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NAIC Pharmacy Benefit Manager Regulatory Issues Subgroup Pharmacist Industry Perspective

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Anne Cassity, JD

VP, Federal and State Government Affairs

Matthew Magner, JD

Director, State Government Affairs

Who are we?

NCPA members are **community-based health care professionals** and entrepreneurs. NCPA members employ more than 250,000 individuals nationwide.

Independent pharmacists are **uniquely positioned** to **customize solutions** to health care challenges affecting **local communities and employers.**

Profile of Community Pharmacists

- **22,000 pharmacies nationwide**
- **Local employers**
 - Contribute to the tax base
 - Provide civic leadership
- **80% located in areas with populations <50,000**
 - Essential health care providers in underserved areas
 - Local health care problem solvers

Full-Line Independent Community Pharmacies



86%

of the respondents to the 2018 NCPA Census consider themselves full-line pharmacies*

Here is what these full-line pharmacies are offering...



82%

provide
**MEDICATION
THERAPY
MANAGEMENT**
services

**MEDICATION
ADHERENCE/
SYNCHRONIZATION**
services are provided by



89%

74%



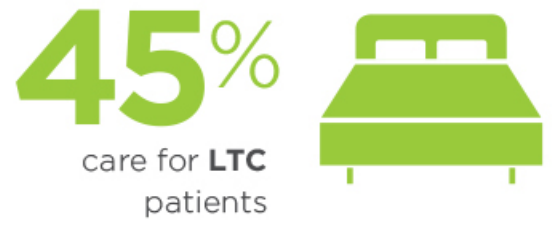
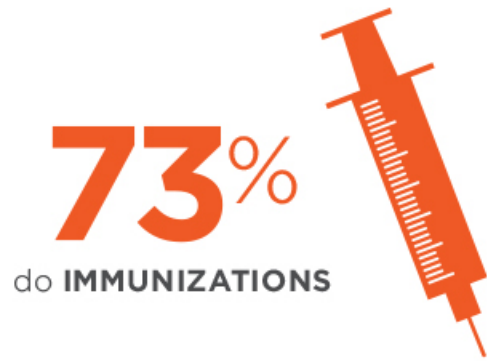
offer **SAME-DAY, IN PERSON DELIVERY**



**BLOOD
PRESSURE
MONITORING**
is offered by

60%

*The 2018 *NCPA Digest* findings are based on pharmacies that self-identify as full-line, apothecary, compounding, long-term care, or specialty stores. These data are for the full-line stores.



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Reality for Community Pharmacies

- 91% of prescriptions are covered by insurance
 - If medication is covered by insurance, the patient's price is set by the PBM, not the pharmacy
 - If cash transaction, the pharmacy sets the price
- What community pharmacies charge patients and are reimbursed is often determined *by a competitor*
 - PBMs own or are affiliated with competing retail, mail-order, and/or specialty pharmacies
 - PBMs often require or incent patients to use the PBM-owned pharmacy

Reality for Community Pharmacies: Effect of Lack of Oversight and Regulation

- Take-it-or-leave-it contracts
- A lack of transparency in reimbursement pricing
- Underwater reimbursements without recourse
- Retaliatory audits
- Network exclusion
- Prior authorization headaches
- No process for appeals or remedy for unfair practices
- Retroactive fees are unpredictable and often untraceable

Reality for Community Pharmacies: Contracts with PBMs

- PBMs control the pharmacy benefits of more than 266 million Americans
- 3 PBMs control as much as 89% of the market: 238 million lives out of 266 million lives^{1,2}
- Role of PSAO in contracting process
 - Anti-trust laws prevent a PSAO from declining a contract on behalf of a pharmacy
 - GAO conducted a study on the role and ownership of PSAOs and stated that "over half of the PSAOs we spoke with reported having little success in modifying certain contract terms as a result of negotiations. This may be due to PBMs' use of standard contract terms and the dominant market share of the largest PBMs. Many PBM contracts contain standard terms and conditions that are largely non-negotiable."³

1: Mathematical calculation based on number of covered lives CMS/Caremark, UnitedHealth and ESI self-reported.

