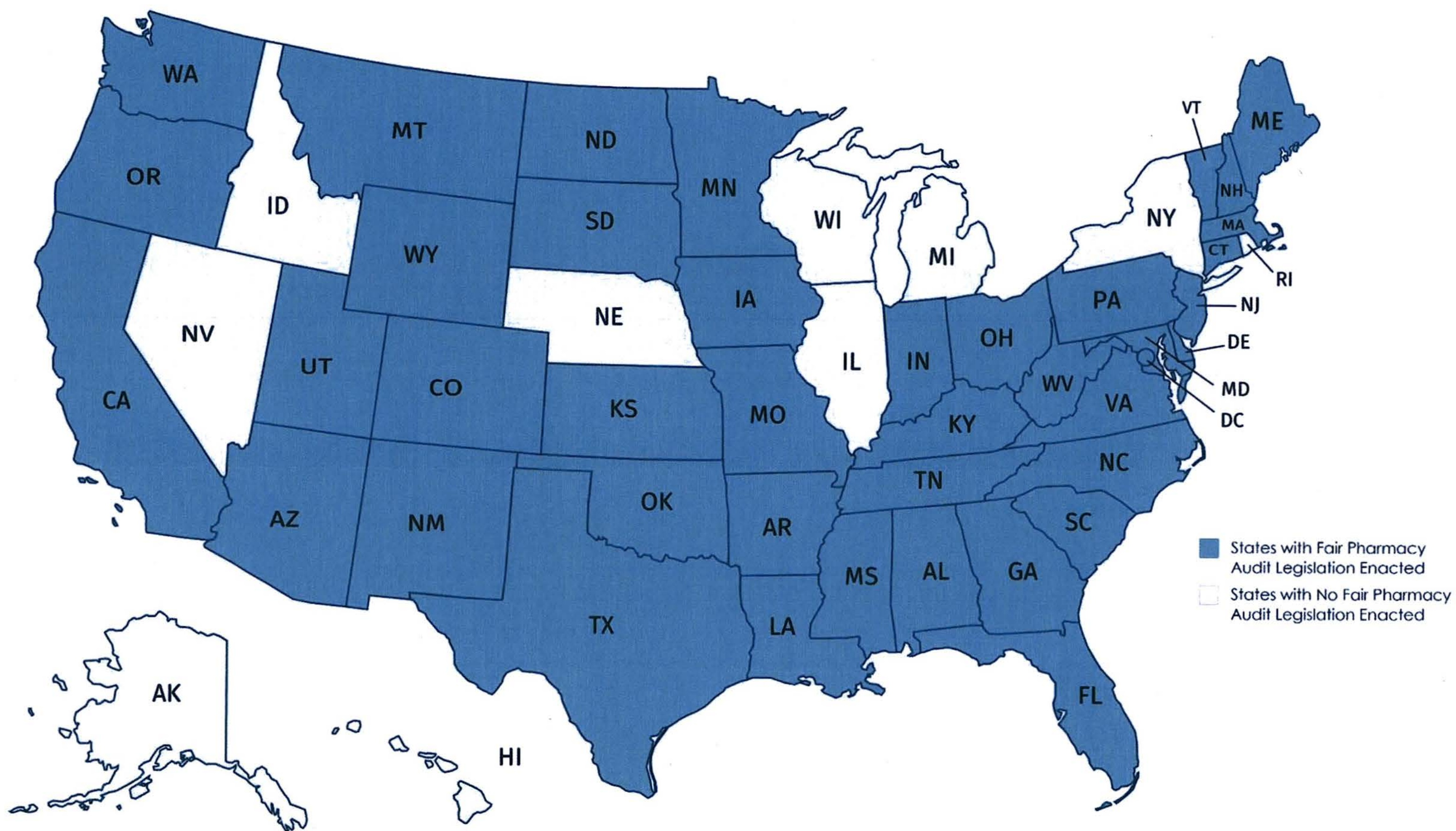
**BILL NO.** HB 240

## Analysis

HB 240 requires Pharmacy Benefit Managers (PBMs) to register with the Director of Insurance as third party administrators, and sets procedures PBMs must follow when conducting pharmacy audits. The bill also establishes procedures related to drug pricing, provides for a pharmacy appeal process related to reimbursement of multi-source generic drugs, and allows a pharmacy to request hearing with the director of the Division of Insurance under existing statute following the appeal process.

The Division of Insurance does not anticipate fiscal impact from this legislation.

# FAIR PHARMACY AUDIT LEGISLATION IN THE STATES




NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

# Time To Lift the Curtain On PBM Wheeling and Dealing

September 29, 2017
Robert Calandra

For all the money he spent on his MBA, Ted Okon says the best life lesson he ever received cost him $80. It came from a guy dealing Three Card Monte on a New York City street corner. He was up $40 but in no time lost that $40 plus $40 more. So what lesson did he learn?

"It showed me that you can't win a rigged game," says Okon, executive director of the not-for-profit Community Oncology Alliance. "And right now PBMs have a rigged game akin to that Three Card Monte where they basically control all the terms."

The Community Oncology Alliance is among several groups fed up with the PBM industry's infamously convoluted pricing schedules and contracts. It's time, they say, for the industry to make its murky business practices Windex clear.

When it comes to drug costs, it's a rigged game, says Ted Okon of the Community Oncology Alliance. "Right now PBMs have a rigged game ... [and] basically control all the terms."

"We'd like to see a tone of more candidness and straightforward communication about what money is being spent for what and what value is being returned to patients and people who pay the bill so we can move past the sloganeering and finger pointing that we are seeing so much of now," says David Lansky, president and CEO of the Pacific Business Group on Health, a 75-member, not-for-profit organization of medium and large private employers and public agencies.

But indignant calls for more PBM transparency are on a loop, according to Brian Henry, vice president of corporate communications for Express Scripts. They first happened decades ago and cycle around every so often. More telling than the message is its provenance, argues Henry.

"It is predominately pharma companies and pharmacies," he says. "If we were transparent with them it has been shown many times over that they would use that information to actually raise prices, not lower them."

Everyone needs to move past sloganeering and finger pointing in order to concentrate on cost transparency, says David Lansky, CEO of the Pacific Business Group on Health.

## RELATED STORIES

- Anthem to Launch New Pharmacy Benefits Manager
- Insurers, PBMs Scrutinized for Their Role in Opioid Crisis
- 2018 CVS Caremark Formulary Removes Jardiance in Favor of Invokana

True, pharmaceutical companies and pharmacists have pushed for transparency, and they are among the noisiest in the current hue and cry. But this time, they have plenty of company. Every sector of the health care economy that deals with prescription drugs—insurance plans, employers, doctors, state legislatures—want PBM pricing decoded.

