April 17, 2019

The Honorable Brian P. Kemp
Office of the Governor
206 Washington Street
111 State Capitol
Atlanta, Georgia 30334

RE: Veto Request for HB 233 – Pharmacy Anti-Steering and Transparency Act

Dear Governor Kemp:

On behalf of the Pharmaceutical Care Management Association (PCMA), we respectfully request your veto of HB 233, the Pharmacy Anti-Steering and Transparency Act. PCMA is the national association representing America's pharmacy benefit managers (PBMs). PBMs administer prescription drug plans and operate mail-order and specialty pharmacies for more than 266 million Americans with health coverage through large employers, health insurers, labor unions, and federal and state-sponsored health programs.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans, and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

HB 233 proposes several unprecedented, wide-ranging changes to the pharmacy market in Georgia: 1) prohibiting health plans and PBMs from offering or implementing plan designs that require patients to utilize affiliated pharmacies—when patients already have a freedom of choice under Ga. Code Ann. §33-20A-9.1 and cannot be required to receive their prescription drugs through a mail-order pharmacy under Ga. Code Ann. §33-30-4.3; 2) proscribing health plans and PBMs from patient or prospective patient specific advertising, marketing, or promoting an affiliated pharmacy; 3) prohibiting proper claims payment for products and services rendered if furnished pursuant to a referral from an "affiliate"; and 4) placing core health plan and PBM operations under the regulatory authority of the Board of Pharmacy.

We believe that HB 233 will have a detrimental impact on pharmacy benefit services in the State of Georgia and respectfully ask for your veto.

Increased Plan, State, and Consumer Costs

If signed into law, HB 233 will result in increased costs to health plans operating in the individual and small group markets, the State of Georgia through the State Employee Health Benefit Plan and the Board of Regents, and ultimately Georgians who receive their health benefits through one of those plans.

HB 233 is premised on assumptions not rooted in any evidence. First, the bill says: "The referral of a patient to a pharmacy by an affiliate for pharmacy care represents a potential conflict of interest…"[1] Last September, when the Department approved the proposed merger of two health care

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corporations that operate in the PBM and insurance markets, the Antitrust Division said that the merger "is unlikely to result in harm to competition or consumers."[2] Last October, as the Department of Justice was approving the merger of two other health care corporations that operate in the PBM, retail pharmacy, and insurance markets, the Antitrust Division said that the merger would "allow for the creation of an integrated pharmacy and health benefits company that has the potential to generate benefits by improving the quality and lowering the costs of the healthcare services that American consumers can obtain."[3] The sponsors of HB 233 wrongly assume that a conflict of interest exists when PBMs or health plans "refer" patients to pharmacies that may be affiliated with that PBM or health plan. If a conflict of interest existed and had implications for consumer health care costs, the Department of Justice would not have approved two major PBM-insurer mergers in 2018 that include so-called "affiliate" pharmacy lines of business.

Second, the bill says that: "[R]eferral practices may limit or eliminate competitive alternatives in the health care services market, may result in overutilization of health care services, may increase costs to the health care system, may adversely affect the quality of health care, may disproportionately harm patients in rural and medically underserved areas of Georgia, and shall be against the public policy of this state."[4] However, PBMs work to keep drug costs down for consumers, increase access, and improve outcomes. Between 2016 and 2025, PBMs are positioned to save Georgians an estimated $19.81 billion between the state Medicaid program ($962 million), Medicare Part D ($7.07 billion), and commercial insurance ($11.77 billion).[5] PBMs achieve these savings by: negotiating price concessions from manufacturers and discounts from drugstores; and encouraging the use of generics and affordable brand medications, and reducing waste while increasing adherence to improve health outcomes.

PBM clients are sophisticated purchasers of health care services and are aware of the various lines of business that PBMs operate—and a client may hire a PBM precisely because that PBM is able to provide more than claims processing services by integrating patient care and providing access to high-quality, specialized services that will save their employees and members money. Employers, health plans, and public programs rely on PBMs to carefully design prescription drug plans for their specific patient populations. HB 233 undermines that by putting government in the middle of private contracting—in favor of independent community pharmacies.

Simply put, this bill will not save Georgians money nor will it improve their health outcomes. This bill is unnecessary and is only targeted to profit independent community pharmacies, which incidentally are economically vibrant in Georgia. As of last year, independent pharmacies comprised 33.2% of the pharmacy market in Georgia, one of the highest market concentrations in the region.[6] Between 2010-2018, the number of independent pharmacies in Georgia increased from 714 to 744, growing 4.2%. At the same time, the number of chain retail pharmacies increased by just 1.1%.[7] Furthermore, according to National Community Pharmacists Association data, over the past decade, gross independent pharmacy profits have held steady at around 23%.[8]

Improper PBM Regulation by the Board of Pharmacy

HB 233 gives the Georgia Board of Pharmacy improper regulatory authority over PBMs—and not just over their lines of business that may be regulated as nonresident pharmacies, such as mail-order or specialty pharmacies. If signed into law, HB 233 would revise the Code to give the Board of Pharmacy the authority to enforce so-called "referrals" to "affiliates," regardless of whether that pharmacy affiliate holds a nonresident pharmacy permit.

