SB0689 - PBMs-Prohibited Acts - FAV - EPIC - HERPE

Uploaded by: DENNIS RASMUSSEN

Position: FAV

3/16/2022 **SB0689**

A Network Of Independently Owned Pharmacies

Testimony offered on behalf of:

EPIC PHARMACIES, INC.

IN SUPPORT OF:
SB0689 - Pharmacy Benefits Managers – Prohibited Actions

Senate Finance Committee
Hearing 3/16/22 at 1:00 p.m.

EPIC Pharmacies, Inc., a Pharmacy Services Administrative Organization (PSAO) that has served Maryland independent pharmacies for 30 years, would like to express its **support for SB0689 – Pharmacy Benefits Managers – Prohibited Actions.**

EPIC has said for years there needs to be transparency and regulation in the prescription marketplace because of the games that are played with the payment of pharmacy claims. This bill regulates many of the issues that have plagued independent pharmacies and given control of the market to a few large PBMs. Restrictive networks, mandatory mail order, spread pricing, differential copays, slow credentialing, and retroactive fees have made it nearly impossible for pharmacies to survive in the current marketplace.

By supporting this bill and it requirements for PBMs, the legislature will help to level the playing field and give consumers the power to choose the pharmacy that best fits their needs. This bill helps patients by allowing their chosen pharmacy to participate in all networks and provide equivalent copays. EPIC has said on many occasions that allowing more pharmacies to provide services to patients doesn't increase costs but does increase access for the consumer.

EPIC requests the Committee's **favorable report on SB0689** to protect patient choice and to enable EPIC to continue providing essential support to independent pharmacies and pharmacies to fulfill their primary function: helping keep Maryland communities healthy.

Respectfully submitted,

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SB 689-IPMD-Favorable.pdf
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Position: FAV

INDEPENDENT PHARMACIES OF MARYLAND

WORKING TOWARDS A STRONGER HEALTH

SB 689

Pharmacy Benefit Managers-Prohibited Actions

Position of: INDEPENDENT PHARMACIES OF MARYLAND

Position: FAVORABLE

THIS BILL WILL PLACE PROHIBITIONS ON CERTAIN PRACTICES OF PHARMACY BENEFIT MANAGERS (PBMs) THAT ARE UNFAIR, ANTI-COMPETITIVE, AND ANTI-CONSUMER.

BACKGROUND OF THIS BILL:

The State of MD recognizes, as a matter of record, the predatory nature of PBMs:

1. The State of Maryland has recognized as a matter of record, that Pharmacy Benefit Managers (PBMs) are in a strong position to take unfair advantage of independent, community pharmacies. In the landmark *Rutledge* decision, decided by the U.S. Supreme Court in 2020, the State of MD, through Attorney General Frosh, joined in an *amicus* brief pointing out the need for state regulation of PBMs, and more particularly, that **PBMs, in operating their own mail order and retail pharmacies, "are particularly susceptible to self-dealing and unfair advantage."**
2. More recently, Md again joined in an *amicus* brief in the U.S. Court of Appeals for the 8th Circuit in 2021, again pointing out the dangers of PBMs. Quotes from the MD *amicus* brief: (1) "**PBMs harm Pharmacies, Consumers, and States."** (2**) "PBMs harm pharmacies by lowering reimbursement rates and favoring certain pharmacies."** (3) PBMs use their **"superior bargaining position" "by steering business-and offering favorable terms-to pharmacies affiliated with the PBM."** (4) **PBMs "steer business away from independent pharmacies and toward PBM-owned or -affiliated pharmacies."** The brief essentially indicts PBMs for their anti-competitive practices.

PBMs use their unfair advantage to rack up tremendous revenues and profits:

3. At the same time as independent pharmacies struggle, PBMs are making record profits because of their "superior bargaining position." Just recently, the largest PBM operation, CVS Caremark, reported staggering 3rd quarter, and 2021 year end results. Just the PBM unit of CVS reported third quarter revenue in excess of $39 Billion, up 9.3%, and year to date revenues of $ 153 Billion, up 8% over a year ago. And as the Wall Street Journal has previously reported, PBMs are by far the most profitable component of the pharmacy drug supply chain, converting a large amount of their revenues into profits. WSJ, February 24, 2018.

WHY THIS BILL IS NECESSARY:

PBMs are the middlemen between insurers, pharmaceutical companies, and pharmacies. Three PBMs control approximately 80% of the market. In addition, PBMs often have common ownership or corporate affiliation with the insurers or managed care organization, and**, significantly, PBMs often own or are affiliated with large chain pharmacies and their own mail order pharmacies.**

Because of these common ownerships, and, again as stated in MD's own court filings, PBMs steer beneficiaries to their own chain or mail order pharmacies, and away from independent pharmacies.

Under current law, PBMs take actions designed to enrich themselves, or their affiliated chain or mail order pharmacies, at the expense of independent, community pharmacies. This bill will address these unfair, anti-competitive and anti-consumer practices:

1. **Spread Pricing. PBMs make substantial revenue off of the deceptive practice of "spread pricing", a practice already banned by a number of states. This is where the PBM is paid for a drug by the plan sponsor at one price, and reimburses the pharmacy for a lesser amount. The PBM pockets the difference as its profit, even though it had absolutely nothing to do with dispensing the drug.** In 2020, a MDH study found that Medicaid PBMs in MD received approximately $72 million by spread pricing. This amount should have been passed through to the pharmacy so that it is adequately compensated, which is simply not happening. Independent pharmacies often lose money in filling these prescriptions, while the PBMs make a profit on the backs of the independent pharmacies. While MD Medicaid now prohibits this, it should be incorporated in statute, and should be prohibited even beyond Medicaid as a deceptive practice.