The widespread agitation is fueling some bipartisan support for legislation that would force more openness about PBM discounts and pricing. In early March, Georgia Republican Rep. Doug Collins introduced HR 1316, the Prescription Drug Price Transparency Act, with Democrat Dave Loebsack of Iowa as a cosponsor.

A few weeks later, Oregon Sen. Ron Wyden, a Democrat, submitted C-Thru, the Creating Transparency to Have Drug Rebates Unlocked Bill. Co-sponsored by his fellow Democrats, Sens. Sherrod Brown of Ohio and Heidi Heitkamp of North Dakota, it hasn't garnered any Republican support so far.

"As dysfunctional as Washington is, as tough as it is to get anything moving, I think this is an issue that is bipartisan," says Okon, whose organization advocates for community oncology practices across the country. "There is a growing concern and awareness that this is out of hand."

Meanwhile, lawsuits against PBMs are also piling up. The website PBM Watch, a not-for-profit organization with the goal of educating consumers about issues surrounding PBMs, notes that in the past few years "numerous federal or multidistrict cases" have been filed against CVS Caremark, Express Scripts, Optum Rx, and Prime Therapeutics. According to the website, the lawsuits stem from a variety of issues including clawbacks of consumer copays; fraud; misrepresentation to plans, patients, and providers; unjust enrichment through secret kickback schemes, and failure to meet ethical and safety standards.

But it just isn't true that PBMs aren't transparent enough or are deliberately obfuscating so they can greedily stuff their pockets, pushes back Henry. Express Scripts' clients, he says, receive about 90% of rebate money. They can also demand an audit at any time of any aspect of their contract to ensure that Express Scripts is adhering to it chapter and verse.

What is true, he says, is that drug prices have increased significantly in recent years, so PBMs, as the prime negotiators with the manufacturers about price, have a larger role than they did five or 10 years ago. Nailing down exactly how much of the prescription and specialty drug market the big three PBMs control can be a bit slippery. But Okon estimates that CVS Caremark, Optum Rx, and Express Scripts control between 80% and 85% of the market.

"We are in a different position, and maybe a more important position, than we have ever been before," Henry says. "But that's because pharmacy costs have gone up and drug costs have gone up and you need us to drive it down."

Industry critics counter Henry, saying that as the PBM industry has grown, the major companies have constructed a complicated, secretive pricing system and cooked up contractual language so confusing that it would tie a linguist in knots. Transparency advocates want contracts simplified so they know exactly how much PBMs are receiving from administrative fees, discounts, rebates, and side deals, and how much of that money is passed on to their customers, insurers, and employers. It is the only way, they say, to assure that the interests of patients and employers are being protected.

"We don't have confidence that the system right now is treating patients and employers fairly," says Lansky. "We need our suppliers to give us that confidence with more transparency and clearer information flow among all the components."

One way to regain that confidence in PBMs, says Linda Cahn, founder of Pharmacy Benefit Consultants in Morristown, N.J., is for PBMs to become more transparent. Until that happens, clients will need consultants like Cahn to comb their existing PBM agreements to clean up their contracts. A long-term solution will require large insurers and employers to flex their market power muscle and demand changes. Or just maybe a new type of player will emerge, one that does things differently.

**Swallowing bitter pills**

There was a time when Okon believed that PBMs served a "valid purpose." Not anymore.

"PBMs now, in my book, are destructive and adversely impacting patient care and they are fueling specialty drug prices," he says.

The discernible edge in Okon's voice when he talks about the PBM industry was honed by reading documented cases from community oncology practices with a retail pharmacy or a dispensing facility where PBMs have switched dosages and swapped out drugs without consulting the patient's physician. In fact, COA has published two volumes of "horror stories" of PBMs getting in the way of patient care.

"These are real-life stories, they are verifiable, and the stories keep flowing in," he says. "You have an entity that gets in the way of a patient getting his medication, not facilitating it. That is absolutely, positively wrong."

In the past few years, Okon says, the number of specialty oral cancer drugs has risen dramatically. In turn, PBMs switched from charging a \$3 to \$5 fee per prescription at retail, to tacking on a percentage of up to 11% per prescription "Why can they do this?" asks Okon. "The answer is, because they can."

PBMs make money in several ways, starting with reimbursing a pharmacy slightly less than what it is paid by the insurer or employer that hired them to manage the group's pharmacy benefits. For example, an insurer or employer may pay \$87 for a medication. The PBM may reimburse the pharmacy \$85 and keep the \$2 difference, which is called the spread.

But the PBM may have also negotiated a \$15 rebate on that medication. Depending on the contract language, all or most of that rebate is supposed to be passed straight through to the insurer or employer. According to Henry, each Express Scripts client decides how much, if any rebate money, the PBM may keep. Most clients, he says, allow Express Scripts to take 10% or 11%.

Administrative fees are another way PBMs make money. Administrative fees can cover things like processing claims for clients, offering solutions to control specialty drug costs, managing adherence programs, and developing narrow networks.

But critics say that over time, all the terms and conditions governing the average wholesale price of a drug; how much of rebates, discounts, and coupons are passed through to the client; what constitutes an administrative fee,

and how side deals with manufacturers are reported have been relabeled or otherwise morphed to take on a different meaning. There seems to be no standard, agreed-upon language or definitions.

"One contract equals one contract," Henry says. "It is not off the shelf. It is tailored to the needs of that client. We work with them to get the value that they realize and we are rewarded for bringing down those costs and realizing better outcomes."

That's not the way John Norton sees it. The public relations director for the National Community Pharmacist Association says his members are offered take-it-or-leave-it contracts where PBMs set the terms and conditions, including reimbursement levels, anytime audits, and monetary clawbacks. And if a small pharmacist doesn't take it?

"We'll go out of business because insured patients will pay more if they still use our pharmacies," says Norton, whose members operate one and two stores located in population centers of 50,000 or less. "They can steer our own patients with chronic conditions or who use specialty drugs to their mail order pharmacies and we can't do anything about it."

**Direct and indirect remuneration**

Norton says his members would just like PBMs to address direct and indirect remuneration. It works like this: Say a pharmacist dispenses a prescription on September 1 and is reimbursed by the PBM later that week. Close the books, right? Not quite. During its quarterly reconciliation, the PBM can claw back more money from the pharmacist.

"You make a certain amount of money on that script, but a portion of that money is probably going to be taken away from you at a time of the PBM's choosing," Norton says.

Even the Pacific Business Group on Health, whose membership includes some Fortune 500 companies, feels it has little choice but to play by the industry's rules because the three major PBMs pretty much follow the same business playbook and with seemingly little incentive to change.

