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Assembly Bill 773

Thank you, Chairman Moses and Members of the Committee on Health, Aging and Long-Term Care, for the opportunity to testify in favor of this Pharmacy Benefit Manager(PBM) reform bill, which will make the purchase of prescription medications more affordable and accessible.

First, I'd like to provide some context on PBMs and recent legislation.

Pharmacy Benefit Managers began in the 1960s to do the complex paperwork when insurance companies began offering prescription drug coverage as part of their health insurance plans. This is a valuable service, and over time, PBMs have found ways to become very profitable. This bill will allow a fair profit without negative consequences to patients.

Please keep in mind that many PBMs are vertical monopolies with insurance companies and pharmacy chains. Attached to my testimony, you will find a press release from the American Medical Association expressing their concerns about how a vertical monopoly affects patient care. These monopolies claim to keep costs down; yet cost savings are often cost-shifting to competitors or to the consumer. Numerous physicians and health care professionals have expressed their frustration that patients are cut off from their prescribed medications due to formulary changes by the PBM and insurers.

That leads us to where we are today. I'm sure some of you are asking yourselves this question:
"Didn't we already regulate PBMs last session?"

As you may recall, there were 104 cosponsors to 2019 AB 114/SB 100. Unfortunately, the substitute amendment removed many of the provisions that would have been most useful to our constituents. The watered down version of the bill was enacted as 2021 Act 9.

Despite the changes in the substitute amendment, Act 9 did make some useful improvements.

- PBMs are required to register with the Office of the Commissioner of Insurance (OCI) and to report on the rebates (kickbacks) they retained and did not pass on to the health plan sponsors. These reports are confidential, so transparency is only to OCI, not to the PBMs' clients.
- Patients must be notified of certain changes to the formulary, although PBMs are not required to approve continued coverage for patients who need to stay on the medication as prescribed.
- Contracts can no longer include a gag clause, which had prohibited pharmacists from telling patients they could save money by paying for medications without using insurance.

- The bill set down some basic procedures for audits of pharmacies by PBMs, although pharmacies report that they are still subject to predatory audits.

These provisions were a start, but to be blunt, they actually do little to protect patients. After all, the pharmacists, PBMs, insurance companies, and prescribers are there to serve the patients. Of course, we want everyone to make a fair profit so that companies can stay in business and fulfill their roles in our complex health care system. I've been upfront all along that this was only the start to effective PBM reform.

For true reform, medications must be affordable and accessible.

This bill does much to address affordability. Many patients don't realize that their prescription might have a different co-pay, depending upon where they fill their prescription. Under the bill, all network providers will have the same co-pay, so patients won't be paying more at some pharmacies than at others. Patients who use the manufacturer copay assistance will be able to count it toward deductibles. Patients will also receive higher quality care, since they can get all of their prescriptions at the same location and at the same price, so their trusted pharmacist can monitor all of their medications.

Patients need to know that when they go to their pharmacy to fill their prescription, the medication will be available to them. Formulary stability is essential. Under the bill, the drugs on the formulary and the co-pay amount will be available before selecting an insurance plan. The formulary cannot remove a medication during the plan year. If the formulary changes for that new plan year, the patient has 90 days' notice.

> The PBMs have pointed out that a "frozen formulary," as they call it, will incentivize drug manufacturers and wholesalers to raise prices. Due to their concerns, I have introduced AA 1 to AB 773, which will allow for formulary changes. There is an exception only for patients who are stable on a medication that their prescriber affirms should not be changed. This should address the business concerns and protect patients.

Another key component of accessibility is simply having a pharmacy nearby. I've heard from a number of pharmacies who are on the verge of closing up shop because they are losing money due to current contracts and practices. This is especially troublesome in rural areas where patients have to travel long distances to access their medications.

Several business practices will be restricted, allowing fair competition and keeping more pharmacies in business to serve our citizens.

Currently, PBMs often drive customers to their own pharmacy chain by offering a lower co-pay. In fact, pharmacies outside of their chain may be reimbursed less than the cost of the drug. This is the most urgent concern of independent pharmacies. They cannot stay in business to serve patients if they repeatedly lose money on sales.

The price that a PBM reimburses a pharmacy is the Maximum Allowable Cost (MAC). The MAC price is sometimes less than their actual cost to purchase the drug wholesale. Under the bill, the MAC price must be based on clearly defined criteria. The bill also provides an appropriate appeals process for insufficient MAC prices. If the reimbursement is less than the cost of the drug, the PBM must revise the MAC price or tell the pharmacy where they can purchase the drug at or below the MAC price.

