Senate Bill 2008

Will Cost Illinois Patients, Employers, and Health Plans

Over $1 Billion Annually

$500 Million Dollars in Increased Dispensing Fees
$670 Million in Prescription Drug Costs

The core mission of pharmacy benefit managers (PBMs) is to reduce prescription drug costs for health plan sponsors so that consumers have affordable access to needed prescription drugs. PBMs offer a variety of services to their health-plan-sponsor clients and patients that improve prescription adherence, reduce medication errors, and manage drug costs.

Section 513b1 (l and n) Reimbursement Mandate: Requiring PBMs to reimburse pharmacies at mandated levels of the National Average Drug Acquisition Cost (NADAC) plus a dispensing fee at least equal to the Medicaid fee-for-service rate of $8.85 will cause spending on prescription drugs to soar.

Enacting just one component of the bill provision could cost the state of Illinois over **$500 million in increased dispensing fee spending** in the first year alone, a **300% increase** for Illinois patients, employers, labor unions, and health plans. Over the next 5 years, these increased costs could be in excess of **$2.5 billion**.

Mandating an $8.85 dispensing fee on every prescription filled using commercial insurance will lead to skyrocketing costs year-over-year for the 7.3 million people in Illinois covered by commercial health insurance. Research also shows that mandating reimbursement at NADAC levels will cause drug spending to go up,[1] adding to the hundreds of millions of dollars in extra costs.

This bill amounts to a big government payout that goes to pharmacies. A 300% increase in fees that a pharmacy charges health plan sponsors to fill every prescription will end up costing Illinois employers and patients big money.

Projected 1-Year and 5-Year Increases in Prescription Drug Dispensing Fee Spending in Illinois Commercial Insurance Market Due to Adopting Proposed Policy

	Fully Insured, Self-Insured, and Non-Group Prescriptions (2019)	1-Year Increased Costs	5-Year Increased Costs
Increased Dispensing Fee Spending	73,619,807	$504,295,678	$2,521,478,390

Methodology: A $2 dispensing fee was assumed for all prescription fills,[1] increased costs for dispensing fees is the difference between all prescriptions filled with a $2 dispensing fee and all prescriptions filled with a $8.85 dispensing fee. Count of prescription fills was held constant at 2019 levels. Given trends of year-on-year increasing prescription utilization, this is likely an underestimation of costs associated with increasing the dispensing fee to $8.85 per prescription.
Data: Commercial market prescriptions is the number of prescriptions filled at retail pharmacies in Oklahoma using commercial group and non-group insurance in 2019 from Kaiser Family Foundation "Number of Retail Prescription Drugs Filled at Pharmacies by Payer." This count does not include prescriptions filled at other types of pharmacies, and is likely an undercount of the total number of prescriptions filled in Illinois using commercial insurance. Prescriptions filled using commercial insurance also includes ones covered by some government programs including Children's Health Insurance Program (CHIP), Veterans Administration (VA) and Indian Health Service, which are not covered by this bill; however, the populations covered by these types of insurance are small.

[1] The Menges Group. "Pennsylvania Medicaid MCO Prescription Drug Repricing: Cost Impacts of Using NADAC Payment Structure."

Senate Bill 2008
Increases Costs Without Increasing Patient Care

The proposed Illinois legislation will seriously undermine the ability of PBMs to control drug costs, and as a result drug spending in Illinois will soar. Although some of the provisions are subject to interpretation, we estimate the bill provisions discussed below could cost the state of Illinois **$670 million in excess drug spending** in the first year alone, and **$8.2 billion** over the next 10 years.

SB 2008 will increase dispensing fees paid to pharmacies, expand Any Willing Provider (AWP) rules, restrict the use of national accreditation standards, preferred pharmacy networks, specialty pharmacies and mail-order pharmacies and would create a fiduciary mandate for PBM's.

Expanding AWP Rules and Restricting the Use of National Accreditation Standards and Pharmacy Networks Could Increase Costs $4.8 Billion Over the Next 10 Years.

According to the Federal Trade Commission (FTC), AWP requirements significantly reduce providers' incentive to engage in price competition.[2] Academic analysis concluded that AWP legislation leads to less competition and higher prices for consumers while providing no compensating benefits.[3] Another academic analysis specific to state AWP laws found that such legislation "is associated with increased pharmaceutical expenditures."[4] Legislation that prevents PBMs from creating preferred networks for retail and mail-order pharmacies will negatively impact the performance of formulary management, utilization and care management programs.

When applied to specialty pharmacies, the consequences of AWP legislation is even greater. Because specialty drugs are dispensed in such low volumes and target rare conditions, it is infeasible for most retail drugstores to stock these medications and provide the specialized services patients require. States do not legally differentiate specialty pharmacies from traditional pharmacies, so essentially any licensed pharmacy can market itself as a specialty pharmacy. PBMs actively work with payers to identify specialty pharmacies that can best serve patient and healthcare provider needs. These payer-aligned specialty pharmacies must meet payers' terms and conditions to be included in preferred pharmacy networks. Terms and conditions focus on quality clinical care, performance, and cost-saving criteria. Qualified specialty pharmacies must also meet payer reimbursement rates to be included in networks. Of the roughly 64,000 pharmacies in the U.S., only about 400—less than 1%—are accredited as specialty pharmacies by the independent Utilization Review Accreditation Commission (URAC). In addition, PBMs utilize credentialing to evaluate a pharmacy's ability to implement plan design, encourage formulary compliance, and meet other contractual obligations.

Adopting Fiduciary Mandate Could Increase Costs $6 Billion

According to the Department of Labor (DOL), PBMs "who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform [certain] administrative functions for an employee benefit plan…are not fiduciaries of the plan." [1] Imposition of a fiduciary mandate would create a conflict between PBMs' contractual obligations to their clients and the fiduciary duty to act "solely in the interest of plan participants." Fiduciary requirements will also create additional legal liability, leading to increased costs related to liability insurance.

Projected 10-Year Increases in Prescription Drug Spending In Illinois, 2022–2031 (Billions)

	Self-Insured Group Market	Fully-Insured Group Market	Direct Purchase Market	Total
Adopt fiduciary mandate	$3.2	$2.3	$0.5	**$6.0**
AWP, accreditation, and restricted use of pharmacy networks [5]	$2.6	$1.8	$0.4	**$4.8**
Maximum Costs – All Provisions [6]	**$4.4**	**$3.1**	**$0.7**	**$8.2**

Methodology: The methodology used to create these cost projections was that used by Visante in the April 2020 paper "Increased Costs Associated With Proposed State Legislation Impacting PBM Tools."

1. "Contract year 2015 policy and technical changes to the Medicare advantage and the Medicare prescription drug benefit programs,"," FTC letter to CMS, Mar. 7, 2014.
2. 29 CFR 2509.75-8 - Questions and answers relating to fiduciary responsibility under the Employee Retirement Income Security Act of 1974.
3. Klick, Jonathan and Wright, Joshua D., "The Effect of Any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures," Am. L. & Econ. Rev. 192 (2015)
4. Durrance, C., "The impact of pharmacy-specific any-willing-provider legislation on prescription drug expenditures," Atlantic Economic Journal, 2009.
5. Includes Any Willing Provider (AWP), restrictions on pharmacy accreditation and mail-order. Illinois may already use some form of AWP. Estimated cost increases are based on comparing "with vs without AWP."
6. Numbers do not sum to totals due to some overlap in the effects of different types of legislation. For example, cost savings associated with utilization management are negatively affected by a fiduciary mandate, but also by Any Willing Provider applied to specialty pharmacies. We adjust the totals to avoid double counting of this cost impact.

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