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# PHARMACY BENEFIT MANAGERS (PBM) AND OPTIONS FOR STATE LEGISLATURES WEBINAR

THURSDAY, JANUARY 28, 2021

1:00 PM ET / NOON CT / 11:00 AM MT / 10:00 AM PT



# ABOUT NCSL

- NCSL is a champion of state legislatures
- All legislators + legislative staff are members
- We do not take positions on state laws or policies
- Here to serve YOU!



# PANELISTS



**Lisa Sorenson**  
Executive Director  
*The State and Local Legal Center*



**Antonio Ciaccia**  
Chief Strategy Officer  
*3 Axis Advisors*



**Lauren Rowley**  
Senior Vice President of State Affairs  
*Pharmaceutical Care Management Association*



# STATE RESPONDENTS



**Delegate Bonnie Cullison (MD-D)**



**Senator Fred Mills (LA-R)**



NATIONAL CONFERENCE OF STATE LEGISLATURES

# WHAT IS A PHARMACY BENEFIT MANAGER (PBM)

Pharmacy Benefit Managers (PBMs) are:

- “Administrators of prescription drug plans for more than 270 million Americans who have health insurance from a variety of sponsors including: commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program (FEHBP), state government employee plans, managed Medicaid plans, and others.” *(Pharmaceutical Care Management Association)*

What they do:

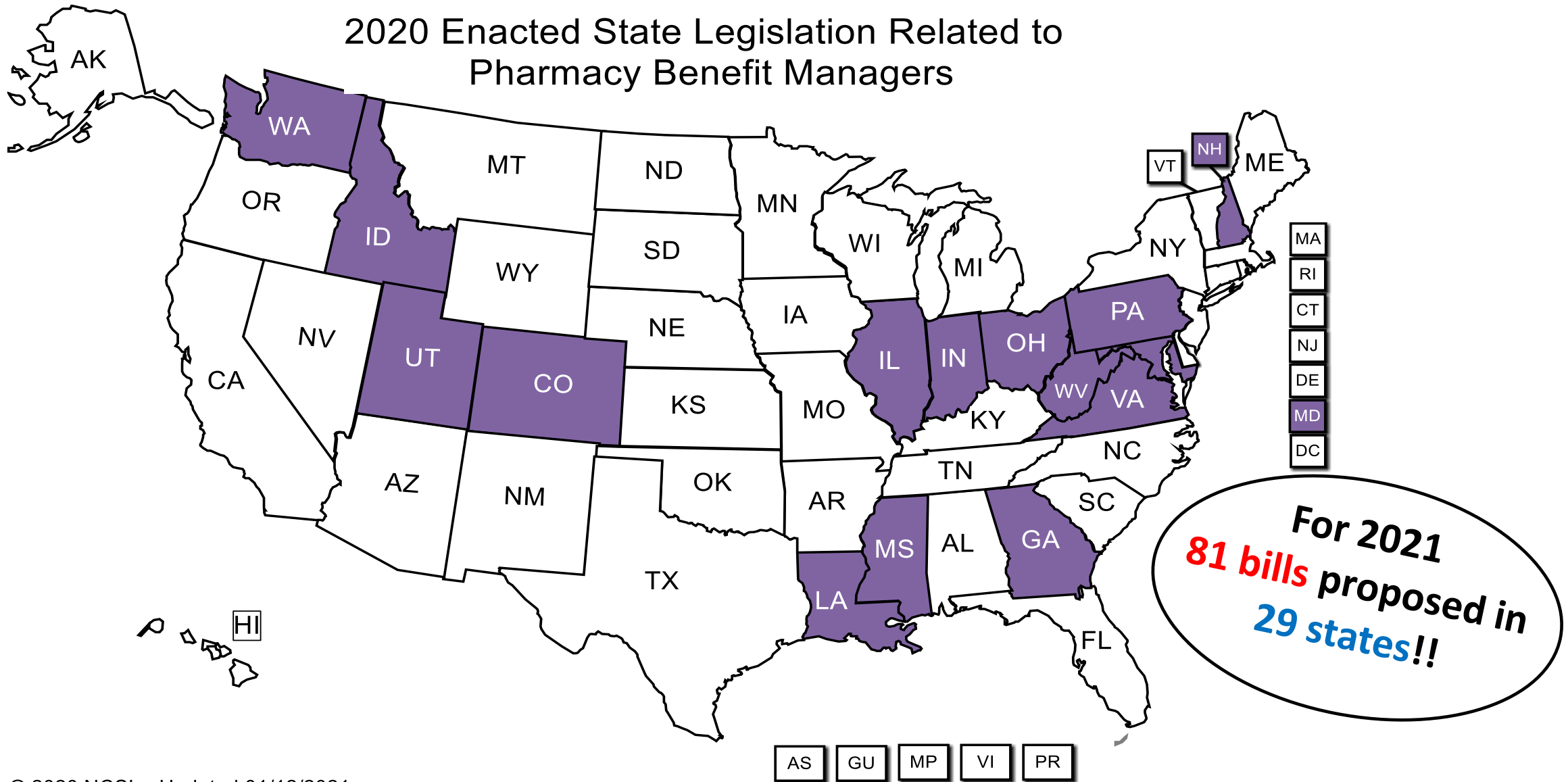
- Develop and maintain formularies
- Claims processing
- Utilization management: Tools used by payers to manage the mix and use of drugs covered under the prescription drug benefit
  - Prior authorization, non-medical switching, step-therapy
- Negotiate rebates, fees and discounts between payers, pharmacies and manufacturers



# PHARMACY BENEFIT MANAGER REFORMS

- Pharmacy reimbursement/auditing standards
  - Prohibitions on gag-clauses and co-payment 'clawbacks'
- Network adequacy standards
- Licensure and registration requirements
- Transparency and reporting requirements
- Fiduciary duty – must act in the best interest of the client
- Spread pricing model vs. pass through – must pass rebates on to consumers at point of sale
- Requiring third-party payments be applied to consumer cost-sharing

# 2020 Enacted State Legislation Related to Pharmacy Benefit Managers



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See NCSL Prescription Drug Law Database for details at [www.ncsl.org](http://www.ncsl.org)

# Overview of *Rutledge v.* *PCMA*

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Lisa Soronen

State and Local Legal Center

[lsoronen@sso.org](mailto:lsoronen@sso.org)



# *Rutledge v. Pharmaceutical Care Management Association*

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- Holding: states may regulate the price at which pharmacy benefit managers (PBMs) reimburse pharmacies for the cost of prescription drugs without violating the Employee Retirement Income Security Act (ERISA)
- 8-0 decision
- Opinion written by Justice Sotomayor
- Thomas concurrence: We do preemption analysis totally wrong. “Here, the parties have not pointed to any ERISA provision that governs the same matter as [Arkansas’s law].”
- Decision in this case not inevitable