Rather than concentrate on a drug manufacturer's initial pricing decision, Lansky and Pacific Business Group focus on trying to identify the loopholes that allow costs to be tacked on between factory and patient. The actual prices paid by the plan sponsor are generally impossible to decipher because of rebates, discounts, and administrative fees loaded into the supply chain, including PBMs. One example is the recent disclosure about PBMs covering high-cost brand drugs instead of generics to get the rebate.

"The supply chain is an incredibly complex, layered system constructed so that one can't really tell who is being paid what for what," Lansky says. "The entire pipeline is acting in the dark and ultimately it is the employer or government payer and their beneficiaries who pay a higher price for all of this lack of clarity."

And there are 15,000 drugs with various dosages, packaging, and pricing. The Pacific Business Group companies that have hired pharmacy expert consultants to go over their PBM contracts with the finest of fine-tooth combs have found that dollars are divvied up in a way that isn't always in their best interest.

One example, Lansky says, is the use of coupons and copay assistance discounts to motivate patients to use a certain drug. The out-of-pocket costs for the patient may be lower because of the PBM but the drug may cost the insurer or employer more. Another hidden cost is the price for various doses on a formulary, says Lansky. The PBM should choose the dosage that brings the highest value to the plan sponsor and the patient.

"Consultants have pulled out example after example where the PBM has turned the formulary to its advantage and not to the customer's advantage," he says. "That creates a lack of confidence that the PBM or health plan is acting fully in your best interest."

The key to finding out if your PBM is working in your best interest, Cahn says, is to ferret out the drug-by-drug rebate and the drug-by-drug total money collected and passed through data.

"With those two sets of information you can figure out if the PBM is acting in your interest or, instead, favoring certain drugs because the PBM is getting scads of money it's retaining and not passing through."

In a recent National Rx Coverage Coalition blog post, Cahn dissected a publicly available draft of a contract between Express Scripts and Genesee County, Mich., which is about 75 miles northwest of Detroit and includes the city of Flint. In her critique, Cahn noted that the contract fails to spell out what share of its rebates Express Scripts will pass on to the county. Cahn also quoted from a financial disclosure that Express Scripts attached to the draft contract that says Express Scripts "often pays an amount equal to all or a portion of the formulary rebates it receives to a client based on the client's PBM agreement terms.

"As a plan administrator or fiduciary, you need to find out whether your plan is receiving 'all' or 'a portion of' the formulary rebates that your PBM obtains from manufacturers," she wrote. And if you are only receiving a portion, she continued, you should determine how much you might otherwise save if your PBM passed through 100% of all formulary rebates. "It's something plan administrators need to be aware of," Cahn said in separate discussion with Managed Care.

Express Scripts also outlined a number of administrative services for which it receives payments in the financial disclosure documents, according to Cahn. Express Scripts' administrative fees in Genesee County's draft contract are "calculated based on the price of the rebate drug or supplies along with the volume of utilization and do not exceed the greater of (i) 4.58% of the average wholesale price (AWP), or (ii) 5.5% of the wholesale acquisition cost (WAC) of the products." As a result of that provision, Cahn wrote, when there is an increase in either the volume of the drug sold or the drug's price, Express Scripts' administrative fees will also likely increase.

"That's a lot of money," Cahn said, "and potentially a conflict of interest."

The Genesee County draft contract, according to the blog post, also stipulates that the money from all of the administrative services "are not part of the formulary rebates or the other manufacturer fees that it collects." The financial disclosure also clearly states that any other financial benefits Express Scripts collects from manufacturers —discounts for its subsidiary pharmacies, payments for selling data, running therapy adherence programs, providing drugs for clinical trials—it retains for itself.

Cahn calls this the "rebate relabeling game." The bottom line is if a PBM calls a payment a rebate, it will pass through all or some of the money to the client. But, she says, a "manufacturer administrative fee" or anything by another label goes straight into the PBM's pocket. In Cahn's opinion, "every client should insist that its PBM pass through 100% of all manufacturer benefits—and 100% of all other payments—that manufacturers pay to its PBM."

**Legislative movement**

Given the current environment in Washington, it's hard to predict the fate of the two pieces of pending legislation. The bill introduced by Wyden would require PBMs to publicly post aggregated data about rebates and discounts from manufacturers for medications that are part of Medicare Part D and Medicare Advantage plans. The bill would also disclose "spread pricing," which is the difference between payments PBMs make to pharmacies compared to payments PBMs receive from health plans.

The Collins bill would require PBMs to update their WAC lists for Medicare Part D, Tricare, and FEHBP every seven days. It outlines the appeals process for pharmacies to dispute reimbursements. The bill would also prevent PBM-owned pharmacies from sharing patient information and mandating patients use those pharmacies.

Lansky and PBGH would like PBMs to provide transparency about net-of-rebate and all other fee prices.

But Lansky and PBGH don't think the political environment is right to push for regulatory or statutory changes concerning PBM transparency. Instead, the group will continue to work with its partners in the supply chain,

including manufacturers and the PBM industry.

"We see our members, as buyers in the market, having a powerful market influence," he says. "If they want to exert pressure on their current supplier and PBM, they can do that through contract renewal negotiations, including bringing in the right consultants to more closely scrutinize the contract and collaborating with stakeholders and with each other to test new and innovative approaches."

Lansky thinks large employers will start to bring their market power to bear. He believes that large insurers and employers will begin to show more interest in smaller PBMs.

"The large PBMs have the obvious advantage of volume purchasing and being able to achieve favorable rebates and discounts," he says. "The smaller PBMs may not have the best discounts but their models might mean more transparency and allow for employers and patients to keep more of the savings. Additionally, they might be more willing to innovate with employers in terms of formulary or benefit design. Purchasers are increasingly recognizing the need to look beyond rebates and focus on total cost of care instead."

The National Community Pharmacist Association's Norton says his group will continue advocating for changes in PBM contracts through state governments where they have had some success. At least 22 states have crafted a total of 39 laws that try to reign in PBMs. Proposed legislation will compel the industry to adhere to fair and uniform pharmacy audits to anti-mandatory mail order requirements.

"We have been able to get a lot of states to create more transparency when it comes to generic reimbursement," he says. "The states are not as difficult, although when a PBM gets particularly concerned about how a law might impact them they go the legal route."

Norton's association has filed an amicus brief with the U.S. Eighth Circuit Court of Appeals in support of an Arkansas law being challenged by the Pharmaceutical Care Management Association, the PBM national association. If upheld, the law would require PBMs to be more transparent in determining generic prescription drug reimbursement to pharmacies.

