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**STATEMENT OF OPPOSITION TO
SENATE BILL 689
“PHARMACY BENEFITS MANAGERS – PROHIBITED ACTIONS”**

TO: Honorable Delores Kelley, Chair, Senate Finance Committee
FROM: Mike Johansen and Camille Fesche, for PCMA
DATE: March 15, 2022

On behalf our client, the Pharmaceutical Care Management Association (PCMA), we respectfully urge an unfavorable report on SB689 (HB755).

This bill is titled “Pharmacy Benefits Managers – Prohibited Actions” – but a more appropriate title is “**Health Plan Sponsors – Prohibited Actions.**” To be clear, PBMs conduct their activities on behalf of carriers and health plan sponsors who make decisions that guide many of the specific activities that this bill seeks to prohibit.

For example, SB689 would prohibit carriers and health plan sponsors from:

1. Entering into a guaranteed pricing agreement with a PBM (‘spread pricing’)
2. Establishing a limited network and negotiating discounted pricing for participation in the network (‘any willing pharmacy’)
3. Establishing preferred retail networks to reduce drug dispensing costs (‘set different copays’ among pharmacies)
4. Establishing mail order discounts and preferences (‘mail order’)

Each of these decisions is made by a carrier or health plan sponsor after considerable deliberation – and often with the express intent of reducing Rx plan costs. In fact, for many health plan sponsors that seek a PBM administrator for their Rx drug plan, these decisions are made with the help of expert industry consultants and after formal bidding and procurement processes. Finally, these plan sponsors may also engage with employee representatives during PBM plan selection and Rx drug benefit structure.

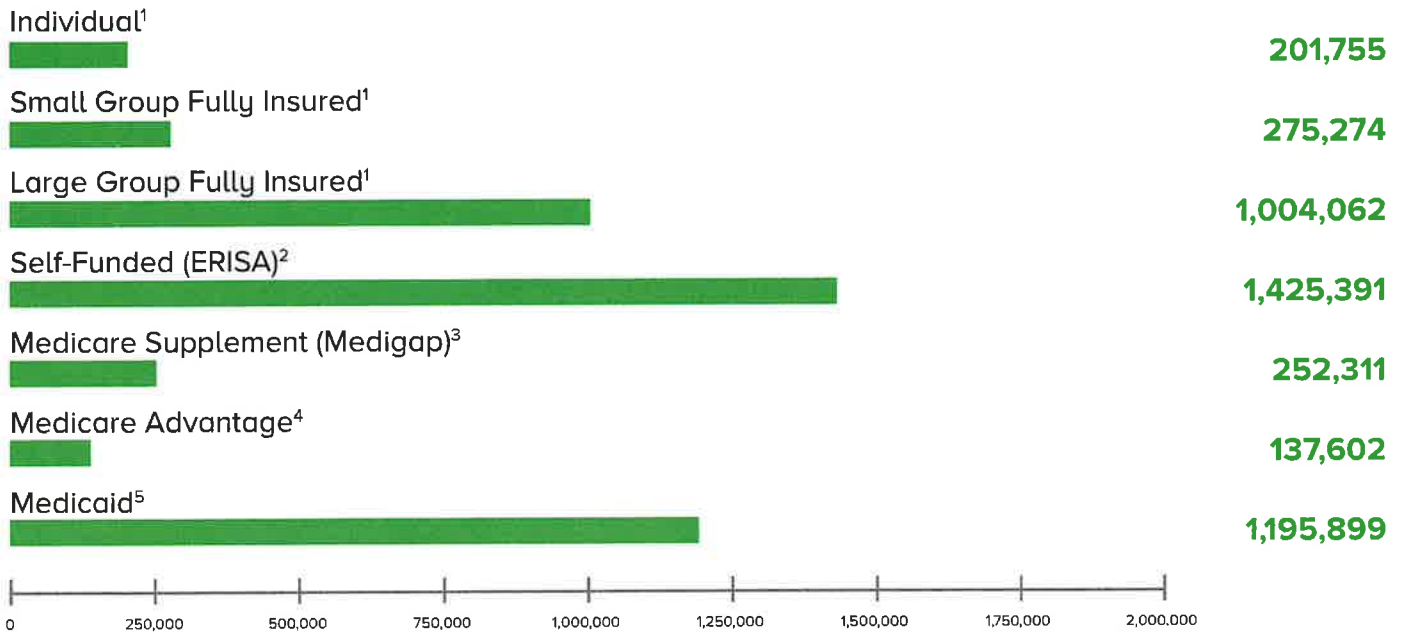
SB689 also extends these prohibitions to self-insured and ERISA exempt plans. While PCMA does not believe the State of Maryland can apply these limitations to federal ERISA exempt plans, recent legal decisions have created uncertainty in the insurance industry. Therefore, we presume the sponsor intends to impact these plans and PCMA reinforces our opposition to this bill.

