February 18, 2020

Chairman Jene Vickrey
Chairman of the House Committee on Insurance
Members of the House Committee on Insurance
300 SW 10th Street – Room 212-N
Topeka, KS

Re: HB2598

Mr. Chairman and Members of the House Committee on Insurance:

Thank you on behalf of the Pharmaceutical Care Management Association (PCMA) for the opportunity to offer comments HB 2598. HB 2598 **will impact a PMBs ability to contract across all lines of business** and **restricts the tools that PBMs use to reduce prescription drug costs** while maintaining high-quality pharmaceutical care. A restriction of these tools will lead to **higher prescription drug costs** for Kansas residents and employers. HB 2598 **interferes with business-to-business contracts** and ignores the consumer by creating contract protections for pharmacies and pharmaceutical companies that will **dictate network standards, undermine formulary cost savings and remove free market forces**. Finally, HB 2598 **interferes with key matters of plan administration and many parts of the bill are expressly preempted by the Employee Retirement Income Security Act of 1974 (ERISA).**

PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through Fortune 500 employers, health insurance plans, labor unions, state and federal employee-benefit plans, and Medicare.

PBMs are venders that exist to meet the specific needs of our clients, employers, health insurance plans, labors unions, state and federal employee-benefit plans, Medicare and Medicaid who pay for the drug benefit. Today, the industry has a 40+ year track record of offering clinical and cost management innovation to our clients. PBMs offer proven tools which are recognized by consumers, employers, policymakers and others as key drivers in lowering prescription drug cost, increasing access, and improving outcomes.

- PBMs reduce drug cost by encouraging the use of generics and affordable brand medications.
- We offer programs that reduce waste and increase drug therapy adherence that improve health outcomes through plan design, clinical management, step therapy and drug formularies.
- We work with our clients to ensure that their members and employees have access to necessary medications through a variety of high-quality pharmacies, including retail, community, mail-order, and specialty pharmacies.
- We manage high-cost specialty medications, negotiate rebates from drug manufacturers and discounts from drugstores.

PBM TOOLS LOWER COSTS FOR PATIENTS AND PAYERS

According to researchers, PBMs hired by plan sponsors to maximize the value of prescription drug benefits, will help patients and payers save over $1 trillion in prescription drug costs over

the next 10 years.[1] Plan sponsors use these savings to benefit patients by lowering premiums or deductibles. Over the next decade, PBM's will save the citizens of Kansas $9.2 billion, including $5.1 billion for commercial and private insurance, $3.7 billion for Medicare part D, and $371 million for Medicaid.[2]

Below are a number of tools that PBMs make available to their plan sponsor clients. Using these PBM tools, PBMs are able to provide savings for payers and patients, generating $6 in savings for every dollar spent by patients and payers.[3]

- **Plan Design:** PBMs advise their clients on various options to structure their drug benefits to ensure appropriate use of resources, including encouraging the use of generic drugs and preferred brands. The plan sponsor can choose how they want to spread their cost savings across the drug benefit.

- **Pharmacy Networks:** PBMs contract with over 65,000 network pharmacies to ensure patient access to prescription drugs, to monitor drug safety, and to alert pharmacists to potential drug interactions. Retail pharmacies provide discounts to be included in a plan's pharmacy network in exchange for increased customer traffic.

- **Mail-service Pharmacy:** PBMs provide highly-efficient mail-service that offers safe and cost-effective home delivery of medication. Mail-service pharmacy channels typically give plan sponsors deeper discounts than retail pharmacies, which are passed onto members in the form of lower copayments. These channels also help encourage the use of preferred products for additional savings. Data show that consumers also benefit from mail-service via increased adherence, which contributes to better health outcomes.

- **Formulary Management:** PBMs engage panels of independent physicians, pharmacists, and other experts to develop lists of drugs approved by the plan sponsor for reimbursement, and administer cost-sharing and utilization management (e.g., step therapy) criteria as directed by the plan sponsor.

- **Clinical Management:** PBMs use a variety of tools to encourage the best clinical outcomes for patients. These include drug utilization review and disease management programs, which are designed to improve medication adherence and health outcomes. For example, PBMs improve drug therapy and patient adherence in diabetes patients, helping to prevent 480,000 heart failures, 230,000 incidents of kidney disease, 180,000 strokes, and 8,000 amputations annually.[4]

- **Manufacturer Rebates and Discounts:** PBMs negotiate discounts from manufacturers of drugs that compete with therapeutically-similar brands and generics. More than 90% of those rebates and discounts are passed on to our clients to help lower out-of-pocket costs and premiums for their members. As a result of PBM roles in negotiating discounts from

[1] *Visante Inc., "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers," Prepared for PCMA, February 2016. https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf*

[2] *"Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers," Visanate, February, 2016*
https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf

[3] *PCMA, Visante, Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers, February 2016*

[4] *PCMA, Visante, The Return on Investment (ROI) on PBM Services, November 2016*

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manufacturers, PBMs have been able to keep drug costs down and the growth in net prices for prescription drugs continues to fall.

