Testimony for House Bill 2598
House Insurance Committee
By Aaron Dunkel, Executive Director
Kansas Pharmacists Association - Topeka, Kansas
February 17th, 2020

Chairman Vickrey and Members of the Committee:

I am Aaron Dunkel, Executive Director for the Kansas Pharmacists Association (KPhA). The Kansas Pharmacists Association is the statewide professional association that represents Kansas pharmacists, pharmacy technicians and student pharmacists from all practice settings, including hospitals, community pharmacies, managed care, specialty pharmacies, and every other setting in which you might see pharmacy professionals. I am here today to ask for your support for HB 2598.

House Bill 2598 requires transparency, oversight and accountability for pharmacy benefit managers (PBMs). The bill:

1. Protects consumer choice and competitive market behaviors
2. Provides transparency to the beneficiary, plan sponsors, and Kansas Insurance Department (KID)
3. Provides oversight of pharmacy benefit manager (PBM) activities

Pharmacies and a few other healthcare professionals have known for years that PBMs are major players in individuals' healthcare spend, pharmaceutical drug pricing, and health management. It has not been until the last couple of years that a much broader audience has learned what a large player they are in the market. What has changed in that time? The change is that in the last few years, with the introduction of broad managed care implementations in Medicaid that states have had access to information across an entire population that could be reviewed and audited. The result of those audits triggered legislation in many states demanding greater oversight and accountability of PBM practices. Even when dealing with state dollars appropriated to fund medical care for the most at-risk among us, PBMs took more than their share. Some examples include:

1. Ohio – PBMs pocketed $225 million between 04/2017 and 03/2018 in spread pricing
2. Kentucky - PBMs pocketed $123 million in 2018 in spread pricing
3. Maryland - PBMs pocketed $72 million in 2018 in spread pricing
4. West Virginia – saved $54 million in the state fiscal year 2018 by removing PBMs from the state Medicaid program
5. Louisiana – PBMs retained $42 million incorrectly listed as “medical costs” in reports

With these results rolling in from around the country, several states have decided to look at PBMs differently. The old argument that they were not insurance and, therefore, should not be regulated is no longer acceptable. Several states have taken steps to protect their state Medicaid program while also asking themselves if this is what is happening in Medicaid, what is happening in our state employee health plan or, even more concerning, the private market?

The bill before you takes some of the best practices language passed in other states that passed with near-unanimous support. House Bill 2598 takes action to ensure beneficiaries in Kansas have a choice of where to receive their medications and other pharmacy services; requires PBMs to provide information about the claims they process to beneficiaries, covered entities or plan sponsors, and the Kansas Insurance Department (KID); and requires PBMs to be licensed and not simply registered, allowing for better oversight and accountability.

You will hear from others about the negative impact of PBMs on their lives and businesses. We believe this bill will help protect the public through accountability, transparency, and a return to a more competitive marketplace. House Bill 2598 will help Kansas protect its citizens and businesses from practices that hide behind a veil of secrecy, drive up costs, and harm free-trade.

PBMs started in 1968 as fiscal intermediaries that processed prescription drug claims. Over the years, the largest of them have developed into companies that negotiate drug rebates with pharmaceutical manufacturers, manage formularies that determine what medications are available to patients, develop pharmacy networks, provide drug utilization reviews, and many other functions and services that control much of the prescription drug market. Through consolidation and acquisition, the three largest PBMs, OptumRx, Caremark, and Express Scripts, now control approximately 80 percent of the prescription market nationally.

Currently, all three of the largest PBMs are owned by companies that also own insurance companies, mail-order pharmacies, specialty pharmacies, and in the case of Caremark, a large retail pharmacy chain. This vertical integration has created additional issues addressed in the bill, which I will discuss later in my testimony.

Over time, PBMs have been allowed to operate virtually unchecked. A lack of transparency in PBM practices has led several states to implement licensure, transparency, and competitive practice legislation to try to level the playing field for patients, plan sponsors, and pharmacies.

Patient Choice and Competition

Kansas pharmacies are strong supporters of patient choice. One way to ensure patient choice in pharmacy is to foster a competitive marketplace. Over the last several years, PBMs have used various tools to limit the marketplace and manipulate the options open to their beneficiaries for pharmacy services. PBMs have:

1. Used financial incentives to drive their beneficiaries to specific pharmacies in their network that are often pharmacies owned by the same company as the PBM, including differential copays. When this happens, patients are lured to specific pharmacies using lower or even zero dollar copays. PBMs set the copay for the pharmacies they contract with, and a contracted pharmacy that is not part of the targeted group cannot change the copay at their discretion to be competitive.

