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Pharmacy Benefit Managers: States Put the Middlemen on the Run – Passing Multiple Laws in 2018

By **Thomas Sullivan** Last Updated **Jun 28, 2018**

As the federal government continues talking on ways it could address drug costs for tomorrow, state legislatures are acting to address the issue today. State lawmakers are targeting everyone within the industry: drug manufacturers, wholesalers, pharmacies, insurance providers, and the middlemen, the pharmacy benefit managers ("PBMs"). But with six months into the 2018 legislative session, state legislation that became law targeting PBMs should not go unnoticed.

The most common issue addressed by lawmakers has been "gag clauses," which have been used as a means to contractually prevent pharmacists from disclosing to patients that they could pay less out-of-pocket, including patients overpaying due to their copayment exceeding the actual cost of the drug (known as "clawbacks"). According to the National Conference of State Legislatures, since 2016, 22 states have enacted legislating prohibiting PBM "gag clauses" with at least 40 legislatures that have considered the prohibition. But of those 22, 18 states have passed law prohibiting the "gag clauses" in 2018. In the Health and Human Services' *American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs* (the "Blueprint"), HHS discusses how it *may* prohibit Part D plans from engaging in similar conduct (see our Policy & Medicine article here on the Blueprint).

Unless otherwise indicated, each bill below has been passed and signed into law, which includes the corresponding session law (e.g., Act 1, Public Law 100, Chapter No. 100, etc.).

Prohibiting "Gag Clauses"

- Alaska (HB240 – awaiting transmittal to governor)
- Arkansas (HB1010 – Act 1; SB2 – Act 3)
- Arizona (HB2107 – Chapter 133)
- Colorado (HB1284 – Chapter 181, pp. 1233-34)
- Florida (HB351 – Chapter No. 2018-91)
- Indiana (HB1317 – Public Law 209)
- Kansas (SB351)
- Kentucky (HB463 – Acts, ch. 144)
- Louisiana (HB436 – Act 597; SB241 – Act 317)
- Maryland (SB576 – Chapter 218; HB736 – Chapter 217)
- Mississippi (HB709 – Chapter No. 331)
- Missouri (SB826; delivered to governor for signature)
- New Hampshire (HB1791 – Chapter 164)
- South Carolina (H5038 – Act No. 177)
- South Dakota (SB141 – Chapter 281)
- Tennessee (SB2362/HB2219 – Public Chapter 1015)
- Utah (SB208 – Chapter 305)
- Virginia (HB1177 – Chapter 245; SB933 – Chapter 602)
- Vermont (S92 – Act 193; see our Policy & Medicine article here)
- West Virginia (SB46 – Chapter 123, Acts, Regular Session, 2018)

Concerning Maximum Allowable Cost ("MAC") Lists

According to the National Community Pharmacists Association ("NCPA"), a "MAC" list refers to a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs and brand name drugs that have generic versions available. Essentially, it leaves pharmacies in the dark about how they will be paid. The NCPA states that MAC legislation would: (1) Provide clarity to plan sponsors and pharmacies with regard to how MAC pricing is determined and updated and establishing an appeals process in which a dispensing provider can contest a listed MAC price; (2) Provide standardization for how products are selected for inclusion on a MAC list; and (3) Compel PBM disclosures to plan sponsors about the use of multiple MAC lists and whether or not MAC pricing is utilized for mail order products.

- Alaska (HB240 – awaiting transmittal to governor)
- Florida (HB351 – Chapter No. 2018-91; moves existing requirement to Office of Insurance Regulation, which gives the office enforcement authority)
- Louisiana (HB 436 – Act 597; also revises appeals related to MAC pricing)
- Maryland (HB1349 – Chapter 451; also revises appeals related to MAC pricing)

Prohibiting PBMs from Requiring Accreditation

These laws would restrict PBMs from setting accreditation standards. For example, some PBMs have imposed requirements that it will only accept and process claims for products if they were purchased from an entity that has been accredited by the National Association of Boards of Pharmacy Verified-Accredited Wholesale Distributor (VAWD) program.

