July 14, 2018

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

RE: RECOMMENDATION FOR THE "PHARMACY BENEFITS MANAGER LICENSURE AND REGULATION MODEL ACT"

Dear Chair Cahill,

I am writing on behalf of the National Community Pharmacists Association to supplement our previous comments submitted on June 7, 2018. In those comments, NCPA voiced support for the Model Act and made several recommendations that would improve the act and put state insurance commissioners in a better position to regulate pharmacy benefits managers (PBMs). NCPA continues to support the bill and would like to add the following recommendations:

Section 12. Maximum Allowable Cost Lists

Recommendation #1: Require a PBM to provide its MAC list in an .xml spreadsheet format or a comparable easily accessible and complete spreadsheet format.[1] This will ensure that pharmacies can access this information in a usable, searchable format.

Recommendation #2: Require a PBM, pursuant to an upheld MAC appeal, to adjust the MAC price and reimburse the pharmacy without requiring the pharmacy to reverse and rebill the claim in question.[2] After an appeal, the PBM has all of the necessary information to reimburse the claim in the proper amount, and requiring the pharmacy to reverse and rebill the claim is unnecessary. Additionally, requiring a pharmacy to reverse and rebill a claim places unnecessary burdens on the pharmacy, because it further delays proper reimbursement and subjects the pharmacy to additional transaction fees imposed by a PBM.

Recommendation #3: Permit a pharmacy services administrative organization (PSAO) to file a MAC appeal on behalf of a pharmacy.[3] 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.

[1] Section (12)(b)(1).
[2] Section (12)(b)(4)(C)(i)(b).
[3] Section (12)(b)(4).

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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 these comments.

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

Matthew Magner
Director, State Government Affairs

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

The Honorable Jonathan Steinberg
Legislative Office Building, Room 3004
Hartford, CT 06106-1591

July 6, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Steinberg,

The National Community Pharmacists Association (NCPA) and Connecticut Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

This model act is particularly important given NCOIL members' expertise in insurance legislation. In some states that have passed PBM legislation, the state insurance commissioners have difficulty enforcing the regulations. For example, in a workgroup report, the Maryland Insurance Administration was unable to determine that the state's PBM regulations were working as intended. One cause is that "independent pharmacists do not file complaints [with the Insurance Administration] because they are then retaliated against by the PBMs through audits and increased scrutiny."[1] Members of NCOIL are uniquely qualified to craft legislation giving insurance commissioners the tools to enforce these beneficial regulations.

The model act's provisions will add reasonable regulations on an industry that has contributed to increasing drug costs and will allow community pharmacists to better serve their patients. As concerned stakeholders, we offer our continued support of your efforts to develop this model act.

Thank you,

National Community Pharmacists Association

Connecticut Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

californiapharmacistsassociation

The Honorable Ken Cooley
State Capitol
P.O. Box 942849
Sacramento, CA 94249-0008

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Assemblyman Cooley,

The National Community Pharmacists Association (NCPA) and California Pharmacists Association (CPhA) are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association California Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, MD, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018)

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

The Honorable Richard Smith
220 CAP, State Capitol
Atlanta, GA 30334

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Smith,

The National Community Pharmacists Association (NCPA) and Georgia Pharmacy Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Georgia Pharmacy Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable Joseph M. Fischer
702 Capitol Avenue, Annex Room 313
Frankfort, KY 40601

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Fischer,

The National Community Pharmacists Association and Kentucky Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Kentucky Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

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The Honorable Jim Gooch, Jr.
702 Capitol Avenue, Annex Room 376
Frankfort, KY 40601

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Gooch,

The National Community Pharmacists Association and Kentucky Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Kentucky Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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The Honorable Jeff Greer
702 Capitol Avenue, Annex Room 424F
Frankfort, KY 40601

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Greer,

The National Community Pharmacists Association and Kentucky Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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The Honorable Dorsey Ridley
702 Capitol Avenue, Annex Room 254
Frankfort, KY 40601

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Senator Ridley,

The National Community Pharmacists Association and Kentucky Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Kentucky Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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The Honorable Bart Rowland
702 Capitol Avenue, Annex Room 416D
Frankfort, KY 40601

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Rowland,

The National Community Pharmacists Association and Kentucky Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Kentucky Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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The Honorable Willie Dove
300 SW Tenth Avenue
Topeka, KS 66612-1504

July 10, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Dove,

The National Community Pharmacists Association and Kansas Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Kansas Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable Mark Abraham
130 Jamestown Road
Lake Charles, LA 70605

July 6, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Abraham,

The National Community Pharmacists Association and the Louisiana Independent Pharmacies Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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National Community Pharmacists Association

Louisiana Independent Pharmacies Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable Greg Cromer
P.O. Box 2088
Lake Charles, LA 70605

July 6, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Cromer,

The National Community Pharmacists Association and the Louisiana Independent Pharmacies Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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The Honorable Dan W. "Blade" Morrish
119 W. Nezpique Street
Jennings, LA 70546-5356

July 6, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Senator Morrish,

The National Community Pharmacists Association and the Louisiana Independent Pharmacies Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

This model act is particularly important given NCOIL members' expertise in insurance legislation. In some states that have passed PBM legislation, the state insurance commissioners have difficulty enforcing the regulations. For example, in a workgroup report, the Maryland Insurance Administration was unable to determine that the state's PBM regulations were working as intended. One cause is that "independent pharmacists do not file complaints [with the Insurance Administration] because they are then retaliated against by the PBMs through audits and increased scrutiny."[1] Members of NCOIL are uniquely qualified to craft legislation giving insurance commissioners the tools to enforce these beneficial regulations.

The model act's provisions will add reasonable regulations on an industry that has contributed to increasing drug costs and will allow community pharmacists to better serve their patients. As concerned stakeholders, we offer our continued support of your efforts to develop this model act.

Thank you,

National Community Pharmacists Association

Louisiana Independent Pharmacies Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

The Honorable Major Thibaut
2004 False River Drive
New Roads, LA 70760

July 6, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Thibaut,

The National Community Pharmacists Association and the Louisiana Independent Pharmacies Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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National Community Pharmacists Association

Louisiana Independent Pharmacies Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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The Honorable Joe Hoppe
543 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, Minnesota 55155

July 11, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Hoppe,

The National Community Pharmacists Association and Minnesota Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Minnesota Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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The Honorable Valerie Foushee
300 N Salisbury Street, Room 517
Raleigh, NC 27603-5925

July 6, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Senator Foushee,

The National Community Pharmacists Association and the North Carolina Association of Pharmacists are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

North Carolina Association of Pharmacists

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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The Honorable Jonathan Casper
P.O. Box 6457
Fargo, ND 58109

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Senator Casper,

The National Community Pharmacists Association and North Dakota Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

North Dakota Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

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The Honorable Lois Delmore
714 South 22nd Street
Grand Forks, ND 58201

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Delmore,

The National Community Pharmacists Association (NCPA) and North Dakota Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

North Dakota Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

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The Honorable George Keiser
422 Toronto Drive
Bismarck, ND 58503

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Keiser,

The National Community Pharmacists Association and North Dakota Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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North Dakota Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

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The Honorable Lewis Moore
2300 N. Lincoln Blvd.
Room 329
Oklahoma City, OK 73105

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Moore,

The National Community Pharmacists Association (NCPA) and Oklahoma Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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National Community Pharmacists Association

Oklahoma Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration, "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable Glen Mulready
2300 N. Lincoln Blvd.
Room 200
Oklahoma City, OK 73105

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Mulready,

The National Community Pharmacists Association (NCPA) and Oklahoma Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable William A. Barclay
LOB 521
Albany, NY 12248

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Assemblyman Barclay,

The National Community Pharmacists Association and Pharmacists Society of the State of New York are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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National Community Pharmacists Association

Pharmacists Society of the State of New York

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration, "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable Neil D. Breslin
172 State Street, Rm. 414
Albany, NY 12247

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Senator Breslin,

The National Community Pharmacists Association and Pharmacists Society of the State of New York are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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National Community Pharmacists Association

Pharmacists Society of the State of New York

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

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The Honorable Kevin A. Cahill
LOB 716
Albany, NY 12248

July 11, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Assemblymember Cahill,

The National Community Pharmacists Association and Pharmacists Society of the State of New York are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Cc:
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Representative Tom Oliverson, Texas

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The Honorable Andrew R. Garbarino
LOB 529
Albany, NY 12248

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Assemblyman Garbarino,

The National Community Pharmacists Association and Pharmacists Society of the State of New York are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

This model act is particularly important given NCOIL members' expertise in insurance legislation. In some states that have passed PBM legislation, the state insurance commissioners have difficulty enforcing the regulations. For example, in a workgroup report, the Maryland Insurance Administration was unable to determine that the state's PBM regulations were working as intended. One cause is that "independent pharmacists do not file complaints [with the Insurance Administration] because they are then retaliated against by the PBMs through audits and increased scrutiny."[1] Members of NCOIL are uniquely qualified to craft legislation giving insurance commissioners the tools to enforce these beneficial regulations.