# Arkansas Law

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- As of 2015 Arkansas required PBMs to reimburse Arkansas pharmacies at a price equal to or higher than that which the pharmacy paid to buy the drug
- Accomplished through three enforcement mechanisms:
  - Reimbursement price is calculated based on an accurate price
  - Appeals process to challenge the reimbursement price
  - Pharmacy can refuse to fill a prescription if the PBM won't reimburse them for the drug at cost

# Why this Law?

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- Arkansas claimed “many pharmacies, particularly rural and independent ones, were at risk of losing money and closing”
- In its petition asking the Supreme Court to decide this case, Arkansas stated that 36 states have enacted similar legislation intended to “curb abusive prescription drug reimbursement practices”

# What is ERISA? From DOL's Website...

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- The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that **sets minimum standards** for most voluntarily established **retirement and health plans in private industry** to provide protection for individuals in these plans.
- ERISA requires plans to provide participants with **plan information** including important information about plan features and funding; provides **fiduciary responsibilities** for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty

# Idea Behind ERISA (according to SCOTUS)

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- ERISA was enacted “to make the benefits promised by an employer **more secure by mandating certain oversight systems and other standard procedures**”
- In pursuit of that goal, Congress sought “to ensure that plans and plan sponsors would be **subject to a uniform body of benefits law**,” thereby “minimiz[ing] the administrative and financial burden of complying with conflicting directives” and ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions

# What Does ERISA Preempt?

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- ERISA pre-empts “any and all **State laws** insofar as they . . . **relate to** any **employee benefit plan**” covered by ERISA
- “[A] state law **relates** to an ERISA plan if it has a **connection with** or **reference to** such a plan”

# Why Doesn't ERISA Preempt Arkansas's Law?

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- According to Justice Sotomayor, “[b]ecause [Arkansas’s law] has neither of those impermissible relationships with an ERISA plan, ERISA does not preempt it”
- Impermissible relationship=**connection with** or **reference to** an ERISA plan

# No Impermissible Connection

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- In previous cases the Court has held that “ERISA **does not pre-empt** state rate regulations that merely **increase costs** or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage”
- Arkansas’s law is “merely a form of **cost regulation**”
- “It requires PBMs to reimburse pharmacies for prescription drugs at a rate equal to or higher than the pharmacy’s acquisition cost. PBMs may well pass those increased costs on to plans, meaning that ERISA plans may pay more for prescription-drug benefits in Arkansas than in, say, Arizona.”



# No Impermissible Reference

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- A law refers to ERISA if it “**acts immediately and exclusively upon ERISA plans** or where the existence of ERISA plans is essential to the law’s operation”
- According to the Court, Arkansas’s law “does not act immediately and exclusively upon ERISA plans because it **applies to PBMs whether or not they manage an ERISA plan**. Indeed, the Act does not directly regulate health benefit plans at all, ERISA or otherwise. It affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract.”
- If I buy health insurance on the Exchange in Arkansas this law would apply to my PBM even though ERISA wouldn’t apply to my health insurance plan

# SCOTUS Rejects Attacks on the Specific Enforcement Provisions of Arkansas's law

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- PCMA argued Arkansas's enforcement mechanisms “both directly affect central matters of plan administration and interfere with nationally uniform plan administration”
- SCOTUS responded:
  - Plan designed isn't affected by mandating a particular pricing method or the appeals process
  - Refusing to dispense drugs doesn't “interfere with central matters of plan administration”
  - Even if Arkansas's enforcement mechanisms interfere with nationally uniform plan administration by creating “operational inefficiencies” these “inefficiencies alone is not enough to trigger ERISA pre-emption”

# Two Questions from a Novice

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- Are all state laws regulating PBMs cost/price-related?
- If so, is this decision broad enough to cover all of them?

# Here is \*An\* Answer

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- Most immediately, *Rutledge* puts PBM regulations passed by more than [45 states](#) on much firmer footing. These laws do [different things](#), **but they are all aimed at reigning in prescription drug costs**. Some ban PBM gag clauses that prevent pharmacies from telling consumers about lower-cost options. Others limit patient cost-sharing, require PBMs to disclose their price lists and manufacturer rebates to improve transparency, or prohibit so-called “spread pricing” where PBMs charge plans more than they reimburse pharmacies. **Justice Sotomayor’s opinion sweeps broadly enough that its reasoning is not limited to the particulars of the Arkansas law.** Applying the logic of *Rutledge*, PBM laws are a form of health care cost regulation, and PBMs are not health plans but rather their administrative contractors, so ERISA should not preempt states’ PBM regulations.
- [Erin C. Fuse Brown](#) and [Elizabeth Y. McCuskey](#), The Implications Of *Rutledge v. PCMA* For State Health Care Cost Regulation, Health Affairs Blog, December 17, 2020



# SCOTUS DECISION

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## *Rutledge v. PCMA*

**Lauren Rowley**  
Pharmaceutical Care Management Association (PCMA)

## What Is a PBM?

A pharmacy benefits manager (PBM) is a health care company hired by insurers, employers, and government programs to administer their prescription drug benefits



# What Is a PBM?

PBMs perform a **variety of services** to ensure high-quality, cost efficient delivery of prescription drugs to consumers.

PBMs **aggregate the buying clout** of millions of enrollees, thereby obtaining lower costs for prescription drugs.

**93%**  
of employees  
are **satisfied** with  
their PBM\*

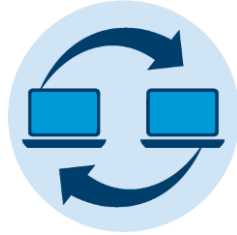
\* North Star Opinion Research, June 2020.

# The Economic Value of PBMs

PBMs save plan sponsors and consumers an average **35%** compared to expenditures made without pharmacy benefit management



# Pharmacy Benefit Management Services



Claims Processing



Price, Discount and Rebate Negotiations with Pharmaceutical Manufacturers and Drugstores



Formulary Management



Pharmacy Networks and Provider Education



Mail-service Pharmacy



Specialty Pharmacy



Drug Utilization Review



Disease Management and Adherence Initiatives

# Rutledge v. PCMA

- The U.S. Supreme Court issued a decision on December 10, 2020.
- The Court said Act 900, an Arkansas MAC law, is a form of “rate regulation”, and therefore, not preempted under ERISA.
- Act 900 established minimum MAC rates and rules for PBMs that pay pharmacies for dispensing generic drugs to health or employer plan members.
- Act 900 also allows a pharmacy to turn away a patient at the pharmacy counter if the pharmacy doesn't think they're making enough profit.

# ACT 900 Guaranteed Profits and Removed Competitive Forces

More than 40 states have passed some form of PBM rate regulation (MAC law).

Unlike most state laws that were unchallenged, PCMA sued in Arkansas because the law will drive up the costs for prescription drug benefits by requiring PBMs to reimburse pharmacies at a rate no lower than the pharmacy's invoice price.

Reimbursing a pharmacy at invoice costs, rather than the actual acquisition cost will lead to higher prices for payers and consumers.

