SB 1004 Testimony.pdf
Uploaded by: Adelaide Eckardt
Position: FAV

Addie C. Eckardt
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Caroline, Dorchester, Talbot
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Budget and Taxation Committee

Health and Human Services
Subcommittee

Joint Committees
Administrative, Executive,
and Legislative Review

Audit

Children, Youth, and Families

Fair Practices and
State Personnel Oversight

Pensions

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

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Testimony for Senate Bill 1004
Health Insurance - Pharmacy Benefits Managers - Reimbursement Amounts
Finance Committee
March 22, 2022

Madame Chair Kelley and Honorable Members of the Committee:

Thank you for the opportunity to present **Senate Bill 1004 – Health Insurance - Pharmacy Benefits Managers - Reimbursement Amounts.**

Under current law, there is not a standardized cost component allowable for prescriptions that are managed by various pharmacy benefits managers. Community pharmacies across the state are experiencing a downward trend in the cost calculation used by the managed care industry, which is based on an effective rate that does not coincide with the cost of the medication. This has made it so many small pharmacies are cross the state are yielding a net loss for supplying medications, and they are required to fill the prescription at a loss.

Senate Bill 1004 would prohibit pharmacy benefits managers (PBM) from reimbursing a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the National Average Drug Acquisition Cost (NADAC) at the time the drug is administered or dispensed plus 10% of that cost. If NADAC is not available at the time a drug is administered or dispensed, a PBM may not reimburse in an amount that is less than the wholesale acquisition cost of the drug. The Insurance Commissioner may (1) require that a PBM pay a fee, to be determined by the Commissioner, in addition to the minimum reimbursement required and (2) adopt regulations to carry out the bill that include a process for periodically reviewing and recalculating the minimum reimbursement amount.

Thank you for your consideration and I respectfully ask for a favorable report of Senate Bill 1004.

Best regards,

Addie C. Eckardt

Senator Addie C. Eckardt

SB 1004 Written Testimony.pdf
Uploaded by: Charles Kelly
Position: FAV

MEDICAL EQUIPMENT & SUPPLY
CRAIG'S
DRUG STORE
Caring Since 1867
409 Race Street Cambridge MD 21613
Pharmacy - P: 410-228-3322 F: 410-228-3666
Medical - P: 410-228-0058 F: 410-228-1399
www.craigsdrugstore.com

March 21, 2022

Craig's Drug Store is a 155 year old pharmacy serving Maryland's Eastern Shore. For a number of years prescription reimbursement has been declining, and I believe that margins are now at non-sustainable levels.

Prescription reimbursement has been impacted by unfair pricing tactics that are not associated with the actual cost of the product. Effective rates and DIR fees unfairly skew the pricing model in favor of the 3rd party. Our margins at the point of sale are not fixed, and our payment can be reduced or retracted after the claim has been adjudicated. Over the last 3 days we have filled 190 prescriptions below cost yielding a -$2475.86 shortfall. Please consider requiring 3rd party vendors to adhere to a pricing model that requires reimbursement above cost not below, and eliminate the claw-back structure that allows the takeback of payment even after the claim is paid.

Thank You,

Charles Kelly

DOCS-#225950-v1-SB_1004_Oppose_2022.pdf
Uploaded by: Matthew Celentano
Position: UNF

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
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March 22, 2022

The Honorable Delores Kelley
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Senate Bill 1004 - Health Insurance - Pharmacy Benefits Managers - Reimbursement Amounts

Dear Chairman Kelley,

The League of Life and Health Insurers of Maryland, Inc. respectfully **opposes** Senate Bill 1004 – Health Insurance - Pharmacy Benefits Managers - Reimbursement Amounts and urges the committee to give the bill an unfavorable report.

Senate Bill 1004 prohibits a Pharmacy Benefits Manager (PBM) from reimbursing a pharmacy for a prescription drug or pharmacy service in an amount less than the National Average Drug Acquisition Cost (NADAC) plus 10% of that cost. The Insurance Commissioner may also require that a PBM pay a fee in addition to the minimum reimbursement fee.