2: From testimony of PCMA CEO Mark Merritt before the U.S. House of Representatives Energy & Commerce Committee Subcommittee on Health, December 13, 2017

3: GAO-13-176.

PBM Impact on Patient Access

- PBM steering to PBM-owned retail, mail-order, or specialty pharmacies leaves patients with little or no control over healthcare decisions
- Network access hurdles – particularly in preferred networks – limit patient access to pharmacies
- Patients lose access to trusted pharmacy providers.
- Between 2003 and 2018, 1,231 independent pharmacies closed in rural areas.

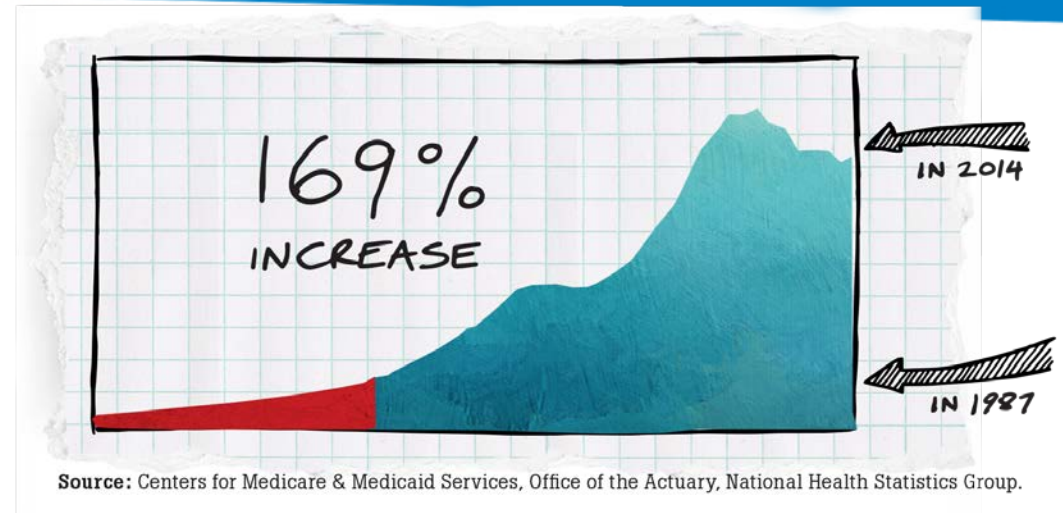
PBM Impact on Patient Access (continued)

- 630 rural communities nationwide that had at least one retail pharmacy in 2003 had **ZERO** retail pharmacies in 2018.
 - Abiodun Salako, Fred Ullrich, Keith Mueller, *Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018*, RUPRI Center for Rural Health Policy Analysis, July 2018, Rural Policy Brief No. 2018-2, available at <https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf>.
- Further exacerbated by arbitrary network participation requirements and limits on a pharmacy's ability to offer drug delivery services to patients.