The model act's provisions will add reasonable regulations on an industry that has contributed to increasing drug costs and will allow community pharmacists to better serve their patients. As concerned stakeholders, we offer our continued support of your efforts to develop this model act.

Thank you,

National Community Pharmacists Association

Pharmacists Society of the State of New York

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

The Honorable James L. Seward
172 State Street, Rm. 430
Albany, NY 12247

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Senator Seward,

The National Community Pharmacists Association and Pharmacists Society of the State of New York are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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The Honorable Steve Westfall
1900 Kanawha Blvd. E., Room 204E, Bldg. 1
Charleston, WV 25305

July 10, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Delegate Westfall,

The National Community Pharmacists Association and West Virginia Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

West Virginia Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

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June 25, 2018

The Hon. Kevin Cahill
Chair, Health, Long-Term Care & Heath Retirement Issues Committee
National Conference of Insurance Legislators
2317 Route 34, Suite 2B
Manasquan, NJ 08736

RE: Comments on NCOIL Proposed "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Chair Cahill and Members of the NCOIL Health Committee:

Thank you for the opportunity to provide written comments in support of the NCOIL discussion draft Pharmacy Benefits Manager (PBM) Licensure and Regulation Model Act. The Independent Pharmacy Cooperative (IPC) is a national trade group representing the interest of nearly 2,700 independent pharmacy store owners in all 50 states. Many of our member pharmacies reside in rural, underserved and economically disadvantaged parts of the country. These community-based, small businesses continue to accept the responsibility of being health care providers that are the first point and often only source for delivering health care in their local communities. Among the services IPC provides to our member stores is legislative and regulatory advocacy that affect independent pharmacy through our Government Relations Department. In that role, I am submitting this written comment in support of the PBM Discussion Draft Model Act, with some suggestions for revisions and the inclusion of other patient protection language.

First, IPC applauds the committee's discussion draft PBM Regulation Model Act as a positive initial effort to create a uniform state model bill of needed state-based regulation of the activities of PBMs. While states iteratively have been passing PBM state laws to addressing many of the issues, this unregulated part of the health care benefits market, which is highly concentrated and lacking a competitive marketplace, needs a consensus approach to protect patients and their pharmacies from PBM abuses that have added to the high cost of

prescription benefits while unnecessarily interfering with the pharmacist-patient relationship.

IPC strongly supports the sections of the model bill to license and regulate PBM activities (Sections 4, 6, 8, 9 and 11). Our experience advocating for passage of state PBM bills is that formal state regulation of PBM and state regulatory enforcement powers in the law are crucial to having effective patient/consumer protections against PBM abuses.

We do have suggestions of changes to the following sections:

1. Under definitions (Section 3), the model should –
    a. Revise "independent pharmacy" to a clearer definition that indicates there is no ownership or legal control of the pharmacy by a PBM.
    b. Eliminate from the definition of "health plan" the exemption for self-funded and ERISA plans [(Section 3 (b) (2) (viii)] since this model is consumer protection legislation that does not impede or infringe the benefit design

    There are other definitions needed that will be address further in our comments.

2. While IPC supports the goal of the PBM Network Adequacy Section (Section 5), IPC recommends the following changes to make sure that PBM pharmacy networks fully work for the benefit of the patient and not the PBM:
    a. In the convenience of access subsection (Section 5 (a) (1) needs to be revised to include "time" in addition to "distance as a factor." This subsection also needs to include language "as determined by the Department of Insurance as promulgated by regulation" to ensure it a standard that protects the patient, not the PBMs.
    b. This section needs to include the anti-mandatory mail order (AMMO) provisions to ensure these state contracts will not force patients to use mail order for both prescriptions and durable medical equipment (DME). Both the New York and Pennsylvania state AMMO laws have been well received and are appropriate language to include in this network adequacy section of the model.

3. The model needs to fully protect a pharmacy patients right to choose its provider for both prescription and pharmacy related services so long as: a) a network pharmacy is willing to agree to a contract; b) the network includes all types of pharmacies (independent, chain, mass retailer, mail-order) and c) all pharmacies in the network receive equal terms (i.e. no incentives for mail-order pharmacies).

4. The Compensation Prohibited Practices Section (Section 6) offers important consumer protections, but it lacks one important provision – prohibitions against PBM conflicts of interests. As some states have enacted, this section needs to include a subsections that prohibits PBM's from having an ownership interest in a mail order facility and language that makes having a conflict of interest in operating a prescription benefit program a regulatory actionable offense under the model bill.

5. The Gag Clause Prohibition (Section 7) is a vital patient protection provision that ensures the pharmacists-patient relationship is strengthened by eliminating contract prohibition of pharmacist being able to discuss prescription costs options with their patient. And the prohibition against allowing pharmacists to talk to policy makers (Section 7 (d)) is an equally important protection. IPC would suggest that this subsection specifically include a sentence to include talking to state legislators about PBM legislation or regulation since many pharmacy owners fear retaliation under their contracts, including network termination, if they participate in the public policy advocacy process.

6. The Enforcement Section (Section 8) is the most important provision in this Model Act if there is to be true consumer protections in this highly non-competitive health care coverage marketplace. The one regulatory tool that this model should include is the ability of the Insurance Commissioner to order a market conduct review of PBMs. Also, a remedy under the individual state's Consumer Protection Act is commendable.

7. The MAC provisions (Section 12) have been passed by 33 states. Several important protections need to be changed in the proposed model to ensure patient access to these prescriptions:
    a. MAC updates should happen no fewer than seven (7) calendar days, rather than "in no event longer" [Section 12 (b) (2)].
    b. Ensure that MAC appeals that are upheld be applied retroactively to the date of the claim and for all similar claims [Section 12 (b) (4) (C) (i) (d)].
    c. Provide a new subsection under Section 12 to ensure against PBM's creating a loophole from the MAC provisions by creating disclosure requirements of how a PBM utilizes and determines its Generic Effective Rate ("GER") reimbursements for all its MAC drugs to all network pharmacies, including mail-order.

The following important pharmacy patient protections not included in this discussion draft model that IPC believes need to be included:

Pharmacy Audit Protections - Forty states have enacted pharmacy audit protections to ensure that PBM's do not recoup claims payment for "technicalities" that are not truly fraudulent claims. These bills ensure that pharmacies do not see all payment taken away for legitimate prescription that have been filled and dispenses because of paperwork violations. IPC suggests that NCOIL include an Audit section based on provisions found in existing state statutes. One additional consumer protection needed in the pharmacy audit protection section of a PBM model bill is that if a PBM recoups a prescription payment through an audit, it must remit back to the patient any out of pocket costs (co-pay, deductible, co-insurance) that is recouped.

PBM role as a Fiduciary - The underlining purpose of this PBM Model bill is to protect consumers, including ultimate payers of prescription claims. This principal requires a PBM model regulation bill to include the same protections for all consumers when it comes to prescription benefits as applies to other health care claims coverage – a fiduciary responsibility for the PBM's in how it conducts its role in prescription benefits management. The Trump Administration is considering such a regulatory requirement under ERISA.

Medicaid Managed Care Reimbursement - A key PBM prescription benefit management activity that this model bill has to address is their role as subcontractor to Medicaid Managed Care Organizations (MCO's) to managed the prescription claims for states that have moved their Medicaid prescription benefits from a State Medicaid fee-for-service benefit, designed and paid for by the State, to a benefit "carved in" to the Medicaid managed care system. Under the MCO model, the Medicaid managed care prescription reimbursement does not have to follow the newly federally-mandated transparent Medicaid fee-for-service reimbursement. That lack of payment standards has led in many instances with PBM MCO prescription payments below pharmacy drug acquisition costs. This disparity is creating access issues for Medicaid MCO beneficiaries for certain drugs. IPC recommends that the Model bill include provisions that would mandate MCO prescription benefits reimburse pharmacies at the same rate as paid for that drug under the state's Medicaid FFS system. Since many states using Medicaid managed care consider it a commercial insurance marketplace product, it is appropriate for inclusion in this model bill. For states that have implemented 100% Medicaid managed care, the adoption of the National Average Drug Acquisition Cost (NADAC) and a surveyed professional dispensing fee.