   The PBMs' claim: this is simply "risk mitigation" whereby the PBM willingly assumes the risk that reimbursement to the pharmacy may be higher than the amount it charges to the drug plan. An absurd claim, given the fact that PBMs take in staggering revenues. One PBM, CVS Caremark, reported revenues of $153 Billion just last year, an amount that demonstrates how little "risk" is actually undertaken by the PBMs, if any.

2. **Any Willing Pharmacy. PBMs control which pharmacies may become participants under a drug plan. Of course, as the MD *amicus* filing notes, PBMs have a vested interest in promoting their own affiliated chain pharmacies as the member pharmacies of the plan, to the exclusion of independent pharmacies.** This is, in itself, anti-competitive and discriminatory against non-PBM owned pharmacies.

In addition, it is anti-consumer. It deprives the consumer his right to have a prescription filled where most convenient, or at a pharmacy that he prefers. As long as a pharmacy is willing to accept the terms and conditions applicable to the plan, including reimbursement, any willing pharmacy should be permitted to join the plan. Approximately 26 states already have a form of "any willing pharmacy" legislation to address this discrimination and self-dealing.

The PBMs claim: AWP would threaten "quality" and "level of service". How, if pharmacies agree to live by the same terms and conditions? And PBMs argue, as with every change that threatens their staggering profits, that it will drive up costs by undermining negotiations. Really? How much competition does anyone believe takes place now when CVS PBM is sitting across from the table from CVS Pharmacy, supposedly negotiating rates? And even if genuine negotiations actually would result in a lower reimbursement, this simply increases the "spread" for more PBM profit, not necessarily any benefit for consumers.

3. **Copays**. PBMs set the **copay** that a pharmacy must charge for a prescription. PBMs set different copay amounts; these are often set lower at PBM affiliated pharmacies in order to steer consumers to use the PBM pharmacy rather than an independent pharmacy.
4. **Mail Order Pharmacy Requirements**. PBMs may require that a specific drug be ordered through a mail order pharmacy. **Mail order pharmacies are often affiliated with or owned by the PBM. This requirement is used to steer consumers to PBM affiliated pharmacies.** While it perfectly fine to allow a consumer to use a mail order pharmacy, the consumer should not be required to do so. It should be his or her choice.

CONCLUSION

This bill will address serious anti-competitive and anti-consumer issues, which the State of MD recognizes exist. We urge a FAVORABLE Report.

James J. Doyle

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SB0689-193823-01 Maryland Retailers.pdf
Uploaded by: Justin Ready
Position: FAV

SB0689/193823/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

10 MAR 22
10:26:00

BY: Senator Ready
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 689
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 5, after "fees," insert "limitations and conditions for beneficiaries using pharmacy services,".

AMENDMENT NO. 2

On page 4, in line 8, after "**PHARMACY**" insert "**; AND**

(5) IMPOSE ON A BENEFICIARY A COPAYMENT, A LIMIT ON THE AMOUNT OF REIMBURSEMENT, A LIMIT ON THE NUMBER OF DAYS OF A DRUG SUPPLY FOR WHICH REIMBURSEMENT WILL BE ALLOWED, OR ANY OTHER LIMITATION OR CONDITION RELATING TO THE USE OF PHARMACY SERVICES, INCLUDING THE DISPENSING OF PRESCRIPTION DRUGS, THAT IS MORE COSTLY OR RESTRICTIVE THAN THAT WHICH WOULD BE IMPOSED ON THE BENEFICIARY IF THE PHARMACY SERVICES WERE USED FROM A MAIL ORDER PHARMACY OR A PHARMACY THAT IS WILLING TO PROVIDE THE SAME PHARMACY SERVICES FOR THE SAME COST AND COST–SHARING AS A MAIL ORDER PHARMACY".

SB0689-523225-01 MD INS Adin (1) (1).pdf
Uploaded by: Justin Ready
Position: FAV

SB0689/523225/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

25 FEB 22
10:02:10

BY: Senator Ready
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 689
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 9, strike "carriers" and substitute "purchasers".

AMENDMENT NO. 2

On page 2, in line 13, strike "**CARRIERS**" and substitute "**PURCHASERS**".

On page 4, strike in their entirety lines 27 and 28; and in line 29, strike "3." and substitute "2.".

SB689PBMsprohibitedtestimony (2).pdf
Uploaded by: Justin Ready
Position: FAV

JUSTIN READY
Legislative District 5
Carroll County

MINORITY WHIP

Finance Committee

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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

March 16, 2022

SB 689 Pharmacy Benefit Managers-Prohibited Actions

Chairwoman Kelly, Vice Chair Feldman, and member of the Finance Committee,

Senate Bill 689 is legislation that would prohibit Pharmacy Benefit Mangers (PBMs) from engaging in practices that take unfair advantage of independent, community pharmacies. PBMs use their unfair advantage to rack up tremendous revenues and profits. Their superior bargaining position allows them to steer business and offer more favorable terms to pharmacies affiliated with the PBMs. Just recently one PBM, CVS, reported 3rd quarter 2021 revenue in excess of $39 Billion, and year-to-date revenues of $153 Billion.

This bill would specifically prohibit the following practices:

1) Spread Pricing: This occurs when a PBM is paid by the drug plan sponsor at one price, and reimburses the pharmacy for a lesser amount. The PBM pockets the difference even though they never took possession of the drug and/or had nothing to do with the dispensing of the drug. This practice has already been banned in a number of states.
2) Any Willing Pharmacy: Currently PBMs control which pharmacies may become participants under a drug plan. They have vested interest in only promoting their own affiliated chain pharmacies, to the exclusion of the independent pharmacies. It deprives the consumer the right to have a prescription filled where most convenient. "Any Willing Pharmacy" or one that agrees to the to the conditions of the plan should be permitted to join the plan. 26 states have already passed some form of "Any Willing Pharmacy" legislation.
3) Copays disparity: PBMs set the copay that a pharmacy must charge for a prescription. PBMs often set different copay amounts. Copays are often lower at a PBM affiliated pharmacies in order to steer customers.
4) Mail Order Pharmacy Requirements: PBMs may require that a specific drug be ordered through a mail order pharmacy. Mail order pharmacies are often affiliated or owned by the PBM. This practice steers the consumer to the PBM pharmacies.