PBMs have a proven track record of delivering high-quality, affordable benefits that address the individual needs of our clients and patients.

TRANSPARENCY REPORTING

HB 2598 would require the disclosure of competitively sensitive information. It is important to keep the competitive marketplace among drug manufacturers in place in order to drive down the cost of prescription medications. Any public disclosure of rebate information could allow manufacturers to learn what type of price concessions other manufacturers are giving and could disincentivize them from offering deeper discounts, which benefit plan sponsors and their beneficiaries. **Mandating the disclosure of competitive pricing information will not lead to better health care or lower health care costs.**

The Federal Trade Commission (FTC) has reviewed a number of state legislative proposals that would have required the public disclosure of competitive rebate information and opined that, "[i]f pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors, then tacit collusion among them is more feasible" and that such knowledge of competitors' pricing information would dilute incentives for manufacturers to bid aggressively "which leads to higher prices."[5] The FTC also concluded that "[a]ny such cost increases are likely to undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford." [6]

While the bill includes provisions to attempt to protect confidential, trade secret, or sensitive information provided to the state, we believe the risk of any disclosure at all of proprietary competitive information is too great. If this information were to be in the public sphere, using basic enrollment and coverage market information, manufacturers could easily figure out what price concessions their competitors are providing which eliminates their incentive to lower the cost of their medications. This will lead to increased costs for plan sponsors and their beneficiaries in Kansas.

According to a recent study, there is no correlation between the prices drug manufacturers set and the rebates they negotiate with PBMs.[7] The findings contradict claims asserted by manufacturers and others, that the prices that drug manufacturers set are contingent on the level of rebates and discounts manufacturers negotiate with PBMs. The study analyzed data on gross and net sales for the top 200 self-administered, patent-protected, brand-name drugs and found no correlation between the prices drug manufacturers set for those drugs and negotiated rebates. A follow-up analysis also noted that: "[t]op brand drugs that offered little to no commercial-sector rebates during the 2011-2016 time period still increased their prices."[8]

ACCREDITATION, FIDUCIARY, FEES, SPREAD PRICING

HB 2598 prohibits pharmacy accreditation standards such as those used by URAC, which are currently allowed under state law. Given the patient population served by specialty pharmacies,

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[5] Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, Jul. 15, 2005.

[6] Id.

[7] *PCMA, Visante, No Correlation Between Increasing Drug Prices and Manufacturer Rebates in Major Drug Categories, April 2017;*

[8] *PCMA, Visante, Increasing Prices Set by Drugmakers Not Correlated With Rebates, June 2017*

[8] *Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); Letter from FTC to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004).*

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it is not only commonplace—but a best practice— for health plans and PBMs to require accreditation for specialty pharmacies to participate in their networks, where there is a greater need for robust infrastructure, such as nursing staff capacity and 24/7 access. These patient-centered services and coordinated benefit management strategies enhance adherence to prescribed drug therapies, improve the quality of care and reduce expenditures on unnecessary hospitalizations. Mandating lower standards to dispense specialty drugs in an age when drugs are getting more complicated and more expensive could put Kansas patients at risk. This mandate will allow underqualified pharmacies to dispense specialty drugs that generally are prescribed for a small segment of the population, require special care and handling, and are extremely expensive. This legislation prohibits a PBM from requiring additional accreditation or recertification standards in addition to the state requirements for licensure in this state. **This prohibition jeopardizes patient safety, and interferes with private contracting, and is contrary to the Employee Retirement Income Security Act of 1974 ("ERISA").**

In addition, HB 2598 requires a PBM to have a fiduciary responsibility to the health plan. Simply put, a fiduciary is a person in a position of trust—like a trustee for a minor's college fund. Under ERISA, "fiduciaries" are those persons or entities who exercise *discretionary authority* over plan assets or management. PBMs merely serve in administrative and advisory roles for health plan and employer clients, performing claims processing and other administrative tasks pursuant to their contracts. **PBMs don't make decisions about whether the plan should offer pharmaceutical benefits or the scope or design of those benefits—that's the plan sponsor's job.** PBMs carry out the terms of their contracts with their customers, who are large, sophisticated health care purchasers. The Department of Labor says specifically that Third Party Administrators such as 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*." Requiring PBMs to be fiduciaries would force contracting parties to enter into a more costly type of relationship for payers, as the PBM necessarily charged additional fees to cover the cost associated with taking on additional liability. At any time, the parties already could have agreed to make the PBM a fiduciary if they so desired, but they chose not to.