Patient Explanation of Benefit (EOB) Mandate - There should be a new patient protection section in the draft model that requires a PBM operating in the state to provide monthly to each covered patient an explanation of their pharmacy benefit for each prescription claim during that month that includes: 1) the contracted prescription price paid to the network pharmacy for each prescription dispensed; 2) the patient out-of pocket cost (co-pays, deductibles and co-insurance); and the amount charged for each prescription to the plan sponsor or health insurance company. Such basic disclosures are required to health care consumers for all health and dental insurance claims. States must provide the same standard of transparency and disclosure to pharmacy patients for state covered prescription benefits claims.

Prompt payment of claims uniform standard - While federal law requires health insurance claims be paid promptly no later than 30 days after receiving a "clean claim", individual states lack uniform standards when it comes to PBM's promptly paying pharmacy claims. Most states require 30 days, but some states allow up to 45 days for pharmacies to receive prescription claims payment. This is a unique problem for pharmacy providers since they have to stock drug inventory in order to serve patient prescription drug needs and they in many cases must pay their

wholesalers every 2 weeks in order to secure enough drug inventory to legally operate their pharmacy. The Medicare Improvement for Patients and Providers Act (P.L. 110-275a) mandates that all Medicare Part D PBM's pay pharmacies "clean" Part D claims within 14 days. The model should also mandate that all PBM's have to pay state commercial insurance prescription claims, including MCO claims, in the same timeframe as required under the MIPAA of 2008.

Continuity of Care - The model should also provide the following care continuity requirements on PBMs to ensure that patients are not harmed by PBM contract practices:

a. Require notice to prescriber, patient and pharmacy at least 90 days prior to a formulary change in a prescription contract that a current prescription drug will no longer be covered by the formulary and allow an initial 30 day fill of the non-formulary drug during the first 14 days for a new contract year. This must include MCO contracts and allow an initial 90 day fill for LTC (SNF and non-SNF) MCO patients.

b. Mandate that any prescription on a PBM formulary contract that is not currently identified by the plan sponsor as a specialty drug, must be allowed to continue to be filled by all network pharmacies at the network contract rate.

IPC is pleased to support NCOIL's effort to develop and adopt an effective and comprehensive PBM regulation bill that protects patient interests and the ability of their pharmacies to serve them, while subjecting PBMs to the same level of market regulation as others in the health care industry. Prescription benefits is an important and growing portion of the health care coverage needs of patients. The activities of PBM's in providing these benefits demands these consumer protections.

IPC looks forward to continuing to work with this NCOIL committee on the process to finalize a PBM Licensure and Regulation Model Act.

Please let me know if you have any questions or need any additional information about the issues in my written comments.

Sincerely,

Mark Kinney

Mark E. Kinney R. Ph. | SVP Government Relations
Independent Pharmacy Cooperative
608-628-7311 | mark.kinney@ipcrx.com

Pennsylvania Pharmacists Association

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Harrisburg, PA 17101

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July 9, 2018

The Honorable Marguerite Quinn
141B East Wing
Harrisburg, PA 17120-2143

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Quinn,

The National Community Pharmacists Association and the Pennsylvania Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

This model act is particularly important given NCOIL members' expertise in insurance legislation. In some states that have passed PBM legislation, the state insurance commissioners have difficulty enforcing the regulations. For example, in a workgroup report, the Maryland Insurance Administration was unable to determine that the state's PBM regulations were working as intended. One cause is that "independent pharmacists do not file complaints [with the Insurance Administration] because they are then retaliated against by the PBMs through audits and increased scrutiny."[1] Members of NCOIL are uniquely qualified to craft legislation giving insurance commissioners the tools to enforce these beneficial regulations.

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Thank you,

Pennsylvania Pharmacists Association

National Community Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

MICHIGAN PHARMACISTS ASSOCIATION

July 10, 2018

The Honorable Michael Webber
N-894 House Office Building
Lansing, MI 48933

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Webber:

The Michigan Pharmacists Association (MPA) and National Community Pharmacists Association (NCPA) are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated pharmacy benefit manager (PBM) industry. While MPA represents only pharmacist in Michigan, NCPA specifically represents America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with PBMs operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' healthcare options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

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Sincerely,

Dianne E. Malburg, pharmacist
Acting Chief Executive Officer

Copy: Matthew Magner, J.D., NCPA director state government affairs
James Lile, Pharm.D., MPA chairman of the executive board
Arika Sinnott, MPA director of governmental affairs

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

The Honorable Martin Carbaugh
200 W. Washington St.
Indianapolis, IN 46204

July 12, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Carbaugh,

The National Community Pharmacists Association and Indiana Pharmacists Alliance are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Indiana Pharmacists Alliance

Cc:
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Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

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The Honorable Dick Hamm
200 W. Washington St.
Indianapolis, IN 46204

July 12, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Hamm,

The National Community Pharmacists Association and Indiana Pharmacists Alliance are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Indiana Pharmacists Alliance

Cc:
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The Honorable Matt Lehman
200 W. Washington St.
Indianapolis, IN 46204

July 12, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Lehman,

The National Community Pharmacists Association and Indiana Pharmacists Alliance are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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The Honorable Peggy Mayfield
200 W. Washington St.
Indianapolis, IN 46204

July 12, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Mayfield,

The National Community Pharmacists Association and Indiana Pharmacists Alliance are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

This model act is particularly important given NCOIL members' expertise in insurance legislation. In some states that have passed PBM legislation, the state insurance commissioners have difficulty enforcing the regulations. For example, in a workgroup report, the Maryland Insurance Administration was unable to determine that the state's PBM regulations were working as intended. One cause is that "independent pharmacists do not file complaints [with the Insurance Administration] because they are then retaliated against by the PBMs through audits and increased scrutiny."[1] Members of NCOIL are uniquely qualified to craft legislation giving insurance commissioners the tools to enforce these beneficial regulations.

The model act's provisions will add reasonable regulations on an industry that has contributed to increasing drug costs and will allow community pharmacists to better serve their patients. As concerned stakeholders, we offer our continued support of your efforts to develop this model act.

Thank you,

National Community Pharmacists Association

Indiana Pharmacists Alliance

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

The Honorable Darlene Taylor
401-J CAP, State Capitol
Atlanta, GA 30334

July 12, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Taylor,

The National Community Pharmacists Association (NCPA) and Georgia Pharmacy Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Georgia Pharmacy Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NCPA
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WWW.NCPANET.ORG

The Honorable Richard Smith
220 CAP, State Capitol
Atlanta, GA 30334

July 9, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Smith,

The National Community Pharmacists Association (NCPA) and Georgia Pharmacy Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

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Thank you,

National Community Pharmacists Association

Georgia Pharmacy Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

The Honorable Bob D. Hackett
1 Capitol Square, 1st Floor
Columbus, OH 43215

July 12, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Senator Hackett,

The National Community Pharmacists Association and Ohio Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Ohio Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable William Botzow, II
1225 South Stream Road
Bennington, VT 05201

July 13, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Botzow,

The National Community Pharmacists Association is writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

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Thank you,

National Community Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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The Honorable Sarah Copeland-Hanzas
P.O. Box 43
Bradford, VT 05033

July 13, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Copeland-Hanzas,

The National Community Pharmacists Association is writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

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Thank you,

National Community Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable Kathleen C. Keenan
8 Thorpe Avenue
St. Albans, VT 05478

July 13, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Keenan,

The National Community Pharmacists Association is writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

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Thank you,

National Community Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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The Honorable Valerie A. Stuart
520 Meadowbrook Road
Brattleboro, VT 05301

July 13, 2018

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Representative Stuart,

The National Community Pharmacists Association is writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

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Thank you,

National Community Pharmacists Association

Cc:
Senator Jason Rapert, Arkansas
Assemblyman Kevin Cahill, New York
Representative Tom Oliverson, Texas

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

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New Mexico Pharmacists Association

2716 San Pedro NE Suite C- Albuquerque, NM 87110
Phone (505) 265-8729 1-800-464-8729 FAX (505) 255-8476
Homepage: www.nmpharmacy.org Email: daletinker@cs.com

The Honorable Carroll Leavell
Senator of the State of New Mexico
PO Drawer D
Jal, NM 88252
Email: leavell4@leaco.net

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Senator Leavell,

The National Community Pharmacists Association (NCPA) and New Mexico Pharmacists Association are writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry. We represent America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

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New Mexico does have a PBM statute which was passed in 2014. We are working with Superintendent of Insurance John Franchini and his PBM staff person, Andy Romero, to bring about compliance by the PBM industry. The issues around PBM enforcement are on the agenda of the Superintendent's advisory committee at every meeting. While there is some progress being made, we believe the language in the

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018)

NCOIL model legislation should be incorporated into our state law to further enhance the Superintendent's ability to regulate the Pharmacy Benefits Management industry.

