MEMORANDUM

TO: Honorable Members, Assembly Appropriations Committee
Lisa Murawski, Staff Consultant

FROM: April Alexander, Senior Director, State Affairs
Pharmaceutical Care Management Association (PCMA)

DATE: May 17, 2017

RE: Oppose AB 315, as amended May 10, 2017: Costly to MediCal, CalPERS and Commercial Health Programs

---

On behalf of PCMA, we must respectfully oppose AB 315 and highlight the cost impact to the state and to health programs within the state. PCMA is the national trade association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through large employers, health insurance plans, labor unions, state government health programs, and Medicare Part D. PCMA believes that AB 315 will have significant cost impact on health programs and state administration, in the following ways:

1. **AB 315's disclosure requirements could raise drug prices, impacting MediCal and CalPERS.**

AB 315 mandates significant disclosures to PBM clients (often called "payers" or "plan sponsors"). PBM clients are large sophisticated purchasers of prescription drug benefits that often provide health care across state lines. They are health insurers, health plans, labor trusts, and state purchasers like CalPERS. There are over 80 PBMs in the country and these PBMs compete fiercely in the market place. If clients want specific information relevant to their business, they can, and do, secure that information through contract. They are also able to audit their contracts to ensure that the PBM is providing the service promised. Today, the clients negotiate and structure their contracts in the way that best suits their needs, for instance, one client may want to receive all the pharmaceutical manufacturer rebates associated with their plan, while another may want to use their rebates to off-set their plan's administrative fees. This bill takes away a client's flexibility to build a PBM contract how they want and forces disclosures of information that a client may not want or need. As the Assembly Health Committee's analysis on AB 29 points out, the FTC says that "mandatory disclosure requirements may hinder the ability of plans to negotiate an efficient level of disclosure with PBMs."

These disclosure reports, in the wrong hands, could be very damaging to the current competitive market place. PCMA is concerned that the information in the reports could become public, allowing drug manufacturers insight into their competitors' discounts and rebates. For example, the bill requires disclosure of rebates and acquisition cost by "therapeutic class." The fewer drugs there are in the class, the easier it will be for manufacturers to "back into" the average rebate amount for each drug. Again, the Assembly Health Committee analysis of AB 29 quotes the FTC: "[I]f such disclosures publicly reveal previously proprietary and private information about discounts negotiated with PBMs, disclosure may result in less aggressive pricing by, or even collusion among, pharmaceutical manufacturers."

The result will be lower discounts, lower rebates and higher drug prices for commercial health coverage and coverage for state employees. Further, as prescription prices go up in the commercial space, federal Medicaid "best price" will go up, too, meaning higher costs in Medicaid (MediCal). In short, rising prices in the commercial market also impacts public programs.

Please see attached letter on AB 29 for more detailed concerns on this provision.

2. **Per the FTC's analysis on a similar provision, AB 315's exemption of plans with in-house PBMs may encourage a shift to integrated systems, which may increase plan costs.**

Section 152002 of the bill exempts health plans or their affiliated companies from the disclosure requirements if the plan offers PBM services and if those services are offered only to enrollees of that plan. [1]

The FTC found that language in AB 1960 (Pavley 2004) that is nearly identical to language in AB 315 could ultimately increase health plans' and health insurers' costs of administering pharmacy benefits through non-integrated PBMs.[2] AB 315 would encourage health plans and health insurers to bring pharmacy benefit management services "in-house." The FTC further stated that, "to the extent that this… would cause firms that would prefer to turn to the market for PBM services to instead provide such services internally… it will induce inefficiency and may well increase the cost of PBM services. As before, increases in the cost of PBM services may well lead to increases in health insurance premiums and reductions in the availability of insurance coverage for pharmaceuticals."[3]

3. **AB 315 encourages pharmacists to file complaints about PBMs to DMHC's Provider Complaint Unit, which is in place to deal with reimbursement issues only. An expansion of this authority will raise DMHC costs.**

Section 152214 of the bill authorizes a pharmacy to report to the DMHC provider complaint line when the pharmacy "believes a PBM is engaging in a violation of" the PBM-pharmacy contract provisions of the bill.[4] According to the DMHC, the "Provider Complaint process is offered as a primary means of ensuring prompt payment [to providers]." This new law would require the Provider Complaint Unit to investigate issues unrelated to payment issues and opens its responsibilities up to investigating other areas of PBM activity. We assume that pharmacies—which openly view PBMs as competitors to pharmacists—will advertise this provision and the provider line will see increased calls. Since existing DMHC Provider Complaint Unit staff investigates payment issues only, staff will have to be trained to respond and investigate new issues, which will be done only through increased costs to DMHC.

---

[1] See AB 315, Page 4, lines 25-37.
[2] Letter from FTC to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-comment-hon.greg-aghazarian-concerning-ca.b.1960-requiring-pharmacy-benefit-managers-make-disclosures-purchasers-and-prospective-purchasers/v040027.pdf (hereinafter "FTC Letter to Aghazarian.").
[3] Id.
[4] See AB 315, page 9, lines 5-10.

4. **AB 315 allows DMHC to revoke or suspend a PBM license but leaves details like the legal standard and due process up to Department regulations, which will be extensive and costly to create.**

Section 152114 of AB 315 allows the DMHC to suspend, revoke or place on probation a PBM under certain circumstances.[5] Subsection (2) states that a license can be revoked based upon complaints that "justify an action" to revoke the license, but provides no standard for *proving* that a complaint or complaints justify an action. The language as drafted is vague to the point of being meaningless and will require a lengthy regulatory process to add further detail. Revoking a license would put a PBM out of business in California, meaning also that patients would lose the relationship with their PBM, likely disrupting their pharmacy benefits. Such an action cannot be done arbitrarily.