Reimbursing pharmacies at invoice costs removes any incentive to seek discounts or shop for lower prices.

# ***Rutledge Did Not Void ERISA Preemption***

- The U.S. Supreme Court acknowledged their decision could lead to higher costs.
- The Court said, “...ERISA plans may pay more for prescription-drug benefits in Arkansas than in, say, Arizona.”
- The Court implied that states are still not allowed to force employer plans to structure benefits in a specific way, and that a law that increases costs so much for employers that the employer must restructure its benefits may run into trouble with the federal law.

# Rutledge Did Not Give States Free Rein



The Court **did not** say that states have the ability to regulate PBMs with respect to every aspect of their ERISA business.



The Court **did not** say that Act 900 was good public policy



The Court **did not** say that every law directed at PBMs is valid or not preempted by ERISA.



The Court **did not** say implementation of laws like Act 900 would not impact costs, in fact the Court said that this law would raise costs for ERISA plans.

## **BOTTOM LINE**

The state can pass laws that set rates that pay providers more, but the employers and the consumer will pay higher costs.



**Questions**



# Opening the Pharmacy Benefit Manager's Black Box

**ANTONIO CIACCIA**

Chief Strategy Officer and Co-founder

3  **AXIS** Advisors

January 2021



# My road

3△XIS Advisors

46brooklyn

- ▶ After years of government affairs work at the [Ohio Pharmacists Association](#), a few anecdotal reimbursement complaints from pharmacies grew into a loud chorus that pushed me into the bowels of the prescription drug supply chain.
- ▶ Severe pharmacy margin pressure in Ohio Medicaid managed care during a period of massive state drug spending growth pushed me to search for where the money was going.
- ▶ Years of learning and digging led to the uncovering of hundreds of millions of dollars in hidden drug costs and a nationwide push for drug pricing reform.
- ▶ Launched [46Brooklyn Research](#) in 2018 to publish and translate publicly-available drug pricing data for free.
- ▶ Launched [3 Axis Advisors](#) in 2019 to help others solve drug pricing riddles using more extensive data research and analysis.
  - Clients include provider groups, research firms, technology companies, law firms, investment analysts, employers, benefit consultants, and private foundations.
  - Serve in advisory role to a number of organizations, including American Pharmacy Cooperative, Inc. (APCI) and American Pharmacists Association (APhA).

# The PBM's black box business model is starting to break open

*“Pharmaceutical companies and PBMs are making an end run around our free-market system and taking taxpayers for a ride. We found the business practices and the competitive relationships between manufacturers and middlemen have created a vicious cycle of price increases.”*

*“In a nutshell: big players along the drug supply chain are in cahoots to game the system to capture more revenue.”*



*“PBMs, acting as middlemen for insurers, fanned the flames to take a bigger cut of the secret rebates and hidden fees they negotiate. Consolidation within the PBM industry has not improved the situation.”*



# Arkansas

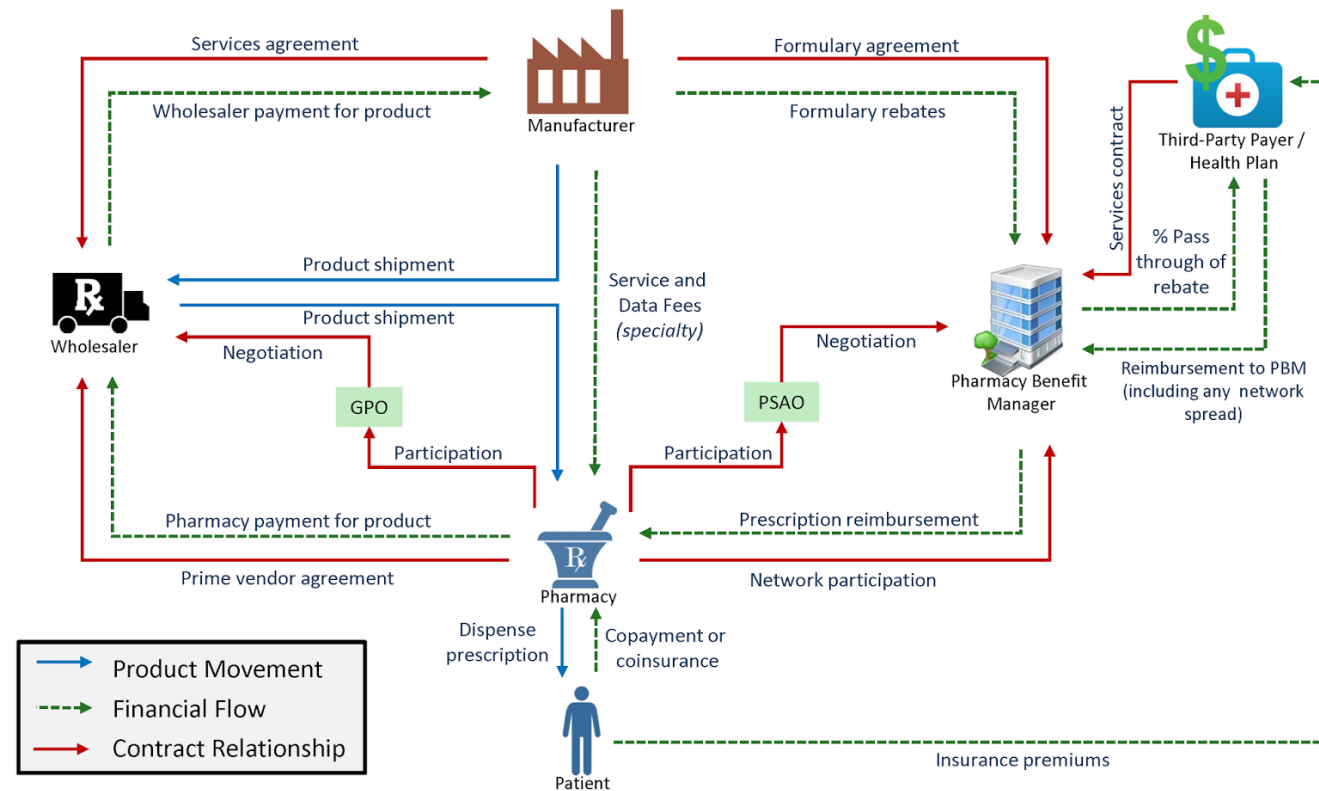
- ▶ Just as has been seen in a number of states, PBMs were eroding reimbursements to Arkansas pharmacies to the point that many drugs are being reimbursed below cost, compromising pharmacy viability.
- ▶ Like many states, Arkansas found a number of instances of PBMs reimbursing their own pharmacies more than competitor pharmacies in the marketplace.
- ▶ Like many states, Arkansas lawmakers sought to end the underpayments by passing legislation (Act 900) in 2015.
- ▶ The law articulates an appeal process for pharmacies to contest claims that are reimbursed below the pharmacy's cost to acquire the drugs.
- ▶ The law also says that the PBM cannot reimburse pharmacies below their invoice acquisition cost for the drug.
- ▶ The law forbids a PBM from reimbursing a PBM-owned pharmacy more than a competitor pharmacy.
- ▶ The law gives pharmacies the right to refuse to fill a prescription that is reimbursed below their cost.