PBMs maintain robust information technology systems that benefit the contracting pharmacy and allow them to dispense prescriptions for employers, health plans, and many government programs across the country. This complex technology network serves over 65,000 pharmacies nationwide and allows them to fill prescriptions for more than 266 million people. Pharmacies agree to contractual arrangements in which—for access to a PBM's health plan and employer clients' members and other services—they pay a fee. This allows pharmacies convenient and timely access to the business of hundreds of millions of consumers. Fees support access to information technology systems that allow pharmacies to fill prescriptions from nearly any benefit plan. This system essentially assists in streamlining the process for pharmacies that would otherwise have to contract with individual employers and plans in order to provide services to their beneficiaries. Fees also support maintaining help lines, benefit manuals, and other services provided to the pharmacy by the PBM. These are not unlike fees paid by retailers to credit card companies in exchange for the risk of consumer fraud and for immediate payment for purchases, or the fees that banks charge consumers for ready access to cash through ATMs. Pharmacies enter into contracts with PBMs, agreeing to pay these fees in return for access to PBM services that enhance their own business practices.

Health plan sponsors contract with PBMs to administer the prescription drug portion of the health care benefit for their enrollees. Plan sponsors and PBMs negotiate contract terms and conditions which may include a risk mitigation model (spread pricing), a pass through (cost-plus)

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pricing model or some other pricing model agreed to by the two parties. Compensation terms are clearly defined and discussed in advance of any contract being signed. Limiting a contract condition between two sophisticated parties, ultimately limits free market innovation.

NETWORK ADEQUACY, ANY WILLING PREFERRED PHARMACY

HB 2598 would gut the ability of health plans and PBMs. In reviewing a Rhode Island "any willing pharmacy" bill, **the Federal Trade Commission (FTC) highlighted that there are dangers to consumers** when the ability of health plans to selectively contract with pharmacies is diminished. "An abundance of empirical evidence now exists demonstrating that, other things equal, selective contracting increases the intensity of competition among providers, which is manifested in lower prices paid by insurers to providers." In addition, **the FTC stated that, "[w]hen insurers have a credible threat to exclude providers from their networks and channel patients elsewhere, providers have a powerful incentive to bid aggressively.** Inclusion in a restricted panel offers the provider the prospect of substantially increased sales opportunities. Without such credible threats, however, providers have less incentive to bid aggressively, and even managed care organizations with large market shares may have less ability to obtain low prices."[9]

COST SHARING

HB 2598 allows a pharmacist to collect a patient cost share from any source. This provision will undermine a PBMs ability to negotiate with a pharmaceutical manufacturer to reduce the overall costs of drugs. Copay coupons are a tool drug manufacturers use to steer insured patients away from generic drugs (with generally lower copays) and toward more expensive brand drugs (with generally high copays), ignoring potentially equally effective, less expensive alternative medications. Copay coupons increase drug costs by undermining the formularies used by employers, unions, and other payers. By definition, copay coupons target only those who already have prescription drug coverage (i.e., those who pay copays). Copay coupons are not means-tested or designed to help the poor or uninsured. Copay coupons *are not* the same as patient assistance programs, which are need-based and offer free or low-cost prescription medicine to low-income people who are uninsured or under-insured. Patient assistance programs have financial or need-based requirements. Copay coupons are deemed illegal kickbacks in public programs like Medicaid and Medicare and, therefore, banned because they unfairly raise costs by forcing coverage of high-priced drugs when more affordable alternatives are available. Though considered illegal kickbacks in federal health programs, they are still allowed in the commercial market.

A study published in the American Economic Journal[10] estimates that copay coupons increased drug spending by up to 4.6 percent. According to the study, each 1 percent increase equals approximately $1.5 billion in higher drug spending annually. The study concluded that for every $1 million in coupon donations, pharmaceutical manufacturers reap $20+ million in profits. If drug companies are concerned about patients accessing medications, they should simply lower their prices, yet drug makers have determined that it is more profitable to use of copay coupons

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[9] Federal Trade Commission Staff Comment to Rhode Island Attorney General Patrick C. Lynch and Hon. Juan M. Pichardo Concerning the Competitive Effects of RI General Assembly Bills Containing Pharmaceutical "Freedom of Choice" and "Any Willing Provider" Provisions, April 2004; available at: https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staffcomment-hon.patrick-c.lynch-and-hon.juan-m.pichardo-concerning-competitive-effects-ri-general-assembly-bills-containingpharmaceutical-freedom/ribills.pdf.