Senate Bill 689 would end these predatory practices that harm consumers and independent pharmacies. I urge a favorable report on Senate Bill 689.

PBM bills HGO.pdf
Uploaded by: cailey locklair
Position: FWA

MARYLAND ASSOCIATION
OF CHAIN DRUG STORES
171 CONDUIT STREET, ANNAPOLIS, MD 21401 | 410-269-1440

HB1006, HB1007, HB1008, HB1009, HB1014, HB1015, HB1274

House Health and Government Operations Committee

March 10, 2022

Position: SUPPORT

These bills will address the following issues pertaining to PBMs:

- Expanding certain existing laws for PBMs to apply to plans otherwise subject to ERISA
- Any willing pharmacy provisions
- Anti-patient steering via copay parity
- Anti-mandatory mail provisions
- Broadening existing statute around supporting beneficiaries' choice in pharmacy
- Network adequacy
- Reasonable credentialing
- Transparency with any fees charged by the PBM at the time of claims adjudication
- Ability to refuse to dispense if the reimbursement does not cover pharmacy cost
- Establishes reimbursement floor, including for MCO Medicaid, of NADAC (of the generic) + FFS professional dispensing fee
- Parity in reimbursement across pharmacy provider types
- Enhancing enforcement actions through cause of action languages for pharmacies
- Prohibiting PBMs from engaging in discriminatory reimbursement practices where a pharmacy provider participates in the 340B program
- Anti-claw back provisions
- Expanding beneficiary options in specialty pharmacy providers
- Broadening existing payment parity statutory provisions addressing amount PBM reimburses pharmacist / pharmacy vs. amount PBM reimburses itself / an affiliate pharmacy

Position: The Maryland Chain Drug Store Association in in full support of efforts to help protect our retail community pharmacies by ensuring PBM transparency and improving patient access to a consumer's chosen pharmacy.

The many issues listed above existed far prior to COVID, and are critical to stabilizing pharmacy reimbursement as we continue to provide patient access to prescription drugs, COVID testing, vaccine and treatment needs.

We fully support this legislation and urge a favorable vote. Thank you for your time and consideration.

2021_Just the Facts_Maryland[1].pdf
Uploaded by: Camille Fesche
Position: UNF

JUST THE FACTS

PRESCRIPTION DRUG PRICES, PBMs, AND PHARMACIES IN MARYLAND

PBMs are advocates for consumers in the fight against high list prices

PBMs will save **$17.32B** across all Maryland health programs over ten years.[1]

PBMs will save **$6.7B** via mail-service and specialty pharmacies (2015–2024) in Maryland.[2]

PBMs will save **$706M** over a 10-year period (2020–2029) in Maryland Medicaid.[1]

PBMs save payers and patients an average of $962 per person per year[3]

PBMs put downward pressure on manufacturer drug prices

PBMs will prevent 1 billion medication errors over the next 10 years nationally[3]

SAVINGS ARE REALIZED THROUGH:

- ✓ Encouraging the use of generic and lower cost brand drugs
- ✓ Reducing waste and increasing adherence
- ✓ Negotiating price concessions with drug manufacturers
- ✓ Creating networks of affordable, high quality pharmacies
- ✓ Providing clinical support to patients taking specialty medications

Drug makers alone set the price of drugs

Although PBMs negotiate with drugmakers to bring down the net cost of Rx drugs, manufacturers are ultimately responsible for setting the list prices of their products. **PBMs drive prices down by forcing manufacturers to compete with one another.**

Nationwide independent pharmacies are increasing, not decreasing[4,5]

Between 2011 and 2021, the number of **independent pharmacies increased by more than 2,645 stores, or 12.8%.[5]**

36.9% of pharmacies in Maryland are independent pharmacies[5]

Independent pharmacies say they're getting squeezed out of business, but NCPA states the number nationally has been "holding pretty steady" for several years.[6] According to Adam Fein and Drug Channels, the number of independent pharmacies has been generally stable, noting that "There is little evidence that independent pharmacies are vanishing."[7]

In Maryland, between 2011 and 2021, **the number grew from 311 to 423, a 36.0% increase.[5]**

1 Visante, PBMs: Generating Savings for Plan Sponsors, Feb. 2020.
2 Visante, Mail-Service and Specialty Pharmacies to Save More than $300 Billion Over 10 Years, 2014.
3 Visante, The Return on Investment (ROI) on PBM Services, 2020.
4 Independent Pharmacies in the U.S. are More on the Rise than on the Decline, March 2020.
5 Quest Analytics, Pharmacy Counts, 2021. Pharmacy count data is from January of a given year.
6 Independent Pharmacies Fight to Survive in Colorado Springs, Gazette, Dec. 1, 2018.
7 Drug Channels, Pharmacy Economics Rebound (A Little) Amid Glimmers of Good News, Feb. 2, 2021.

A 21st Century Pharmacy - Mail-Service Pharmacies[

Uploaded by: Camille Fesche

Position: UNF

A 21st Century Pharmacy

Mail-Service Pharmacies Offer a Convenient, Reliable, and Affordable Option for Patients to Safely Access Prescription Drugs

Many Americans rely on mail-service pharmacies for convenience and value. Having regularly needed medications delivered by mail is more convenient and promotes adherence for patients with restricting health conditions or limited transportation. Better adherence and avoidance of acute care episodes can lead to improved health outcomes. Throughout the COVID-19 pandemic, mail-service pharmacy has helped Americans access their prescriptions while sheltering in place or practicing physical distancing.