The Community Oncology Alliance's Okon, once a proponent of PBMs, says the big three have become a virtual monopoly and should be broken up. Smaller, more competitive PBMs, he says, would be more responsive and not block cancer patients from getting the medications they need. And he would end all back-end rebates—those that are not passed on to patients—in Medicare Part D to put an end to "this arbitrage game of list and net that the PBMs are playing."

He's "not jumping up and down" that a bill will pass, but he does expect Washington to weigh in with legislation possibly this fall.

"It's easy to imagine a new entity could come into the market and blow up the existing PBM business model," says pharmacy benefit consultant Linda Cahn.

Not going to happen, is Cahn's take on a legislative remedy. The state laws, she says, are a "hodgepodge" that are "barely scratching the surface of the problem" or "sufficiently comprehensive" enough to have an impact. And the

idea of federal legislation relief is "very farfetched."

Cahn is advising plans and employers stuck with a bad contract to file what is known as an accounting procedure. The procedure would allow the client to determine exactly how much money the PBM is collecting and not passing through. And then she pondered another possibility. "It's easy to imagine a new entity could come into the market and blow up the existing PBM business model," she says. "They could do it differently. A Walmart or Costco or Amazon could create an entirely transparent PBM."

Robert Calandra, a regular contributor to Managed Care, is an independent journalist in Philadelphia with more than 20 years experience writing about health care.

## Trending

Will Smith, MD Paramedic: Answering the Call of the Wild Creates A Different Kind of Medical Director
With Direct Contracting Boeing Cuts Out the Middleman
Patients Slammed With Huge Ambulance Costs Because Insurers, Ambulance Companies Can't Negotiate Contracts
Cigna's Eva Borden Champions 'The Stepchild': Behavioral Health
Underused Weapon In the War on Addiction

View More >

## Subscribe to Our Newsletters

**Monthly table of contents**

Be notified as each issue of Managed Care is available online.

**Biweekly newsletter**

Recent topics have included:

- Doug Jones and the ACA, Epic misses a White House meeting, and man caves for man-flu sufferers
- CVS-Aetna deal may trigger merger mania, Johns Hopkins criticized for lack of asthma prevention, & Columbia sees free-ride future for all of its med students

**PTCommunity news**

New drug approvals, clinical trials, drug management. Three times per week.

## UP NEXT

Drug management
Underused Weapon In the War on Addiction
By Timothy Kelley
Drug management
Is CAR-T Really Putting Us On Road to Gene Therapy?
By Thomas Reinke
2018 Year in Preview
PBMs: Will the Amazon cometh?
By Robert Calandra

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

EXECUTIVE UPDATE

ADVOCACY
CONNECTIONS
SOLUTIONS

**January 26, 2018**

## Payments That Give You Fever and Chills

Dear Colleague,

This year's flu is the most widespread on record. The predominant strain is H3N2, which is known to cause the worst outbreaks. And this year's flu season started a bit early, in October, and may linger on into spring. It's hit children particularly hard. So far, 37 have died, and the flu is on track to be the worst we've seen in 15 years.

So, we all want to get our flu patients the medicine they need. And community pharmacists are doing just that but, unfortunately, you're often losing money every time you help a flu patient.

As the number of flu cases started to increase in the fall, so did the reports sent to NCPA from members that their pharmacy was being paid less than what it cost them to buy the medicine. Unfortunately, being paid below acquisition cost happens all too often. Being paid *significantly* below cost for an important medicine to treat the flu during the middle of a bad flu season sticks out as particularly egregious. So earlier this week, we took a flash survey of our membership to find out about Tamiflu/oseltamivir shortages and under-reimbursements. To those of you who took the time to respond, thank you. The results are disturbing.

Here's one member's comment: "Here is a good example ... just received Rx for one box of Tamiflu, which we attempted to fill with generic. Cost from wholesaler is $57.99. [PBM] reimbursement was $19.95. We see these types of things now all day every day, and you and I know that the lower reimbursement doesn't filter back to employers."

Share and share alike is usually a good thing, but not when it comes to the flu. Sometimes a physician will prescribe Tamiflu for an entire family. When a family of four

walks into a pharmacy, the pharmacy could be looking at loss of $200 or more. That's all-over achiness your bank account feels that 400 mg of ibuprofen won't help.

In just 36 hours, we received 455 responses to our survey. The results didn't surprise us. We're used to PBM corporations abusing their power to set prices and reimbursement. It's not just on generic Tamiflu. This happens to community pharmacies every day.

Almost 88 percent of those responding tell us that they've experienced multiple incidents of below-cost reimbursements on Tamiflu/oseltamivir in the past 60 days. And more than half are telling us that they're having trouble getting oseltamivir.

As one member told us: "It is very disheartening that this is allowed to happen."

We all know that it's common practice for the PBMs to squeeze community pharmacies on generic Tamiflu and many, many other medications, and then bill their client, an employer, government entity or other plan sponsor, a much higher price than the amount they paid the pharmacy, pocketing that excessive spread. When that is the case, the plan sponsor may be none the wiser or may be unclear on how much the PBM is holding back for themselves. Maybe the PBMs are opportunistic — like the H3N2 virus.

Tell this story to just about anybody, and the answer will be, "That's ridiculous! There ought to be a law against that!"

Yes, there should be. And NCPA is doing our part to change areas we can influence, all day, every day. Unfortunately, the take-it-or-leave-it contracts that pharmacies have little choice in signing or risk losing a chunk of their business seem to allow PBMs to do whatever they want, no matter how unethical.

We're also telling your story to officials. We're fighting back. PBMs' unchecked power to profiteer needs to stop. Now.

Best,

---

**STAY CONNECTED**

**Note: This message was distributed from an email account used for sending messages only. The inbox associated with this email account is unattended. Please do not reply to this message.**

***NCPA Executive Update*** *delivers insights on legislative, regulatory, policy, and industry developments from NCPA CEO B. Douglas Hoey, Pharmacist, MBA, to NCPA members and pharmacy leaders every Friday. We welcome your comments at* info@ncpanet.org.

To unsubscribe from promotional emails and surveys but continue to receive important updates about community pharmacy issues, click here to manage your subscription preferences.

THE STATE of ALASKA
GOVERNOR BILL WALKER

**Department of Commerce, Community, and Economic Development**

BOARD OF PHARMACY
P.O. Box 110806
Juneau, AK 99811-0806
Main: 907.465.2589
Fax: 907.465.2974

May 9, 2017

The Honorable David Guttenberg
House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Re: HB240: Pharmacy Benefit Managers and Auditing of Pharmacy Records

The Alaska Board of Pharmacy at its March meeting via teleconference, voted unanimously in favor of supporting House Bill 240 (An act establishing oversight for pharmacy benefits managers (PBM) including procedures and guidelines for auditing pharmacy records transparency of reimbursement/pricing methodology, and providing for an effective date). The Board feels that with 34 other states having established some form of oversight regarding PBM's, auditing practices, and pricing transparency, it is time Alaska follows through and adopts similar practice standards to help protect not only our pharmacies in the state, but the patients they serve. We ask this bill enacted in its current form and without delay.

