March 1, 2021

The Honorable David Osborne
Speaker of the House

Re: HB 532-An Act Relating to Pharmacy Benefit Managers

Speaker Osborne and Members of House Leadership,

On behalf of the Pharmaceutical Care Management Association, I am writing to express our serious concern with HB 532 which is currently being debated by the Kentucky General Assembly that will have a negative impact on the ability of employers and individuals to offer or purchase affordable prescription drug coverage.

HB 532 outlines several mandates regarding how pharmacy benefit coverage must be offered in Kentucky.

PBMs are business-to-business vendors who administer pharmacy benefits on behalf of employers, health plans and government sponsored programs, including Kentucky's Medicaid program. Though employers, health plans and government programs are not required to use PBMs, most choose to because PBMs help lower the costs of providing prescription drug coverage.

Just last year the General Assembly passed SB 50, which contained sweeping reforms to Kentucky's Medicaid program as it relates to prescription drug benefits. The Commonwealth, as the plan sponsor in this case, does and should have the flexibility to design the benefit in a way that best serves its population. However, eliminating an employer's ability and flexibility to use proven cost savings tools such as mail-order or specialty pharmacies and performance-based contracting runs counter to that very idea.

In addition to the mandates contained in HB 532, there are also several pieces of prescription drug and healthcare related legislation being debated by the General Assembly, including:

- SB 44-An Act relating to the payment of insurance premiums and cost sharing
- SB 45-An Act relating to prescription drugs
- HB 48-An Act relating to reimbursement for pharmacist services
- HB 95-An Act relating to prescription insulin
- HB 114-An Act relating to prescription drugs
- HB 222-An Act relating to pharmacy benefits in the Medicaid program

With employers constantly trying to balance their responsibility of providing practical health and pharmacy benefits for their employees, while seeking out opportunities to contain costs when possible, this bill will increase the cost of care and interject the state government into the business of private contracting. Employers utilizing a pharmacy benefit manager (PBM) do so to ensure their employees have adequate pharmacy benefit coverage that is accessible and convenient, yet affordable. PBMs have delivered on that need by achieving an overall low-cost trend by encouraging competition among drug manufacturers and drugstores, offering more affordable

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

dispensing channels, and employ several highly specialized services that improve quality for millions of Kentucky patients.

In past legislative sessions, PCMA and its members have always come to the table in good faith to discuss these important, complex issues with other stakeholders and legislators**. Given the broad impact of this legislation, we believe the issues contained in this legislation require and deserve more consideration and urge you to hold HB 532.**

***

We appreciate your consideration of our concerns and are happy to provide more information or answer any questions regarding HB 532's negative impact on Kentucky employers and patients.

Sincerely,

Connor Rose
Director, State Affairs
PCMA

Cc: David Meade, Speaker Pro Tem
Steve Rudy, Majority Floor Leader
Suzanne Miles, Majority Caucus Chair
Chad McCoy, Majority Whip
Joni Jenkins, Minority Floor Leader
Derrick Graham, Minority Caucus Chair
Angie Hatton, Minority Whip

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

HB 532 Threatens Patient Safety, Access, and Affordability

Mandating Contracting Terms Between Private Entities

- Last year, the Kentucky General Assembly passed SB 50, which contained significant reforms to Kentucky's Medicaid program as it relates to pharmacy benefits. The Commonwealth, as the plan sponsor in this case, does and should have the flexibility to design the benefit in a way that best serves their population. This same flexibility should continue to be extended to the plan sponsors in the private marketplace trying to achieve that same goal.

- HB 532 inappropriately interferes with private contracts and restricts the tools pharmacy benefit managers (PBMs) use to reduce prescription drug cost and maintain high-quality patient care, which will result in higher costs for Kentucky's patients and small employers.

- PBMs are business-to-business vendors who ***administer*** pharmacy benefits on behalf of employers, health plans, and government sponsored programs, including the Commonwealth's Medicaid pharmacy benefit. There is no requirement to use a PBM, but these entities choose to do so in order to offer affordable and accessible prescription drug benefits to enrollees.

- The broad mandates contained in HB 532 strip away several proven, market-based tools that plan sponsors demand in order to design a benefit that effectively balances increasing spending on prescription drugs and the ability to provide consumers and small employers with accessible and affordable drug coverage.

- Prohibiting PBMs (and by extension those paying for prescription drugs) from offering services that promote affordable and high-quality health care like performance based contracting, accreditation of specialty pharmacies, and offering pharmacy channels that provide significant value for patients only limits small employers and individuals from obtaining affordable benefits.

Undermining Competition, Raising Cost, and Risking Patient Safety with Network Mandates

- HB 532 would create an "any willing provider" (AWP) requirement for pharmacy networks, which would gut the ability of health plans and PBMs 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.

- **If the 'any willing specialty pharmacy' requirement contained in HB 532 were implemented in Kentucky, cost for fully insured employers and commercial health plans would increase by $234 million over the next ten years.**[1]

- HB 532 prohibits specialty pharmacy accreditation, putting patient safety at risk and increasing costs for Kentuckians. Research shows that only 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]

- Given the patient population served by specialty pharmacies, it is not only commonplace-but a best practice for health plans and PBMs to require accreditation for specialty pharmacies to participate in the networks, where there is a greater need for patient care such as 24/7 access to pharmacists and clinicians trained in specific, complex disease states and proper handling and distribution of high cost specialty drugs. These patient-centered services and coordinated benefit management strategies enhance adherence to prescribed drug therapies, improve quality of care and reduce expenditures on unnecessary hospitalizations.