We are all aware that there are also overhead expenses. Pharmacies have the expense of hiring highly trained professionals, physical work sites, maintenance, insurance, energy, and inventory. The bill requires a dispensing fee equal to the current amount that the state pays for Medical Assistance dispensing fees. With both a fair reimbursement and a reasonable dispensing fee, pharmacies can stay in business to serve our Wisconsin citizens.

We all agree that audits for waste, fraud, and abuse are absolutely appropriate and necessary. However, when no errors are found, yet targeted pharmacies face repeated extensive audits for only high-priced drugs, something isn't right. This practice unnecessarily increases the workload and expense to pharmacies. The bill will require randomized audits that are comparable for all pharmacies. It also specifies that any recoupment for financial harm goes to the individual or insurer who is harmed.

I have introduced AA 2 to AB 773 requiring PBMs to submit reports to OCI on recoupments received and disbursed.

Audits for waste, fraud, and abuse should work both ways, so I have also introduced AA 3 to AB 773, which allows OCI to audit the PBMs and allows the State Auditor to examine these audits and the confidential reports from PBMs to OCI. Transparency and accountability can only make our health care system better.

Let's take a look at the PBM position.

The Pharmacy Benefit Managers and their vertical monopoly partners oppose this bill. We have been open to consider amendments, but have received no proposals from them. When Sen. Felzkowski asked the lobbyist for the Pharmaceutical Care Management Association (PCMA) for the most egregious provision of the bill, his response was "All of it."

The coalition of insurers and PBMs sent out their 18-page memo on December 5, and PCMA read it at the Senate hearing on the next day. Let me take a few moments to respond to some of the major concerns expressed in the document.

They "met in good faith with legislators," and I was present in those large meetings. The authors of the bill, however, were not party to the "compromise." I agreed, with the understanding that this was the first step, and that I would come back and strengthen protections for patients.

PCMA points out that a lower co-pay is a benefit to patients, and it is. However, an equal co-pay is a benefit to everyone, not forcing competitors out of business or forcing patients

to use certain pharmacies or mail order. While they see "no additional benefit provided," I see a great benefit to maintaining access for all patients.

Drug manufacturers could increase prices, which is a valid concern. As I explained earlier, I have introduced an amendment to address this objection, only retaining formulary stability for patients who are already stable on a covered medication for the plan year.

PBMs strongly object to the co-pays count provision, yet co-pay assistance should benefit those that the assistance was intended to help. You will hear testimony today from individuals who have been directly impacted by current practice.

Pharmacies should be evaluated on items over which they have complete and exclusive control, such as filling prescriptions as prescribed. It is unreasonable to base evaluations on criteria which they cannot control, such as whether patients refill their prescriptions on time.

Of course, businesses have a responsibility to audit to find waste, fraud, and abuse. The bill preserves the right for appropriate audits, but limits the use of audits as a tool against competitors.

That is the intent of the bill, to regulate business practices so Pharmacy Benefit Managers can perform their role profitably, while being fair to pharmacies and patients.

Thank you, Chairman Moses and Committee Members, for your time and attention to this necessary reform bill. I will be happy to respond to your questions.

MARY FELZKOWSKI
STATE SENATOR • 12TH SENATE DISTRICT

Testimony on AB 773: Pharmacy Benefit Manager Accountability

Assembly Committee on Health, Aging and Long-Term Care
February 14th, 2024

Good afternoon Chairman Moses and Committee Members,

Thank you for taking the time to hear testimony on our Pharmacy Benefit Manager Accountability legislation.

As Representative Schraa explained, pharmacy benefit managers (PBMs) have been around for a long while, and are a very valuable tool that health insurers use in providing their members with prescription drug coverage. It's not our intent to debate their need or their purpose. We are sitting here today because of some of the practices and tactics they've engaged in in recent years have caused significantly more harm to our healthcare ecosystem than the savings that they generate.

Representative Schraa and Representative Rozar illustrate the challenges PBMs create for patients far better than I could, so I'd like to discuss the perspective of the care providers affected the most by PBM practices: our pharmacists.

Representative Schraa touched on some of the unfair business practices our bill addresses, and later today you will hear from Wisconsin pharmacists about what it is like dealing with the PBMs in our current unregulated, Wild West environment. I'd like to take my time to discuss a more abstract fear that I have – one that I am watching come true because of PBM practices in this state. Our independent pharmacies are disappearing. PBMs are forcing pharmacies to sell at a loss, they are pressuring them into unfavorable contracts, and they are continuing to engage in predatory audits, years after the Legislature attempted to address this issue.