# Rutledge v. PCMA

- ▶ SCOTUS upholds Arkansas law allowing for regulation of PBMs
- ▶ SCOTUS held that “State rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage are not preempted by ERISA.”
- ▶ By ruling that the Arkansas law amounts to rate regulation, states can choose to pass laws and rules aimed at ensuring community access to pharmacies, reining in wasteful drug cost drivers, cracking down on anti-competitive behavior, and eliminating opacity and hidden arbitrages.


# How do pharmacies get paid?

## U.S. Distribution and Reimbursement System: Patient-Administered, Outpatient Drugs



Source: Fein, Adam J., *The 2017 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Drug Channels Institute, 2017. Chart illustrates flows for **Patient-Administered, Outpatient Drugs**. Please note that this chart is illustrative. It not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.  
 GPO = Group Purchasing Organization; PSAO = Pharmacy Services Administrative Organization





# What's the price?

***When you make (things) vastly complicated ... the system often goes out of control***

Charlie Munger

# Which price are you talking about?

MANY PRICES ARE AVAILABLE FOR DRUGS IN THE U.S.

A word cloud of drug pricing terms in blue, including NADAC, AAC, ASP, AWP, WAC, FSS, MAC, PAC, Non-FAMP, DP, NC, AMP, and 304B Ceiling.

# Drug prices are...





# The system is built on “fake prices”

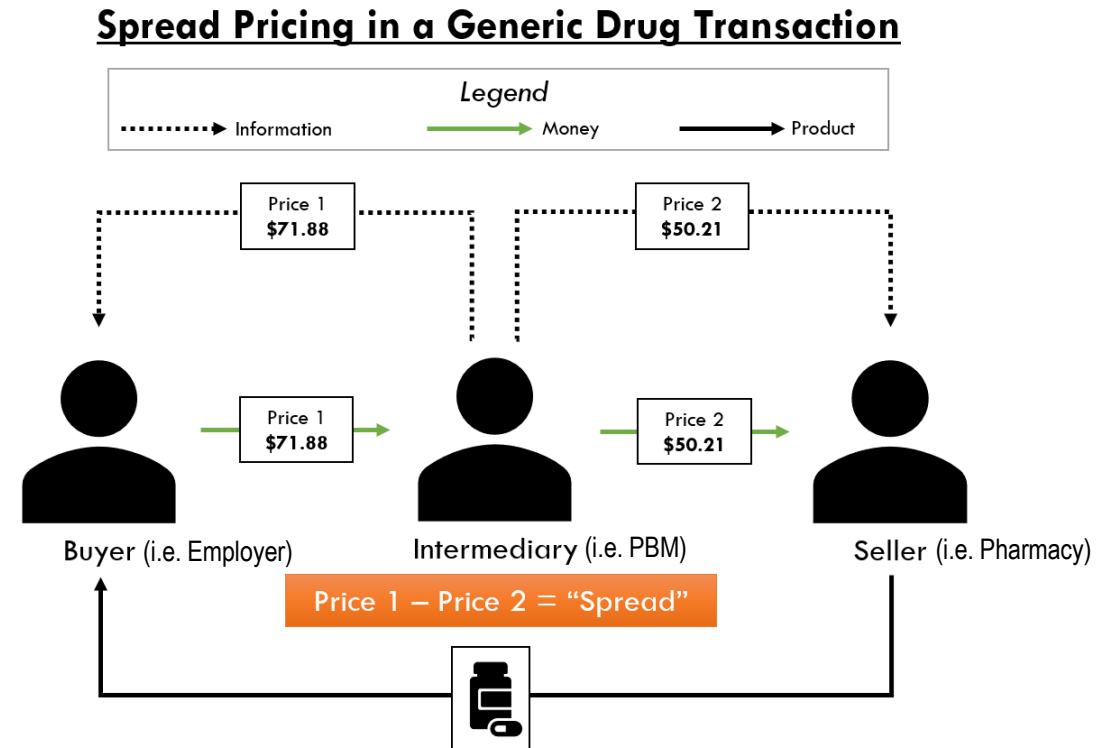
- ▶ List prices for prescription drugs are **wildly overinflated** relative to their actual cost.
- ▶ PBMs use those list prices (Average Wholesale Price, or AWP) as the basis for their pricing guarantees to pharmacies and plan sponsors.
- ▶ Brand name drugs have high AWP's that are offset by negotiated rebates and discounts that make those net prices much lower.\*
- ▶ Generic drugs have high AWP's (derived from brand drugs) that in no way reflect the actual prices pharmacies pay to acquire those drugs.\*\*
- ▶ In both regards, **the “actual” prices of both brand and generic drugs are hidden from the plan sponsor and patient.**
- ▶ Manipulation of hidden prices provides big opportunities for waste and abuse



# Generic Drug Pricing Games

# PBMs generate profits on generic drugs through “spread pricing”

- ▶ For generic drugs, PBMs have the power to directly set prices on generic drugs for both their clients, their own pharmacies, and other pharmacies in the market
- ▶ PBMs generate profit by charging a higher price to the client/ employer and paying a lower price to the pharmacy... for the exact same collection of drugs
- ▶ This is called “spread pricing”



Small to mid-size employers receive the worst generic drug pricing

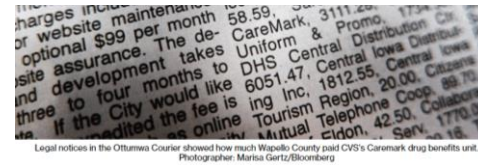
# Why spread pricing matters

Ohio Medicaid audit revealed \$244 million in spread pricing from Q2 2017 to Q1 2018

Spread pricing = the difference between the reimbursements paid to pharmacies and the rates reported back to the payer; PBM retains the difference

Ohio's state Auditor Dave Yost conducted his own audit, and found that spread equated to 31.4% of gross generic spending in Ohio Medicaid managed care

Ohio banned spread, fired its PBMs, and now plans to save \$150-200 million per year



Legal notices in the Ottumwa Courier showed how much Wapello County paid CVS's Caremark drug benefits unit. Photographer: Marisa Gertz/Bloomberg

## The Secret Drug Pricing System Middlemen Use to Rake in Millions

By Robert Langreth, David Ingold and Jackie Gu  
September 11, 2018

Not everybody reads the legal notices inside the Ottumwa Courier. But in January, Iowa pharmacist Mark Frahm noticed something unusual in the paper.

Bob Herman July 31, 2018 | updated August 1, 2018

The data showing drug pricing games

Illustration: Sarah GRIFFIN/Axios

Data analyses from [ahbrooklyn Research](#), a new firm started by two people with experience in the pharmacy industry, outline historic trends of drug prices and costs in Medicaid programs across the country in an open, transparent format.