2. Mandated mail order. As mentioned above, the companies that own the three biggest PBMs also own mail-order pharmacies. PBMs often require maintenance medications, or in some instances, all medications to be ordered through a mail-order pharmacy. Often these pharmacies are the same ones commonly owned with the PBM. In several of these situations, the patient has no choice but to use the mail-order pharmacy, and other pharmacies are blocked from competing with the mail-order pharmacy regardless of their willingness to accept the same contract terms. In fact, many local pharmacies are down the street to their patient but the patient is required to get their medications in the mail from an out of town, out of the community, out of state mail-order pharmacy

3. Mandated use of specific "specialty" pharmacies. As with mail-order pharmacies, the companies that own the three biggest PBMs also own "specialty" pharmacies. As with the Kansas State Employee Health Plan, plans are often locked into a "specialty" pharmacy that handles "specialty" medication. There is no standard definition of "specialty" medication. Traditionally they have had at least one of the following; expensive, difficult to administer, require special handling, or are being taken by patients needing ongoing clinical assessment to manage challenging side effects. While certain medications obviously require special handling or administration, what we have seen in the past five years is a trend

to over categorize medications as a “specialty” medication. The result has been beneficiaries forced to move their medications to “specialty” pharmacies owned by the same companies that own the PBM when the medications in question can be easily and safely be obtained and dispensed by almost any pharmacy. In many cases, this takes revenue from the patient's pharmacy of choice unnecessarily.

4. Utilized differential pay to pharmacies. One item we have seen come up several times is the practice of a PBM paying a pharmacy owned by the same parent company as the PBM more than they pay other pharmacies in their network.

The bill has provisions that protect against each of these behaviors and promote competition. The bill requires similarly situated pharmacies to be treated similarly regarding contracting, payment, and access to beneficiaries. It also would stop PBMs from driving beneficiaries, through mandates or incentives, to specific pharmacies within the same network unfairly.

Transparency

Not everyone has all of the information they need to make the best decision when it comes to their pharmacy benefit. To make the most educated decisions about anything in life, you need relevant information. In the world of pharmacy, that information has been controlled and hidden by one side, the PBM. PBMs have made it difficult for beneficiaries and plan sponsors to know what they need to know about their pharmacy investment. We think it is time to change that.

We are glad to see that HB 2598 introduces a requirement that PBMs provide monthly reports, or explanations of benefits, to beneficiaries outlining basic information relating to their claims. This report is similar to what someone on Medicare Part D would receive currently and is the pharmacy version of the explanation of benefit we all get from our insurance company when we receive any services where a claim is made in your name. What most of us receive right now is something that tells you your co-pay and, if you are lucky, how much your insurance saved you. This “savings” is most often the difference between your co-pay and the retail price of the drug, which, by the way, no one ever pays, even if they are paying cash without insurance.

The bill assists plan sponsors by requiring reports that provide much of the information they would need to determine if they are receiving a good deal from the PBM for the management of their plan. We have heard repeatedly from employers that while they often know what their PBM charges them, they do not have any idea what PBMs are making off them and their employees’ backs in the way of rebates and spread pricing. The reports required by this bill would give them insight into basic information, such as how much the plan was charged for medications. It would also provide information that currently is either not available to them or is very difficult to get, such as how much the PBM was making in rebates and spread pricing off of the business generated by the plan. It would also indicate how much of the plan’s business was fulfilled at pharmacies owned by the same parent company as the PBM versus how much business was done with others.

The last required report would be an annual report to KID on the PBMs business in Kansas. This report would have the same type of information as the plan sponsor report. This report, in particular, is incredibly important to assure that PBMs are meeting the requirements of other parts of the bill.

Licensure

Since 2006 PBMs have been required to register to do business in Kansas. Registration does nothing to protect Kansans from harmful business practices of PBMs. PBMs are the largest entities related to insurance coverage that are involved in the day-to-day management of beneficiaries’ lives and are not licensed in the state. PBMs make decisions every day that affect what medications you have access to, where you can get them, and how much you will pay for them. Due to the extensive control they wield regarding patient choice, plan costs, and medical care, we agree that PBMs should be licensed. HB 2598 builds the necessary structure to ensure that anyone doing business in Kansas as a PBM, not only is known but also has a state agency with authority to hold

them accountable when they are breaking the law, are acting fraudulently, or it is necessary to protect the safety and the interest of the consumer.

Placing this new responsibility with KID is appropriate for several reasons, but the two most important reasons are:

1. KID already regulates all of the other significant organizations involved in providing insurance and insurance-related services in Kansas.
2. KID has demonstrated the skills necessary to review the information required by HB 2598 meaningfully and they hold a unique place in state government, allowing them to understand how PBM activities play into the larger overall picture of insurance costs.