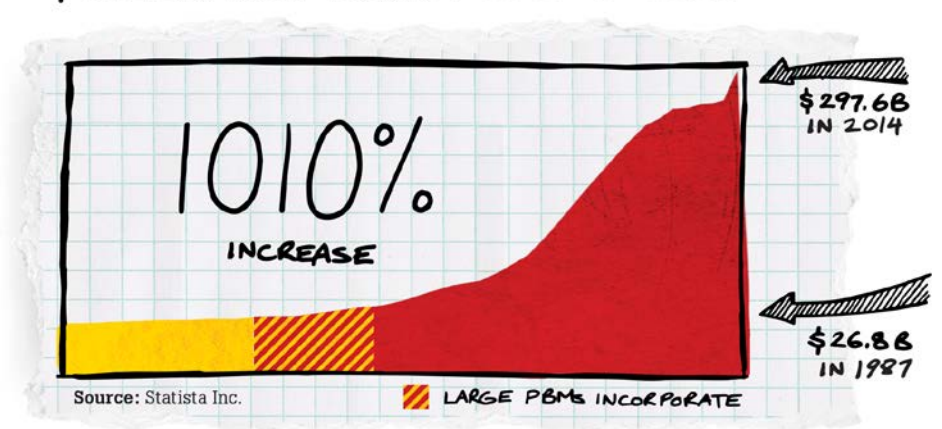
PBM Impact on Patient and Payer Costs

- PBMs have no fiduciary duty to anyone but their shareholders
 - Not to patients
 - Not to health plans/plan sponsors
 - Not to the state
- Results in a lack of accountability
 - Lawsuit against PBM for failure to contain costs: “[Express Scripts] was not ‘contractually obligated’ to contain costs.”
 - *60 Minutes*, <https://www.cbsnews.com/news/the-problem-with-prescription-drug-prices/>

PATIENTS' ACTUAL OUT-OF-POCKET COSTS



PRESCRIPTION DRUG BENEFIT COST



PBM Impact on Patient and Payer Cost

- “I am concerned that spread pricing is inflating prescription drug costs that are borne by beneficiaries and by taxpayers.”
 - CMS Administrator Seema Verma ([CMS Issues New Guidance Addressing Spread Pricing](#))
- “PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies.”
 - New York Senate Committee on Investigations and Government Operations ([Final Investigative Report](#))

Realization of the Need for Reform

- **National Council of Insurance Legislators (NCOIL)** adopted a PBM Regulation Model Act: December 2018
 - Would give the Insurance Commissioner the authority to license and regulate PBMs
 - Would allow the Commissioner to adopt rules addressing network adequacy, pharmacy audits, and reimbursements issues
 - NCPA and our state partners have worked for years to advance model legislation
- **National Academy for State Health Policy (NASHP)** PBM transparency model act
 - Imposes fiduciary duty on PBMs
 - Addresses anti-mandatory mail-order and pharmacy choice
 - Almost identical to NCPA's model language
- **32 State Attorney Generals** signed an Amicus brief to the U.S. Supreme Court defending states' rights to regulate health care insurance-specifically pharmacy benefit managers

Solutions: Transparency

- **West Virginia:** saved \$54 million in one year through increased transparency by carving pharmacy benefits out of the Medicaid managed care program – still using assistance of a PBM to process claims.
- **Terrebonne Parish Council, Louisiana:** saved \$1.2 million by switching to pass-through model with PBM.
- **Ohio:** discovered \$224 million being kept by PBMs through spread pricing alone.
- **Kentucky:** discovered \$123.5 million being kept by PBMs through spread pricing alone.

Solutions: Transparency

- Reimbursement transparency
- 39 states have “maximum allowable cost” transparency laws
- PBMs have moved away from MAC-lists towards generic effective rate reimbursement methodologies.
- MAC transparency laws must be updated to address this change.

Solutions: Accountability

PBM licensure

- Licensure with the insurance commissioner
 - PBMs administer a health insurance benefit
 - Insurance commissioner is logical overseer
 - Defining PBM, including their role as both a drug benefits manager and a pharmacy.
- 33 states currently license PBMs in some capacity
 - Not all as PBMs (e.g., third-party administrators)
 - Not all licensed by insurance commissioner (e.g., Board of Pharmacy)
- Claims that laws and rules are not being enforced

Solutions: Ensuring Patient Access

- Patient choice and network adequacy
 - Anti-mandatory mail-order provisions
 - Allows patients to choose between retail pharmacies and mail-order
 - Network adequacy requirements
 - Ensures patients have access to face-to-face interaction with a trusted pharmacist.
 - Limits on conflicts of interest
 - Anti-steering provisions
 - Ensures patients know they have a choice.

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