## Medicine middlemen reap millions

By Lucas Sullivan and Catherine Cassidy  
The Columbus Dispatch

A middleman company hired to keep the state's prescription-drug prices in check for Ohioans on Medicaid is receiving millions in taxpayer money meant to provide medications for the poor and disabled.

Records of transactions provided to The Dispatch from 40 pharmacies across Ohio show that CVS Caremark routinely billed the state for drugs at a far higher amount than it paid pharmacies to fill the prescriptions. The state-sanctioned practice, known as "spread pricing," allows the middlemen, called pharmacy benefit managers, to keep the difference on medications used to treat health concerns ranging from mental illness to osteoporosis.

CVS Caremark received more than \$1.6 million for

See MIDDLEMEN, A3



Press Releases · Ohio Auditor of State

## Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth \$208M in One-Year Period

Geographic Price-Spread Disparities Found in Medicaid Pharmacy Payments

Facebook Twitter Email Print More 341

Thursday, August 16, 2018

Columbus - Ohio's Pharmacy Benefit Managers (PBMs) charged the state a "spread" of more than 31 percent for generic drugs - nearly four times as much as the previously reported average spread across all drugs, according to a new report by Ohio Auditor of State Dave Yost.



# Brand Drug Rebate Retention

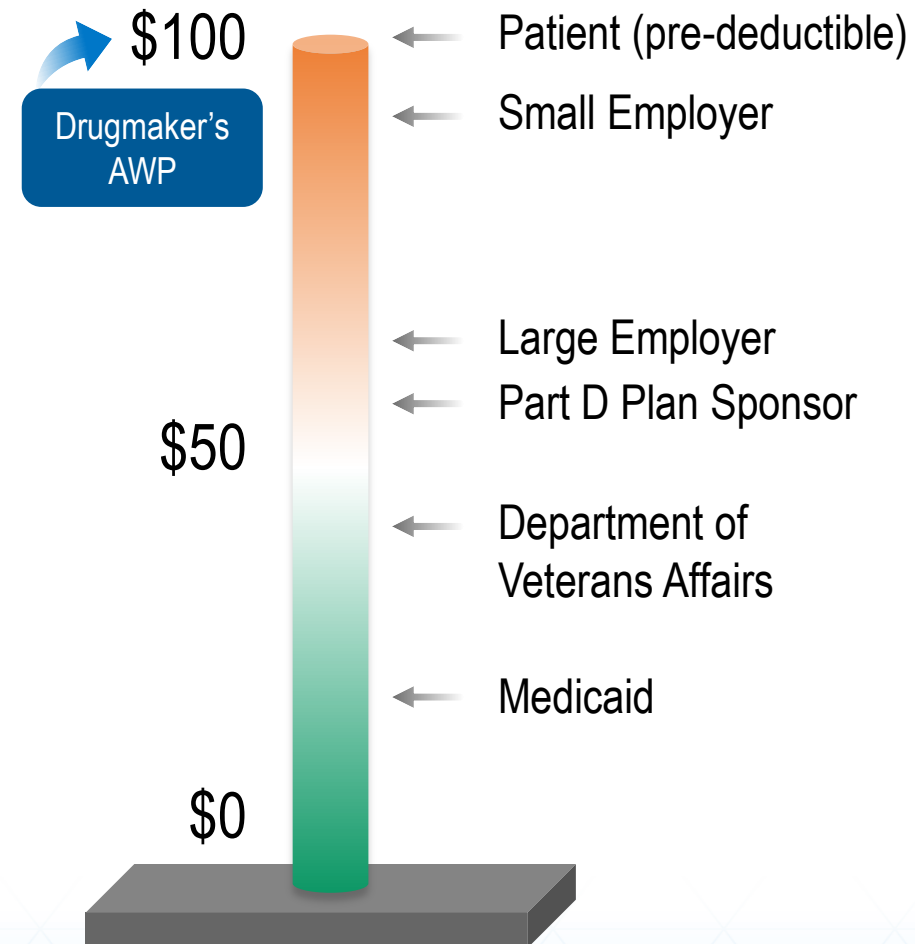
# How PBMs manipulate brand drug prices using price discrimination

**PRICE DISCRIMINATION** is a strategy that charges customers different prices for the same product based on what the seller thinks they can get the customer to agree to

PBM and Drug Manufacturer negotiate a net price, but the extent to which that net price true is passed through to a payer depends on the payer's **ACCESS TO INFORMATION** and negotiating leverage

**HIDDEN PRICE CONCESSIONS** are the key enabler allowing PBMs to capture benefits of drug price discrimination

Variation in Net Prices by Payer Type

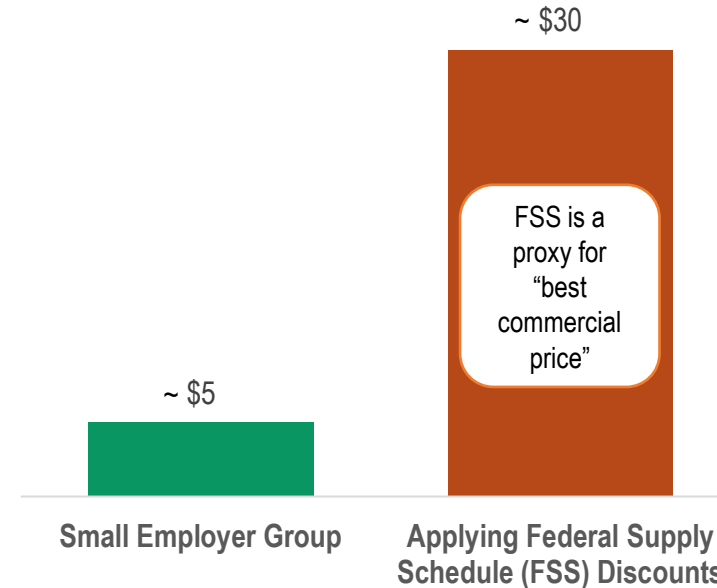


# Some small employers are getting a pittance of negotiated rebates

- ▶ 3 Axis Advisors analyzed data for a group of small self-insured employers
- ▶ Total group spending on brand name drugs exceeded \$110 million in 2018
- ▶ On that spend, we identified only ~\$5 million in rebates
- ▶ In a world free from drug price discrimination, where all employers received the “best commercial price”, **their rebates would have been roughly 6x higher**
- ▶ PBMs (and/or affiliated insurance companies) appear to have retained these rebates