It is important to note that neither health plan sponsors nor their represented employee units are supporting this legislation – these organizations do not need this bill to help them set up their Rx drug plans and control pharmacy costs

Maryland

HEALTH INSURANCE BY THE NUMBERS

ACCESS TO INSURANCE



Health Insurance Employment in Maryland

EMPLOYEES

Health Plan Employees ⁶	11,726
Insurance-Related Employees ⁷	18,103

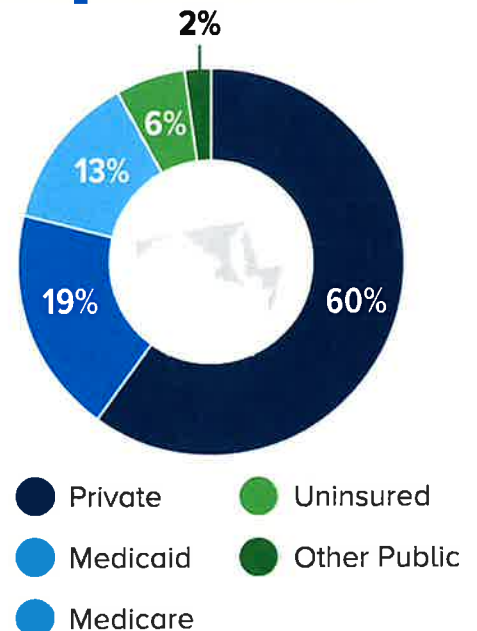
PAYROLL

Health Plan Employees ⁶	\$1,000,895,000
Insurance-Related Employees ⁷	\$1,338,849,000