Sincerely,
Leif Holm, PharmD.
Chair, Alaska Board of Pharmacy

p.p.
Donna Bellino
Licensing Examiner

Db:lh

May 8, 2017

Representative David Guttenberg
Alaska State Senate
Juneau, Alaska

**RE: HB 240: An act relating to the registration and duties of pharmacy benefit managers...pharmacy audits...**

Dear Representative Guttenberg;

I came to Fairbanks 46 years ago and worked in community pharmacies until I retired a couple of years ago. In the early days, most of our patients paid cash for their prescriptions. Today, the majority of prescriptions are billed to 3rd parties, and along with the 3rd party billing, has come Pharmacy Benefits Managers (PBM's) and audits of prescription records.

Like a similar bill that passed in the Alaska State Senate in 2012**, HB 240** will require that PBM's doing business in Alaska register with the state. The 25 or 30 other states that have passed similar bills have found that a $300-$500 registration fee will cover most of the administrative costs.

Audits of prescription records can be a useful tool to detect fraud and abuse, but, they should not be used as a method of generating additional income for the PBM or the auditing company. **HB 240** will bring fairness and standardization to the audit process by establishing parameters for auditing pharmacy records. The bill sets out procedures regarding notification of an audit by the PBM, what records need to be available to the auditor, and how overpayments, underpayments, and appeals will be handled.

In my long career I have experienced a number of audits from both DEA and insurance company auditors or their agents. They are never pleasant experiences, but, with proper notification and conduct, they can be done is such a way that they cause the least disruption to the patient care we provide in our pharmacies.

Thank you for your support of **HB 240**.

Margaret D. Soden, RPh
PO Box 61328 (mailing), 3222 Anella Avenue (home)
Fairbanks AK 99706-1328
(907) 479-6793
margaretdsoden@gmail.com

Ron's Apothecary Inc.
9101 Mendenhall Mall Rd.
Juneau, AK 99801
(907)789-0458 voice (907)789-1356
Foodland Pharmacy
615 W. Willoughby Ave.
Juneau, AK 99801
(907) 796-2280 voice (907) 586-2280

May 8, 2017

Representative David Guttenberg
Room 501 Capital Bldg.
Juneau, AK 99801-1182

Re: HB 240: Pharmacy Benefit Managers and Auditing of Pharmacy Records

I am writing in full support of HB 240 and hope that Alaska can join the 34 other states that have established guidelines for the oversight of PBM's and their auditing practices and pricing transparency. This bill is needed to create a fair relationship between providers and the PBM's so that health care members can continue to receive services in the state at their pharmacy of choice.

This bill will not prevent the detection for any fraud, waste, or abuse and will not prevent the recoupment of the PBM's from the pharmacy providers if such occurs. If fraud is alleged by a pharmacy or pharmacy employee the PBM's have full access to audit and recoup.

We are continually, read daily, dispensing medications below our cost due to the drug pricing list of PBM's (also called MAC lists-maximum allowable cost). These lists are set by the PBM, and change without notice. Currently there is no appeal process with the PBM's, most do not even have a phone number for these departments and we are left in a phone tree maze of wasted time and effort. While these lists are one mechanism to keep drug costs down, it is unfair if PBM's do not adequately update these lists to reflect increases in cost and to provide an adequate appeals process.

In providing pharmacy services to Southeast Alaska Residents in communities with no retail pharmacy we occasionally mail their prescriptions to their home in addition to the prescriptions they pick up in store while in town. According to many PBM's this is a breach of contract and those prescriptions need to come from the PBM's mail order pharmacy. During an audit the PBM could recoup the entire amount of these prescriptions.

If a PBM is truly interested in cost savings for health plans, the transparency required will not be an issue. It is stated from some PBM's that we are not to disclose the payment to a pharmacy from the PBM, this is confidential information. Why they expect this is one of the many reasons I hope this bill can be passed with undue delay.

Sincerely,
Scott Watts R.Ph

Julie McDonald
Whale Tail Pharmacy
Pharmacist in Charge
PO Box 709
333 Cold Storage Road
Craig, AK 99921

Monday, May 8, 2017

Representative David Guttenberg
State Capitol Room 501
Juneau, AK 99801-1182

Honorable Representative Guttenberg,

I would like to express my **strong support for HB 240**, Pharmacy Business Managers (Audit Bill) due to the absence of regulation for large corporation PBMs.

As a small business owner on remote Prince of Wales Island I quite often am paid under cost and ignored by PBMs. Maximum Allowable Cost (MAC) pricing causes our pharmacy to be paid below purchase cost several times daily and our appeals for MAC pricing are rarely responded to or are completely disregarded. At any point a PBM can change their MAC pricing and they can have multiple MAC price list leaving essentially no transparency. When trying to address these issues during contracting, I am presented with "take or leave it" contracts. However, since we are the only retail pharmacy for the island, if we are not contracted our patients will not have local access to pharmacy services.

I appreciate all of the time and work that you have put into State House Bill 240: Pharmacy Business Managers (Audit Bill).

Sincerely,

Julie McDonald

Julie McDonald, Pharm.D.

**Island Pharmacy**
**3526 Tongass Ave.**
**Ketchikan, AK 99901**
**907-225-6186**
**e-mail: island.pharm@juno.com**

January 18, 2017

Representative David Guttenberg
State Capitol Room 501
Juneau AK, 99801

RE: HB 240 Pharmacy Benefits Managers

Dear Representative Guttenberg,

Thank you for sponsoring HB240 Pharmacy Benefit Managers (PBM). Our family operates Island Pharmacy in Ketchikan which has been serving Alaskans in southern Southeast Alaska for forty-four years. The passage of HB 240 is important and necessary for Alaskan pharmacies like ours to remain viable in the future.

While there are many important provisions in HB 240, I will outline two examples from our pharmacy that show the necessity of the legislation: timely allowance of appeal and generic drug pricing.