NADAC has several fundamental flaws that should preclude its use as a basis for pharmacy reimbursement arrangements in both public and private health care coverage settings. The survey responses from retail pharmacies that make up the survey are *strictly voluntary* and CMS sees only an 18-24% response rate. It is important to remember that only a small group of respondents determine the NADAC benchmark. Additionally, the survey over represents smaller pharmacies who do not have the same purchasing power as large chains. These larger chains are better able to leverage their purchasing power with wholesale drug distributors to obtain lower drug prices. This means that the average drug acquisition cost determined by the NADAC survey is artificially high. Setting reimbursement at the NADAC benchmark results in an increased benefit for large pharmacy chains, at the cost of healthcare consumers.

Imposing NADAC in health care coverage settings effectively removes the ability of health plans to harness the power of competition for the benefit of patients, all to exempt pharmacies from the same competition every other stakeholder/participant in the health care industry faces. The proposed reimbursement of NADAC plus 10% in Senate Bill 1004 will only add to healthcare expenditures and cost consumers in the form of drug prices and premiums. Additionally, the bill will not create any significant benefit to independent pharmacies in the long term, as large chains will see the greatest rewards.

NADAC pricing increases costs for prescription drug coverage. Health plan sponsors and PBMs are committed to deploying value-based benefit designs that drive down costs while still providing the most effective and highest quality care to all patients. For these reasons, the League urges the committee to give Senate Bill 1004 an unfavorable report.

Very truly yours,

Matthew Celentano
Executive Director

cc: Members, Senate Finance Committee

2021_Just the Facts_Maryland[1].pdf
Uploaded by: Michael Johansen
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.

2022 Regular Session - Fiscal and Policy Note for

Uploaded by: Michael Johansen

Position: UNF

HB 1007

Department of Legislative Services

Maryland General Assembly
2022 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1007 (Delegate Kipke)
Health and Government Operations

Maryland Medical Assistance Program and Managed Care Organizations That Use Pharmacy Benefits Managers - Reimbursement Requirements

This emergency bill requires Medicaid to establish minimum reimbursement levels for drugs with a generic equivalent that are at least equal to the National Average Drug Acquisition Cost (NADAC) of the generic drug plus the fee-for-service (FFS) professional dispensing fee. If a prescriber directs a specific brand name drug, reimbursement must be based on NADAC of the brand name product plus the FFS professional dispensing fee. A pharmacy benefits manager (PBM) that contracts with a pharmacy on behalf of a Medicaid managed care organization (MCO) must reimburse the pharmacy in an amount that is at least equal to NADAC plus the FFS professional dispensing fee.

Fiscal Summary

State Effect: Medicaid expenditures increase by $24.1 million (60% federal funds, 40% general funds) in FY 2022 to increase pharmacy reimbursement, as discussed below. Federal fund revenues increase accordingly. Future years reflect annualization and inflation. **This bill increases the cost of an entitlement program beginning in FY 2022.**

($ in millions)	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
FF Revenue	$14.5	$59.0	$60.2	$61.4	$62.6
GF Expenditure	$9.6	$39.3	$40.1	$40.9	$41.7
FF Expenditure	$14.5	$59.0	$60.2	$61.4	$62.6
Net Effect	($9.6)	($39.3)	($40.1)	($40.9)	($41.7)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None. In FY2023 the expenditures increase by $98.1 million ($59M FF and $39.3 GF).

Small Business Effect: Meaningful.

Analysis

Current Law: Medicaid must establish maximum reimbursement levels for the drug products for which there is a generic equivalent based on the cost of the generic product. If the prescriber directs a brand name drug, the reimbursement level must be based on the cost of the brand name product.

Chapter 534 of 2019, among other things, required Medicaid to contract with an independent auditor for an audit of PBMs that contract with Medicaid MCOs and provide the results to the General Assembly.

Outpatient pharmacy coverage is an optional benefit under Medicaid. Reimbursement for prescription drugs varies between FFS Medicaid (which covers about 15% of Medicaid enrollees) and HealthChoice (under which Medicaid MCOs cover about 85% of Medicaid enrollees).

In FFS, Medicaid reimburses pharmacies based on a two-part formula consisting of the ingredient cost of the drug and the professional dispensing fee. Effective April 2017, Maryland adopted the NADAC methodology to calculate the ingredient cost of the drug. This methodology estimates the national average drug invoice price paid by independent and retail chain pharmacies. For any drug not included in NADAC, the State uses its own State actual acquisition cost (SAAC) as a secondary benchmark. Thus, for FFS pharmacy expenditures, Medicaid reimburses pharmacies as follows:

- the ingredient cost of the drug based on NADAC or a provider's usual and customary charges, whichever is lower; if there is no NADAC, the lowest of the wholesale acquisition cost, the federal upper limit, SAAC, or a provider's usual and customary charges; and
- a professional dispensing fee of $10.67 for brand name and generic drugs.