- PBMs require pharmacies to compete on service, price, convenience, and quality to be included in preferred networks. Pharmacies that agree to participate in such arrangements are designated as 'preferred', and become members of a preferred pharmacy network. These types of networks have gained traction among employer sponsored plans. In 2013, 26% of large employers utilized preferred pharmacy networks. By 2019, that has increased to 48% of those plans using this cost saving tool.[3]

- According to the Federal Trade Commission, networks and selective contracting generates significant savings that are passed on to consumers in the form of lower premiums, lower out-of-pocket costs, and better services while AWP laws lead to higher drug prices when a retail pharmacy "faces no threat of sales losses if it fails to bid aggressively for inclusion in the payer's network" it has no incentive to offer its most competitive terms. Opening networks to any willing provider reduces the volume of sales for all network participants, ultimately resulting in smaller discounts.[4]

- HB 532 also prohibits the use of performance-based contracting arrangements, which are commonly found in nearly all parts of the healthcare system. These types of arrangements exist in Medicare, Medicaid, and commercial markets to give hospitals, physicians, and other clinicians

[1] Increased Costs Associated With Proposed State Legislation Impacting PBM Tools," Visante, April 2020.
[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] Adam Fein. (2020). *The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers.*
[4] Federal Trade Commission. (March 7, 2014). Letter to the Centers for Medicare and Medicaid Services, Department of Health and Human Services

incentives to provide the most high-quality, cost effective care. The prohibition on this practice in HB 532 is a significant departure from the trend of payment for value.

Creating a Solution in Search of a Problem with Affiliated Lines of Business

- HB 532 proposes unprecedented intrusions into the private market by prohibiting plan sponsors from offering or implementing plan designs that may require patients to utilize affiliated pharmacies that are able to offer cost savings and improved quality.

- 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. HB 532 elminates the ability for plan sponsors to use these cost saving tools.

- In September 2018, when the U.S. Department of Justice approved the merger of health care corporations that operate in the PBM and insurance markets, the Antitrust Division said that one merger "is unlikely to result in harm to competition or consumers."[5] In October 2018, the Antitrust Division said that another 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."[6]

Who Will Pay For These Costly Mandates?

Mandating contract terms and the extent to which plan sponsors are able to utilize the services offered by Pharmacy Benefit Managers that reduce prescription drug spending and increase quality ultimately harms consumers and small employers looking to purchase and offer affordable benefits.

Enrollment in Kentucky's Medicaid program has increased by 300,000 individuals since the COVID-19 pandemic, now is not the time to enact costly mandates to the that would price individuals and small employers out of the private marketplace.

[5] 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

[6] 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. Retrieved from https://www.justice.gov/opa/pr/justice-department-requires-cvs-and-aetna-divest-aetna-s-medicare-individual-part-d.

RUTLEDGE V PCMA (SCOTUS)

The U.S. Supreme Court issued a narrow decision on Dec. 10, 2020 in Rutledge v. PCMA, reversing the lower court's decision and holding that Arkansas's Act 900 (MAC law) is not preempted by federal law (ERISA). The Court said Act 900 is simply a "cost regulation," which is something states are typically allowed to do, even when it impacts an ERISA plan's costs. The Court relied on an earlier case, Travelers, in which New York imposed an up to 13% hospital bill rate increase, for patients not covered by Blue Cross Blue Shield New York. The Court concluded that this surcharge was merely a form of "cost regulation" that is not preempted by ERISA. The Court did not overturn the lower court's decision that Act 900 is invalid on Medicare plans.

More than 40 states have passed some form of PBM rate regulation (MAC law). Unlike most state laws that were unchallenged, PCMA sued in Arkansas because the law will drive up the costs for prescription drug benefits by requiring PBMs to reimburse pharmacies at a rate no lower than the pharmacy's invoice price, thus removing any incentive for wholesalers to sell drugs to pharmacies at a discounted rate, or for pharmacies to shop for better prices. Further, the law allows a pharmacy to turn a plan participant away at the pharmacy counter if the pharmacy does not believe dispensing that participants prescription will result in a high enough profit.

The Court said....

- ✔ The Court said Arkansas's Act 900 (MAC law) is not preempted by federal law (ERISA).
- ✔ The Court said Act 900 is simply a "cost regulation," which is something states are typically allowed to do, even when it impacts an ERISA plan's costs.
- ✔ The Court said Act 900 could raise costs for ERISA plans.
- ✔ The Court said, "...ERISA plans may pay more for prescription-drug benefits in Arkansas than in, say, Arizona."
- ✔ The Court said that a law that allows a pharmacy to turn a patient away at the pharmacy counter if they do not make the minimum required profit is not preempted by ERISA, because it is part of "cost regulation".
- ✔ The Court implied that states are still not allowed to force employer plans to structure benefits in a specific way, and that a law that increases costs so much for employers that the employer must restructure its benefits may run into trouble with the federal law.

The Court did not say...

- ✖ The Court did not say that states have free ability to regulate PBMs with respect to every aspect of their ERISA business.
- ✖ The Court did not say that Act 900 was good public policy.
- ✖ The Court did not say implementation of laws like Act 900 would not impact costs; it in fact said that this law would raise costs for ERISA plans.
- ✖ The Court did not overturn the lower court's decision that Act 900 is invalid on Medicare plans.
- ✖ The Court did not say that every law directed at PBMs is valid or not preempted by ERISA.

© Pharmaceutical Care Management Association