KPhA is proud to support HB 2598 as a major step in shining a light on the costs of prescription medication in Kansas. Thank you, Chairman and Committee, for your consideration of HB 2598.

HB 2598

Testimony to House Insurance Committee

Aaron Dunkel, Executive Director

Kansas Pharmacists Association

Pharmacy Benefit Manager Transparency, Oversight, Patient Choice and Market Behaviors

HB 2598

- This bill addresses three major concerns related to PBMs
  - Patient choice and cost
    - Ensures pharmacy choice is not limited solely by PBM business decisions
    - Creates an even playing field for pharmacy providers
    - Supports a patient driven system
  - Transparency
    - Provides beneficiaries and plan sponsors with necessary information to make decisions related to their pharmacy spend
    - Allows for verification by Kansas Insurance Department (KID)
  - Oversight
    - Allows for licensure by KID
    - Provides necessary tools to remediate poor behavior

What are PBMs?

Third party contractors that process prescription claims for insurance

Negotiate drug rebates from pharmaceutical manufacturers

Manage preferred drug list, determining what medications patients have access to

Develop pharmacy networks

Provide drug utilization reviews

What Do PBMs Control?

Patient co-pay – pharmacy must charge what PBM says

What the plans are charged for prescriptions

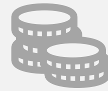
What medications you can take and still have them paid for by the plan

Where you can get your medications

What the pharmacy gets paid – sometimes months after the initial transaction

What Is Spread Pricing?

Patient picks up medication at pharmacy



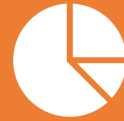
Pharmacy is paid $10 for prescription

PBM claims $20 against for the same claim with the insurance plan

PBM pockets the $10 difference

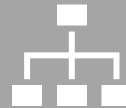
One Kansas employer was being spread $10.90 per claim

Why Do We Need HB 2598?



Market Share

Three largest PBMs (OptumRx, Caremark, and Express Scripts) cover 80% of the insured in the United States



Vertical Integration

OptumRx, Caremark, and Express Scripts are owned by companies that also own insurance providers, mail order, and specialty pharmacies.

Steering

PBMs often use financial incentives and exclusive agreements to either coerce or force patients to use pharmacies owned by their parent companies.

Secrecy

Information is not provided to beneficiaries or plan sponsors in a way that allows them to make informed decisions regarding their pharmacy spend.

Vertical Integration

- In many cases PBMs direct business to their own, commonly owned, specialty and mail-order pharmacies.
- This practice directs business away from competitors and often results in additional costs to patients and plans.

Why Vertical Integration is an Issue

Parent Company	UnitedHealth Group	CVS Health	Cigna Corporation
Owned PBM	OptumRX	CVS/Caremark	Express Scripts
Owned Insurance Provider	UnitedHealthcare	Aetna	Cigna
Mail order Pharmacy	✓	✓	✓
Specialty Pharmacy	✓	✓	✓
Retail Pharmacies		✓	