In HealthChoice, all nine Medicaid MCOs use a PBM. PBM reimbursement amounts are proprietary and confidential. However, narrative in the 2018 *Joint Chairmen's Report* requested that the Maryland Department of Health (MDH) report on various aspects of pharmacy reimbursement. MDH's response summarized MCO PBM costs for a sample of drugs according to a low, high, and average rate across all MCOs.

The report noted that the FFS average ingredient cost per unit was lower than the MCO average ingredient cost per unit for 37 of the drugs analyzed. However, the professional dispensing fees paid by MCOs were much lower than those paid under FFS. Of the drugs sampled, only 3 had higher MCO dispensing fees than the FFS rate, and the average dispensing fee paid by MCOs across the sample was only $2.63.

State Expenditures: Medicaid expenditures increase by an estimated $24.1 million (60% federal funds, 40% general funds) in fiscal 2022, which assumes April 1, 2022, implementation of the emergency bill. This estimate reflects the additional cost for PBMs used by all nine Medicaid MCOs to reimburse for prescription drugs according to the bill's requirements.

On an annualized basis, MCOs' estimated total ingredient costs are estimated to *decline* by $12.9 million due to use of NADAC for all generic drugs. However, MCO expenditures for dispensing fees are estimated to *increase* by $109.3 million to pay the current FFS professional dispensing fee of $10.67 for a *net increase* of $96.4 million. Future years reflect 2% annual inflation in the cost of prescription drugs and the federal match remaining at 60%. Thus, in fiscal 2023, Medicaid expenditures increase by a *net* $98.4 million. By fiscal 2027, the *net* increase is projected to be $106.5 million.

Small Business Effect: Small business pharmacies benefit from increased professional dispensing fees for Medicaid MCO enrollees, particularly those pharmacies that serve a high proportion of Medicaid enrollees.

Additional Information

Prior Introductions: HB 602 of 2021 received a hearing in the House Health and Government Operations Committee but was withdrawn. HB 756 of 2020 received a hearing in the House Health and Government Operations Committee, but no further action was taken. As introduced, HB 589 of 2019 was substantially similar. The bill was amended and enacted as Chapter 534 of 2019.

Designated Cross File: None.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - March 7, 2022
km/ljm

Analysis by: Jennifer B. Chasse

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2022 Regular Session - Fiscal and Policy Note for

Uploaded by: Michael Johansen

Position: UNF

HB 1009

Department of Legislative Services

Maryland General Assembly
2022 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1009 (Delegate Kipke)
Health and Government Operations

Health Insurance - Pharmacy Benefits Managers - Reimbursement and Cost Sharing

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This bill establishes the minimum reimbursement level that a pharmacy benefits manager (PBM) must provide a pharmacy or pharmacist for a prescription drug or pharmacy service. A PBM is prohibited from specified actions relating to reimbursement. The bill specifies that the prohibition against a PBM reimbursing a pharmacy or pharmacist in an amount less than the PBM reimburses itself or an affiliate for the same product or service applies to all reimbursement paid by any PBM. The bill repeals provisions of law relating to maximum allowable cost (MAC) pricing, disputes regarding cost pricing, and reimbursement and fees for performance-based reimbursement. A beneficiary's cost sharing must be calculated at the point of sale and based on a specified price. The Insurance Commissioner may order reimbursement to an insured, pharmacy, or pharmacist that has incurred a monetary loss as a result of a violation of the bill. **The bill takes effect January 1, 2023, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Expenditures for the State Employee and Retiree Health and Welfare Benefits Program increase by an estimated $40.0 million annually beginning in FY 2023, as discussed below. Any additional impact on the Maryland Insurance Administration (MIA) can be handled with existing budgeted resources. Revenues are not affected.

Local Effect: To the extent the cost of pharmacy services increases, local expenditures for prescription drug coverage increase by an indeterminate amount.

Small Business Effect: Meaningful.

Analysis

Bill Summary:

Minimum Reimbursement Amount for Pharmacies and Pharmacists

A PBM may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the National Average Drug Acquisition Cost (NADAC) at the time the drug is administered or dispensed plus the professional dispensing fee determined by the federal Centers for Medicare and Medicaid Services (CMS) that is in effect at the time the drug is administered or dispensed.