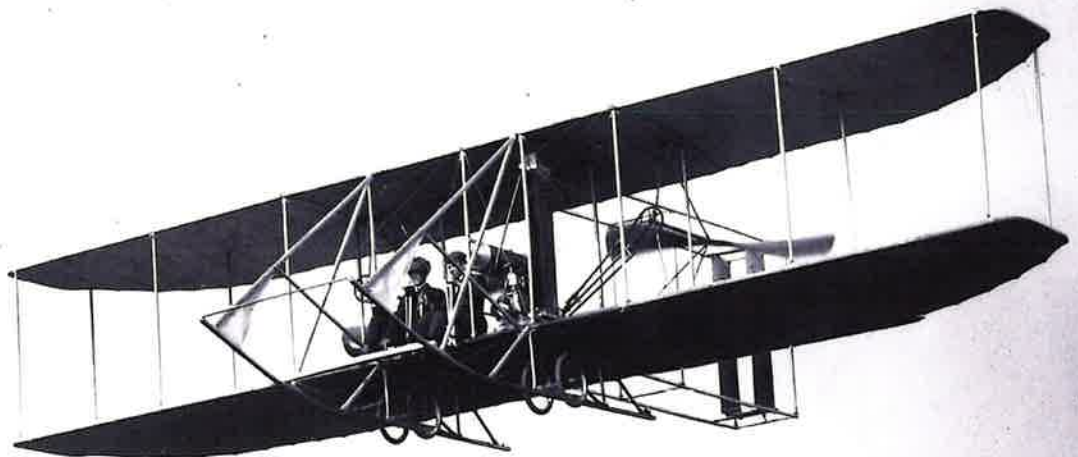
AVERAGE WAGE

Health Plan Employees ⁶	\$85,357
Insurance-Related Employees ⁷	\$73,957

Health Insurance Coverage of Maryland Residents⁸



Benefits inspired by the way you



live!

Montgomery County Benefits Guide

OHIO

Plan Year: January 1, 2022 – December 31, 2022



Medical and Prescription Drug Coverage

Your Medical Benefits

We offer two high deductible health plans administered by Anthem Blue Cross Blue Shield (Anthem). The medical network is the Anthem blue card network..

In-Network	Basic	Enhanced
Premiums	↓	↑
Deductible	↑	↓
Coinsurance After Deductible	Montgomery County pays 70%	Montgomery County pays 90%
Out-of-Pocket Maximum	↑	↓

Both the Basic and Enhanced Plans are designed to help you think about your health care in the same way you think about anything else you spend money on. Our medical plans are **self-funded**. Self-funding our health care plans means that instead of purchasing health care coverage in a one-size-fits-all approach, we elect to pay the full cost of our plans (to self-fund) in order to customize our plans to meet the specific health care needs of Montgomery County employees.

You read that right: the full cost of our medical and prescription drug benefits is paid by Montgomery County — and thus our taxpayers. When you use medical services or fill a prescription, the costs for that are not paid by Anthem, but in fact are paid directly by Montgomery County with the general plan administration handled by Anthem.

When we are smart shoppers with our health care, using the right facility for the right situation and shopping around, we directly improve the bottom line for the County.



②

Medical Plan Has a Network !!

	Basic Plan		Enhanced Plan	
Plan Summary	In-Network	Non-Network	In-Network	Non-Network
Annual Deductible (Employee Only / Employee + Child(ren), Employee + Spouse, or Family)	\$1,600 / \$3,200	\$3,200 / \$6,400	\$1,400 / \$2,800	\$2,800 / \$5,600
Annual Out-Of-Pocket Maximum (Employee Only / Employee + Child(ren), Employee + Spouse, or Family)	\$5,000 / \$10,000*	\$10,000 / \$20,000	\$2,800 / \$5,600	\$5,600 / \$11,200
Co-Insurance (After deductible) (Plan pays/You pay)	70% / 30%	60% / 40%	90% / 10%	60% / 40%
Wellness (Preventive care, in-network only) Includes annual physicals, routine eye exams, well-baby and well-child care, pap smears, mammograms, prostate exams, colonoscopies	Covered at 100%	Not Covered	Covered at 100%	Not Covered
Physician/Specialist Office Visit	70% / 30%	60% / 40%	90% / 10%	60% / 40%
Diagnostic X-ray and Lab (Outpatient)	70% / 30%	60% / 40%	90% / 10%	60% / 40%
Hospital/Treatment Facility (Both inpatient and outpatient)	70% / 30%	60% / 40%	90% / 10%	60% / 40%
Surgery (Physician's charges)	70% / 30%	60% / 40%	90% / 10%	60% / 40%
Emergency Room (Treatment of a medical emergency)	70% / 30%		90% / 10%	
Urgent Care	70% / 30%	60% / 40%	90% / 10%	60% / 40%
Ambulance (Emergency transportation only)	70% / 30%	60% / 40%	90% / 10%	60% / 40%
Physical Therapy Short-term rehab including speech therapy, physical therapy & occupational therapy. Maximum 60 visits combined; limitations and exclusions may apply.	70% / 30%	60% / 40%	90% / 10%	60% / 40%
Chiropractor (Up to 25 visits; limitations and exclusions may apply)	70% / 30%	60% / 40%	90% / 10%	60% / 40%

*On the Basic Plan, each individual covered within a family will not pay more than \$7,350 (the embedded out-of-pocket maximum).