- Arkansas (HB1010 – Act 1; SB2 – Act 3)
- New Hampshire (SB591 – Chapter 236; HB1746 – Chapter 92)

Prohibiting PBMs from Retaining Drug Rebates

- Louisiana (SB130 – Act 483; requires Medicaid pharmacy benefit manager contracts to be limited to a set per transaction rate for every pharmacy claim paid; also prohibits pharmacy benefit managers from retaining federal drug rebates, credits, or "spread pricing" amounts in excess of what they paid the pharmacist)

PBM Reimbursement Report

- Utah (SB208 – Chapter 305; requires a "pharmacy service entity" (includes PBMs) to report certain information to pharmacies or the pharmacies' pharmacy services administration organization)

Audit Restrictions

- Alaska (HB240 – awaiting transmittal to governor; if signed into law, would impose certain auditing limitations on PBMs)
- Alabama (HB457 – Act No. 2018-457; imposes limitations on recoupment for certain errors by a pharmacy, unless error resulted in overpayment to the pharmacy)

Takeaway

With some state legislatures still in session, there is a good chance the list above could grow. Clearly, the state lawmakers have the PBM middlemen on the run.

THE WALL STREET JOURNAL.

Hidden Profits In the Prescription Drug Supply Chain

Pharmacy benefit managers far more profitable than they seem, which makes them vulnerable to new competitors

By Charley Grant
Feb. 24, 2018 10:00 a.m. ET

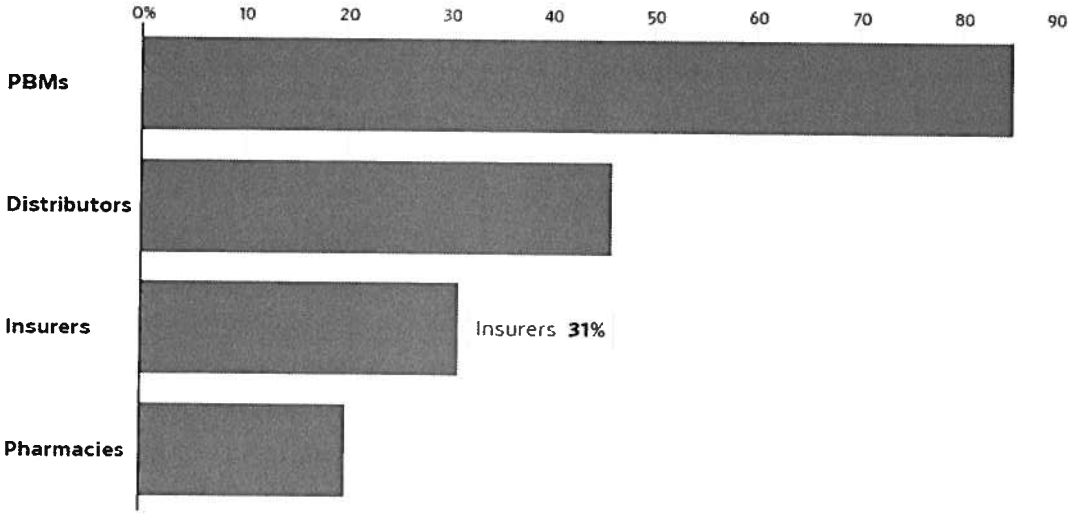
Depending on how you look at them, pharmacy-benefit managers are either low-margin middlemen that fight to reduce drug costs, or highly profitable intermediaries that take a cut of every prescription and earn more when drug prices rise.

Pharmacy-benefit managers are hired by businesses such as insurers that pay for drugs to negotiate lower prices with pharmaceutical companies. When the largest pharmacy-benefits manager, Express Scripts Holding, reports fourth quarter earnings on Tuesday, analysts expect a profit margin of just 4.7%, according to FactSet. Rival companies owned by CVS Health CVS 1.74% and UnitedHealth Group UNH 0.45% report similarly low margins.