The model act's provisions will add reasonable regulations on an industry that has contributed to increasing drug costs and will allow community pharmacists to better serve their patients. As concerned stakeholders, we offer our continued support of your efforts to develop this model act.

Thank you,

National Community Pharmacists Association and New Mexico Pharmacists Association

Sincerely,

R. Dale Tinker

R. Dale Tinker
Executive Director
New Mexico Pharmacists Association

Cc:
John Franchini, Superintendent of Insurance
Andy Romero, PBM Division, NM Office of the Superintendent of Insurance
Minda McGonagle, New Mexico Pharmacy Business Council
Danny Cross, President, New Mexico Pharmacists Association

john.franchini@state.nm.us, andy.romero@state.nm.us,

ALLIANCE of Independent Pharmacists of TEXAS

The Voice of Independent Community and Compounding Pharmacists in Texas

July 13, 2018

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

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Chair Cahill,

The Alliance of Independent Pharmacists is writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry.

The Alliance is a statewide nonprofit professional organization, representing more than 800 independent pharmacy owners. Our mission is to ensure the economic viability and security of community independent and compounding pharmacists in Texas.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately driving up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

This model act is particularly important given NCOIL members' expertise in insurance legislation. Texas passed PBM legislation; however, the state insurance commissioner has difficulty enforcing the regulations. For example, when meeting with TDI they note they still don't believe they have the proper authority to regulate PBMs in Texas. Another issue is that independent pharmacists do not file complaints with TDI because they are then retaliated against by the PBMs through audits and increased scrutiny. Members of NCOIL are uniquely qualified to craft legislation giving insurance commissioners the tools to enforce these beneficial regulations.

The model act's provisions will add reasonable regulations on an industry that has contributed to increasing drug costs and will allow community pharmacists to better serve their patients. As concerned stakeholders, we offer our continued support of your efforts to develop this model act.

Thank you,

Audra L. Conwell, CAE
Chief Executive Officer

P.O. Box 170323 | Austin, TX 78717 | (512) 260-7986
Fax: (737) 210-8844 | www.aiptexas.org

July 13, 2018

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

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Chair Cahill,

The American Pharmacy Cooperative, Inc., representing over 1,600 independent pharmacy owners in 25 states, is writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

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Thank you,

Bill Eley, Director of Legislative Affairs

{www.apcinet.com}
5601 Shirley Park Drive, Bessemer, AL 35022 | P 800.532.2724 F 205.277.1088 IN ALABAMA 205.277.1007

July 13, 2018

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

Re: NCOIL's "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Chair Cahill,

Northeast Pharmacy Service Corporation is writing today to voice our strong support for the National Council of Insurance Legislators' "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would provide greater oversight of the massive, largely unregulated PBM industry.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state. The model act will protect patients by establishing common sense licensure requirements and regulatory authority over PBMs.

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Thank you,

David G Benoit

David G. Benoit, MHP,RPh
Vice President, Patient Care Services

[1] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018)

Northeast Pharmacy Service Corporation
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www.northeastpharmacy.com

PSSNY
Pharmacists Society of the State of New York, Inc.

COMMENT LETTER

The National Council of Insurance Legislators
Assemblyman Kevin Cahill
Chairman, Health Subcommittee
2317 Route 34, Suite 2B
Manasquan, New Jersey 08736

10 July, 2018

RE: Comments to Pharmacy Benefits Manager Licensure and Regulation Model Act

Dear Chairman Cahill and NCOIL Health Subcommittee Members:

The National Council of Insurance Legislators' ("NCOIL") model Pharmacy Benefits Manager Licensure and Regulation Model Act is a welcome and necessary step forward in the development of policy solutions that promote the delivery of safe, cost-effective healthcare solutions to America's families.

The Pharmacists Society of the State of New York ("PSSNY") was formed in 1879, with the goal of achieving formal recognition of pharmacy as a profession. Today, PSSNY has evolved into the voice of pharmacists throughout the state with more than 20,000 licensed pharmacists residing in New York State. PSSNY agrees with the NCOIL's conclusion that PBMs must be licensed and regulated by the states. In fact, PSSNY has identified PBMs as the most disruptive actors in the delivery of healthcare to patients. PBMs are middlemen who began as health insurance claims processors but have become multi-billion-dollar corporations that we believe are responsible for raising the cost of prescription drugs for consumers, health plans, and the State of New York. PBMs raise drug prices by extracting rebates from pharmaceutical manufacturers for formulary positioning. As a result, manufacturers are forced to increase drug prices to offset rebates they anticipate paying to the PBMs. PBMs often keep a sizable portion of manufacturer rebates, which are not transparent to the payers, i.e. health plans, insurers, and large employers. This lack of transparency negatively impacts consumers who are uninsured or have high deductible policies as well as unions, employers, health plans, and any others who don't have full access to the rebates. The big three PBMs control approximately 85% of covered lives in the United States, yet they are the only member of New York's healthcare provider community that is not regulated. This must change.

While we applaud and support the intent of the model act, in particular the reference to the fact that the Act is not applicable to health benefit plans that are self-funded and specifically exempted from regulation by The Employee Retirement Income Security Act of 1974 (ERISA), PSSNY must point out a few areas of concern. First, the model act's definitions do not include a definition of "patient" or "consumer." Ultimately, legislation such as this must keep patients/consumers at the forefront, by defining them in the law and providing a mechanism for them to identify and report bad actors in the PBM arena. PSSNY also believes that the definition of a "PBM" is drafted too narrowly in the model act. Considering the mergers occurring in this space, PSSNY supports a definition of "PBM" that captures the conduct of a pharmacy benefit manager, in addition to the corporate entity that engages in the conduct.

The second issue that the model act should address is Generic Effective Rates (GER). PBMs have been applying GER to mitigate their responsibility under existing maximum allowable cost ("MAC") laws. Rather than provide

continuously updated MAC rates for their drugs, PBMs will retroactively reimburse the GER, which is AWP minus a certain percentage, resulting in lower than expected rates to pharmacies. This is becoming a common manipulation by PBMs, and must be addressed in any proposed law.

Third, the model act should consider the steps that must occur once a PBM is sanctioned. If a PBM is forced to cease operations in a state, the existing patients/customers must be provided with continuous coverage. Additionally, the PBM must be ordered to satisfy existing claims as well as technical and administrative support for patients to transition to another service. Ultimately, the sanctions levied against a PBM must not harm the patient.

Finally, PSSNY recommends that the enforcement provisions be modified to contemplate the size, sophistication, and financial resources of PBMs. As huge, multi-billion dollar corporations, PBMs can easily navigate around loosely written laws (as illustrated in the GER discussion above), and absorb minor financial penalties for non-compliance. Therefore, PSSNY recommends that the model act provide significant financial penalties for bad actors, as well as the revocation of a PBM's privilege to operate in the state if certain bad acts are committed (fraud, deceit, misrepresentation of terms, etc.).

PSSNY has worked closely with Members of the New York State Legislature to develop a bill that provides a comprehensive PBM licensing and regulatory apparatus. We ask NCOIL and fellow pharmacist associations to consider the approach that we have developed in New York. A10985 (Gottfried) / S8934 (Rivera) is an important piece of legislation that, if enacted, will rein in New York's PBMs. The comprehensive bill, which is annexed to these comments, provides for the Commissioner of the Department of Health to license, regulate, and prosecute PBMs who provide services to New Yorkers. The bill provides for the Commissioner to "establish minimum standards for pharmacy benefit management services which shall address the elimination of conflicts of interest between PBMs and health insurers, plans, and providers; and the elimination of deceptive practices, anti-competitive practices, and unfair claims practices. Importantly, the bill also allows for the revocation or suspension of a PBM's license to operate in New York if that PBM has been found to have "used fraudulent, coercive or dishonest practices." These are important bulwarks against the practices that PSSNY's members have experienced for years.