Subsection (5) states that a PBM can have its license revoked or suspended if it violates the disclosure provisions of the bill. Originally, this bill required that the disclosures be given to a state agency (the Board of Pharmacy). The author eventually dropped that language, presumably because of arguments by the FTC (see attached FTC letter dealing with the disclosure issue) that public disclosure of rebates and discounts will result in lower rebates and lower discounts, resulting in higher drug prices. But with the amendment providing DMHC with authority to enforce the disclosure provisions, it appears that the author is once again providing a pathway for the information to be shared with a state agency, because it is likely the DMHC would have no other practical way to determine whether the PBM has complied with the law. Given that there are no clear confidentiality provisions for information provided to DMHC, the risk of public disclosure of proprietary information is very real. The result will be public disclosure of proprietary information on rebates and discounts, meaning higher drug prices for all, including MediCal managed care plans and CalPERS.

From a fiscal point of view, this will be very costly because of both the DMHC oversight requirements and the threat of public disclosure of pricing information that would discourage competition and negatively impact health care consumers.

5. **AB 315's grant of authority to DMHC is overly broad and rules will be costly to enact.**

Section 152004 authorizes the DMHC to enforce the provisions of the bill and provides rulemaking authority for "any rules and regulations not inconsistent with the laws of this state…"[6] We believe this grant of authority is overly broad and open-ended. The justification for this bill has been to create a clear process for addressing consumer complaints. This DMHC authority goes far beyond that limited policy goal. For this reason, we would like to work with the author and the Chair to further understand the problem to be addressed and ensure that DMHC's authority is tailored to achieve that policy goal. Either way, from a fiscal point of view, the current version of AB 315 will require the creation of extensive regulations.

[5] See AB 315, page 7, lines 1-18.
[6] See AB 315, page 4, lines 38-40 and page 5, lines 1-2.

6. AB 315's language appears to prohibit the use of certain mail-service programs, which will raise costs for plan sponsors and consumers.

Section 152212 (b) of the bill prohibits a PBM contract from prohibiting a pharmacy from "dispensing a particular amount of a prescribed medication, if the PBM allows that amount to be dispensed through a pharmacy owned or controlled by the PBM."[7] While the language is slightly unclear, it appears that the author's intent is to prevent plan sponsors from using mandatory mail-service programs. This prohibition could impact both mail and specialty pharmacies, which provide safe, affordable high-quality services with round-the-clock patient care.

On the issue of cost savings, mail service pharmacies have been repeatedly shown to be a lower-cost dispensing channel for payers. An issue similar to AB 315's anti-mail provision was examined by this committee in 2014, when it analyzed AB 2418, which would have required health plans and insurers to allow patients to "opt-out" of a mandatory mail-service program if the plan used one. AB 315's language—or at least the intent, as we understand it—appears to be more restrictive than AB 2418. The Assembly Appropriations Committee analysis said the following about the anti-mail provision:

> *To the extent this bill precludes the ability of plans and insurers to direct enrollees, for certain drugs, to mandatory mail order or to networks of specific pharmacies with which plans have pricing agreements for certain drugs, there could be significant cost pressures to the market beyond that estimated by CHBRP. This cost pressure is likely to grow over time, as this bill will limit the ability of pharmaceutical benefits managers to use mandatory mail order, and may limit the use of narrower networks of pharmacies for certain high-cost drugs.*

The mail-service provisions were dropped from AB 2418 in the Senate and the bill was ultimately vetoed.

California is not alone in its acknowledgment that moving away from using mail service pharmacy will raise costs. In its review of PBM mail service pharmacies and relationships with payers, the FTC found that for 30-day scripts, generic drug prices were 23.9% higher at retail than at mail, and single-source brands were 13.9% higher.[8] A Visante analysis projects that mail-service pharmacy will yield a 10-year savings (2015-24) of $59.6 billion for consumers, employers, and other payers. This analysis is based on a 2013 cost analysis conducted by the Centers for Medicare and Medicaid Services that compared prescription costs at mail-service pharmacies to costs at brick-and-mortar drug stores in Medicare Part D. The agency found that costs at mail-service pharmacies were 16 percent less than drug stores across all drugs examined.[9] Additionally, when the State of Indiana reviewed legislation that would have restricted the use of mail service pharmacies, it found $8 million increased costs annually for the state employees' health benefit.[10]

---

[7] See AB 315, page 9, lines 1-4.
[8] FTC, Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies, August 2005.
[9] Centers for Medicare & Medicaid Services, "Part D Claims Analysis: Negotiated Pricing Between General Mail Order and Retail Pharmacies," December 2013, available at https://www.cms.gov/Medicare/Prescription-DrugCoverage/PrescriptionDrugCovGenIn/Downloads/Negotiated-Pricing-Between-General-Mail-Order-and-RetailPharmaciesDec92013.pdf.
[10] Indiana Legislative Services Agency, Fiscal Impact Statement for SB 359 (2012).

PCMA remains committed to helping plan sponsors provide affordable access to prescription drug benefits, but we believe that AB 315 is counterproductive to this goal. Please contact me at 916-769-2094, or our Sacramento advocate, John Caldwell, at 916-441-0702 if you have any questions or would like to discuss our position further.

Thank you.

Attachments

- PCMA Letter re: AB 29 (Nazarian)
- FTC Letter