What is a mail-service pharmacy? Mail-service pharmacy is a convenient option for patients to have their prescription delivered safely and reliably—straight to their front doors. Pharmacy benefit managers (PBMs) build networks of pharmacies – including retail, mail service, and specialty – to provide consumers convenient, high-quality, and affordable access to their needed medications.

How does mail-service pharmacy work?

Patients typically first use their local pharmacy to fill a new prescription, whether for an acute or chronic condition.

Once stabilized on the medication(s), patients with chronic conditions can choose to use a mail-service pharmacy for home delivery.

Mail-service pharmacies typically dispense 90-day supplies of a medication, which are filled and shipped usually within 3 to 5 business days or, depending on patients' needs, 24 to 48 hours.

If patients have more than one prescription, they can request synchronized delivery so that all are delivered on the same day.

Mail-service pharmacies put patient safety first and improve health outcomes. Along with the convenience of mail, more than 10 years of peer-reviewed evidence details the benefits of mail-service pharmacy, which include higher rates of prescription adherence, improved health outcomes, and greater cost savings from use of generic drugs.

- Patients receiving their medications in 90-day supplies, the typical quantity dispensed by mail, have **higher adherence rates** compared to those receiving 30-day supplies.[1,2,3,4]
- Patients with diabetes who received prescribed heart medications by mail **were less likely to visit the emergency room** than those patients who picked up their medications in person.[5]
- **Having regularly needed medications delivered by mail also is reliable.** Mail-service pharmacies ship hundreds of millions of prescriptions via the U.S. Postal Service and other national mail carriers.

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[1] Elena V. Fernandez, Jennifer A. McDaniel, Norman V. Carroll. Examination of the Link Between Medication Adherence and Use of Mail-Order Pharmacies in Chronic Disease States. *Journal of Managed Care & Specialty Pharmacy* 22, 11 (1247-1259). November 2016.
[2] Matthew Hermes, Patrick P. Gleason, and Catherine I. Starner. Adherence to Chronic Medication Therapy Associated with 90-Day Supplies Compared with 30-Day Supplies. *Journal of Managed Care Pharmacy* 16 (141-142). 2010.
[3] Michael Taitel, Leonard Fensterheim, Heather Kirkham, Ryan Sekula, and Ian Duncan. Medication Days' Supply, Adherence, Wastage, and Cost Among Chronic Patients in Medicaid. *Medicare & Medicaid Research Review* 2, 3. 2012.
[4] Sarah King, Celine Miani, Josephine Exley, Jody Larkin, Anne Kirtley, and Rupert A. Payne. Impact of issuing longer- versus shorter-duration prescriptions: a systemic review. *British Journal of General Practice* 68, 669 (e286-e292).
[5] Julie A. Schmittdiel, Andrew J. Karter, Wendy T. Dyer, James Chan, and O. Kenrik Duru. Safety and Effectiveness of Mail Order Pharmacy Use in Diabetes. *American Journal of Managed Care*. November 2013.

- **Pharmacists and patient counselors often are available 24/7 to provide confidential counseling.** Pharmacists also provide clinical case management, patient education, and support to promote adherence and improved health outcomes.

Mail-service pharmacies enhance safety and accuracy. Computer-controlled quality processes, robotic dispensing, and advanced workflow practices allow mail-service pharmacies to fill large quantities of prescriptions with greater accuracy and reduce potential medication errors to zero in several of the most critical areas, including dispensing the correct medication, dosage, and dosage form.

- **Greater dispensing accuracy.** Peer-reviewed data found that highly automated mail-service pharmacies fill large quantities of prescriptions with 23x greater dispensing accuracy.[6]
- **Fewer medication errors, such as drug-to-drug interactions.** Before mailing a prescription, mail-service pharmacies electronically review the patient's medications to detect any potentially harmful adverse drug reactions—even when the patient uses several pharmacies.[7]
- **Associated with less waste.** A 2011 study of patients taking statin medications found that, on a yearly basis, four 90-day prescriptions dispensed by mail were associated with 3.08 days of waste, as compared to 4.04 days for prescriptions dispensed through retail pharmacies.[8]
- **Safe shipping of prescriptions requiring special handling.** While the vast majority of prescriptions do not require special handling or packaging, for those that do, mail-service pharmacies use U.S. Pharmacopeia guidelines to determine handling needs and leverage proprietary software to map out the ideal packaging journey, which accounts for the acceptable temperature range, forecasted weather conditions, and destination temperatures.

Mail-service pharmacies could save consumers and health plan sponsors, including employers, $59.6 billion over 10 years.[9] Maximizing the appropriate use of mail-service pharmacy may lead to savings of up to 1.2% on overall drug costs.

- Based on a national survey of employer plan sponsors, the median mail-service pharmacy **discount on brand drugs is 3-5 percentage points better.**[10]
- **Mail-service pharmacies have been found to be more cost-effective by several federal agencies,** including the Federal Trade Commission, Department of Defense, Centers for Medicare & Medicaid Services, and U.S. Government Accountability Office, including savings of 16.7% for the TRICARE program and 16% in Medicare Part D.[11]

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[6] In contrast, retail pharmacies had an average error rate of one in 50 prescriptions. *See* J. Russell Teagarden et al. Dispensing Error Rate in a Highly Automated Mail-Service Pharmacy Practice. *Pharmacotherapy: Official Journal of the American College of Clinical Pharmacy* 25, 11 (1629-1635).