Although A10985 (Gottfried) / S8934 (Rivera) provides important measures that will improve the delivery of healthcare throughout the State of New York, PSSNY believes that it would be best practice to locate the regulations within insurance law. However, due to the unique dynamics here in New York, the bill places regulatory responsibility within the Department of Health. However, despite that feature, A10985 (Gottfried) / S8934 (Rivera), is a tremendous step forward in New York's effort to protect patients, pharmacies, and the State from the aggressive and abusive practices of PBMs.

In conclusion, PSSNY supports NCOIL's model legislation. With the proper amendments, the model act could provide important patient protections. PSSNY encourages NCOIL's legislative members to introduce robust PBM licensure in their home states to protect their constituents from the least-regulated player in the healthcare community.

Respectfully Submitted,

Kathy Febraio, CAE
Executive Director

June 7, 2018

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

RE: COMMENTS ON THE "PHARMACY BENEFITS MANAGER LICENSURE AND REGULATION MODEL ACT"

Dear Chair Cahill,

I am writing on behalf of the National Community Pharmacists Association to provide comments on the "Pharmacy Benefits Manager Licensure and Regulation Model Act," which would empower state insurance commissioners to regulate and license pharmacy benefits managers doing business in their states. This model act is a step towards greater oversight of a massive, largely unregulated industry.

NCPA represents the interest of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies across the United States. The nation's independent pharmacies, independent pharmacy franchises, and independent chains dispense nearly half of the nation's retail prescription medicines. Independent pharmacists are small business entrepreneurs and multifaceted health care providers who represent a vital part of the United States' health care delivery system.

We hope the committee finds our recommendations and comments helpful as it finalizes the model act. We have divided our recommendations and comments by topic.

Definitions

NCPA urges the Committee to make the following two amendments to the model act's definitions:

- Remove 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.

[1] Section (3)(b)(2)(viii).

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- Amend 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. Referencing pharmacy benefits manager affiliate, which is defined in the act,[3] will bring clarity to the definition of "independent pharmacy."

Licensure by Insurance Commissioner

Twenty-nine states currently require some type of licensure for PBMs to do business within their state, and most of those states provide licensing authority to the state's department of insurance. PBMs are involved with almost every aspect of the prescription drug supply chain, including plan designs, formulary design, and contracting with health plans and pharmacies. PBMs control where beneficiaries can access medications and determine what the plan – and the patient – will pay for those drugs. Despite this level of involvement in providing health insurance benefits, there is little regulatory oversight over PBMs' actions. NCPA supports the model act's licensure requirements because they protect beneficiaries by appropriately requiring licensure of PBMs and allowing for oversight of the PBM industry by the Insurance Commissioner.

Network Adequacy Standards

Ensuring that beneficiaries may readily access their prescription drug needs and receive face-to-face pharmacy provider services is the most vital component of any pharmacy benefit program. Several PBMs own automated dispensing facilities that fill and ship prescriptions. PBMs refer to them as "mail-order pharmacies," but these closed environment, robotics-driven assembly lines do not deliver the patient benefits of a traditional pharmacy. Face-to-face consultation between a pharmacist and patient, by far the most effective type of intervention to ensure that patients adhere to their prescribed medication regimen and receive adequate counseling about potential side effects, is replaced in mail-order with impersonal email communication or long waits on phone calls to a toll-free number. PBMs "hard sell" health plans on implementing complex benefit schemes requiring beneficiaries to use PBM-owned dispensing facilities for maintenance or specialty medications. They promise outrageous savings to health plans but often fail to mention the excessive costs and additional patient burden associated with mail-order waste – discontinued prescriptions for which medications are still mailed to the patient for months, temperature-sensitive medications that are left vulnerable to the elements until patients get home, increased potential for lost or stolen medications, et cetera. Mail-order pharmacies do not provide an adequate pharmacy network for patients – quite the opposite. NCPA supports the model act's network adequacy requirements because they will protect the personal, face-to-face interaction

[2] Section (3)(d).
[3] Section (3)(m).

between pharmacist and patient by preventing PBMs from including mail-order pharmacies in their calculations for network adequacy.

Compensation – prohibited practices

NCPA supports the model act's provisions allowing the insurance commissioner to review and approve PBM compensation programs to ensure that the programs are fair and reasonable to provide an adequate pharmacy benefits manager network. PBMs' opaque compensation practices have a direct negative impact on locally owned community pharmacies in the form of "underwater" reimbursements – in which the amount a pharmacy pays for the medication is more than what the PBM reimburses them for the prescriptions they dispense. Community pharmacists' primary concern has always been the health of their patients. However, there is a limit to the number of underwater reimbursements pharmacies can withstand. Eventually, these under-reimbursements will run community pharmacies out of business, further limiting patient access to local pharmacy services.

NCPA supports the provisions protecting patient access to pharmacy services by prohibiting PBMs from requiring accreditations and certifications beyond the requirements of the State Board of Pharmacy. PBMs have no place interfering in the regulatory aspect of pharmacists and pharmacies operating in the state. PBMs are simply middlemen that have been employed to reduce administrative costs for insurers, validate patient eligibility, administer plan benefits, and negotiate costs between pharmacies and health plans. State boards of pharmacy already have the necessary requirements for pharmacies in place to serve and protect the residents of their states. Additional accreditation and certification requirements implemented by PBMs beyond those mandated by a state board of pharmacy are often used to create narrow networks that inhibit patient access to qualified, trusted pharmacy providers and are well beyond the scope of appropriate PBM practices.

NCPA also supports the provision prohibiting a PBM from reimbursing an independent pharmacy less than it reimburses a PBM affiliate. This will help to minimize the conflicts of interest that occur when PBMs own pharmacies. NCPA urges the committee to remove the language limiting the application of the provision to generic products only.[4]

Pharmacist Provision of Information to Patients

Often community pharmacists are forced to sign take-it-or-leave-it contracts from PBMs with multiple contract provisions or requirements embedded in lengthy provider manuals that include overly broad confidentiality requirements and non-disparagement clauses, as well as requirements that pharmacies charge insured patients what the PBM says at point of sale. This

[4] Section (6)(b)(4).

has the effect of chilling a range of pharmacist communications with patients and others for fear of retaliation by the PBM. While they dislike these provisions and the negative impact they have on communicating with patients, independent pharmacists cannot negotiate these clauses out of PBM contracts, so they sign the contracts anyway to continue filling prescriptions and providing care for patients whose pharmacy benefits are managed by the PBM. Violation of any of these provisions or others may lead the PBM to terminate the contract with the pharmacy and remove the pharmacy from the PBM's networks, resulting in the inability of the pharmacy to continue to serve a significant percentage of its customers and potentially causing access problems for patients. NCPA supports the model act's provisions that protect pharmacy patients by preventing PBMs from prohibiting a pharmacist or pharmacy from, or penalizing them for, providing information to their patients regarding the options that patient has in paying for prescription medications. **Twenty-four states have passed similar laws.**

Enforcement and rules

NCPA supports the model act's provisions allowing the insurance commissioner to adopt rules and set penalties and fines for violations of the act. This enforcement authority is necessary to ensure all parties comply with its requirements.

Maximum allowable cost lists

NCPA urges the committee to make the following changes to the provisions addressing maximum allowable cost (MAC) lists:

- The act should require MAC lists to be updated no fewer than every seven days. 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.
- When a MAC appeal is upheld, the applicable change in the maximum allowable cost should be made effective retroactively to the date of the original claim and should apply to all similar claims. This will ensure that the pharmacy is reimbursed at the appropriate rate.
- Provisions should be added that address generic effective rate (GER) reimbursement. Under a GER reimbursement methodology, a PBM retroactively manages MAC lists by defining an average discount off the Average Wholesale Price (AWP) for all generic drugs. GER is becoming a more common standard and a way for PBMs to avoid existing laws addressing MAC lists. The model act should address GER to ensure PBMs cannot skirt protections in state codes.