[10] American Economic Journal: Economic Policy 2017, 9(2): 91-123. https://doi.org/10.1257/pol.20150588

rather than simple make their medications more affordable. The simplest, most effective way to reduce patient cost for drugs is for manufacturers to lower the price the drug.

In 2016, researchers from Harvard, Kellogg, and ULCA released an analysis of the impact coupons have on generic drug utilization and drug spending.[11] They found coupons increase brand drug sales by more than 60%, increasing drug makers' revenue by $700 million. More importantly, they concluded consumers paid at least $700 million to $2.7 billion more in health care spending because of coupons.

According to a 2017 AARP report, "Even after accounting for their research investments drug companies are among the most profitable public businesses in America. And an analysis from the research company Global Data revealed that 9 out of 10 big pharmaceutical companies spend more on marketing than on research."[12] Coupons are, at their core, a marketing tool and will drive up the costs of prescription drugs in Kansas if they are allowed to be used as a substitute for a patients cost share.

MANDATED PHARMACISTS REIMBURSEMENT

HB 2598 mandates increased reimbursement for pharmacists. The new provision requires in statute that all drugs will be reimbursed under a newly expanded definition for MAC plus an inflated government dispensing rate ensuring a guaranteed profit on every transaction for every pharmacy in Kansas. The bill does nothing to reduce prescription drug costs and is protectionist legislation meant to increase the profits of Kansas pharmacies.

ERISA PREEMPTIONS

ERISA's express preemption provision—one of the broadest preemption provisions in the United States Code—preempts all state laws that "relate to" ERISA-governed employee benefit plans.[13] **Congress's purpose in including this sweeping express preemption provision was to establish a uniform federal regulatory scheme and protect ERISA plans from the administrative and compliance burdens of satisfying a patchwork of different state regulations.[14]**

HB 2598 runs afoul of ERISA, which preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."[15] **Kansas cannot impose requirements upon PBMs, which administer pharmaceutical benefits for employee benefit plans if those requirements effectively either directly or indirectly regulate the administration of those ERISA plans.[16]**

The ERISA insurance–savings clause allows states to regulate the business of insurance and does not preempt state *"laws….which regulate [ ] insurance."* [17] But in order to be "saved" from

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[11] When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization, October 4, 2016. https://www.hbs.edu/faculty/Publication%20Files/DafnyOdySchmitt_CopayCoupons_32601e45-849b-4280-9992-2c3e03bc8cc4.pdf

[12] Why Our Drugs Cost So Much, AARP Bulletin May 1, 2017 https://www.aarp.org/health/drugs-supplements/info-2017/rx-prescription-drug-pricing.html

[13] Id. § 1144(a).

[14] See, e.g., Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 11–12 (1987).

[15] 29 U.S.C. § 1144(a).

[16] See Pharm. Care Mgmt. Ass'n v. District of Columbia, 613 F.3d 179, 188 (D.C. Cir. 2010).

[17] *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329,342 (2003)

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preemption, a state law must (1) be *"specifically directed toward entities engaged in insurance"* and (2) *"substantially affect the risk pooling arrangement between the insurer and the insured."* [5] **State laws that seek to regulate plan structure and administration through the regulation of a vender such as the provisions found throughout HB 2598 are strictly preempted and therefore prohibited by ERISA.**

ERISA's *"comprehensive system for the federal regulation of employee benefit plans"* [18] whether a fully-insured or self-insured employer-based plan,[19] preempts the interference with plan design and administration including those found in HB 2598.

The central design of ERISA *"is to provide a single national scheme for the administration of ERISA plans without interference from the laws of several states."* [20] To create a unique requirement for Kansas is contrary to the intent the congressional intent. Again, ERISA dictates that no state can directly or indirectly interfere with the key matters of plan administration, such as dictating terms of the PBMs contract with its clients.

The courts have ruled that states simply cannot *"undermine the congressional goal of minimizing the administrative and financial burden on plan administrators – burdens ultimately borne by the beneficiaries."* [21] **And is the case with all the ERISA preemptions including those in HB 2598 the courts have been clear that these protections are extended to all employer based plans, both fully insured and self-insured.**

In closing, we urge caution when considering the many anti-competitive cost drivers in HB 2598 that will drive out competition and increase the costs of health care in Kansas. This is a slippery slope that could lead to many unintended consequences.

Thank you for the opportunity to provide input.

Sincerely,

Melodie Shrader
Assistant Vice President - State Affairs

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[18] *District of Columbia v. Greater Was. Bd. Of Trade*, 606 U.S. 125, 127 (1992)
[19] *Mitchell Williams Letter to PCMA* dated February 21, 2018
[20] *Gobeille v. Liberty Mutual ins. Co*, 136 S. Ct. 936, 947 (2016)
[21] *Gobeille*, 136 S. Ct. at 944

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