[7] In such cases, mail-service pharmacies operated by PBMs do not have purview into competitively sensitive information of their competitors (e.g., pharmacy pricing, reimbursement data, etc.).

[8] T. Vuong et al. Statin Waste Associated with 90-day Supplies Compared to 30-day Supplies. Presented to the Academy of Managed Care Pharmacy. 2011.

[9] Visante. Mail-Service and Specialty Pharmacies Will Save More than $300 Billion for Consumers, Employers, and Other Payers Over the Next 10 Years. September 2014.

[10] Pharmacy Benefit Management Institute (PBMI). 2018 Trends in Drug Benefit Design. February 2019.

[11] Federal Trade Commission, "Pharmacy benefit manager: Ownership of mail-order pharmacies" (August 2005); Office of Inspector General, U.S. Department of Defense, "The TRICARE Mail Order Pharmacy Program Was Cost Efficient and Adequate Dispensing Controls Were in Place" (July 2013); CMS, "Part D Claims Analysis: Negotiated Pricing Between General Mail Order and Retail Pharmacies" (December 2013); and U.S. Government Accountability Office (GAO), "Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies," Figure 2 (January 2003).

Any Willing Pharmacy[1].pdf
Uploaded by: Camille Fesche
Position: UNF

Any Willing Pharmacy (AWP) Policies Undermine Competition and Raise Costs

Health plans and pharmacy benefit managers 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. 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.

How preferred pharmacy networks provide value to patients and payers:

- ***Exclusivity.*** Pharmacies participating in a preferred network can count on a predictably higher volume of sales. Increased sales mean that the pharmacy can pass savings on to patients by setting lower product prices and/or lower dispensing fees—while still meeting its bottom line.

- ***Enhanced Level of Services.*** Plan sponsors typically require preferred pharmacies to deliver higher levels of service, (e.g., enhanced clinical review and management) and access (e.g., longer operating hours).

- ***Emphasis on Quality.*** Participating pharmacies are typically required to comply with quality of care factors measured by Medicare Star Ratings or recommendations from standard-setting bodies such as the National Committee for Quality Assurance (NCQA), URAC, or the Pharmacy Quality Alliance (PQA).

- ***Value-Based Innovation.*** Preferred pharmacy networks are more likely to participate in value-based care activities, such as those with accountable care organizations and preferred provider organizations, where services are rated on quality, cost, and efficiency factors.

- ***Reduction of Fraud, Waste and Abuse.*** Preferred networks enhance a plan sponsor's ability to exclude pharmacies that pose a higher risk of engaging in fraud, waste or abuse.

The utilization of pharmacy networks is growing and effective in driving down costs.

- Preferred networks are gaining traction among employer sponsored plans. In 2013, only 18 percent of these plans were using preferred networks**. By 2017, over half of all employer-sponsored plans were utilizing these exclusive networks.**[1]

- Restrictions on pharmacy networks would cost employers and commercial health plans **$35.56 billion between 2019 and 2028**,[2] diminishing their ability to offer quality health insurance to employees.

The FTC has found that AWP laws undermine competition and raise consumer prices.

According to the Federal Trade Commission, networks and selective contracting generate 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 because:

- When a retail pharmacy "faces no threat of sales losses if it fails to bid aggressively for inclusion in the payers' networks," 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.[3]

PBMs offer their clients a choice of selective networks as a way to reduce costs.

- A selective network provides plan sponsors a great degree of economic control over prescription fulfillment, while maintaining adequate access to pharmacies for members. A pharmacy will offer deep discounts, or a lower dispensing fee to participate in a more exclusive network due to increased volume of business.

- CVS Health found that its network programs have saved payers 4 percent on retail drug costs and that narrow networks tailored to plan sponsors' beneficiaries can reduce retail drug spending by 5-8 percent.[4]

- Express Scripts' clients saved 4.5 percent on pharmacy costs using networks with 20,000 pharmacies.[5]

AWP requirements are not needed to maintain consumer access to pharmacies.

- Proponents of AWP laws claim that these policies are needed to ensure patient access to retail pharmacies. The data tell a different story:

    - Today, consumers have unprecedented levels of access to retail pharmacies. **Since 2005, the number of retail pharmacies has increased 6,000 stores and currently stands at 63,000, and of that number over 23,000 are independent pharmacies.[6]**

    - According to Medicare, **90 percent of Medicare Part D Beneficiaries live within 5 miles of a retail pharmacy and in urban areas that number drops to only 1.1 miles.[7]**

- **Put simply, there is no evidence that consumer access to pharmacies is a problem. Preferred pharmacy networks benefit both plan sponsors and patients.**

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[1] Adam Fein. (2018). *The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers.*
[2] Visante. (2015). *Increased Costs Associated with Proposed State Legislation Impacting PBM Tools.* Available at: https://www.pcmanet.org/increased-costs-associated-with-proposed-state-legislation-impacting-pbm-tools/.
[3] Federal Trade Commission. (March 7, 2014). Letter to the Centers for Medicare and Medicaid Services, Department of Health and Human Services.
[4] CVS Health (2016). "Made-To-Order Networks". Available at: http://investors.cvshealth.com/~/media/Files/C/CVS-IR-v3/reports/cvs-health-insights-executive-briefing-made-to-order-networks-october-2016.pdf.
[5] Joanna Shepherd. (2014). "Selective Contracting in Prescription Drugs: The Benefits of Pharmacy Networks." *Minnesota Journal of Law, Science & Technology.*
[6] Quest Analytics analysis of NCPDP data, January 2018.
[7] Adam Fein. (2018). *The 2018 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers.*

Explaining Types of Pharmacy Benefit Contracts[1].