PBMs typically establish a MAC list for multi-source generic drugs that includes the amount a PBM will pay for certain drug products. The process PBMs use to determine the drugs and the prices of

the drugs included on the list, however, lacks any degree of transparency. This process is further complicated by the fact that PBMs frequently maintain multiple lists. There is no standardization in the industry for the criteria or methodology used to determine inclusion or pricing of a drug on one of these lists. In most cases, these lists remain entirely confidential to both the PBM's client – the health plan sponsor – and the pharmacy; therefore, there is no way of knowing how or why a health plan sponsor or pharmacy is paying or being paid the PBM-set price for a drug. This gives PBMs the ability to gain significant revenues through questionable business practices.

For example, PBMs will typically use an aggressively low price list to reimburse their contracted pharmacies and a different, higher list of prices when they sell to their clients or plan sponsors. Essentially, the PBMs reimburse low and charge high with their price lists, pocketing the significant "spread" between the two prices, and we can demonstrate the impact this practice has on ever-increasing prescription drug plan costs.

At the federal level, CMS has recognized the fiscal benefits of the type of transparency required by the model act. In their Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule, CMS stated that "updating maximum allowable cost prices for drugs at least every 7 days generally should have a downward pressure on overall drug costs. Therefore we do not agree with the commenters that the requirement will necessarily increase costs."

The model act is not requiring anything that would result in a negative fiscal impact to the health care system or to any state agency or plan. **Of the thirty-eight states with enacted legislation similar to this act, no state has reported a negative fiscal impact.**

Fair pharmacy audit procedures and guidelines

NCPA urges the committee to add language addressing pharmacy audits. Pharmacists understand that audits are a necessary practice to identify fraud, abuse, and wasteful spending, and they are not opposed to appropriate audits to identify such issues. Current PBM audits of pharmacies, however, 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. In many instances, the PBM not only recoups the money paid to the pharmacy for the claim in question but also recoups for every refill of that claim, even if all other fills were dispensed without error.

In their 2014 Final Call Letter, the Centers for Medicare and Medicaid Services indicated their recognition of abusive pharmacy audit practices occurring within the Medicare Part D program. CMS found that pharmacy audits in the Part D program were not focused on identifying fraud and financial harm but on targeting clerical errors that "may be related to the incentives in contingency

reimbursement arrangements with claim audit vendors." CMS concluded that "full claim recoupment should only take place if the plan learns that a claim should not have been paid under Part D at all; for example, because it is fraudulent." **Forty states have also recognized that abusive practices occurring during pharmacy audits are not limited to the Part D program and have enacted legislation to address these practices.**

A model act of comprehensive PBM regulation should address fair pharmacy audit requirements.

Almost all of the provisions in this model act have been enacted in some form in states across the nation. Ninety-one percent of all prescriptions are covered by insurance, and state legislators realize the need to regulate a PBM industry that touches almost every one of their constituents. Each time a bill is proposed that will protect patients, payers, and pharmacy providers from opaque PBM practices and abuses, the PBM industry has fought against the proposed protections. By adding reasonable regulations on an industry that has contributed to increasing prescription drug benefit costs, this model act will allow community pharmacists to better serve their patients without PBMs imposing unfair and burdensome requirements.

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

Matthew Magner
Director, State Government Affairs

June 8, 2018

[Submitted electronically to wmelofchik@ncoil.org]

Attn: Will Melofchik, NCOIL Legislative Director
State Assem. Kevin Cahill, NY, Chair
Health, Long-Term Care & Health Retirement Issues Committee
The National Council of Insurance Legislators (NCOIL)
Atlantic Corporate Center
2317 Route 34 Suite 2B
Manasquan, NJ 08736

RE: APhA Support Letter for the Pharmacy Benefits Manager Licensure and Regulation Model Act, Sponsor Senator Jason Rapert (Arkansas), Discussion Draft as of May 8, 2018

Dear Assem. Cahill:

As the national representative and advocate of the pharmacy profession, the American Pharmacists Association (APhA) writes to provide support for the development of the Pharmacy Benefits Manager Licensure and Regulation Model Act (the "Act") sponsored by The National Council of Insurance Legislators (NCOIL) current President and Arkansas State Senator Jason Rapert. This legislation would provide fairness in the marketplace by allowing the state insurance commissioner to establish rules regarding licensing, fees and other standards for pharmacy benefit managers (PBMs).

APhA, founded in 1852 as the American Pharmaceutical Association, represents 62,000 pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in improving medication use and advancing patient care. APhA members provide care in all practice settings, including community pharmacies, physicians' offices, hospitals, long-term care facilities, community health centers, managed care organizations, hospice settings and the uniformed services.

The Act coincides with a number of regulatory activities at the federal level from the Centers for Medicare and Medicaid Services (CMS) to limit PBM efforts to restrict pharmacies' access to Part D networks and increase transparency including protecting any willing pharmacy provisions, prohibiting onerous pharmacy accreditation and credentialing requirements that go beyond state laws, improving timelines for terms and conditions,[1] and prohibiting PBM "gag clauses".[2]

[1] *See*, CMS. Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program. Final Rule. 83 FR 16440. April 16, 2018. Available at: https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare

[2] *See*, Verma. Seema. CMS. Letter to All Part D Sponsors. Subject: Unacceptable Pharmacy Gag Clauses. May 17, 2018. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/Other-Content-Types/2018-05-17.pdf

Patients are negatively impacted by insurer and PBM practices such as "claw backs", and "gag clauses" that mask the real price of medications, increase the price patients pay, and interfere with pharmacists' ability to provide patient care. A recent study by the University of Southern California Schaeffer Center for Health Policy & Economics found that these practices forced customers to overpay for their prescriptions 23 percent of the time, with an average overpayment of $7.69 on those transactions.[3] These practices are also dramatically impacting pharmacies, many of which are small businesses. Retroactive fees or claw back mechanisms, often assessed weeks or even months after a prescription has been filled, prevent pharmacies from knowing at the time of dispensing what their true reimbursement will be for a prescription and result in a final reimbursement that has no relationship to what the pharmacy actually paid for the product. Such procedures are impacting the sustainability of pharmacies and accordingly, patients' access to care. Additionally, some PBM practices drive a wedge between pharmacists and patients because the incentives drive patients into narrow networks which adversely affect care continuity and force the patient away from a trusted health care provider who has knowledge about the patients' past medical and medication history. Complex PBM coverage and payment policies hinder the full potential of community pharmacists' clinical education and training from being realized as much of their day is spent on addressing coverage issues instead of providing care. Administrative inefficiencies and burdens placed on practitioners interferes with the ability of pharmacists and other practitioners to provide sufficient time and attention to patients.

APhA supports recent efforts by federal and state policy makers to prohibit these types of practices to allow better transparency regarding the cost of medications, allow patients to make more informed decisions, and permit pharmacists to know their actual reimbursement for a product at the point-of-sale. For years pharmacists have been frustrated by policies restricting their ability to help their patients who they know are struggling with high co-payments. However, in order to get the greatest benefit from medications, patients must understand how to use their medications safely and effectively. Unfortunately, many insurer policies prevent patients from receiving pharmacist-provided services to optimize safe and appropriate medication use and the impact of their medications. APhA emphasizes the need for public and private payers to cover pharmacist-provided services to optimize safe and appropriate medication use and the impact of medications on patients.

APhA appreciates the Committee's consideration of this important issue and hopes NCOIL will adopt the Act. If you have any questions or require additional information, please contact Michael Baxter, Director of Regulatory Affairs, at mbaxter@aphanet.org or by phone at (202) 429-7538.

Sincerely,

Stacie J. Maass

Stacie Maass, BSPharm, JD
Senior Vice President, Pharmacy Practice and Government Affairs

[3] Van Nuys, Karen, PhD. Et. al. OVERPAYING FOR PRESCRIPTION DRUGS: THE COPAY CLAWBACK PHENOMENON. USC Schaeffer Center for Health Policy and Economics. March 2018. Available at: http://healthpolicy.usc.edu/documents/2018.03_Overpaying%20for%20Prescription%20Drugs_White%20Paper_v.1.pdf

cc: State Senator Jason Rapert (Arkansas), President, NCOIL
Mr. Thomas B. Considine, CEO, NCOIL

Arkansas Pharmacists Association

The National Council of Insurance Legislators
Assemblyman Kevin Cahill
Chairman, Health Subcommittee
2317 Route 34, Suite 2B
Manasquan, NJ 08736

June 6, 2018

Dear Chairman Cahill and NCOIL Health Subcommittee Members,

The purpose of this letter is to provide written support for the development of the Pharmacy Benefits Manager Licensure and Regulation Model Act sponsored by the current NCOIL President and Arkansas Senator Jason Rapert. In March of 2018, Arkansas passed similar legislation, Act 3 of 2018, the Arkansas Pharmacy Benefits Manager Licensure Act. This law places a referee on the playing field to establish fairness in the marketplace by allowing the state insurance commissioner to establish rules regarding licensing, fees and other standards for pharmacy benefit managers (PBMs).