But a closer look shows the business is far more attractive than those low margins would suggest. Included in Express Scripts' revenue is the cost of the underlying drugs they sell.

Thus Express Scripts generated gross profit of just $1.8 billion on total sales of $24.7 billion in the third quarter. Gross profit is revenue minus the cost of goods sold, but nothing else.
In general, however, the pharmacy-benefits manager doesn't actually take delivery of the drug. That means these companies don't spend much on fixed assets, which keeps selling and administrative costs, as well as depreciation and amortization charges, very low.

Big Profits



Rate at which drug supply chain converts gross profit into Ebita
Note: Ebita: earnings before interest taxes depreciation and amortization / Source: Bernstein

Analysts at Bernstein tried to get a better picture of how profitable these companies are by excluding the cost of the drugs that are included in their revenue. The analysts compared the rate at which gross profit converts into earnings before interest, taxes, depreciation and amortization for pharmacy-benefits

Independent pharmacists say they first noticed a decline in Medicaid payment rates three years ago. CVS slashed them further last fall. For 35 years Larry Hildebrand ran a pharmacy in Marengo, a town with a few hundred people. When he started to lose money from declining Medicaid payments, he sold his pharmacy to CVS, which bought his drug inventory and prescription files. After he closed, his customers had to travel 25 more miles to get prescription filled at CVS.

Dominic Bartone has been a pharmacist for 41 years and operated three retail pharmacies in Dayton and two in Lebanon. After CVS cut payment rates last fall, his Lebanon pharmacies were losing money on between 40 to 50 prescriptions a day. When Mr. Bartone complained to the MCOs about below-cost reimbursements, he didn't get a response. Eventually he had to stop delivering prescriptions to patients in institutions. In February he and his business partners sold the stores to CVS.

Most pharmacists don't want to be publicly identified because their CVS contract bars them from disclosing payment rates. But one said he was getting paid 18 cents per capsule of the generic antidepressant duloxetine while his wholesale cost is about 23 cents. According to Centers for Medicare and Medicaid Services data, PBMs in Ohio last fall were charging Medicaid $1.53 per duloxetine pill. The spread pricing for a 60 mg dosage of duloxetine during the first nine months of 2017 totaled $6.3 million.

Several pharmacists said that they were losing between $60 and $100 last fall on each prescription of buprenorphine, a generic opioid addiction treatment.
Ohio state Senator Dave Burke, who runs an independent pharmacy and serves on the state Joint Medicaid Oversight Committee, says two-thirds of the Medicaid drug claims he processes are below his drug acquisition cost. He's fortunate that Medicaid patients make up less than a quarter of his customers.

CVS payment rates, he says, are "take it or leave it." Independent pharmacists have no negotiating leverage. If pharmacists refuse to accept Medicaid prescriptions, they risk losing CVS contracts for Medicare Part D and commercial plans that typically pay more.
Some pharmacists said that after the Medicaid payment reductions they received solicitations from CVS Pharmacy Regional Director of Acquisitions Shane Stockton saying: "I'm a pharmacist myself. I know what independents are experiencing right now; declining reimbursements; increasing costs, a more complex regulatory environments. Mounting challenges like these make selling your store to CVS Pharmacy an attractive and practical option."

In the last three years, Ohio has lost 164 independent pharmacies while CVS has added 68. A CVS Caremark spokesperson told us that the company maintains a firewall between its PBM and retail pharmacies as required by a 2007 Federal Trade Commission merger agreement. CVS also says it pays independent pharmacies on an aggregate basis more than chains, though the spokesperson didn't define aggregate.

When Arkansas Independent Pharmacies obtained insurance explanation of benefits data from Medicaid patients, they found that CVS Caremark billed Medicaid plans more than twice as much on average as what their pharmacies got paid. Data from fully-insured commercial health plans showed that CVS paid itself over $60 on average more per prescription than independent pharmacists.