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This guide is meant to be an overview. For specific plan details, please refer to the Summary Plan Description available at www.mcbenefits.org.

Prescription Drug Benefits

When you enroll in medical coverage, you will automatically receive coverage for prescription drugs administered through IngenioRx. IngenioRx is a subsidiary of Anthem. Let your doctors know you have a high deductible health plan (HDHP) to see if any lower cost prescription options are available or talk to your pharmacist about options. Don't forget, Montgomery County contributes funds to the health savings account (HSA) of qualifying employees to help you cover those initial costs.

The IngenioRx drug list is set up with Tiers. Drugs are placed on different tiers based on how well they work to improve health, whether there are over-the-counter (OTC) options and their costs compared to other pharmaceutically equivalent medications.

- Tier 1: Usually generics, these drugs offer the best value compared to other drugs that treat the same conditions.
- Tier 2: Generally preferred brand drugs, but includes some generics that are newer to the market.
- Tier 3: Typically non-preferred brand, higher cost medications, as well as generic drugs that cost more than an alternative in a lower Tier. This tier also includes medications that were recently approved by the FDA.
- Tier 4: Most commonly specialty drugs, which are very costly and sometimes require special handling.

	Basic Plan	Enhanced Plan
You pay 100% until deductible is met then...		
Tier 1		
Retail	30% up to \$100 max per Rx	10% up to \$100 max per Rx
Eligible 90-Day Supply	30% up to \$300 max per Rx	10% up to \$300 max per Rx
Tier 2		
Retail	30% up to \$200 max per Rx	10% up to \$200 max per Rx
Eligible 90-Day Supply	30% up to \$600 max per Rx	10% up to \$600 max per Rx
Tier 3		
Retail	30% up to \$250 max per Rx	10% up to \$250 max per Rx
Eligible 90-Day Supply	30% up to \$750 max per Rx	10% up to \$750 max per Rx
Tier 4		
Specialty	30% up to \$300 max per Rx	10% up to \$300 max per Rx

Medications You Take Daily:

Fill at a 90-day Retail or Have Delivered

Under our prescription drug coverage, you must fill prescriptions for maintenance medications at either a 90-day Retail Pharmacy or through IngenioRx mail order home delivery in a 90-day supply. If you fill maintenance medications at other pharmacies, the cost will not be covered under your plan and will not count toward your deductible or out-of-pocket maximum.

Log on to www.anthem.com, and navigate to the Pharmacy page to find a pharmacy participating in the 90-day Retail program. On the go? Download Anthem's mobile app, Sydney Health, and navigate to Prescriptions.

Helping You Manage Specialty Drugs

Certain medications for complex medical conditions such as cancer, cystic fibrosis and rheumatoid arthritis require special handling or administration. To ensure that your medications are handled and administered correctly, you must fill these prescriptions through IngenioRx. Orders may be shipped to a location of your choice.

Free Preventive Medications

Montgomery County covers an extensive list of preventive drugs (as identified by the Affordable Care Act) at 100 percent (no deductible) if filled through either mail order or 90-day retail.

