June 6, 2019

The Honorable Kathy L. Rapp
Chair, Pennsylvania House Health Committee
213 Ryan Office Building
Harrisburg, PA 17120

The Honorable Dan Frankel
Democratic Chair, Pennsylvania House Health Committee
332 Main Capitol Building
Harrisburg, PA 17120

RE: HB 941 - Medicaid Pharmacy Benefit

Dear Chairwoman Rapp:

On behalf of the Pharmaceutical Care Management Association (PCMA), I am writing you to express PCMA's concern on HB 941 (Medicaid Pharmacy Benefit). PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through large and small employers, health plans, labor unions, state and federal employee-benefit plans, and government programs.

HB 941 calls for the establishment of new requirements for plans, PBMs, and the Department of Human Services (DHS) for Medicaid, including disclosures, minimum reimbursement amounts for pharmacies, and creates language that confuses the roles of DHS, Medicaid managed care organizations (MCOs), and PBMs.

Last fall, changes made to contracts between DHS, MCOs, and PBMs brought greater transparency to these relationships and to the Medicaid program, and created significant reporting obligations for PBMs and MCOs on pharmacy encounters, including reimbursements. Essentially, DHS identified areas where it wanted better clarity in pharmacy benefit management relationships, and amended its contracts with MCOs accordingly. DHS is now getting a wealth of information on pharmacy encounters, spread pricing, administrative fees, and supplemental rebates. The federal Centers for Medicare and Medicaid Services (CMS) also recently provided guidance to MCOs on how to report PBM spread to ensure that there is correct accounting of administrative and medical services. Some of the new DHS contract requirements are restated in HB 941 and thus those provisions of this bill are an unnecessary mandate on DHS. However, this bill goes significantly beyond those contract changes.

Most notably, HB 941 establishes minimum reimbursement rates for pharmacies in both fee-for-service and managed Medicaid that (1) are significantly higher than current rates; (2) replace competitive pricing, which is cost-deflationary, with reimbursements based on invoice costs,

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which are cost inflationary[1]; and (3) are written in HB 941 in a way that confuses the roles of DHS, MCOs and PBMs.

HB 941 changes the reimbursement methodology to the lesser of the NADAC amount, plus the CMS dispensing fee rate (currently $10 per prescription) or the Usual & Customary (U&C) price (also known as "cash" price, which has the pharmacy's overhead and profit built into it). Currently, Medicaid reimburses pharmacies based on "lesser of" logic, which includes other factors, including NADAC, U&C, the state's or MCO/PBM's maximum allowable cost, or an AMP-based Federal Upper Limit methodology. This is common practice across the country in both fee-for-service and managed Medicaid. The "lesser of" logic using many different pricing benchmarks ensures that the state is not overpaying for its prescription drugs.

NADAC and U&C are typically on the higher-cost side of these benchmarks, so any mandate to base reimbursements on these benchmarks are likely to increase state costs. Federal law requires states to pay Medicaid MCOs actuarially sound capitation rates that are expected to cover the medical costs and reasonable administrative costs. Any reimbursement mandate that increases medical costs will necessarily result in higher capitation rates for MCOs, ultimately funded by taxpayers. Because the reimbursement methodology established in HB 941 uses benchmarks that are on the higher end of pricing, there would be a significant spike in pharmacy costs, raising state Medicaid costs, likely by hundreds of millions of dollars annually. This mandate would simply enhance pharmacy margins at the expense of taxpayers.

For medications that do not have a listed NADAC price, HB 941 would mandate a payment rate set at the Wholesale Acquisition Cost (WAC) of the drug. This would result in a substantial increase in payments to pharmacies, since the current rate set in the fee-for-service program for drugs without a NADAC price is WAC minus 3% for brands and WAC minus 50.5% for generics. This legislation could result in an immediate increase in payments for some medications by 3% for brands and over 50% for generics. Reimbursement for specialty drugs would be based on a national survey-based reference price. It is unclear what this reimbursement methodology would be, as NADAC does not include specialty drugs in the price surveys. Without knowing upon which pricing benchmark these reimbursement rates would be established, it is impossible to evaluate the financial impact of this policy.

HB 941 also requires *DHS* to reimburse pharmacies in both fee-for-service and managed care system at these minimum rates. However, MCOs (or through their PBM partners) are the ones that actually are responsible for processing claims and managing reimbursement for services provided to beneficiaries in Medicaid Managed Care. This language confuses the role of DHS, MCOs, and PBMs.

Finally, HB 941 creates a new, variable "care management fee" for pharmacies that provide certain services for patients taking specialty drugs. While some specialty pharmacies do provide enhanced services including care management for patients, assistance with administering medications, and offer special handling of drugs when needed, among other services, it is unclear

[1] *See*, David A. Hyman, H. Ross & Helen Workman Chair in Law, The Adverse Consequences of Mandating Reimbursement of Pharmacies Based on Their Invoiced Drug Acquisition Cost, University of Illinois, January 2016.

what this new fee is and what program it covers. PCMA would need more info to assess the need and additional costs to cover this fee.

Ultimately, HB 941 appears to be a policy focused on benefitting pharmacy profits, rather than protecting consumers or taxpayers, and raises more questions than answers on administration of the benefit. It is for these reasons that at this time, PCMA respectfully opposes HB 941 and requests a discussion with House policy staff and the Chair to go over questions and concerns. Our local counsel, Mike Kriner, will follow up. Thank you for your consideration.

Sincerely,

April C. Alexander
Assistant Vice President, State Affairs

cc: House Health Committee Members

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