Uploaded by: Camille Fesche
Position: UNF

Explaining Types of Pharmacy Benefit Contracts

Employers and other plan sponsors contract with pharmacy benefit managers (PBMs) to administer the pharmacy benefit for their enrollees. Plan sponsors typically issue requests for proposals (RFPs) detailing their pharmacy benefit needs, to which PBMs respond and compete on quality, cost effectiveness, and accountability. Once a plan sponsor has selected a PBM, the plan sponsor and PBM negotiate contract terms and conditions. The plan sponsor typically retains rights to audit their PBM as set forth in the contract negotiated with the PBM.

Types of Pharmacy Benefit Contracting Models

Plan sponsors use two basic approaches to pay for the services that their selected PBM performs: risk mitigation or pass-through pricing.

- Risk Mitigation Pricing Model

A **risk mitigation** (sometimes referred to as "spread") pricing model provides employers and other health plan sponsors cost predictability by giving a price-certain for prescription drug benefit reimbursement to pharmacies. If the pharmacy charges more than the rate agreed to between the plan sponsor and the PBM, the PBM takes a loss, as it must pay the pharmacy more than it will be reimbursed by the plan sponsor. If the pharmacy charges less than the PBM's negotiated rate with the plan sponsor, the PBM earns a margin.

Through this model, the PBM takes on the risks of daily fluctuations in drug prices and differing pharmacy charges for the same drug. It also encourages performance-based contracts with pharmacies that reward higher generic dispensing and more cost-effective drug acquisition.

- Pass-through Pricing Model

In a **pass-through pricing model,** the amount paid by the PBM to the pharmacy is passed through to the plan sponsor, and the PBM is compensated through administrative fees. Under this model, the plan sponsor takes on *greater risk* for each prescription dispensed because of the likelihood of pricing differences between and among pharmacies, as well as pricing fluctuation.

The plan sponsor also has less cost *predictability*, as the PBM is passing through the amount paid to the pharmacy of each prescription. For example, there could be a higher volume of prescriptions from higher-cost pharmacies, which the plan sponsor would only discover after the prescriptions have been dispensed.

Considerations for Plan Sponsors

Plan sponsors have every opportunity to choose the pricing model that best suits their needs and typically require PBMs to submit bids for both approaches. Some employers and other plan sponsors choose risk mitigation pricing to ensure *predictability* in knowing what their prescription drug costs will be. **That choice should be theirs to make.**

Risk Mitigation Models in Health Care and Other Industries

- **Risk mitigation is not unique to PBMs and the pharmacy benefit; other health care sectors and industries employ risk mitigation models to manage financial risks.**
    - Capitated Payment in the Medicaid Program: Increasingly since the mid-1990s, state Medicaid agencies have pursued risk-based contracting with private health plans ("managed care organizations," or MCOs) seeking to increase budget predictability, constrain spending, improve access to care, and promote value. In exchange for a set per member, per month capitated payment, Medicaid MCOs provide comprehensive services to enrollees. MCOs are at financial risk for the Medicaid services specified in their contracts should costs exceed the capitation rate.
    - Fuel Price Risk Management by the Airline Industry: Fuel (petrol) costs are a large part of an airline's overhead, which means price fluctuations can affect their costs and the prices they charge. Airlines commonly practice "fuel hedging," whereby they buy or sell the expected future price of fuel, protecting the airline against rising prices.
    - Price Protection Heating Oil Contracts: Similarly, the oil-heat industry often offers a range of heating oil contracts for commercial facilities, such as provider offices and hospitals, to help limit oil-heat costs when oil prices rise. Such options may include fixed-price plans, pre-payment plans, and price protection or "cap" plans.

- **Like these examples, so-called "spread" in pharmacy benefit contracts is not a mark-up.** Simply, it is the average over time of the difference in the *totality* of pharmacy reimbursements agreed to between the plan sponsor and the PBM, and the *totality* of the *actual reimbursement charged by the pharmacy* to the PBM.
    - Again, if the pharmacy charges less than the agreed-upon plan sponsor-PBM rate, the PBM earns a margin for each prescription dispensed.
    - If the pharmacy charges more, and patients fill their prescriptions from these higher-cost pharmacies, the PBM loses money.
    - Either way, the plan sponsor is held harmless and experiences predictable costs—regardless of what pharmacy its employees or enrollees use.

The plan sponsor, as the purchaser of PBM services and as payer of the prescription drug benefit, should have the final say on the type of pricing model it prefers. Reimbursement is and should be a contract term privately negotiated at the plan sponsor's discretion and without government interference.

PBMs provide value by taking on financial risk and negotiating lower drug costs. Removing options from employers and plan sponsors will not do anything to reduce drug prices, premiums, or enrollee's out-of-pocket costs. It will only *increase* costs and *undermine* cost predictability for employers, plan sponsors, and patients.

How Pharmacy Networks Encourage Competition and Pr

Uploaded by: Camille Fesche
Position: UNF

How Pharmacy Networks Encourage Competition and Promote Access

Plan sponsors hire PBMs to manage pharmacy benefits on their behalf. As part of the management of these benefits, PBMs assemble networks of retail and mail pharmacies so that the plan sponsor's members can fill prescriptions easily in multiple locations.

PBMs lower costs and encourage quality care by developing a network of retail pharmacies willing to accept discounted pricing in exchange for access to a plan's members.