We received a large desk audit from a PBM which generated over 100 pages of documentation. Our two choices for transmission for the material was either unsecured e-mail or fax. Naturally, we choose fax, however since our fax machine will only hold/send 50 faxes at a time we had to send two separate faxes which was so noted on cover letters and also in e-mail to the auditor. Imagine our surprise when we got our audit results which showed we didn't include half the claim documentation. When we contacted the auditor they claimed the never received the second fax (even though we had confirmation that the fax went thru!). They did allow us to resend the second fax however they only allowed a five day period on the final audit findings for appeal. This included a $400 claim for an RX that wasn't even present in the audit prescriptions claims that were send to us! The auditor claimed that they randomly select claims to send to prescribers to verify. In this case we checked with the prescribers office and they had no documentation asking to verify the prescription but they were willing to write a letter on our behalf indicating the validity of that prescription and two others deemed "not verified by prescriber". In this case we received the final audit findings document from the PBM on a Thursday afternoon and were told any additional documentation needed to reach their office in the Midwest by the following Tuesday via USPS MAIL.

This meant we had basically less than 24 hours to get our documents (and letter from prescriber mentioned above) in the mail so it would reach them. We do not believe that was a fair submission turn around time and quite frankly it was a miracle we were able to respond in time.

During the first two weeks of this year we had approximately 150 RX claims (excluding Medicaid claims) for generic drugs that were paid to us below invoice cost by the PBM's. These amounted to over $2,000. Under the terms of our contract we are required to submit these claims. Yes, we can and do submit pricing appeals but rarely do we receive a positive result and even if we do we are rarely allowed to resubmit for the date of service of the Rx appeal. Obviously, any business cannot operate long under payment mechanisms that reimburse below cost and we ask for help in making sure generic drug pricing in Alaska by the PBM's is fair.

We agree that audits are necessary to ensure that fraud, waste and abuse activities are checked. However, we feel that it is time for Alaska to enact laws that provide clarity in the audit process and timely price updates like 30 plus states have already done.

I appreciate you and your staff's efforts to help provide audit relief to Alaska pharmacies and the patients we serve.

Respectfully,

Barry Christensen, RPh

Justin Ruffridge
Soldotna Professional Pharmacy
Juneau Drug Company
299 N Binkley
Soldotna, Alaska 99669

907-262-3800
907-262-6429
jruffridge@icloud.com

January 22, 2018

Representative Guttenburg
Alaska House of Representatives
State Capitol Room 501
Juneau, AK 99801

For your consideration,

In regards to HB 240, I extend my gratitude for sponsoring legislation to protect pharmacy services being offered by our pharmacies across the state. I would ask for consideration on the following:

First, consider a majority of states have passed similar legislation. This may be seen as an indicator that legislation is necessary to protect local businesses from oft overzealous audit practices and less than fair recoupments using methods such as extrapolation. To be fair, the audit is a necessary process to ensure that all participants in the billing of insurance are justly reconciling their claims and to prevent fraud. However, the creation of structure for how and when these audits occur and the penalties they may enforce only helps level the field for insurers and healthcare providers.

Second, consider the difference between an insurer and a local pharmacy. An insurer has full control of all aspects of the billing process while the pharmacy is, in many respects, left at the mercy of the insurer. In many cases, an insurer may pay well below the acquisition cost of medications and local pharmacies are left with no reasonable recourse to protect their investment. It is vital to the sustainability of local pharmacies to ensure we have a fair and equitable path to appeal pricing and to ensure that pricing is updated on a regular basis.

Certainly HB 240 is a valiant effort towards solving these issues and more and it is my sincerest hope the legislature will be able to pass this bill, protect local pharmacies, and look forward to a healthy future of the practice of pharmacy in Alaska

Sincerely,

Justin Ruffridge

*Owner*
Soldotna Professional Pharmacy

Juneau Drug Company

# Alaska Pharmacists Association

May 16, 2017

Representative David Guttenberg
Alaska State Capitol
Juneau AK, 99801

RE: HB240 Pharmacy Benefits Managers

Dear Representative Guttenberg,

This letter is in response to the fiscal note dated May 15, 2017 from the Department of Administration regarding HB 240. The department's analysis included a few "potential" areas of fiscal impact which I will respond to below.

As you are aware HB240 requires the PBM to pay the Division of Insurance a fee to cover the costs associated of the pharmacy appeals process. We feel this fee would be part of the PBMs cost of doing business and should not be passed on as administrative fees payable from Alaskacare. Pharmacies are not allowed to bill back costs associated with PBM audit requests such as time and copying fees. Presumably this is a cost of doing business for the pharmacy with the PBM.

We feel HB 240 merely outlines the audit procedures and does not prevent the PBM from detecting fraud, waste or abuse patterns. Similarly, we do not believe the legislation restricts recoupment overpayments. The language in HB 240 is closely mirrored to model legislation that has passed in the majority of other states.

HB 240 does not require reimbursement of generic drugs at "certain levels". It merely says that PBM must prove that pharmacies can buy the drugs from wholesalers at the reimbursed rate. There is nothing in the bill that would delay or limit the ability of Alaskacare or other plans to benefit from cost savings with generic competition with brand name drugs that have lost their patent.

We agree with the administrations assessment that "it is difficult to know how this bill will impact pricing..." However, we are not aware of significant increases in generic drug spends in other states that have passed similar MAC pricing legislation. Generic drugs provide good value for consumers and insurance purchasers resulting in significant savings when compared to brand name drugs.. We feel the State should feel obligated to at least reimburse Alaskan pharmacies the purchase cost of dispensed generic drugs.

**E-mail: akphrmcy@alaska.net**

**203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880**

Lastly, we take issue with the idea that wholesalers will increase generic drug prices simply because of this legislation. This would imply that there is collusion in the drug wholesaler industry. If the department really feels that this is or could be occurring then we would encourage it to undertake an investigation accordingly.

Thank you for the opportunity to comment on this matter. Please feel free to contact our association with questions.

Regards,

Barry Christensen, RPh
Co-Chair Legislative Committee

**E-mail: akphrmcy@alaska.net**

**203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880**

May 15, 2017

The Honorable Sam Kito
Chair House Labor and Commerce Committee
State Capitol, Room 124
Juneau, AK 99801

**RE: House Bill 240 – Relating to Pharmacy Benefit Managers – Please Oppose**

Dear Senator Kito,

Aetna is writing to respectfully oppose HB 240, Relating to Pharmacy Benefit Managers. HB 240 creates costly and unnecessary regulation. Aetna uses Pharmacy Benefit Managers to balance both the health needs of our members and the practical needs of businesses.

Issues of concern with HB 240 include furthering the oversight for Pharmacy Benefit Managers under the Division of Insurance. Pharmacy Benefit Managers are required to be licensed with the Alaska Board of Pharmacy; as a Third Party Administrator with the Division of Insurance and registered with as a business entity in the state. In addition, at the federal level, Pharmacy Benefit Managers hold multiple federal licenses to operate with the DEA, CMS (Medicare Part-D) and as a federal contractor. Adding the ability for the Division of Insurance to weigh into private contracts between a Pharmacy Benefit Manager and a Pharmacy, establish an alternative forum outside of the legal contract to address disputes and re-create an already existing arbitration process is unnecessary.