ObamaCare requires MCOs to spend at least 85% of all taxpayer dollars on patient medical claims and care improvements. The rest can be split among overhead, marketing and profits. Contracting with PBMs allows MCOs to off-load administrative costs and thus take more profit. Rising drug claims also let them pocket more money. Mr. Burke, the Ohio legislator, says this dynamic encourages a "don't ask, don't tell" relationship between PBMs and MCOs.
States ostensibly have an incentive to curb their Medicaid spending and scrutinize PBM payments. Yet many may be turning a blind eye because they can pass on the bills to the federal government, which picks up 63% of the costs for Ohio's pre-ObamaCare population and 94% for the expansion population.

But as neighborhood pharmacies close, health-care access for low-income patients diminishes. That at the very least should concern politicians.
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LAW360
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GOP Lawmakers Seek FTC Scrutiny Of Drug Benefit Managers

 By **Jeff Overley**

Law360 (July 27, 2018, 6:47 PM EDT) -- Republicans on the House Energy & Commerce Committee asked the Federal Trade Commission on Friday to examine how consolidation among pharmacy benefit managers has affected drug prices, adding to fast-rising scrutiny of PBMs.

In a letter to FTC Chairman Joseph J. Simons, three committee leaders urged the commission to review how past mergers involving PBMs have affected prices paid by consumers. The Republicans also sought an analysis of whether PBMs have saved money for the health insurers and large employers that they represent in negotiations with drugmakers.

It has long been assumed that PBMs drive down costs. But that assumption has come under a microscope lately, and the administration of President Donald Trump is **moving to curtail rebates** that PBMs negotiate. Its view is that rebates encourage higher list prices for drugs, harming consumers if discounts aren't passed along.

In Friday's letter, the GOP lawmakers — Reps. Greg Walden of Oregon, Gregg Harper of Mississippi and Michael Burgess of Texas — noted that "there is conflicting information ... on the impact of PBMs on health care costs for patients."

"Because some mergers may benefit patients while other mergers may harm patients, we believe it is important to closely monitor these [consolidation] trends," the lawmakers wrote.

The activities of PBMs have already landed on the FTC's radar. In November, for example, it staged a conference that was devoted partly to discussion of how PBM negotiations "ultimately affect the prices consumers pay for prescription drugs."

Significant consolidation has occurred among PBMs in recent years, and the industry is now dominated by three companies: CVS Health Corp., Express Scripts Inc. and UnitedHealth Group Inc. division OptumRx Inc. The industry is poised for further evolution: CVS is looking to scoop up health insurer Aetna Inc., and health insurer Cigna Corp. is planning to buy Express Scripts.

The Pharmaceutical Care Management Association, which is the PBM industry's main trade group, has aggressively pushed back against suggestions that PBMs aren't all they're cracked up to be. After the Trump administration recently disclosed plans to alter an Anti-Kickback Statute safe harbor for drug rebates, the PCMA said that the move raised "troubling questions" and would not bring down list prices.

Drugmakers that have faced withering criticism over price hikes in recent years have seized on the opportunity to shift blame to PBMs. Another trade group, the Pharmaceutical Research and Manufacturers of America, earlier this month called for "reforms that prevent pharmacy benefit managers ... from having their compensation calculated as a percent of the list price of a medicine and instead a fee based on the value their services provide."

Representatives of the PCMA and the FTC could not immediately be reached for comment Friday.
--Editing by Dipti Coorg.

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Kentucky's Business News Source

Pharmacy benefit manager bill goes to governor

April 3, 2018

FRANKFORT, Ky. (April 3, 2018) – The state Senate gave final passage today to a bill intended to ensure independent pharmacists are fairly reimbursed for filling prescriptions of Medicaid recipients.