Your Monthly Medical Contributions

Employee share

HealthCare Plan/Tiers		Employee Share	Montgomery County Share	Total Plan Cost
Tier 1: Annual Salary < \$60,000		2022 Monthly Premium Rates		
Basic Plan	EE Only	\$43	\$686	\$729
	EE + Child(ren)	\$77	\$1,244	\$1,321
	EE + Spouse /Family	\$121	\$1,950	\$2,071
	Percentage of Total Plan Cost	6%	94%	
Enhanced Plan	EE Only	\$76	\$705	\$781
	EE + Child(ren)	\$138	\$1,277	\$1,415
	EE + Spouse /Family	\$200	\$2,018	\$2,218
	Percentage of Total Plan Cost	10%	90%	
Tier 2: Annual Salary \$60,000 and above		2022 Monthly Premium Rates		
Basic Plan	EE Only	\$64	\$665	\$729
	EE + Child(ren)	\$116	\$1,205	\$1,321
	EE + Spouse /Family	\$181	\$1,890	\$2,071
	Percentage of Total Plan Cost	9%	91%	
Enhanced Plan	EE Only	\$99	\$682	\$781
	EE + Child(ren)	\$179	\$1,236	\$1,415
	EE + Spouse /Family	\$281	\$1,937	\$2,218
	Percentage of Total Plan Cost	13%	87%	

Annual salary for purposes of tier placement is based on an hourly rate as of September 1, 2021 (or date of hire if later) multiplied by 2080 hours.

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SAMPLE

REQUEST FOR PROPOSALS

FOR

SPECIALTY AND NONSPECIALTY DRUG CONSULTING

FOR THE

PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN

RFP 21-006

ISSUE DATE: May 6, 2021

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PEEHIP REQUEST FOR PROPOSAL
Pharmacy Benefit Consulting

SECTION I – GENERAL INFORMATION FOR THE PROPOSER

A. PURPOSE

This Request for Proposals (RFP) solicits proposals for the performance of clinical pharmacy consulting services on an ongoing, as-needed basis for a 3-year period beginning October 1, 2021 and ending September 30, 2024, with two possible one-year extensions, for the Alabama Public Education Employees' Health Insurance Plan (PEEHIP). The services will focus on controlling PEEHIP total drug spend on specialty and non-specialty drugs in any of PEEHIP's benefit programs. PEEHIP requires consulting drug expertise on both the Pharmacy and Medical Drug Plans, with some drug consulting on our Retiree MAPD Plan. Proposers are expected to possess excellent analytical capabilities and in-depth industry knowledge and provide expert advice to assist PEEHIP in managing its formularies and prescription drug spend.

B. BACKGROUND

The Public Education Employees' Health Insurance Plan provides hospital medical health insurance benefits for all full-time employees and some part-time employees of the Alabama public educational institutions, which provide instruction at any combination of grades K-14. These insurance benefits are also available to retired employees with a portion of the retiree's cost paid through the employer premium for active employees. Coverage is also offered to eligible dependents.

PEEHIP provides the following coverages to eligible members and dependents:

- Hospital medical coverage administered by Blue Cross and Blue Shield of Alabama – Actives and Non-Medicare eligible retirees.
- Drug coverage administered by MedImpact Healthcare Systems – Actives and Non-Medicare eligible retirees.
- Health Maintenance Organization – Viva – Actives and Non-Medicare eligible retirees.
- Medicare Advantage Prescription Drug Plan (MAPDP) – Humana – Medicare eligible retirees
- Optional Coverage administered by Southland Benefit Solutions, LLC – consisting of Dental, Hospital Indemnity, Vision, and Cancer.

In 2020, the Commercial Plan (MedImpact) drug spend was \$255M, and the Hospital Medical Plan drug spend was \$87M. PEEHIP has approximately, 223,000 covered persons on its non-Medicare eligible population for BCBS Hospital Medical and MedImpact Prescription Drugs. On the MAPD plan for the Medicare eligible population, there are about 76,000 members.

C. OTHER GENERAL INFORMATION:

Other supporting documents that are considered as part of this RFP may be located via the internet as follows:

- www.rsa-al.gov/ - RSA home page
- www.rsa-al.gov/peehip/ - PEEHIP Section of RSA web page
- www.sos.alabama.gov - Secretary of State home page
- PEEHIP Law – *Code of Alabama 1975, Title 16, Chapter 25A*

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PEEHIP REQUEST FOR PROPOSAL
Pharmacy Benefit Consulting

right to reject all proposals. All responding proposers will be notified of PEEHIP's decision in writing within a reasonable length of time following the selection.