If NADAC is not available at the time a drug is administered or dispensed, a PBM may not reimburse in an amount that is less than the wholesale acquisition cost of the drug plus the professional dispensing fee determined by CMS that is in effect at the time the drug is administered or dispensed.

A PBM may offer a purchaser the option of charging the purchaser the same price for a prescription drug as it pays a pharmacy for the prescription drug as reimbursed by a Medicaid program.

Prohibitions on Pharmacy Benefits Managers

A PBM may not discriminate in reimbursement, assess any fees or adjustments, or exclude a pharmacy from the PBM's network on the basis that the pharmacy dispenses drugs subject to a specified federal agreement or engage in any practice that (1) unless agreed to by the pharmacy in advance, bases pharmacy reimbursement for a drug on patient outcomes, scores, or metrics; (2) imposes a point-of-sale fee or retroactive fee; or (3) except for receiving deductibles or copayments, derives any revenue from a pharmacy or insured in connection with performing pharmacy benefits management services.

Beneficiary Cost Sharing

A beneficiary's defined cost sharing for a prescription drug must be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100% of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug. Any rebate over the defined cost sharing must be passed on to the purchaser to reduce premiums. This provision does not preclude a purchaser from decreasing a beneficiary's defined cost sharing by an amount greater than what was previously agreed to by the purchaser and the beneficiary. The Commissioner may adopt regulations to carry out this provision.

Current Law: A PBM is a business that administers and manages prescription drug benefit plans. A PBM must register with MIA prior to providing pharmacy benefits management services.

A PBM that provides pharmacy benefits management services on behalf of a carrier may not reimburse a pharmacy or pharmacist for a pharmaceutical product or pharmacist service in an amount less than the amount that the PBM reimburses itself or an affiliate for providing the same product or service. This prohibition does not apply to reimbursement for specialty drugs, mail order drugs, or to a chain pharmacy with more than 15 stores or a pharmacist who is an employee of the chain pharmacy.

Maximum Allowable Cost Pricing

MAC means the maximum amount that a PBM or a purchaser will reimburse a contracted pharmacy for the cost of a multisource generic drug, a medical product, or a device. MAC does not include dispensing fees. A PBM must (1) establish a reasonable process by which a contracted pharmacy has access to the current and applicable MAC price lists in an electronic format as updated in accordance with specified requirements and (2) immediately after a pricing update, use the updated pricing information in calculating the payments made to all contracted pharmacies. Before placing a prescription drug on a MAC list, a PBM must ensure its availability, as specified.

Disputes Regarding Cost Pricing

Each contract between a PBM and a contracted pharmacy must include a process to appeal, investigate, and resolve disputes regarding cost pricing and reimbursement under a pharmacy contract, as specified. A PBM may not retaliate against a contracted pharmacy for exercising its right to appeal or filing a complaint with the Commissioner. A PBM may not charge a contracted pharmacy a fee related to the readjudication of a claim or claims resulting from upholding of an appeal.

If a PBM denies an appeal and a contracted pharmacy files a complaint with the Commissioner, the Commissioner must (1) review the compensation program of the PBM to ensure that the reimbursement paid to the pharmacist or pharmacy complies with specified law and the terms of the contract and (2) based on this determination, dismiss the appeal or uphold the appeal and order the PBM to pay the claim or claims in accordance with the Commissioner's findings. All information and data collected by the Commissioner during such a review is confidential and proprietary and not subject to disclosure under the Public Information Act.

Reimbursement and Fees for Performance-based Reimbursement

A PBM or carrier may not directly or indirectly charge a contracted pharmacy, or hold a contracted pharmacy responsible for, a fee or performance-based reimbursement related to the adjudication of a claim or an incentive program. A PBM or carrier may not make or allow any reduction in payment for pharmacy services by a PBM or carrier or directly or indirectly reduce a payment for a pharmacy service under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payments.

State Expenditures: The Department of Budget and Management (DBM) advises that the State Employee and Retiree Health and Welfare Benefits Program is significantly impacted by the bill's provision establishing a minimum reimbursement level of NADAC plus the CMS professional dispensing fee (currently $10.49). The program has negotiated dispensing fees of $0.35 and $0.50 per script for the active employee and retiree populations, respectively. Approximately 1,860,800 prescriptions are filled annually under the program. Thus, expenditures for the program increase by more than $18.6 million annually for additional dispensing fees alone. In total, DBM advises that the bill's provisions increase costs by nearly $40.0 million in calendar 2023; however, this cost estimate does not account for any rebate impact.