However, giving the Board of Pharmacy regulatory authority over a PBM's ability to administer the drug benefit is a conflict of interest. PBMs negotiate rates with pharmacies and audit them for fraud and abuse. Boards of Pharmacy, populated by pharmacists, cannot impartially regulate those paying their claims and auditing them for fraud. It is akin to the "fox guarding the henhouse." PBMs are not acting as pharmacies with respect to their benefits management functions. PBMs are standing in the place of employers and health plans—*payers* of pharmacy services—when they determine an enrollee's eligibility and cost-sharing, pay claims, conduct prior authorization and utilization review, and negotiate rates with pharmacies. PBMs clearly are not providing pharmacy services when they undertake these benefits management functions.

Insurer subcontractors such as PBMs are regulated by state insurance departments. As subcontractors, PBMs in their benefit management capacity are subject to the same state laws—designed to protect consumers—as are insurers. Mail-order and specialty pharmacies are already regulated as pharmacies. Mail-order and specialty pharmacies provide pharmacy *services*, which every state already recognizes and regulates them accordingly. There is a distinction, however, between these pharmacy *services* and the administrative and management functions outlined above that HB 233 would inappropriately give the Board of Pharmacy to regulate.

The Federal Trade Commission (FTC) weighed in on this issue in Mississippi, stating that "pharmacists, who negotiate retail prescription drug prices with PBMs and compete against PBM-owned mail order pharmacies, would now be regulating PBMs."[9] The FTC correctly reasoned that "[b]ecause pharmacists and PBMs have a competitive, and at times, adversarial relationship, we are concerned that giving the pharmacy board regulatory power over PBMs may create tensions and conflicts of interest for the pharmacy board."[10] The Mississippi Board of Pharmacy has never promulgated a rule governing PBMs—and in fact, the Board rescinded a rule that would have defined its regulatory authority over PBMs.

The U.S. Supreme Court struck down anticompetitive regulation in *North Carolina State Board of Dental Examiners v. FTC*,[11] ruling that a state dental board controlled by active market participants was not shielded from antitrust law.[12] The Supreme Court said that for these types of boards that are made up of market participants, states have to have in place "review mechanisms [that] provide 'realistic assurance that the nonsovereign actor's anticompetitive conduct 'promotes state policy, rather than merely the party's individual interests.'"[13] For "nonsovereign actors," such as the North Carolina Board of Dental Examiners—and state Boards of Pharmacy—the antitrust shield can be used "only if the State accepts political accountability for the anticompetitive conduct it permits and controls."[14] States have to "review the substance of the anticompetitive decision[s]," and "have [mechanisms in place] to veto or modify particular decisions to ensure they accord with state policy."[15] In sum, implementing HB 233 in compliance with the Supreme Court's ruling will require *more*—not less government.

ERISA Concerns

As drafted, HB 233 raises significant legal concerns with regard to the Employee Retirement Income Security Act of 1974. ERISA broadly preempts state laws that "relate to" ERISA-governed employee benefit plans to ensure a uniform federal regulatory scheme and to relieve ERISA plans from the burdens of satisfying a patchwork of state laws. Recently, however, several states have enacted legislation designed to regulate the contracts between PBMs and pharmacies (and between PBMs and health plans) even when the PBMs serve as third-party administrators for ERISA-governed plans. These laws and regulations run afoul of ERISA.[16]

The U.S. Supreme Court has construed ERISA's broad preemption provision as preempting any state law that has a "reference to" or "connection with" ERISA-governed plans. Under the Supreme Court's "connection with" test, ERISA preempts state laws that govern central matters of plan administration or that interfere with nationally uniform plan administration. Matters of plan administration include calculating benefit levels, making disbursements, monitoring the availability of funds, and keeping records to comply with reporting requirements. Where a state law impacts either the structure or administration of ERISA-governed plans, preemption occurs.[17]

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We stand ready to work with you, your Administration, and the General Assembly to find ways to ensure access to affordable prescription drugs in Georgia, and we urge you to veto HB 233. Thank you for your consideration.

Sincerely,

R. Scott Woods
Senior Director, State Affairs
Pharmaceutical Care Management Association

[1] HB 233, 2019-2020 Regular Session. (Ga. 2019) at Ga. Code Ann. §26-4-119(b)(1).
[2] U.S. Department of Justice. "Statement of the Department of Justice Antitrust Division on the Closing of Its Investigation of the Cigna–Express Scripts Merger." September 17, 2018. Available at: https://www.justice.gov/atr/closing-statement.
[3] U.S. Department of Justice. "Justice Department Requires CVS and Aetna to Divest Aetna's Medicare Individual Part D Prescription Drug Plan Business to Proceed with Merger." October 10, 2018. Available at: https://www.justice.gov/opa/pr/justice-department-requires-cvs-and-aetna-divest-aetna-s-medicare-individual-part-d.
[4] HB 233, 2019-2020 Regular Session. (Ga. 2019) at Ga. Code Ann. §26-4-119(b)(2).
[5] Visante. "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers." Available at: https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf.
[6] National Community Pharmacies 2017 Digest. "Region" includes Alabama (44.9%), Tennessee (36.2%), South Carolina (31.0%), and Florida (29.9%).
[7] Quest Analytics analysis of NCPDP data, January 2018.
[8] National Community Pharmacies 2017 Digest.
[9] Federal Trade Commission letter to Representative Mark Formby, Mississippi House of Representatives, (March 22, 2011).
[10] *Id.*
[11] *North Carolina State Board of Dental Examiners v. FTC*, 574 U.S. __ (2015).
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] M. Miller Baker & Sarah P. Hogarth. "ERISA Broadly Preempts State Regulation of PBM-Pharmacy and PBM-Plan Agreements." Available at: https://www.mwe.com/insights/erisa-preempt-pbm-pharmacy-pricing-agreement-2/.
[17] *Id.*