- A PBM must establish a network of retail pharmacies so that consumers with prescription drug insurance can fill their prescriptions. Plan sponsors want members to have convenient access to pharmacies providing high quality service. A consumer with a prescription drug benefit plan must utilize a pharmacy that accepts payment for that plan. Therefore,
    - Retail pharmacies must compete to be part of the retail pharmacy network for a particular PBM or risk losing access to the consumer. Store-based retail pharmacies enter into contracts with a PBM to participate in the PBM's retail network and provide prescriptions to a plan's beneficiaries. A GAO study confirmed that PBMs reimburse pharmacies at levels below cash-paying customers, but above the pharmacies' estimated drug acquisition costs.[1]
    - A consumer's out-of-pocket costs and co-payments are typically identical regardless of which pharmacy in the network dispenses the prescription. Therefore, network pharmacies compete on service, convenience, and quality to attract consumers within a particular plan.

PBMs offer their clients a choice of more selective networks as a way to reduce costs further.

- A more selective network provides the plan sponsor with the greatest degree of economic control over prescription fulfillment. A pharmacy will offer bigger discounts or a lower dispensing fee to be in a more exclusive network because each pharmacy in the network will fill a larger percentage of prescriptions for the plan.
- Plan sponsors must balance the access and availability of pharmacies against a higher level of discounts achieved by a smaller network. The network must be sufficient to maintain access but selective enough to garner the necessary discounts.

Consumers using a pharmacy in a PBM's network can have their claim processed almost instantaneously.

- As the claim is adjudicated, PBMs also perform drug utilization review (DUR) to alert the pharmacist to any harmful drug interactions. PBMs are often the only entity with complete information on a patient's medications— particularly when enrollees are prescribed medication by more than one physician or fill prescriptions at different pharmacies.

Pharmacy networks reduce costs because PBMs can screen pharmacy claims for fraud, waste, and abuse.

- Approximately 1 percent of prescription drug costs result from fraud, waste, and abuse. Typical fraud, waste, and abuse detected prior to a claim being paid include prescription claims submitted with the improper quantity, improper days supply, improper coding, duplicative claims, and other irregularities.
- PBMs detect pharmacy fraud, waste, and abuse by screening and auditing prescription claims for common errors, irregular information, and suspicious patterns over time. Claims are compared with historical information as well as claims submitted by similarly situated pharmacies. Substantial changes in the volume of claims or the dollar amount of claims from particular pharmacies can indicate fraudulent activity.

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[1] *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers On Health Plans, Enrollees, And Pharmacies*, General Accounting Office, GAO-03-0196.

Mandated 340B Reimbursement Talking Points[2].pdf
Uploaded by: Camille Fesche
Position: UNF

Mandated Reimbursement Reduces Competition And Raises Costs for Patients and Payers

Private Market Interference Will Raise Costs

- State-mandated contract terms on private market agreements would impede the health plans' and employers' ability to dictate favorable terms through bid and contract negotiations.
- State legislation that mandates reimbursement for pharmacies effectively function as "guaranteed profits". No matter how much a pharmacy spends to acquire a drug, they are guaranteed they will be repaid at least that amount, and likely more.
- Invoiced prices **may not** reflect actual drug acquisition costs because of rebates and discounts – further inflating the guaranteed profits.

Inefficient Cost-Based Procurement Is a Bad Deal For Consumers

- The inflationary consequences of similar cost-based reimbursement systems are well known. For many years, the federal government relied heavily on cost-based procurement for defense contracts, only to discover that this approach resulted in large cost over-runs, because defense contractors knew their costs would be reimbursed, however much they were.
- In the pharmaceutical setting, cost-based reimbursement legislation, similar to government cost based-based procurement systems, is likely to have a number of specific undesirable consequences, including:
    - Increased spending on prescription drugs and costs to employers and other plan sponsors providing pharmacy benefits;
    - Reduced market competition at the wholesaler and manufacturer level;
    - Increased use of off-invoice discounting, thereby decreasing transparency of pharmaceutical pricing and reducing pricing competition;
    - Guaranteed profits for pharmacies, irrespective of their actual efficiency or ability to deliver value-based care; and
    - Reduced patient welfare.

When the Government Picks Winners & Losers the Consumer Pays More

- Legislation being considered that mandates pharmacy reimbursement for employers and other plan sponsors, is designed to benefit pharmacies, at the expense of patients, taxpayers, employers, and other plan sponsors.
- The proponents' goal of price protections is to increase reimbursements and profitability for pharmacies. While some believe that enriching a specific set of private businesses is a laudable goal, these increases in reimbursements will ultimately be funded by someone: in this case, payers—employers, unions, and individual health care consumers.

MMCOA SB689 03 16 2022 UNFAV.pdf
Uploaded by: Jennifer Briemann
Position: UNF

MMCOA
MARYLAND MCO ASSOCIATION

Senate Bill 689 – Pharmacy Benefits Managers – Prohibited Actions

OPPOSE

Senate Finance Committee
March 16, 2022

Thank you for the opportunity to submit testimony in opposition to Senate Bill 689- Pharmacy Benefit Managers- Prohibited Actions.

The Maryland Managed Care Organization Association's (MMCOA) nine member Medicaid Managed Care Organizations (MCOs) that serve over 1.5 million Marylanders through the Medicaid HealthChoice program are committed to identifying ways to improve quality and access to care for all Medicaid participants.

The MCOs are regulated by the Maryland Department of Health with a focus on ensuring high quality care and cost effectiveness. While we applaud the sponsor's efforts to enhance access and quality of pharmacy services in the Program, we believe SB 689 may undermine those processes adopted by MDH and currently utilized to address pharmacist's concerns regarding participation in the HealthChoice program.

As you may recall, MDH recently enacted regulations eliminating the practice of spread pricing which were adopted by MDH to improve the experience of pharmacists in the Medicaid program. Given the nuances and complexity of the Medicaid program, we respectfully oppose measures that would codify in statute what already exist in regulation and in the annual contracts executed by the MCOs. The MCO contracts- signed yearly by each MCO participating in the HealthChoice program- reflect the policies and guidance provided by CMS, and therefore must remain flexible to include or eliminate policies based on best practices for the HealthChoice program and our members. Codifying policies such as the elimination of spread pricing would take away the flexibility needed by MDH and CMS to adjust the provisions of the HealthChoice program.