We look forward to hearing the discussion, reading the comments from stakeholders and are willing to provide information from the Arkansas experience on why such model legislation is critical to ensure safe and effective medication use in America. We applaud your efforts to consider model pharmacy benefit manager legislation to promote, preserve, and protect the public health, safety, and welfare through (1) effective regulation and licensure of pharmacy benefits managers; (2) provide for powers and duties of the Insurance Commissioner, the State Insurance Department; and (3) prescribe penalties and fines for violations of this Act.

Why is this type of model legislation supported in Arkansas and needed in all states?

Prior to the Arkansas Pharmacy Benefits Manager Licensure Act in 2018, Arkansas like many other states had attempted to pass laws regulating unfair business practices by pharmacy benefit managers as the issues arose. Disappointingly, these laws were not comprehensive, were handled by multiple different state agencies, were difficult to enforce and were not effective in ensuring a properly functioning marketplace.

The community pharmacy marketplace in Arkansas was severely broken in early 2018. Patients in underserved areas were often turned away at the pharmacy because of unannounced and unjustified below cost drug manipulation by pharmacy benefit managers in both government funded Medicaid expansion plans and commercial insurance plans. Furthermore, when pharmacies challenged these rates with appeals, the appeals were mostly ignored by the responsible pharmacy benefit managers despite existing state laws that required their cooperation. The Arkansas Pharmacists Association was also able to collect data from pharmacists and patient explanation of benefit statements from the insurance carriers and subcontracted PBMs that revealed possible Deceptive Trade Practices violations in Arkansas. One especially disturbing finding was that across 267 unique claims, including all top 200

Arkansas Pharmacists Association

most commonly prescribed drugs, CVS Caremark in commercial private insurance was acting in an anticompetitive fashion and reimbursing itself (CVS retail pharmacies) $63 more per prescription than contracted independent pharmacies in Arkansas. In addition, both OptumRx and CVS Caremark were using benefit design that utilized spread pricing in state government funded health insurance plans. The PBMs would pay the pharmacy a very low amount and then report to the insurance carrier and patient (patient explanation of benefits) a much higher amount paid to the pharmacy.

The concerns and written complaints from Arkansas pharmacists led to Arkansas Attorney General Leslie Rutledge announcing on Thursday, Feb. 8, 2018, that she would investigate complaints about reimbursement rates between pharmacy benefits manager, CVS Caremark, and Arkansas pharmacies. Investigators and attorneys for the AG's office have requested information pertinent to establishing if the reimbursement rate change triggers provisions of Arkansas' Deceptive Trade Practices Act.

While pharmacists work to improve the health of their patients and better their communities, pharmacy benefit managers squeeze as much money from pharmacists and patients to line their pockets. As critical pharmacies are squeezed out and closed, patients are ultimately harmed, especially in rural communities that have far fewer healthcare professionals. The community pharmacy health care marketplace in America has failed and the market is broken. Patients, purchasers and pharmacists are looking to state and federal leaders to create legislation and rules that ensure a fair playing field and healthy marketplace that delivers value and improved patient outcomes, rather than one that is anticompetitive, more expensive and is exploited for profit by unregulated middlemen pharmacy benefit managers.

Respectfully,

Scott Pace, Pharm.D., J.D.
Executive Vice President & CEO

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June 25, 2018

The Hon. Kevin Cahill
Chair, Health, Long-Term Care & Heath Retirement Issues Committee
National Conference of Insurance Legislators
2317 Route 34, Suite 2B
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RE: Comments on NCOIL Proposed "Pharmacy Benefits Manager Licensure and Regulation Model Act"

Dear Chair Cahill and Members of the NCOIL Health Committee:

Thank you for the opportunity to provide written comments in support of the NCOIL discussion draft Pharmacy Benefits Manager (PBM) Licensure and Regulation Model Act. The Independent Pharmacy Cooperative (IPC) is a national trade group representing the interest of nearly 2,700 independent pharmacy store owners in all 50 states. Many of our member pharmacies reside in rural, underserved and economically disadvantaged parts of the country. These community-based, small businesses continue to accept the responsibility of being health care providers that are the first point and often only source for delivering health care in their local communities. Among the services IPC provides to our member stores is legislative and regulatory advocacy that affect independent pharmacy through our Government Relations Department. In that role, I am submitting this written comment in support of the PBM Discussion Draft Model Act, with some suggestions for revisions and the inclusion of other patient protection language.

First, IPC applauds the committee's discussion draft PBM Regulation Model Act as a positive initial effort to create a uniform state model bill of needed state-based regulation of the activities of PBMs. While states iteratively have been passing PBM state laws to addressing many of the issues, this unregulated part of the health care benefits market, which is highly concentrated and lacking a competitive marketplace, needs a consensus approach to protect patients and their pharmacies from PBM abuses that have added to the high cost of

prescription benefits while unnecessarily interfering with the pharmacist-patient relationship.

IPC strongly supports the sections of the model bill to license and regulate PBM activities (Sections 4, 6, 8, 9 and 11). Our experience advocating for passage of state PBM bills is that formal state regulation of PBM and state regulatory enforcement powers in the law are crucial to having effective patient/consumer protections against PBM abuses.

We do have suggestions of changes to the following sections:

1. Under definitions (Section 3), the model should –
    a. Revise "independent pharmacy" to a clearer definition that indicates there is no ownership or legal control of the pharmacy by a PBM.
    b. Eliminate from the definition of "health plan" the exemption for self-funded and ERISA plans [(Section 3 (b) (2) (viii)] since this model is consumer protection legislation that does not impede or infringe the benefit design

    There are other definitions needed that will be address further in our comments.

2. While IPC supports the goal of the PBM Network Adequacy Section (Section 5), IPC recommends the following changes to make sure that PBM pharmacy networks fully work for the benefit of the patient and not the PBM:
    a. In the convenience of access subsection (Section 5 (a) (1) needs to be revised to include "time" in addition to "distance as a factor." This subsection also needs to include language "as determined by the Department of Insurance as promulgated by regulation" to ensure it a standard that protects the patient, not the PBMs.
    b. This section needs to include the anti-mandatory mail order (AMMO) provisions to ensure these state contracts will not force patients to use mail order for both prescriptions and durable medical equipment (DME). Both the New York and Pennsylvania state AMMO laws have been well received and are appropriate language to include in this network adequacy section of the model.

3. The model needs to fully protect a pharmacy patients right to choose its provider for both prescription and pharmacy related services so long as: a) a network pharmacy is willing to agree to a contract; b) the network includes all types of pharmacies (independent, chain, mass retailer, mail-order) and c) all pharmacies in the network receive equal terms (i.e. no incentives for mail-order pharmacies).

4. The Compensation Prohibited Practices Section (Section 6) offers important consumer protections, but it lacks one important provision – prohibitions against PBM conflicts of interests. As some states have enacted, this section needs to include a subsections that prohibits PBM's from having an ownership interest in a mail order facility and language that makes having a conflict of interest in operating a prescription benefit program a regulatory actionable offense under the model bill.

5. The Gag Clause Prohibition (Section 7) is a vital patient protection provision that ensures the pharmacists-patient relationship is strengthened by eliminating contract prohibition of pharmacist being able to discuss prescription costs options with their patient. And the prohibition against allowing pharmacists to talk to policy makers (Section 7 (d)) is an equally important protection. IPC would suggest that this subsection specifically include a sentence to include talking to state legislators about PBM legislation or regulation since many pharmacy owners fear retaliation under their contracts, including network termination, if they participate in the public policy advocacy process.

6. The Enforcement Section (Section 8) is the most important provision in this Model Act if there is to be true consumer protections in this highly non-competitive health care coverage marketplace. The one regulatory tool that this model should include is the ability of the Insurance Commissioner to order a market conduct review of PBMs. Also, a remedy under the individual state's Consumer Protection Act is commendable.