Aetna uses Pharmacy Benefit Managers in pharmacy plans for a variety of reasons including ensuring pharmacy claims are being processed and paid in an appropriate manner. Audits allow a health plan and the businesses it serves to make certain that the pharmacy claims they are paying for are appropriate and do not contain instances of fraud, waste and abuse. In a time of rising health care cost, preventing fraudulent activity is an important tool to help keep health care cost down. HB 240 would limit Pharmacy Benefit Manager's ability to audit pharmacies by limiting the number of prescriptions available to audit, limiting the days that an audit can occur and dictating the methods a Pharmacy Benefit Manager can use to audit a pharmacy.

HB 240 limits the ability of Pharmacy Benefit Managers to use an over forty-year-old tool, called the Maximum Allowable Costs (MAC) list. A MAC list is a common cost management tool that is utilized by Pharmacy Benefit Managers, state Medicaid agencies, CMS and Health Plans taking into account marketplace dynamics, product availability and pricing. The federal government and many state Medicaid programs use MAC lists for reimbursement purposes. MAC is the maximum allowable reimbursement by a Pharmacy Benefit Manger to a pharmacy for a

particular generic drug. Every manufacturer has its own price for a particular generic drug and these prices can differ extensively by manufacturer. MAC lists are continuously updated to reflect the current market dynamics and encourage pharmacies to purchase generics at the lowest possible cost, driving competition among wholesalers and manufacturers, thereby lowering costs for payers and members.

Healthcare costs in Alaska are among the highest in the United States and are continuing to rise each year. HB 240 will create more unfunded regulations that do nothing to improve access to care for Alaskans and will not aid in the efforts to control health care costs in Alaska.

Thank you for the opportunity to submit our concerns about HB 240.

Sincerely,

Shannon Butler
Senior Director of Government Affairs, West Region

ALASKA TEAMSTER-EMPLOYER

SERVICE CORPORATION

January 23, 2018

Honorable Sam Kito
House Labor & Commerce
State Capital Room #105
Juneau, Alaska 99801

Re: House Bill No. 240

Dear Representative Kito:

On behalf of the approximately 4000 Teamster members and their families covered under the Alaska Teamster-Employer Welfare Trust, we continue to oppose House Bill No. 240 which proposes to regulate the audit of our members' prescription drugs.

The Plan's Prescription Benefit Manager (PBM) OptumRx performs infrequent onsite audits within Alaska; however, during any given calendar year would perform a maximum audit volume of 6-8% of the network pharmacies. The PBM's audit approach has also transitioned away from extensive onsite audits. The audits being conducted which incorporate claim reviews are done very concurrent to claim submissions to mitigate client prolonged risk to inaccurate payments due to repetitive errors. Our PBM conducts a large volume of daily audits on high risk medications and performs desktop audits monthly to monitor pharmacy claims for aberrancies in claims payments. Audit expectations and processes are clearly outlined in the PBM's Provider Manual which acts as an extension to the Provider Agreement.

While we understand the pharmacy position on the need to mitigate risk associated with punitive and aggressive audit tactics, the relationship between the pharmacy and the pharmacy benefit manager is a negotiated contract and should remain as such. Business entities should be allowed to enter a business arrangement and dictate the limitations of that arrangement. This should not require legislation.

We ask that you not move this bill from committee.

Sincerely,

Dennie Castillo
Administrator
Alaska Teamster- Employer Welfare Trust

c: Vice-Chair Adam Wool
Member Representatives – Josephson, Stutes, Birch, Edgmon, Knopp and Sullivan-Leonard

520 E. 34th Ave., Suite 107 | Anchorage, AK 99503-4116 | 907-751-9700 | fax 907-751-9738
benefits@959trusts.com | www.959trusts.com

**America's Health**
**Insurance Plans**

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

January 25, 2018

Representative Sam Kito
Chairman, House Labor and Commerce Committee
Pouch V
Juneau, AK 99801

**Re: HB 240, Pharmacy Benefit Managers**

Dear Representative Kito,

I write today on behalf of America's Health Insurance Plans (AHIP) to respectfully oppose HB 240, a bill that requires pharmacy benefit managers to register with the Division of Insurance and establishes troublesome provisions regarding pharmacy appeals and audits.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Insurers contract with pharmacy benefit managers (PBMs) as an efficient and effective way to administer prescription drug benefits and ensure that pharmacies and other health care providers are providing quality care. PBMs help consumers save on the cost of prescription drugs while using clinically based services to reduce medication errors, achieve higher rates of medication adherence, and improve health outcomes. PBMs are able to negotiate directly with manufacturers and pharmacists to obtain discounts for their customers. To encourage further savings, PBMs are committed to educating their customers about safe, effective, and lower cost generic drugs.

***PBMs are not insurers and should not be subject to the Division of Insurance's regulatory authority.***

HB 240 allows the Division of Insurance to be the ultimate arbiter of prescription drug pricing disputes between pharmacies and PBMs and funds the Division's new duties through a registration and renewal fee on PBMs. This would increase costs to consumers and insurers, and yet, the pharmacies initiating the disputes would have no fees or assessments imposed on them.

PBMs are predominantly business and administrative entities – not insurers. Giving the Division regulatory authority over such commercial business entities would be akin to having the division oversee other businesses that provide services to insurers, like accountants. We are also concerned that the Division lacks subject matter expertise on drug pricing issues and does not

have the authority to render decisions over disputes between commercial entities that are not subject to the Insurance Code.

PBMs and pharmacies' disputes are already arbitrated through avenues provided within contracts between such entities, making the appeal provisions in HB 240 a solution in search of a problem. Giving the Division the authority to be the ultimate arbiter in these disputes would inappropriately insert them into privately negotiated contracts between PBMs and pharmacies.

***This bill limits insurer's and PBMs' tools to prevent wasteful spending, fraud, and abuse.***

In an effort to ensure that pharmacies and other health care providers are providing quality care, insurers and PBMs utilize various auditing procedures to identify and correct errors and uncover fraud and abuse that leads to poorer quality of care and higher costs. Audits are used to recoup monies incorrectly paid for claims with improper quantity, improper days' supply, improper coding, duplicative claims, and other irregularities. In a time of rising health care costs, preventing fraudulent activity is an important tool to keeping health care costs down. Like pharmacy appeals, audit procedures are already contained in contracts between PBMs and pharmacies. We are once again opposed to the attempt to legislate privately negotiated contracts.