## Small Employer Group 2018 Rebates (in Millions)

*Actual vs. Federal Projected*



Source: 3 Axis Advisors analysis



# PBM Affiliated Pharmacies



# PBMs and Health Plans nearly all have affiliated specialty pharmacies

- ▶ Specialty drugs represent <1% of all claims, but make up 33% of drug spend
  - Based on 2018 Medicare Part D drug spending\*
- ▶ Nearly all PBMs and health plans own their own specialty pharmacies
- ▶ PBMs use contracts to drive drug fills to their affiliated pharmacies
- ▶ There is standard definition for a specialty drug, so PBMs can define as they see fit

| PBM / Health Plan                      | Affiliated Specialty Pharmacy |
|--|-------------------------------|
| CVS / Caremark / Aetna                 | CVS Specialty                 |
| Cigna / Express Scripts                | Accredo                       |
| UnitedHealth / Optum                   | BriovaRx                      |
| Centene                                | AcariaHealth                  |
| WellCare (acquired by Centene in 2019) | Exactus                       |
| Humana                                 | Humana Specialty              |

# PBMs are steering specialty drugs, and then overpaying themselves on them

- ▶ 3 Axis has investigated specialty pharmacy steering and drug mispricing for small commercial payers
- ▶ We found that “cheap” generic drugs were filled at pharmacies affiliated with a PBM/Health Plan only 11% of the time, with a \$26 profit to the pharmacy
- ▶ Meanwhile, “expensive” generic drugs were filled at pharmacies affiliated with a PBM/Health Plan 51% of the time, with a \$3,448 profit to the affiliated pharmacy
- ▶ Employers have no way of knowing if they are getting fair prices for specialty drugs as the PBM is removing all pharmacy competition

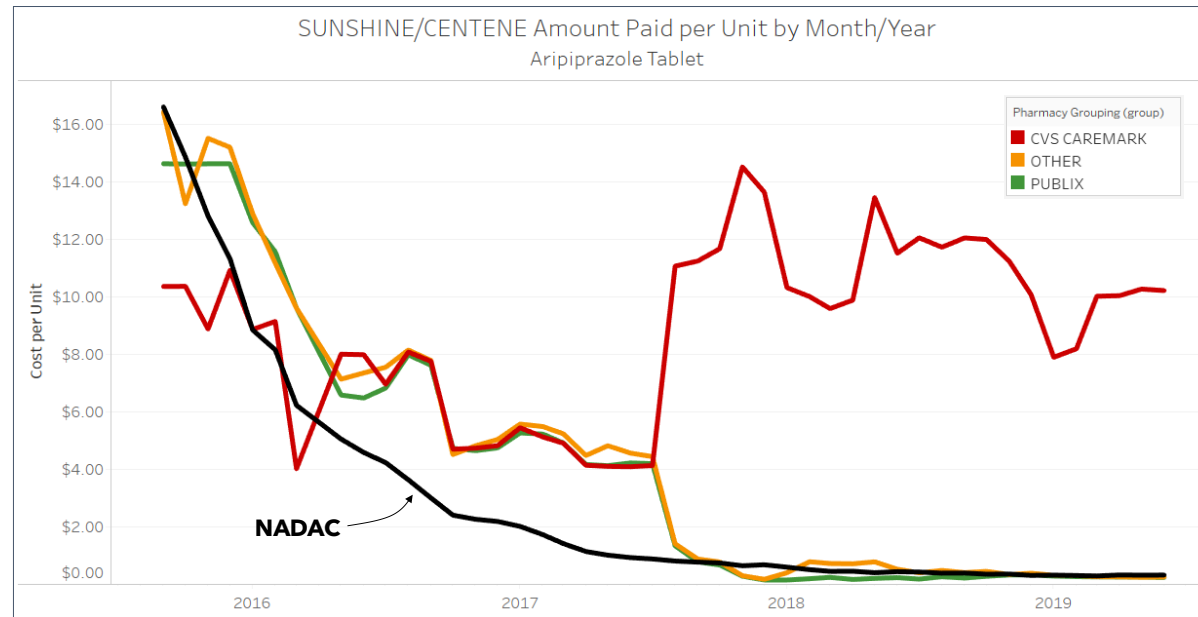
| <b>Small Commercial Payer Analysis</b>                              |                              |                              |
|---|------------------------------|------------------------------|
|   | <b>&lt;\$1,000 per claim</b> | <b>&gt;\$1,000 per claim</b> |
| <b>Percent of generic drug claims filled at affiliated pharmacy</b> | 11%                          | 51%                          |
| <b>Gross profit per generic drug claim</b>                          | \$26                         | \$3,448                      |

# Why it matters: Differential generic drug pricing

In 2017, Caremark joined Envolve (owned by Centene) as the provider of Sunshine's (owned by Centene) PBM services in Florida

The same month, Caremark dramatically increased the rates reported on claims dispensed at its affiliated CVS pharmacies on generic Abilify - Florida Medicaid's #1 spend generic antipsychotic drug

At the same time, it dramatically reduced the rates paid to all other pharmacy groups in the state.



**Overall, in 2018, 94% of the margin (revenue above acquisition cost) reported on generic drug claims by Sunshine/Centene was reported on claims dispensed at CVS pharmacies.**

<https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management>

# Why it matters: Differential generic drug pricing & steering

In Ohio, after spread pricing was eliminated in Medicaid, PBMs began overpaying pharmacies on specialty drugs, which PBMs tend to steer through their own pharmacies.

This enabled PBMs to margin-shift dollars from spread to specialty medications filled at their affiliated pharmacies.

These problems persist today, but are by no means unique to Ohio and by no means unique to Medicaid programs.

## Special prices

CVS Caremark already was charging a healthy price markup in providing specialty prescription drugs to some Ohio pharmacies through the Medicaid program in 2018. But when the state removed the pharmacy benefit manager's "spread pricing" revenue stream in 2019, the prices went way up — far above the National Average Drug Acquisition Cost maintained by the federal government. The move by CVS' PBM presumably benefited the company greatly because it requires many specialty drugs to be bought from CVS' own pharmacies. The prices below are per pill.

| Specialty drug              | 2018 price for Ohio | 2018 US avg price | 2018 markup | 2018 % markup | 2019 price for Ohio | 2019 US avg price | 2019 markup | 2019 % markup |
|-----------------------------|---------------------|-------------------|-------------|---------------|---------------------|-------------------|-------------|---------------|
| SILDENAFIL 20 MG TABLET     | \$3.45              | \$0.24            | \$3.21      | 1,338%        | \$3.90              | \$0.16            | \$3.74      | 2,338%        |
| IMATINIB MESYLATE 400MG TAB | \$120.00            | \$83.00           | \$37.00     | 45%           | \$270.00            | \$14.50           | \$255.50    | 1,762%        |
| ENTECAVIR 0.5 MG TABLET     | \$5.70              | \$4.21            | 1.49        | 35%           | \$30.00             | 1.86              | \$28.14     | 1,513%        |
| CAPECITABINE 500 MG TABLET  | \$7.40              | \$5.40            | \$2.00      | 37%           | \$29.00             | \$3.33            | \$25.67     | 771%          |
| TACROLIMUS 5 MG CAPSULE     | \$2.20              | \$2.86            | \$(0.66)    | -23%          | \$3.50              | \$1.52            | \$1.98      | 130%          |
| OTEZLA 30 MG TABLET         | \$51.00             | \$49.88           | \$1.12      | 2%            | \$58.00             | \$54.75           | \$3.25      | 6%            |