O. NEWS RELEASES: News releases pertaining to this RFP or the service to which it relates will be made only with prior written approval of PEEHIP.

P. ADDENDA TO THE RFP: PEEHIP may modify this RFP at any time prior to the deadline for receiving proposals. Any such modifications made to the RFP prior to the proposal due date will be posted on STAARS and the RSA website.

Q. AGENTS: No agent's fees will be payable by PEEHIP or successful proposer. PEEHIP will respond only to parties interested in proposing and performing the services.

R. PEEHIP RESERVATION OF RIGHTS: PEEHIP reserves the right to award any service in whole or in part, to issue no award or cancel or alter the procurement at any time. In addition, PEEHIP reserves the right to extend the proposed RFP period, if needed. Proposals containing the lowest cost will not necessarily be awarded the contract.

SECTION II – NATURE OF SERVICES REQUIRED

PEEHIP wishes to contract with a vendor that has a proven record of driving significant specialty and nonspecialty drug savings in medical and commercial plan prescription drug benefits. The successful proposer must have extensive experience implementing innovative, proven, and immediate cost savings activities. PEEHIP anticipates proposer services to be conducted under the resulting contract that may include but not be limited to, the following:

- PEEHIP has a customized Commercial Rx Drug Benefit. Under the guidance of proposer's pharmacist consultants and Pharmacy Benefit Manager (PBM) Account Team Pharmacists, PEEHIP makes most Utilization Management (UM) decisions regarding drug exclusions, Step Therapies, Quantity Limits, and Prior Authorizations. The proposer's independent pharmacist consultants will develop and modify our Prior Authorizations (PA) based on the manufacturers' full prescribing information, for specialty and non-specialty drugs to ensure clinical appropriateness, adequate supporting documentation, and requisite renewal criteria. PAs written in accordance with the package label inserts have resulted in little pushback from the medical and patient communities in the last six years.
- The proposer will occasionally audit our PBM to ensure that our PA criteria is being followed.
- Proposer must provide PEEHIP with a web-based application that is already built and functional which utilizes an easy-to-use Dashboard interface that provides drill down functionality into integrated Rx and Medical claims. Medical Claim diagnoses should also be provided. A demo of this Dashboard may be requested by PEEHIP.
- On a periodic basis, proposer analyzes PEEHIP's pharmacy and Medical Drug Claims with its data tools to determine the most obvious and immediate savings. This analysis should include Specialty Drugs, Brand Drugs and Generic Drugs across both the Rx and Medical Benefits.
- Works with our Pharmacy, Medical, and MAPD vendors on bi-weekly, quarterly, or semi-annual calls in the pursuit of cost and coverage efficiencies with a desire to coordinate the formularies as much as possible. The MAPD drug consulting is limited to annual reviews of the vendor's recommendations of the



PEEHIP REQUEST FOR PROPOSAL
Pharmacy Benefit Consulting

drug coverage for the next calendar year. It is acknowledged that when it comes to the MAPD Plan, CMS requirements may be inconsistent with best savings practices on the Pharmacy and Medical drug formularies.

- Is familiar with National Average Drug Acquisition Cost (NADAC) pricing.
- Assist PEEHIP in the evaluation of PBM proposed rebate opportunities for the purpose of finding the lowest net cost option.
- Assist PEEHIP with PBM Network performance analysis as requested.
- Assist PEEHIP in the evaluation of PBM rebate reports.
- Assist PEEHIP with PBM or other pharmacy benefit related RFPs if requested.
- Assist PEEHIP with PBM contract and performance guarantee development if requested.
- Assist PEEHIP with PBM contract monitoring, market checks, and performance guarantee penalty calculations if requested.
- Provide support to an established specialty variable copay program that utilizes manufacturer revenue coupon programs.
- Provide support to an established retail variable copay program that utilizes manufacturer revenue coupon programs.
- Provide support to an established medical drug variable copay program that utilizes manufacturer revenue coupon programs.
- Assist with provider/member communication and education on PEEHIP's efforts to reduce its drug spend without harm or inconvenience to the member.
- Other clinical pharmacy consulting or data analytics services reasonably requested by PEEHIP and agreed to be performed by vendor during the term of the agreement.