Furthermore, we have concerns with the provision requiring PBMs to give pharmacies 10 days written notice before conducting an initial on-site audit. Advanced notice before an audit would give individuals ample time to hide evidence of fraudulent activities or evade authorities altogether. Proposals for written notice requirements include the range of prescription numbers subject to the audit or the date on which prescriptions subject to the audit were dispensed. We are also concerned with the provision limiting the number of prescriptions which may be audited in a 12-month period. These types of limitations impede the ability of auditors to detect fraudulent prescriptions. Such a restriction would allow pharmacies acting illegally to beat the system easily and not get caught.

***This bill would limit the use of MAC pricing – driving up the cost of prescription drugs.***

Health plans are committed to assuring that consumers have access to quality, affordable prescription drugs. We are therefore concerned that the bill would limit the use of the maximum allowable cost (MAC) pricing structure to multi-source generic drugs only. MAC pricing, used in nearly 50 states, was developed to encourage pharmacies to seek and purchase generic drugs at the best and lowest price in the marketplace. Restricting the use of MAC would do immeasurable harm to the market by removing a critical component in market pricing and negotiations. This would further drive up prescription drug costs – already the fastest growing driver of health care costs – without providing additional benefits for consumers.

For those reasons, we oppose HB 240. We appreciate the opportunity to provide comments on this important issue. If you have any questions, please do not hesitate to contact me at sorrange@ahip.org or 703-887-5285.

Sincerely,

Sara Orrange
Regional Director

February 2, 2018

The Honorable Sam Kito
Chair, House Labor and Commerce Committee
Alaska State Capitol
120 4th Street
Juneau, Alaska 99801

**RE: NATIONAL COMMUNITY PHARMACISTS ASSOCIATION SUPPORTS HOUSE BILL 240**

Dear Representative Kito,

I am writing to you today on behalf of the National Community Pharmacists Association (NCPA) in support of HB 240. The bill would take steps to strengthen Alaska's pharmacy provider laws, allowing community pharmacists in Alaska to better serve their patients without pharmacy benefits managers (PBMs) imposing unfair and burdensome requirements.

NCPA represents the interest of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies across the United States and 24 independent community pharmacies in Alaska. These Alaskan pharmacies filled over 1.4 million prescriptions last year, impacting the lives of thousands of patients in your state.

**Requiring Pharmacy Benefits Manager Registration**

PBMs are involved with almost every aspect of the prescription drug supply chain, including plan designs, formulary design, and contracting with health plans and pharmacies. Despite this level of involvement, PBMs are largely unregulated. More than twenty states require some type of registration for PBMs to do business within their state, and most of those states require that PBMs register with the state's division of insurance.

NCPA believes this section of HB 240 is a step towards more oversight for a massive, predominately unregulated industry.

**Ensuring Fair Audit Practices for Pharmacies**

Pharmacists understand that audits are a necessary practice to identify fraud, abuse, and wasteful spending, and they are not opposed to appropriate audits to identify such issues. Current PBM audits of pharmacies, however, are often used as an additional revenue source for the PBM. PBMs routinely target community pharmacies and recoup vast sums of money for nothing more than harmless clerical errors where the correct medication was properly dispensed and no financial harm was incurred. In many instances, the PBM not only recoups the money paid to the pharmacy



100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

for the claim in question but also recoups for every refill of that claim, even if all other fills were dispensed without error.

In their 2014 Final Call Letter, the Centers for Medicare and Medicaid Services (CMS) indicated their recognition of abusive audit practices occurring within the Part D program. CMS found that pharmacy audits in the Part D program were not focused on identifying fraud and financial harm but on targeting clerical errors that "may be related to the incentives in contingency reimbursement arrangements with claim audit vendors." CMS concluded that "full claim recoupment should only take place if the plan learns that a claim should not have been paid under Part D at all; for example, because it is fraudulent." NCPA supports the finding of CMS and recognizes that these types of abusive PBM audits do not occur only in Medicare Part D plans.

PBMs will argue that this bill limits the ability of PBMs and health plans to conduct pharmacy audits, but this legislation does not prevent audits from occurring for their intended purpose – preventing fraud, waste, and abuse. In fact, HB 240 specifically states that PBMs may conduct audits and recoup money in such instances.

NCPA is confident HB 240 will establish reasonable standards to ensure that PBM audit abuses are curtailed without undermining the ability to identify fraud or legitimate errors.

**Providing Transparency for Multi-Source Generic Drug Pricing**

PBMs typically establish a list, often referred to as a maximum allowable cost (MAC) list, for multi-source generic drugs that determines the amount a PBM will pay for certain drug products. The process PBMs use to determine the drugs and the prices of the drugs included on the list, however, lacks any degree of transparency. This process is further complicated by the fact that PBMs frequently maintain multiple lists. There is no standardization in the industry for the criteria or methodology used to determine inclusion or pricing of a drug on one of these lists. In most cases, these lists remain entirely confidential to both the PBM's client – the health plan sponsor – and the pharmacy; therefore, there is no way of knowing how or why a health plan sponsor or pharmacy is paying or being paid the PBM-set price for a drug. This gives PBMs the ability to gain significant revenues through questionable business practices.

For example, PBMs will typically use an aggressively low price list to reimburse their contracted pharmacies and a different, higher list of prices when they sell to their clients or plan sponsors. Essentially, the PBMs reimburse low and charge high with their price lists, pocketing the significant "spread" between the two prices. HB 240 is not requiring anything that would result in a negative fiscal impact to the healthcare system or to any state agency or plan. Of the thirty-three states with enacted legislation similar to HB 240, not a single state has reported a negative fiscal impact.

At the federal level, CMS has recognized the fiscal benefits of this transparency. In their Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule, CMS stated that "updating maximum allowable cost prices for drugs at least every 7 days generally should have a downward pressure on overall drug costs. Therefore we do not agree with the commenters that the requirement will necessarily increase costs."

HB 240 allows for a reasonable degree of transparency and reporting so that Alaska's small business owners and healthcare providers have access to pricing lists that accurately reflect the current pharmaceutical marketplace figures. This bill simply provides pharmacies with the information they need to determine what they will be paid for their services.

NCPA urges your support of HB 240 so that community pharmacists can better serve their patients without PBMs imposing unfair and burdensome requirements.

If you have any questions about the information contained in this letter or wish to discuss the issue in greater detail, please do not hesitate to contact me at alliejo.shipman@ncpanet.org or (703) 600-1179.

Sincerely,

Allie Jo Shipman, PharmD
Associate Director, State Government Affairs

cc: Members of the House Labor and Commerce Committee