SOURCE: DISPATCH ANALYSIS OF MEDICAID PRESCRIPTION DATA FROM SOME THREE DOZEN OHIO PHARMACIES

Reference: <https://www.46brooklyn.com/research/2019/4/21/new-pricing-data-reveals-where-pbms-and-pharmacies-make-their-money>;  
<https://www.dispatch.com/news/20190430/ohio-medicaid-officials-to-crack-down-on-pbm-specialty-drug-practice>

# 3ΔXIS Advisors

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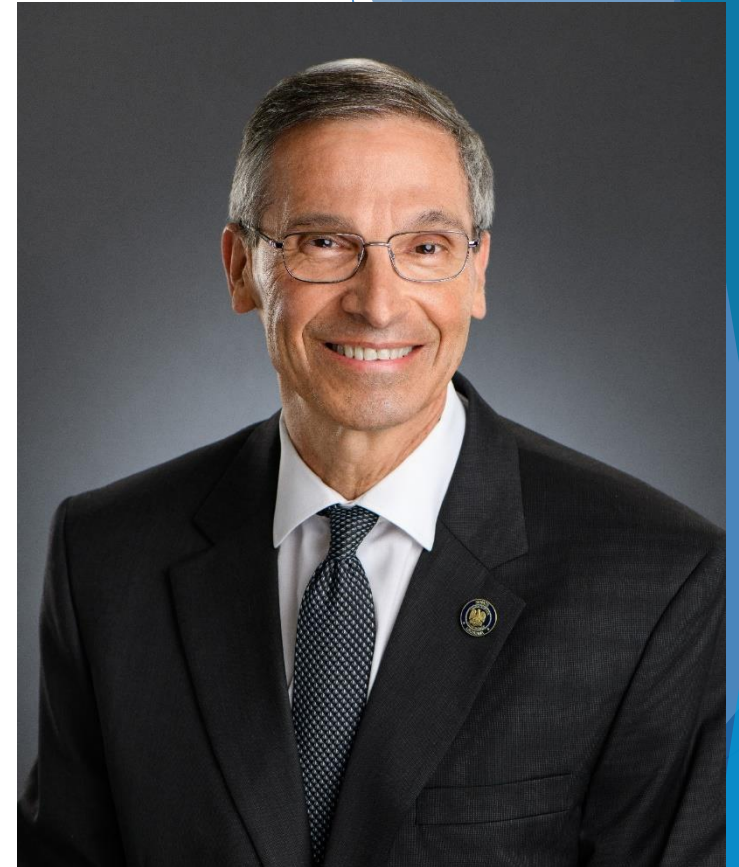
Twitter: [@A\\_Ciaccia](https://twitter.com/A_Ciaccia)



## NCSL Webinar

### Pharmacy Benefit Managers (PBMs) and Options for State Legislatures

January 28, 2021



Senator Fred H. Mills, Jr  
Louisiana Senate District 22

Chairman, Committee on Health  
and Welfare

# Why are states forced to legislatively address the PBMs?

## ▶ PBMs Are Unregulated

- ▶ “Although LDI (Louisiana Department of Insurance) has the discretion to conduct regulatory reviews of PBMs, it has not conducted any.” - *Louisiana Legislative Auditor; Performance Audit; 5/2/2018.*

## ▶ PBMs Hide Behind ERISA and “Plan Design”

- ▶ “There’s going to be some aspects of healthcare that the State of Louisiana just can’t touch . . .ERISA . . .the federal government jealously guards their territory. . .when you try to invade that territory the federal government pushes back on the states. . . we are not able to let the states change that.. .there is just no way to overcome ERISA preemption. **There is a relatively small number of PBMs over which the state of Louisiana can exercise its sovereign authority.**” - *CVS Health Opposition to SB 41; 5/21/2019*

## ▶ PBMs Cost State Medicaid Programs Billions of Dollars

- ▶ Louisiana Medicaid expended nearly \$100 million in “spread pricing” in just two years. - *Myers and Stauffer; LDH Medicaid Managed Care MLR Audits; Issued 2017, 2018)*

RPh KW Tech Rx Edit/Label Login: KW

Patient [REDACTED] Phone [REDACTED] Rx # 521492  
 Doctor [REDACTED] DCB [REDACTED] Rf # 1  
 Phone [REDACTED] NPI 1114002698  
 SN APO4678

Drug\*DESVENLAFAXINE SUC ER 100 M Onhand 0 Last Qty 30 On 04/02/19

C-ESIBLA (PRIMARY PLAN)

|       |       |  |
|-------|-------|--|
| \$    | 30.88 | Ingredient Cost: INGREDIENT COST PAID AT MAC PRICE |
| \$    | .10   | Dispensing Fee                                     |
| \$    | .00   | Incentive Amount                                   |
| \$    | .00   | Service Fee  |
| \$    | .00   | Other Payor Recognized                             |
| \$    | .00   | Other Amounts                                      |
| \$    | .00   | Percentage Tax                                     |
| \$    | .10   | Flat Tax   |
| ===== |       |  |
| \$    | 31.08 | Total Amount                                       |
| \$    | 21.08 | Plan Pays \$10.00 Copay                            |
| \$    | 10.00 | Patient Pays                                       |

 Drug Claim Detail

|  |             |            |           | Amount Charged | - | Plan(s) Discounts & Payments | =         | Your Responsibility |                    |
|--|-------------|------------|-----------|----------------|---|------------------------------|-----------|---------------------|--------------------|
| Drug Name/ Claim Number                                | Date Filled | Filled By  | See Notes |                |   | Not Covered                  | Plan Paid | Deductible          | Copay/ Coinsurance |
| IBU<br>Quantity: 30<br>190985144800                    | 4/2/2019    | [REDACTED] | A         | \$4.49         |   | \$0.00                       | \$0.10    | \$0.00              | \$4.39             |
| DESVENLAFAXINE SUCCINA<br>Quantity: 30<br>190985146000 | 4/2/2019    | [REDACTED] | A         | \$172.49       |   | \$0.00                       | \$162.49  | \$0.00              | \$10.00            |
| <b>TOTAL</b>   |             |            |           | \$176.98       |   | \$0.00                       | \$162.59  | \$0.00              | \$14.39            |
| <b>Amount You May Have Paid</b>                        |             |            |           | \$176.98       | - | \$162.59                     | =         | \$14.39             |                    |

**Claim Notes**  
 A - Any payment made to you may be owed to your provider.



# Louisiana PBM Laws

For more than 15 years, the Louisiana Legislature has tried to legislatively manage the ever-evolving PBM business practice.

**2005-2017** multiple laws enacted on consumer Rx payment, pharmacist reimbursement, pharmacy record audits/payment recoupments, price calculation, provider fees, claim liability, and MAC.