Small Business Effect: Small business pharmacies receive additional reimbursement under the bill.

Additional Information

Prior Introductions: None.

Designated Cross File: None.

Information Source(s): Department of Budget and Management; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - March 9, 2022
fnu2/ljm

Analysis by: Jennifer B. Chasse

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Requiring Cost-Based, Cost-Plus Pharmacy Reimburse

Uploaded by: Michael Johansen

Position: UNF

Requiring Cost-Based or Cost-Plus Reimbursement of Pharmacies Raises Costs and Undermines Value

Various states are considering legislation mandating a certain level of reimbursement for pharmacies by employers and other plan sponsors, whether by limiting the circumstances under which maximum allowable cost (MAC) programs can be used or requiring a specific methodology for reimbursing pharmacies (e.g., AWP, AAC, NADAC) plus a set dispensing fee. For example, one state enacted legislation requiring pharmacy benefit managers (PBMs) to reimburse pharmacies at least their invoiced acquisition cost – even if a lower priced option was available. These kinds of requirements do nothing to actually lower drug costs or improve value for patients; rather, they guarantee profits for pharmacies and increased revenue for wholesalers at everyone else's expense.

Cost-Based or Cost-Plus Reimbursement Undermines Affordability

"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."[1] When employers and other plan sponsors are *required* to reimburse pharmacies at whatever cost the pharmacy purchases[2] a drug or using a specific cost-based methodology, an important cost and quality restraint is removed from the drug supply chain. These kinds of "guaranteed profit" requirements impose a "blank check" approach to reimbursement and undermine affordability for patients.[3]

Cost-Based and Cost-Plus Reimbursement Limits Competition and Transparency

Pharmacy reimbursement requirements promote use of off-invoice discounting, which decreases transparency of drug prices and further hamstrings pricing competition.

If the goal is to understand exactly how much drugs cost, it is necessary to consider all discounts and rebates associated with pharmacies' actual purchase price – whether they appear on an invoice or are recorded elsewhere. Survey-based reimbursement methodologies or reliance on pharmacy invoices cannot do that. Rather, they *can* lead to cost inflation (as high as 10%)[4], guaranteed profits for certain drug supply chain actors, and reduced transparency – all at the expense of patients, taxpayers, and plans.

Requiring Cost-Based or Cost-Plus Reimbursement Raises Costs

State officials set pharmacy reimbursement rates for Medicaid that often are higher than those for Medicare and the commercial market. If all state Medicaid programs were to use market-based pharmacy reimbursement, taxpayers would save an estimated $9 billion over 10 years.[5]

[1] David A. Hyman. The Adverse Consequences of Mandating Reimbursement of Pharmacies Based on Their Invoiced Drug Acquisition Costs. January 2016.
[2] Because of rebates and discounts, pharmacies' invoiced prices may not reflect actual drug acquisition costs – further inflating the potential for guaranteed profits.
[3] 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.
[4] Washington Health Care Authority Fiscal Note for SSB 5857. *See* https://scholarship.law.gwu.edu/cgi/viewcontent.cgi?article=2483&context=faculty_publications.
[5] The Menges Group. Medicaid Pharmacy Savings Opportunities: National and State-specific Estimates. October 2016.

February 2021

Creating an Incentive for Pharmacies to Buy at the Lowest Price

Because pharmacies purchase different drugs at different times and in different volumes, the price of a particular drug can vary significantly among pharmacies—even within a specific drug class or type. If patients can fill their prescription at lower-cost pharmacy locations, they, and, if they are insured, their health plans, can spend less.

Employers and other plan sponsors, with their PBMs, contract with pharmacies for a set price for the same reason.[6] **These pharmacies, which typically form a plan's pharmacy network, are incented to *purchase* the drugs that they dispense efficiently and based on competitive market rates.**

How Market-based Pharmacy Reimbursement Models Work

MAC and other market-based pharmacy reimbursement models ensure patients, taxpayers, employers, and other plan sponsors – those ultimately paying for a drug – get the lowest possible price. These models are designed to give pharmacies an incentive to shop around among wholesalers to find a given drug at the lowest cost available.

