August 20, 2018

Assem. Kevin Cahill
Chair, Health, Long-Term Care & Health Retirement Issues Committee
National Council of Insurance Legislators

RE: EXPLANATION OF AMENDMENTS TO "PHARMACY BENEFITS MANAGER LICENSURE AND REGULATION MODEL ACT"

Dear Chair Cahill,

I am writing to provide an explanation of the National Community Pharmacists Association's proposed amendments to the "Pharmacy Benefits Manager Licensure and Regulation Model Act."

Section 3. Definitions

Amendment #1 removes the provision that exempts "[h]ealth benefit plans that are self-funded and specifically exempted from regulation by the State by The Employee Retirement Income Security Act of 1974 (ERISA)" from the definition of "health benefit plan."[1] With this overly broad exemption, the model act's protections would not apply to a significant number of beneficiaries who receive health benefits through self-funded employer plans. Under Supreme Court precedent, the model act's provisions, which apply to PBMs, not health benefit plans, are not of the type that run afoul of ERISA.

Amendment #2 amends the definition of "independent pharmacy" to "a pharmacy that is not a pharmacy benefits manager affiliate." Currently, the definition is "a pharmacy that is not in any way affiliated with a pharmacy benefits manager."[2] This broad language may lead to confusion because all pharmacies contract with PBMs. Tying the definition to pharmacy benefits manager affiliate, which is defined in the act,[3] will bring clarity to the definition of "independent pharmacy."

Section 9. Rules

Amendment #3 clarifies that the Insurance Commissioner's authority to adopt rules relating to "pharmacy benefits manager network adequacy" includes the authority to adopt "any willing pharmacy" rules.[4] "Any willing pharmacy" rules would require a PBM to allow a pharmacy to participate in a provider network if the pharmacy is willing to accept the PBM's terms and conditions. Thirty states currently have "any willing pharmacy" rules in one form or another. Under the model legislation's current provisions, the Insurance Commissioner is tasked with

[1] Section (3)(b)(2)(viii).
[2] Section (3)(d).
[3] Section (3)(m).
[4] Section (9)(a)(2)(D).

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ensuring that PBMs provide a reasonably adequate and accessible provider network.[5] To accomplish this task, the Commissioner is authorized to review distance requirements,[6] PBM compensation programs,[7] and accreditation and certification standards.[8] Allowing the adoption of "any willing pharmacy" rules gives the Commissioner another tool to ensure PBM networks provide patients with reasonable access to pharmacy services and is consistent with the legislation's intent.

Amendment #4 allows the Insurance Commissioner to adopt rules relating to procedures for pharmacy audits conducted by PBMs.[9] Pharmacy audits are meant to identify fraud, abuse, and wasteful spending. However, audits are often used as an additional revenue source for the PBM. PBMs routinely target community pharmacies and recoup vast sums of money for nothing more than harmless clerical errors where the correct medication was properly dispensed, and no financial harm was incurred. The adoption of pharmacy audit procedures will ensure that audits are used for their intended purpose.

Section 12. Maximum Allowable Cost Lists

Amendment #5 requires a PBM to provide its MAC list in an .xml spreadsheet format or a comparable easily accessible and complete spreadsheet format.[10] This will ensure that pharmacies can access this information in a usable, searchable format.

Amendment #6 requires PBMs to update MAC lists no fewer than every seven days.[11] The current language requires an update within seven days from an increase of 10% or more in the pharmacy acquisition cost from 60% or more of the pharmaceutical wholesalers doing business in the state. Calculating such a change can lead to confusion, which can be avoided by requiring an update every seven days.

Amendment #7 permits a pharmacy services administrative organization (PSAO) to file a MAC appeal on behalf of a pharmacy.[12] Pharmacies frequently contract with PBMs through PSAOs, which help pharmacies achieve administrative and payment efficiencies. Because PSAOs sign network contracts with PBMs on behalf of pharmacies, a PSAO should have the authority to file an appeal to resolve a dispute with the PBM over that contract, thus allowing the pharmacy to focus on providing care to patients.

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[5] Section (5).
[6] Section (5)(a)(1).
[7] Section (6)(a)(1).
[8] Section (6)(b)(3).
[9] Section (9)(a)(2)(L).
[10] Section (12)(b).
[11] Section (12)(b)(2).
[12] Section (12)(b)(4).

Amendment #8 requires the PBM, when a change in the maximum allowable cost is made pursuant to an upheld appeal, to make the applicable change effective retroactive to the date of the original claim and apply the change to all similar claims.[13] This will ensure that the pharmacy is reimbursed at the rate that was appropriate on the day the claim was first adjudicated.

Amendment #9, instead of permitting the pharmacy or pharmacist to reverse and rebill a claim, requires the PBM to provide reimbursement at the adjusted rate without requiring the appealing pharmacy to reverse and rebill the claim.[14] Requiring a pharmacy to reverse and rebill a claim is problematic because it further delays the pharmacy's proper reimbursement, and PBMs frequently charge a pharmacy a transaction cost to reverse and rebill a claim, even though the pharmacy already properly submitted the claim. For these reasons, state insurance commissioners have found that the obligation to reverse and rebill a claim should be shifted to the PBM,[15] and state legislatures have enacted legislation that shifts the obligation to the PBM.[16]

Conclusion

We commend NCOIL's efforts to promote, preserve, and protect the public health, safety, and welfare by establishing common sense standards and criteria for the regulation and licensure of PBMs. We thank the committee for the opportunity to provide this explanation.

If you have any questions about the information contained in this letter or wish to discuss the issue in greater detail, please do not hesitate to contact me at matthew.magner@ncpanet.org or (703) 600-1186.

Sincerely,

Matthew Magner
Director, State Government Affairs

[13] Section (12)(b)(4)(C)(i)(a).
[14] Section (12)(b)(4)(C)(i)(b).
[15] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 10 (Jan. 21, 2018) ("A PBM should be able to pay the pharmacy any additional money owed without the pharmacy having to reverse and rebill the claim.").
[16] H.B. 1349, Md. General Assembly § 15-1628.1(f)(5)(I)(2) (2018).