## 2018

- ▶ SB 29 (Act 423) requires a single uniform prescription drug PA form.
- ▶ SB 108 (Act 482) Medicaid MCO transparency report to include specific PBM data.
- ▶ SB 130 (Act 483) Medicaid funded PBM services shall be limited a transaction fee only; the PBM shall not retain any portion of state or state supplemental rebates, state credits, or "spread pricing" charges reflective of over-inflated billing to the managed care organization.
- ▶ SB 241 (Act 317) prohibits PBM from imposing contract "gag orders" on pharmacists.
- ▶ SB 282 (Act 579) notice to enrollees that the insurer is shifting an excess consumer cost burden onto the patient and not sharing the benefit of the rebates offered to the insurer by the pharmaceutical manufacturers at the point of sale.
- ▶ SB 283 (Act 371) transparency report requiring PBMs to report to the commissioner of insurance the aggregate amount of certain data elements including rebates received from pharmaceutical manufacturers, administrative fees charged, and rebates received and not passed through to the insurer.

## 2019

- ▶ HB 433 (Act 161) allows a pharmacist to decline to fill a prescription if the patient's PBM or MCO reimburses an amount less than what the pharmacist paid for the drug as long as the pharmacist directs the patient to another pharmacy that can fill the prescription.
- ▶ HB 538 (Act 167) when a PBM audits a Louisiana pharmacist for purposes of clinical judgment, the audit must be in consultation with a LA Licensed pharmacist.

# SB 41 “Pharmacy Benefit Manager Licensing Law” ACT 124 of the 2019 Louisiana Legislature

- ▶ Intent is to have meaningful licensure, permitting, and monitoring of PBMs
- ▶ Prohibits “spread pricing” unless the PBM provides written notice of the practice to members
- ▶ Grants the Louisiana Board of Pharmacy the authority to regulate PBMs; issuance or permits
- ▶ Continues to provide for regulation by the Department of Insurance
- ▶ Creates the PBM monitoring advisory council
- ▶ Random compliance audits
- ▶ Enforcement
  - ▶ LDI for Insurance Code Violations
  - ▶ Board of Pharmacy for Louisiana Pharmacy Practice Act Violations
- ▶ Monthly reports to the Attorney General on PBM complaints
- ▶ Prohibits unfair and deceptive trade practices
  - ▶ Buy, sell, or trade beneficiary information
  - ▶ Participate in “spread pricing”
  - ▶ Patient steering to a pharmacy in which the PBM has an ownership interest
  - ▶ Retaliation or attempts to influence the patient; inducements for specific retailers
  - ▶ Retroactively deny or reduce an approved claim
  - ▶ Reimburse local pharmacies less than chains
  - ▶ Failure to update prices
  - ▶ Failure to honor MAC
  - ▶ Failure to pay taxes to the taxing authority
  - ▶ Restrict early refills
  - ▶ Require step therapy
  - ▶ Engage in drug repackaging and markups

# Action Steps for Legislators Concerned with PBMs

- ▶ Talk to your local healthcare providers. Ask your physicians and pharmacists about how the PBMs have made caring for your constituents harder over the years. Ask about prior authorizations, substitutions, steering, reimbursement, audits, and denials. Get hard numbers.
- ▶ Talk to your Medicaid director and ask if they have seen any budget reductions or quantifiable savings in their pharmacy program or if their populations are healthier because of the PBMs.
- ▶ Talk to your Medicaid fiscal officer and pharmacy director to find out the real dollar amount for prescription drugs that are “spread” between the PBM and the MCO (which are most often subsidiaries of each other) and how that inflates the PMPM your state is paying for patient care.
- ▶ Talk to your fellow legislators about their personal experience with a PBM. You have probably all had an encounter where a PBM intervened in the doctor - patient relationship you have with your own physician.

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# Maryland Competitive Pharmacy Benefits Manager Marketplace Act 2020

Delegate Bonnie Cullison  
NCSL Webinar

Pharmacy Benefits Managers (PBMs) and Options for State Legislatures  
January 28, 2021

# Legislative Intent

- Build upon Maryland General Assembly's efforts to control costs of pharmaceuticals for State Employee and Retiree Health and Wellness Benefit programs



- Increase legislative control over the procurement of pharmaceuticals in a way that was aligned with Federal regulations

# Rationale

- New Jersey program was cited in the discussion of the Prescription Drug Affordability
- The information from New Jersey leaders on the savings they had incurred since implementation



# Current RFP Process

- Request for proposal includes few details about needs of program—heavy reliance on PBMs to define their processes, reimbursements and pricing contracts
- Each PBM is unique with respect to purchasing and reimbursement contracts so it is impossible to compare them
- Decisions often based on previous interactions and faith in the knowledge and expertise of the PBMs





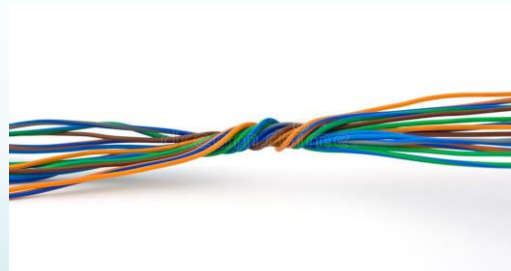
# Reverse Auction

- State defines the contract terms based on intensive analysis of needs and utilization
- PBM bidders respond based on the terms of the contract
- State technology platform translates each bid in terms of how they meet contract terms
- Lowest bid is shown to each bidder at the end of each round, who are offered the opportunity to rebid
- Bids are evaluated based on financial costs and qualitative factors identified in the contract



# Requisite Technology

- Department of Budget and Management consults with Departments of Information and Technology and General Service to procure a technology platform that can complete the intensive analysis of need, translate the PBM bids AND monitor and evaluate the performance of the PBM



# Other Potential Beneficiaries

- The following health plans in the State may use the reverse auction process individually or collectively as a joint purchasing group with the State Employee and Retiree Health and Welfare Benefits Program
  - other State-funded health plans
  - a self-funded county, municipal, or other local government employee health plan;
  - a public school employee health plan;
  - and a health plan of a public institution of higher education

# Contingency Plan

- Bill went into effect on June 1, 2020
- If implementation not administratively feasible, can delay one year to 2022
- If needed, Board of Public Works may approve a request for exemption from specific procurement requirements

# Support

- Prescription Drug Affordability Board
- Office of the Attorney General
- Maryland Citizen's Health Initiative
- AFSCME 3—representing State Employees
- Baltimore County Executive and Council
- Maryland State Education Association (MSEA)—representing 70K+ educators

# Opposition

- EPIC—representing small independent pharmacies in the State
- (Their opposition was removed when the bill was amended to require an analysis of the impact of the program on reimbursement to pharmacies)

# Current Steps

- Investigating possible technology platform vendors
- Gathering data on utilization
- Moving forward during a pandemic

# Contact

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# QUESTIONS AND DISCUSSION

THANK YOU!

Follow up questions?

Contact: [Health-info@ncsl.org](mailto:Health-info@ncsl.org)



NATIONAL CONFERENCE OF STATE LEGISLATURES