National Alliance of State Pharmacy Associations

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February 12, 2020

Representative Jene Vickrey
Chair, House Committee on Insurance
Kansas State Capitol
SW 8th & SW Van Buren
Topeka, KS 66612

Re: Letter of Support for House Bill 2598

Dear Representative Vickrey:

The National Alliance of State Pharmacy Associations (NASPA) supports House Bill 2598, which would provide much-needed oversight of pharmacy benefits managers (PBMs), ensure greater transparency in prescription drug pricing, and increase patient access to health care. We encourage the Committee on Insurance to pass HB 2598.

The National Alliance of State Pharmacy Associations (NASPA), founded in 1927 as the National Council of State Pharmacy Association Executives, is dedicated to enhancing the success of state pharmacy associations in their efforts to advance the profession of pharmacy. NASPA's membership is comprised of state pharmacy associations and over 70 other stakeholder organizations. NASPA promotes leadership, sharing, learning, and policy exchange among its members and pharmacy leaders nationwide.

Current PBM practices lead to decreased access for patients.

With three large PBM companies now making up nearly 80% of the market, pharmacies (especially those that are independently owned, but also chains) are faced with "take-it-or-leave-it" contracting. The terms pharmacies are forced to accept frequently include:

- Negative reimbursements (payments for products that are lower than the cost the pharmacy pays to acquire the product)
- Vague fees (such as direct and indirect remuneration fees or DIR) that are assessed months after a particular prescription is filled – giving the pharmacy little opportunity to predict the effect of those fees on their business
- Dispensing fees that are vastly lower than the true cost to dispense a prescription
- Administrative burdens such as harsh auditing procedures

Private contracting is usually not the concern of policy makers – even if the party with less bargaining power cannot negotiate better terms, often they can walk away from the deal. However, PBM consolidation creates a unique problem. If a pharmacy rejects a PBM's contract because a particular term will not work for their business, it could result in nearly one-third of their patients being forced to find another pharmacy, undermining patient choice and potentially limiting access.

Consider a small town where there is only one pharmacy. If that pharmacy stops contracting with one of the three big PBMs, up to 30 percent (or more if one of the PBMs has a larger share of the local market)

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will have no local pharmacy from which they can access their medications. The pharmacy is then in the impossible position of deciding between their bottom line and harming the community they serve. As trusted healthcare advisors, pharmacists often choose to protect their patients and take the PBMs' terms. Over time, accepting negative reimbursements to the detriment of their bottom line has resulted in increasing numbers of pharmacies closing altogether. Consequently, the entire community is left without access to a pharmacy, exacerbating existing health care access issues across the state, especially in rural communities.

Lack of transparency results in increased overall costs.

A lack of transparency in PBM practices are resulting in increased overall costs in the health care system. For example, manufacturer rebates are negotiated between PBMs and pharmaceutical manufacturers to induce PBMs to include certain drugs on the prescription drug formulary or to include them at a lower copay tier. A fraction of the same rebate is then given to PBM clients to induce the same drug to be included on their individual organization's formulary. This practice causes higher-cost prescription drugs – that would normally be placed on a higher copay tier in order to incentivize consumer use of an equally effective but less expensive alternative – to be used more frequently and produce higher costs in the long run, usually exceeding the small financial benefit the PBM's client receives from the rebate. Since the PBM is not designated as a fiduciary to their clients, they have no legal obligation to stop this from happening and instead benefit greatly from the significant portion of the manufacturer rebate that goes to the PBM's bottom line.

PBMs also maintain multiple proprietary maximum allowable cost (MAC) lists which they use to reimburse pharmacies and to bill their clients for the cost of generic drugs. These MAC lists were initially developed to motivate pharmacies to seek the lowest price for generic medications, but this system does not work without some degree of transparency. Pharmacies have no idea what sources are used to develop these MAC lists and may not be able to access generics at the MAC list prices due to the pharmacy's geographic location or size, resulting in negative reimbursement levels and pharmacies dispensing multiple drugs at a loss, as mentioned above. In addition, PBMs will often use one MAC list to charge a higher price to their clients while using another MAC list to reimburse pharmacies at a lower price, pocketing the spread.

Many factors in the health care industry have dramatically changed in the last decade. Patients, pharmacies, and payers are experiencing significant challenges, and states are struggling to find effective solutions. Greater transparency and accountability is needed in the PBM industry, and HB 2598 would create that transparency and accountability. We appreciate the opportunity to share our comments, and we strongly encourage the Committee on Insurance to pass HB 2598.

Sincerely,

Allie Jo Shipman

Allie Jo Shipman, PharmD, MBA
Director, State Policy
National Alliance of State Pharmacy Associations

Cc: House Committee on Insurance