All services listed above will be provided on an "as requested" basis, and no work should begin prior to receiving approval to proceed.

SECTION III – INFORMATION REQUIRED FROM PROPOSERS

To be considered, the proposal must respond to all requirements and questions in this part of the RFP in a separate document using the numbering system below.

A. STATEMENT OF THE PROBLEM: State in succinct terms your understanding of the services required.

B. BUSINESS ORGANIZATION: State the full name and address of your organization, and if applicable, the branch office or other subordinate element that will perform or assist in performing the work hereunder. Indicate whether you operate as an individual, partnership, limited liability company, corporation, or

GET STARTED
your plan cost and analyze how and where those costs are occurring.

This data drives further optimization of your pharmacy benefit – helping your plan deliver healthy performance and a healthy, engaged workforce.

The Gallagher Pharmacy Alliance: self-funded for more control

To help our clients under 3K lives gain better pricing and servicing options, Gallagher has developed a pharmacy coalition. The Gallagher Pharmacy Alliance is designed to specifically to provide smaller employers with better pricing and services than they would be able to access on their own. This is a good option for:

- self-funded
- quick RFP turnaround time
- highly focused on price
- interested in working with one of the larger PBMs but can't do so based on their size
- no budget to complete a pharmacy RFP

The Gallagher Difference

The problem.

A large, self-insured benefit trust asked us to assess the quality of services provided by a national PBM and their specialty pharmacy for members who were receiving high cost medications for complex medical conditions. To understand the costs, we had to review a high cost claimant who received multiple medications (Firazyr, Cinryze, and Berinert) for the treatment/prevention of hereditary angioedema (HAE).

Our approach.

We conducted detailed case evaluations of the PBM's and specialty pharmacy's records. These records documented the clinical services provided to patients who had received specialty medications. It also shared the evaluation of routine follow-ups for medication refill coordination, routine screening and assessment by a pharmacist or healthcare professional of medication-related problems, clinical interventions, and care coordination.

The result.

We were able to find several ways to improve service and keep costs the same. The PBM and their specialty pharmacy took the several steps to enhance their clinical support services and care coordination efforts based on our findings:

- Enlisted an external physician expert to perform a case review and provide recommendations.
- Established a relationship between the PBM's Medical Director and prescriber to provide peer-to-peer review of the patient's

case. The prescriber agreed to modify therapy.

GET STARTED

Gallagher
Consulting

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GET STARTED

- Claims surveillance showed a 25% drop in utilization of the patient's HAE medications in the first three months following therapy modification, for annualized savings of up to \$500,000.
- Prompted the PBM to modify its prior authorization criteria of high cost drugs to include:
 - Discontinuing routine lifetime authorization periods, in consideration of a maximum authorization periods of twelve months.
 - Placing quantity limits at average doses that will trigger a detailed case review, including review of medical records, and/or physician peer-to-peer review.
 - Providing additional triggers that will prompt PBM and specialty pharmacy staff to perform robust clinical reviews for drug appropriateness, proactive follow-up with prescriber, and enlisting expert consultation (e.g., medical director, external specialist expert).

Health Plan
Sponsor
asked PBM
to make
changes

Pharmacy Benefit Management Consulting

- ✓ Leverage our robust industry knowledge and experience
- ✓ Get help navigating the changing landscape and cost-drivers like specialty drugs
- ✓ Manage your PBM relationship more effectively
- ✓ Achieve better pricing and services with Gallagher Pharmacy Alliance

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