Senate Bill 2008
$1 Billion in New Healthcare Costs for Patients and Employers

SB 2008 Mandates Will Result in $1 Billion Additional Costs to IL Patients and Employers

- Employers, Illinois' Medicaid program, and other plan sponsors hire Pharmacy Benefit Managers (PBMs) to control the cost of providing high quality, affordable prescription drug coverage. Over the last five years, PBMs have saved the State of Illinois and taxpayers nearly $340 million. The special interest mandates in SB 2008 add over **$1 billion in increased spending** leaving Illinois' employers and taxpayers to bear those costs while getting nothing in return.

- This $1 Billion increase in spending is not hyperbole. SB 2008 adds these additional costs through mandates requiring inflated payments to pharmacies, eliminating the use of cost-effective pharmacy networks, prohibiting pharmacy accreditation standards for complex and costly medications, and inappropriately designating PBMs as fiduciaries to their clients.

- **Enacting just one component of the bill, requiring employers and other plan sponsors to pay pharmacies an inflated dispensing fee of $8.85 on every prescription, would cost employers, health plans and Illinois Medicaid program $500 million and $210 million, respectively.**

Prohibiting Plan Designs Offering More Affordable Dispensing Channels
10 Year Increase in Prescription Drug Spending: $4.8 Billion

- SB 2008 creates an "any willing provider' (AWP) requirement for pharmacy networks which will gut the ability of health plans and employers to create preferred pharmacy networks. PBMs contract with independent, chain, mail-order, and specialty pharmacies to provide patients with access to a range of high-quality pharmacies while balancing savings for patients and payers.

- This legislation does nothing to lower drug costs or broaden access for patients. In fact, SB 2008 would prohibit employers from designing a benefit that incentivizes patients to use more affordable mail-service, retail, and specialty pharmacies with lower out of pocket costs for patients.

- Plan sponsors are aware of the various lines of business PBMs operate and may be hired precisely because that PBM is able to provide more than claims processing services and create additional value through the use of mail-service and specialty pharmacies. It is the plan sponsor, not the PBM who makes decisions regarding cost-sharing requirements, the use of mail-service and specialty pharmacies, and other factors that go into designing a benefit. SB 2008 eliminates the ability for plan sponsors to use these cost saving tools.

- AWP requirements significantly reduce incentives for pharmacies to engage in price competition, leading to higher out-of-pocket costs for patients. PBMs require pharmacies to compete on service, price, convenience, and quality to be included in preferred networks. Research has shown that if all

commercial health plans adopted preferred pharmacy networks, drug spending would be reduced by more than $1.3 Billion[1].

- When the mandates contained in SB 2008 are applied to specialty pharmacies, the consequences are even greater. Specialty pharmacies dispense low volume, high cost drugs that target rare conditions. PBMs actively work with payers to identify specialty pharmacies that can best serve patient and healthcare provider needs including 24/7 access to pharmacists and clinicians trained in the care of complex, specific disease states.

- A recent survey found that 2% percent of specialists who work with specialty pharmacies believe that all drug stores "have the expertise and capability to provide the different types of specialty medications to patients."[2]

- SB 2008 prohibits accreditation for specialty pharmacies beyond those established by the Illinois Food, Drug, and Cosmetic Act. Without robust accreditation programs, patient safety and the integrity of costly specialty medications could be compromised if payors are forced to contract with pharmacies that are ill-equipped to handle these types of drugs.

Designating Pharmacy Benefit Managers as Fiduciaries
10 Year Increase in Prescription Drug Spending: $6 Billion

- SB 2008 inappropriately designates PBMs as fiduciaries to their health carrier clients. Imposing a fiduciary mandate would end up increasing drug costs due to the restrictions that would be placed on effectively implementing cost management tools for their clients.

- According to the Department of Labor (DOL), Third Party Administrators, such as PBMs "have no power to make any decisions as to plan policy, interpretation, practices or procedures, but who perform administrative functions for an employee benefit plan….are not fiduciaries to the plan".[3] Additionally, PBMs do not have "discretionary authority" over a plan's assets, a key threshold requirement for fiduciary status under federal law.

- Imposing the fiduciary mandate in SB 2008 would also create conflict between a PBMs' contractual obligations to their clients and patients. For example, a contract with a fiduciary mandate may call for the use of PBM tools such as prior authorization or step therapy that are designed to reduce costs for ALL participants, but which may result in higher costs or less access to a given drug for a particular group of patients.

[1] 'One Percent Steps': Promoting Preferred Pharmacy Networks. Starc, Swanson. Columbia University (2021)
[2] North Star Opinion Research, https://www.pcmanet.org/wp-content/uploads/2016/08/pr-dated-06-15-15-final-ny-specialty-pharmacy-summarymemo.pd
[3] 29 CFR 2509.75-8 - Questions and answers relating to fiduciary responsibility under the Employee Retirement Income Security Act of 1974.