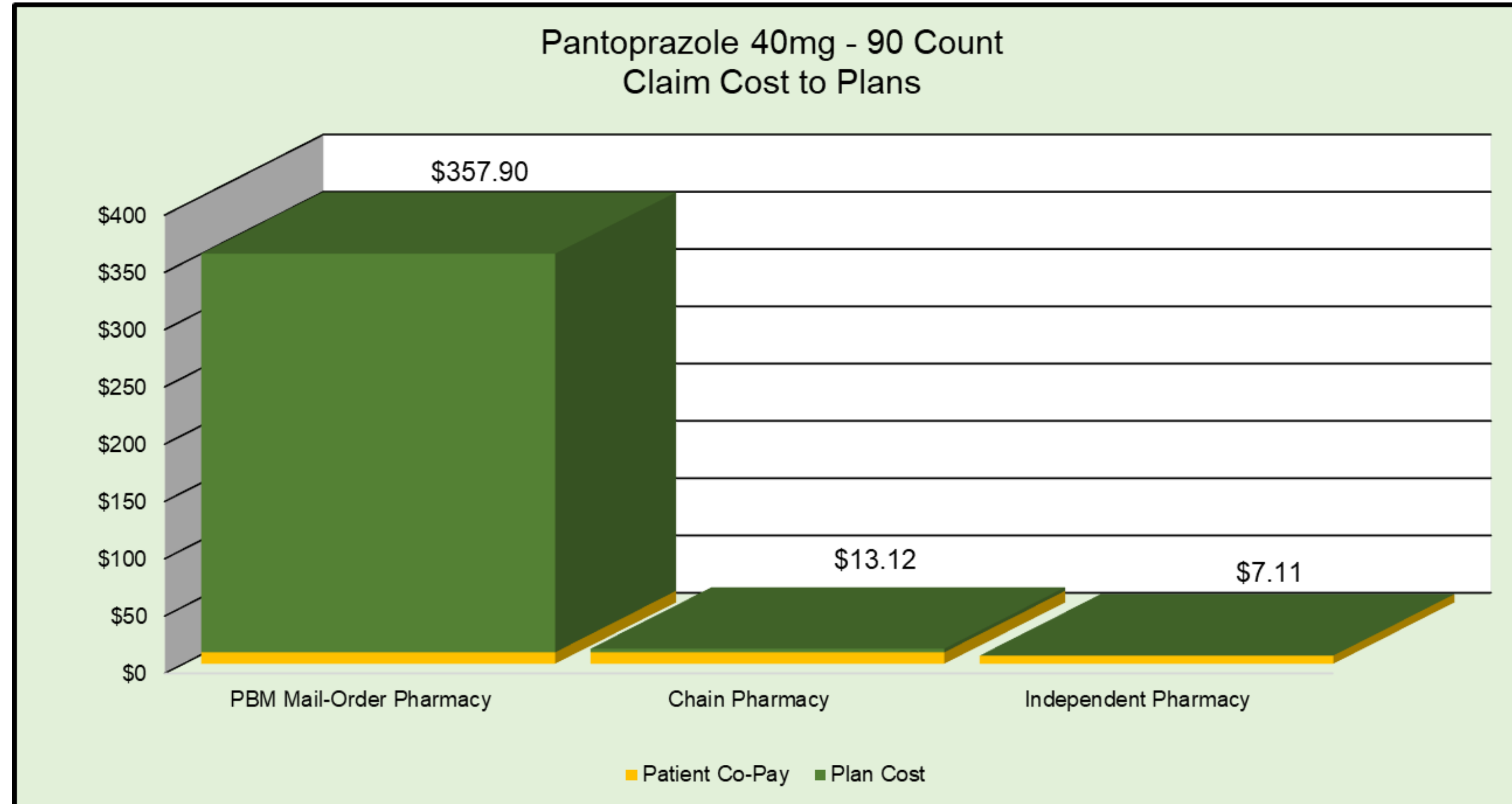
Steering

Self-referrals by physicians and other healthcare providers have been prohibited by federal and state laws for decades (e.g. Stark Law; Anti-Kickback Statute)

However, many PBMs have leveraged their affiliations with pharmacies to steer patients to their affiliated pharmacies without much regulatory oversight or transparency resulting in increased profits for the PBMs while negatively impacting patient choice and quality of care.

The Cost of Mail-Order

- This is just one example of a PBM charging a plan a much higher rate for medication filled at a mail-order they own than for the same medication at competitors' pharmacies.



Transparency Reports

All reports would be proprietary

Patient – Similar to Medicare Part D report or explanation of benefit from your health insurance provider after a doctor visit

Plan Sponsor – Allows them to see:

- what they paid compared to what the pharmacy was paid
- how much was earned in rebates and fees
- any differential between what a pharmacy owned by the same company as the PBM and what a non-related pharmacy was paid

KID – Allows them to review book of business in state of Kansas

Transparency:
Impact on Medicaid
An Example

- Since late 2017 various state reviews of PBM behavior related to state Medicaid programs have shown:
  - Ohio – PBMs pocketed $223.7 million per year in spread pricing
  - Kentucky - PBMs pocketed $123.5 million per year in spread pricing
  - Maryland - PBMs pocketed $72 million per year in spread pricing
  - West Virginia – saved $54.4 million a year by removing PBMs from the state Medicaid program
  - Texas – estimates getting rid of Medicaid PBMs will save the state $90.3 million a year
  - Louisiana – PBMs retained $42 million incorrectly listed as “medical costs” in reports

Insulin Costs

Reason for Increases

Humalog® (U100) is the most broadly used Lilly insulin product. Because of rebates and fees Lilly provides insurers and/or PBMs, increases in list prices do not always reflect increases in net prices.

HUMALOG® (U100) AVERAGE LIST AND NET PRICE (USD) PER PATIENT PER MONTH, IF TAKEN AS PRESCRIBED

Rebate | Pharmacy Gross Margin[1] | Wholesaler Gross Margin[1] | Manufacturer Net Price[2]

1. THE FLOW OF MONEY THROUGH THE PHARMACEUTICAL DISTRIBUTION SYSTEM USC Shaeffer, Leonard D. Schaeffer Center for Health Policy & Economics (June 2017)
2. ELI LILLY AND COMPANY - 2018 INTEGRATED SUMMARY REPORT

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