Senate Bill 5, as amended by the House, would make the Kentucky Department for Medicaid Services in charge of setting the reimbursement rates for a pharmacist. The rate is currently set by pharmacy-benefit managers (PBMs) hired by the state's Medicaid managed-care organizations (MCOs).

"As many of you know, the Kentucky legislature has spent an inordinate amount of time over the past several sessions of the General Assembly trying to play the role of policeman between PBMs and pharmacists," said Sen. Max Wise, R-Campbellsville, who sponsored the legislation. "The (amendment) gives the Kentucky Medicaid department clear authority to police pricing terms and contracts while we are not in session."

He said Kentucky Medicaid spends $1.7 billion annually on prescriptions and SB 5 would help authorities track that money and determine whether locally-owned pharmacies were being reimbursed fairly.

Another provision would allow the state Medicaid and insurance departments to issue penalties if a PBM fails to comply with the legislation.

"This bill … truly is a very transparent bill," Wise said, adding SB 5 may become a model for the nation.

Independent pharmacies in several states have claimed in recent months that PBMs owned by national pharmacy chains are not fairly reimbursing them. The dominate PBM in Kentucky, for example, is only paying independent pharmacists a professional dispensing fee of 85 cents per prescription, Wise said. The Centers for Medicare and Medicaid Services states that fee should be around $10.64, plus the cost of the drug being dispensed. The measure passed by a 37-0 vote.

AXIOS

By Bob Herman, August 1, 2018

The data showing drug pricing games

Data analyses from 46brooklyn Research, a new firm started by two people with experience in the pharmacy industry, outline historic trends of drug prices and costs in Medicaid programs across the country in an open, transparent format.

The bottom line: These datasets are the clearest examples yet that show specifically how some states are getting bad deals on prescription drugs — and how middlemen like pharmacy benefit managers manipulate the current drug pricing system for their own gains.

The details: 46brooklyn's visualizations use and merge several sources of federal data. The resulting maps and graphics detail what PBMs charge state Medicaid programs for certain drugs and what those drugs cost pharmacies. The spread between those figures essentially is the profit that PBMs and other middlemen collect.

Eric Pachman, a former manager of pharmacies, and Antonio Ciaccia, a lobbyist with the Ohio Pharmacists Association, decided to mine the data independently after noticing pharmacy margins tied to Ohio's managed Medicaid program were dropping everywhere. "It's exposing how the system works," Pachman said.

The data mostly show PBMs are reaping large Medicaid windfalls on *generic* drugs, not brand-name drugs (although clandestine rebates make brand-name drugs lucrative in other markets).

In numerous instances, after a brand-name drug loses patent protection and generics hop onto the scene, the costs of that drug decrease dramatically.

However, many states are not benefiting from those falling generic prices and are paying significantly more.

How it works: One of the most visible examples is imatinib mesylate, the generic version of Novartis' cancer drug Gleevec. A pharmacy's acquisition cost of a 400-milligram tablet of generic Gleevec roughly costs $84. But Indiana's Medicaid program paid middlemen almost $300 per pill, while Washington's Medicaid agency paid only $109 per tablet. Several other states paid more than $200 per pill.

"That's right — same drug, same time, different state, way different price," Pachman and Ciaccia wrote.

But this is not a one-off phenomenon.

Pharmacies were paid about $0.39 per unit of hydroxychloroquine, an immunosuppressive drug, and that amount has decreased steadily since 2015. But PBMs billed Kentucky more than $2.50 per unit.

Costs for a 6-milligram tablet of paliperidone, a schizophrenia drug, were about $12 in Ohio. But the state was charged more than $17.50 per unit, which the Columbus Dispatch has reported. The spreads for paliperidone were even larger in Arizona, Indiana, Nevada and New Hampshire.

"One of the key components of the system is that transition of brand-name drug to generic drug," Ciaccia said. "That is the core cost-containing measure of the U.S. system. And if you would allow a PBM or any third-party vendor to over-inflate that amount ... you are being set up to lose every time."