For these reasons, we respectfully urge an unfavorable report on Senate Bill 689. The MMCOA looks forward to continued collaboration with the State as we work to identify ways to improve access to affordable high-quality care for all Medicaid participants.

Please contact Jennifer Briemann, Executive Director of MMCOA, with any questions regarding this testimony at jbriemann@marylandmco.org.

2022-03-15 SB689 PCMA Opposition Testimony.pdf
Uploaded by: Michael Johansen
Position: UNF

RWL | RIFKIN WEINER LIVINGSTON LLC
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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.

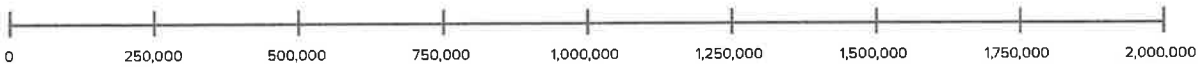
SB689 also extends these prohibitions to self-insured and ERISA exempt plans. While PCMA does not believe the State of Maryland can apply these limitations to federal ERISA exempt plans, recent legal decisions have created uncertainty in the insurance industry. Therefore, we presume the sponsor intends 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	COVERED LIVES
Individual[1]	201,755
Small Group Fully Insured[1]	275,274
Large Group Fully Insured[1]	1,004,062
Self-Funded (ERISA)[2]	1,425,391
Medicare Supplement (Medigap)[3]	252,311
Medicare Advantage[4]	137,602
Medicaid[5]	1,195,899



Health Insurance Employment in Maryland

EMPLOYEES

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

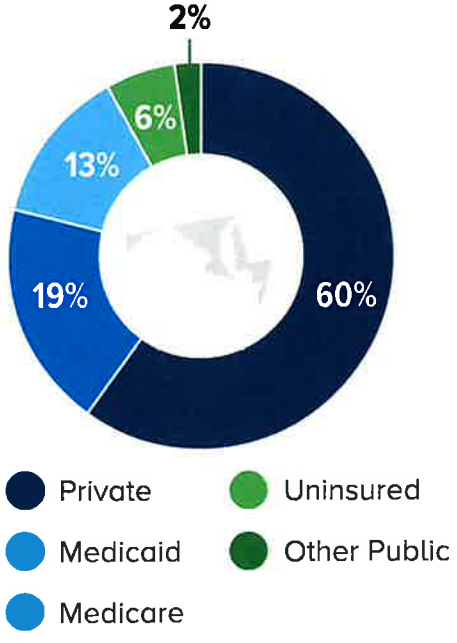
PAYROLL

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 Residents[8]



Data compiled by America's Health Insurance Plans (AHIP), Center for Policy and Research, March 2021.

Benefits inspired by the way you

Montgomery County Benefits Guide

OHIO

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

MONTGOMERY COUNTY

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.

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 Therpy 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).*

3

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		
Speciality	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.

4

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
		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.

(5)

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

6

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*

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

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

(9)

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.

Gallagher Consulting

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

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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1 - X - SB 689 - FIN - MDH - LOI.docx.pdf
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Position: INFO

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

March 16, 2022

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East Miller Office Building
Annapolis, MD 21401-1991

RE: SB 689 – Pharmacy Benefits Managers – Prohibited Actions – Letter of Information

Dear Chair Kelley and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of information on Senate Bill (SB) 689 – Pharmacy Benefits Managers – Prohibited Actions. SB 689 will make §15–1611(B) of the Insurance Article applicable to Pharmacy Benefits Managers (PBM) that contract with Medicaid managed care organizations (MCOs). Among other requirements, PBMs will be prohibited from engaging in spread pricing; taking longer than 30 days to review an application from a pharmacy or pharmacist; denying a pharmacy the right to participate in a policy or contract if they agree to meet the terms of the policy or contract; or requiring a beneficiary to use a mail order pharmacy to fill a prescription.

The requirements in SB 689 will have an indeterminate, but potentially significant, fiscal impact on MDH. The bill will effectively shift PBMs to an any willing provider model. Requiring PBMs to engage with any pharmacy if they agree to meet the terms of the PBMs policy or contract has the potential to significantly impact the PBM's ability to negotiate with drug manufacturers, resulting in the loss of savings realized today. MDH also anticipates that certain PBMs may not be able to meet the 30-day deadline for reviewing new applications from pharmacies and pharmacists, increasing the administrative burden on the PBM, which will be passed on to the MCOs in the form of new costs. To the extent that costs to the PBMs, and by extension the MCOs, to deliver pharmacy benefits increase, these costs will be passed on to MDH and require payment of higher capitation rates to the MCOs.

SB 689 will also reverse the General Assembly's previous policy direction to MDH to have the MCOs administer the Medicaid pharmacy benefit to ensure access to prescription drugs by Marylanders and to manage skyrocketing drug costs.[1] MDH further notes that legislation is not required to eliminate spread pricing from the MCOs' agreements with PBMs. MDH has already taken action on this issue and prohibited this practice as part of the MCOs' contracts since

[1] HB 1290 (2015); report available at:
https://mmcp.health.maryland.gov/Documents/JCRs/MCOpharmacynetworksJCRfinal12-15.pdf

calendar year 2021. Further, MCO enrollees already have the ability to opt out of the use of mail order pharmacies under existing State regulations.[2]

If you have any questions, please contact Healther Shek, Director of Governmental Affairs, at heather.shek@maryland.gov or (410) 260-3190.

Sincerely,

Dennis R. Schrader
Secretary

[2] COMAR 10.67.06.04