Under market-based pharmacy reimbursement models, if pharmacies purchase a higher-priced product, they may not make as much profit or, in limited instances, may lose money on that specific drug. Alternatively, if they purchase drugs at a more favorable price available in the marketplace, pharmacies will make a higher profit. Market-based reimbursement models play an important role in keeping incentives aligned for payers and pharmacies.

Cost-Based or Cost-Plus Reimbursement Undermines Value-based Care

Reimbursement requirements discourage pharmacies from joining plans' preferred pharmacy networks, which undermines value for patients. In addition to lowering total drug spending and patients' out-of-pocket costs[7], preferred networks improve health outcomes, promote high-quality care, and advance the transformation to value-based care by:

- Incorporating risk sharing with preferred pharmacies to encourage higher use of cost-effective generics and other evidence-based health promotion strategies
- Including pharmacists in teams that integrate care for high-risk patients
- Incentivizing pharmacies to provide patient care services and supports as part of accountable care arrangements and other ways to further health outcomes

Bottom Line: Legislation requiring pharmacy reimbursement by employers and other plan sponsors is designed to benefit pharmacies, at the expense of patients, taxpayers, employers, and other plan sponsors.

[6] For example, when Medicare Part D plans switch to preferred pharmacy networks, beneficiaries, on average, pay lower premiums and lower out-of-pocket prices for drugs, with no concurrent reduction in access to drugs or pharmacies. *See* Oliver Wyman. Impact of the Elimination of Preferred Pharmacy Networks in the Medicare Part D Program. March 7, 2014.

[7] Amanda Starc and Ashley Swanson. "Promoting Preferred Pharmacy Networks." 1% Steps for Health Care Reform. 2021; and Milliman. The Value of Alternative Pharmacy Networks and Pass-through Pricing. 2010.

SB 1004 2022 MIA Letter of Information FINAL.pdf
Uploaded by: Kathleen Birrane
Position: INFO

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

KATHLEEN A. BIRRANE
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TESTIMONY OF
THE
MARYLAND INSURANCE ADMINISTRATION
BEFORE THE
SENATE FINANCE COMMITTEE

MARCH 22, 2022

SENATE BILL 1004 – HEALTH INSURANCE - PHARMACY BENEFITS MANAGERS - REIMBURSEMENT AMOUNTS

POSITION: LETTER OF INFORMATION

Thank you for the opportunity to provide written comments on SB 1004.

SB 1004, if enacted, would create a new § 15-1628.3(c) of the Insurance Article. Proposed § 15-1628.3(c) establishes the minimums that a Pharmacy Benefits Manager (PBM) must reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service. In addition, proposed § 15-1628.3(c)(3) would allow the Maryland Insurance Administration (MIA) Commissioner to require that a pharmacy benefits manager pay "a fee," to be determined by the Commissioner, in addition to the reimbursement amount required under this subsection. The Commissioner would also have the option of issuing regulations to carry out the subtitle, including a process for periodically reviewing and recalculating "the reimbursement amount" under this subsection.

The MIA has identified several technical issues with the bill as drafted.

First, §15-1628.3(c) effectively creates a new payment model, where the standard minimum reimbursement amount is NADAC plus 10%. This conflicts with existing § 15-1628.1 (not changed by SB 1004) which addresses Maximum Allowable Cost (MAC) pricing, as well as existing § 15-1628.3(a) and (b) (also not changed by SB 1004).

Second, the proposed bill would vest the Commissioner with discretion to determine when a PBM should be required to pay an additional amount as a fee to pharmacists and to

promulgate regulations to review and recalculate any pharmacy reimbursement amounts. As drafted, SB 1004 does not identify what the additional fee is for and provides no guidance or standards for when such a fee would be appropriate and no benchmark for setting the fee. Likewise, SB 1004 would empower the Commissioner to adopt regulations to review and "recalculate" pharmacy reimbursement amounts, also without benchmarks or standards to be used to guide any such review or recalculation.

The MIA does not believe that setting reimbursement rates and fee schedules for pharmacy services is properly within the purview of the Insurance Commissioner. It is the role of the Commissioner to enforce reimbursement and fee standards set by the legislature or other governmental authorities. **Given this, the MIA respectfully suggests that § 15-1628.3(c)(3) be removed and/or replaced with a different methodology for establishing any additional fees to be paid by PBMs and for adjusting reimbursement rates and fees, which the MIA would then enforce.**

The MIA thanks the committee for its attention to this information concerning SB 1004.