7. The MAC provisions (Section 12) have been passed by 33 states. Several important protections need to be changed in the proposed model to ensure patient access to these prescriptions:
    a. MAC updates should happen no fewer than seven (7) calendar days, rather than "in no event longer" [Section 12 (b) (2)].
    b. Ensure that MAC appeals that are upheld be applied retroactively to the date of the claim and for all similar claims [Section 12 (b) (4) (C) (i) (d)].
    c. Provide a new subsection under Section 12 to ensure against PBM's creating a loophole from the MAC provisions by creating disclosure requirements of how a PBM utilizes and determines its Generic Effective Rate ("GER") reimbursements for all its MAC drugs to all network pharmacies, including mail-order.

The following important pharmacy patient protections not included in this discussion draft model that IPC believes need to be included:

Pharmacy Audit Protections - Forty states have enacted pharmacy audit protections to ensure that PBM's do not recoup claims payment for "technicalities" that are not truly fraudulent claims. These bills ensure that pharmacies do not see all payment taken away for legitimate prescription that have been filled and dispenses because of paperwork violations. IPC suggests that NCOIL include an Audit section based on provisions found in existing state statutes. One additional consumer protection needed in the pharmacy audit protection section of a PBM model bill is that if a PBM recoups a prescription payment through an audit, it must remit back to the patient any out of pocket costs (co-pay, deductible, co-insurance) that is recouped.

PBM role as a Fiduciary - The underlining purpose of this PBM Model bill is to protect consumers, including ultimate payers of prescription claims. This principal requires a PBM model regulation bill to include the same protections for all consumers when it comes to prescription benefits as applies to other health care claims coverage – a fiduciary responsibility for the PBM's in how it conducts its role in prescription benefits management. The Trump Administration is considering such a regulatory requirement under ERISA.

Medicaid Managed Care Reimbursement - A key PBM prescription benefit management activity that this model bill has to address is their role as subcontractor to Medicaid Managed Care Organizations (MCO's) to managed the prescription claims for states that have moved their Medicaid prescription benefits from a State Medicaid fee-for-service benefit, designed and paid for by the State, to a benefit "carved in" to the Medicaid managed care system. Under the MCO model, the Medicaid managed care prescription reimbursement does not have to follow the newly federally-mandated transparent Medicaid fee-for-service reimbursement. That lack of payment standards has led in many instances with PBM MCO prescription payments below pharmacy drug acquisition costs. This disparity is creating access issues for Medicaid MCO beneficiaries for certain drugs. IPC recommends that the Model bill include provisions that would mandate MCO prescription benefits reimburse pharmacies at the same rate as paid for that drug under the state's Medicaid FFS system. Since many states using Medicaid managed care consider it a commercial insurance marketplace product, it is appropriate for inclusion in this model bill. For states that have implemented 100% Medicaid managed care, the adoption of the National Average Drug Acquisition Cost (NADAC) and a surveyed professional dispensing fee.

Patient Explanation of Benefit (EOB) Mandate - There should be a new patient protection section in the draft model that requires a PBM operating in the state to provide monthly to each covered patient an explanation of their pharmacy benefit for each prescription claim during that month that includes: 1) the contracted prescription price paid to the network pharmacy for each prescription dispensed; 2) the patient out-of pocket cost (co-pays, deductibles and co-insurance); and the amount charged for each prescription to the plan sponsor or health insurance company. Such basic disclosures are required to health care consumers for all health and dental insurance claims. States must provide the same standard of transparency and disclosure to pharmacy patients for state covered prescription benefits claims.

Prompt payment of claims uniform standard - While federal law requires health insurance claims be paid promptly no later than 30 days after receiving a "clean claim", individual states lack uniform standards when it comes to PBM's promptly paying pharmacy claims. Most states require 30 days, but some states allow up to 45 days for pharmacies to receive prescription claims payment. This is a unique problem for pharmacy providers since they have to stock drug inventory in order to serve patient prescription drug needs and they in many cases must pay their

wholesalers every 2 weeks in order to secure enough drug inventory to legally operate their pharmacy. The Medicare Improvement for Patients and Providers Act (P.L. 110-275a) mandates that all Medicare Part D PBM's pay pharmacies "clean" Part D claims within 14 days. The model should also mandate that all PBM's have to pay state commercial insurance prescription claims, including MCO claims, in the same timeframe as required under the MIPAA of 2008.

Continuity of Care - The model should also provide the following care continuity requirements on PBMs to ensure that patients are not harmed by PBM contract practices:

a. Require notice to prescriber, patient and pharmacy at least 90 days prior to a formulary change in a prescription contract that a current prescription drug will no longer be covered by the formulary and allow an initial 30 day fill of the non-formulary drug during the first 14 days for a new contract year. This must include MCO contracts and allow an initial 90 day fill for LTC (SNF and non-SNF) MCO patients.

b. Mandate that any prescription on a PBM formulary contract that is not currently identified by the plan sponsor as a specialty drug, must be allowed to continue to be filled by all network pharmacies at the network contract rate.

IPC is pleased to support NCOIL's effort to develop and adopt an effective and comprehensive PBM regulation bill that protects patient interests and the ability of their pharmacies to serve them, while subjecting PBMs to the same level of market regulation as others in the health care industry. Prescription benefits is an important and growing portion of the health care coverage needs of patients. The activities of PBM's in providing these benefits demands these consumer protections.

IPC looks forward to continuing to work with this NCOIL committee on the process to finalize a PBM Licensure and Regulation Model Act.

Please let me know if you have any questions or need any additional information about the issues in my written comments.

Sincerely,

Mark Kinney

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June 8, 2018

The Honorable Kevin Cahill
Chairman, Health, Long-Term Care & Health Retirement Issues Committee
National Council of Insurance Legislators
2317 Route 34, Suite 2B
Manasquan, NJ 08736
Via email to William Melofchik, NCOIL Legislative Director

RE: NCOIL Draft Pharmacy Benefits Manager Licensure and Regulation Model Act

Dear Chairman Cahill:

The Pharmaceutical Research and Manufacturers of America (PhRMA) supports the draft Pharmacy Benefits Manager Licensure and Registration Model Act that would place comprehensive licensure and oversight of PBMs operating in states, which could lead to better patient protections.

Under the draft model act, a PBM would be required to provide an adequate and accessible PBM network for health benefits plans, and require an appropriate number of network pharmacies to have a physical location in the service area versus allowing mail order to count as an adequate network. It would also allow for reimbursement of valuable pharmacy services that help the patients achieve improved health outcomes and ultimately lowers costs for the patients, plans, and the state. A state's Insurance Commissioner would have discretion under this model to enact additional protections and parameters around the network adequacy requirements, if necessary.

Included in the draft model act provisions are requirements that pharmacists be allowed to share important information with patients or government entities, removing the current "gag clause" that prohibits pharmacists from doing so currently. Patients deserve to have truthful and accurate information, and this draft model act would provide patients with important decision-making information at the point of sale. In addition, the draft model act would prohibit PBMs from using untrue or misleading solicitations.

Newly released PBM data show medicine spending is growing at the slowest rate in years. After accounting for discounts and rebates negotiated with biopharmaceutical companies, PBMs report that medicine spending growth in 2017 was in the low single digits or slightly negative. Express Scripts reported spending on medicines grew just 1.5%, which is the smallest increase since they tracked spending data 25 years ago.[1] This information is important because it begs

[1] "Express Scripts 2017 Drug Trend Report." Express Scripts. http://lab.express-scripts.com/lab/drug-trend-report. Accessed June 7, 2018.

the question as to where savings go. The Berkley Research Group found brand biopharmaceuticals retained just 63 percent of the list price for brand medicines and the rest is rebated back to PBMs, insurers and others in the supply chain.[2] These discounts and rebates create a savings of more than $193M in manufacturer rebates that is not always shared with patients who face rising out-of-pocket costs when they go to the pharmacy to get their medicines filled. This legislation is a good start to ensure that state insurance regulators can provide appropriate oversight over PBMs and that patients are not able to share in the savings generated from manufacturer rebates and discounts.

For these reasons, PhRMA strongly encourages NCOIL to adopt the draft Pharmacy Benefits Manager Licensure and Regulations Model Act.

Sincerely,

Saiza Elayda, JD
Director, State Policy
PhRMA

[2] Vandervelde, A and Blalock, E. (January 2017) *The Pharmaceutical Supply Chain: Gross Expenditures Realized by* Stakeholders. Berkley Research Group. https://www.thinkbrg.com/media/publication/863_Vandervelde_PhRMA-January-2017_WEB-FINAL.pdf. Accessed June 7, 2018.