A pharmacist from a small Wisconsin town in another Senator's district reached out to me once we introduced this bill and shared that he had been audited *30 times* by OptumRx in the span of *one* year. None of the audits unearthed a single issue. Before any of the Committee Members ask, "What town?" to make sure it's not in their district, I purposely don't share this publicly because multiple PBMs who practice in this state engage in repeated, sustained retaliatory behaviors against pharmacists who speak out about concerns with the PBMs.

The PBMs have assured me that it is not their goal to harm the independent pharmacies, and that any negative impacts our independent pharmacies face at their hands are incidental.
Incidental or not, the reality is that many of our pharmacies have egregious experiences with PBMs. I don't think there is any malice or ill-intent from PBMs as they go about their business, but it does illustrate the fact that we have allowed a healthcare model to evolve where we incentivize consolidation and risk harming access. The insurers own the PBMs. The PBMs own specialty pharmacies. The insurers own the MCOs that manage care for our rapidly aging population that are consistent, inevitable users of prescription drugs.

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We are *not* keeping a close enough eye on these entanglements as a state, and we will come to regret it sooner than we know. Regulatory frameworks like the ones proposed in our bill are the Legislature's only chance at protecting access, and ensuring our constituents have choices when it comes to their healthcare.

In any other industry, we would be saying that the PBMs are crossing a line with some of these practices. The problem in this case is that, that line isn't there to cross because we never drew one for them. That's what we're looking to do with our bill.

Thank you for your time today, and for your consideration of this bill.

DONNA M. ROZAR

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Testimony before the Assembly Committee on Health, Aging and Long-Term Care

Assembly Bill 773

February 14th, 2024

Thank you, Chair Moses and members of the Assembly Committee on Health, Aging and Long-Term Care for holding this hearing on Assembly Bill (AB) 773, relating to regulation of pharmacy benefit managers, fiduciary and disclosure requirements on pharmacy benefit managers, and application of prescription drug payments to health insurance cost-sharing requirements.

I will be limiting my testimony today to the copay accumulator portion of this Bill. Other legislators and experts will speak on the other sections.

The primary issue I would like to discuss is the affordability of the medications covered by the copay accumulator. Some medications for treating chronic illnesses, such as cancer, multiple sclerosis, and cardiac medications are expensive and have large copays for the patients using them. Pharmaceutical manufacturers may offer copay assistance to cover the expensive upfront cost of these medications. The issue at hand is health plans and pharmacy benefit managers (PBMs) in Wisconsin are frequently telling their own "premium-paying" insureds that financial assistance from some sources doesn't count toward their deductibles and out of pocket costs.

Buried deep in their insurance contracts are notifications to insureds, like the following two examples from Wisconsin plans below, "alerting" the insureds that copay assistance is being excluded from counting toward their cost-sharing requirement.

> "Coupons or any other form of third-party prescription drug cost sharing assistance will not apply toward any deductibles or annual out-of-pocket limits."[1]

> "If You participate in certain drug Cost Share assistance programs offered by drug manufacturers or other third parties to reduce the Cost Share (Copayment, Coinsurance) You pay for certain Specialty Drugs, the reduced amount You pay may be the amount We apply to Your Deductible and/or Out-of-Pocket Limit when the Specialty Drug is provided by a Network Provider. We may discontinue applying such reduced amounts to Your Cost Share at any given time."[2]

Even though the carriers do not *count* the assistance they still *collect* the financial assistance at the pharmacy counter! Plans and PBMs let the patient use the assistance, but exclude it from counting toward the patient's deductible. This results in the individual patient double-paying their deductible/out-of-pocket maximum before they receive their insurance benefit. The health plans and PBMs redirect the financial assistance to themselves, rather than counting the assistance towards the patient's deductible or out-of-pocket maximum. **That is *"double dipping!"***

A secondary issue that needs to be considered with medication affordability is a patient's treatment plan. Patients who are worried about affording their medication are more likely to find ways to make their medication "stretch." This can result in reducing or skipping critical dosages of their medication. Patients who try to stretch their medication put themselves at risk of their medication being less effective, or not working at all, which influences patient's quality of life and increases the chances of negative impacts on the patient's health.

Remember, the health plans and PBMs already negotiate a fair price with the drug manufacturer on the front end so the manufacturer's drugs would be available to patients on the plan's formulary. The patients are meeting their financial obligation to the insurer as outlined in their contract, but the insurer is not counting that assistance toward their copay. The insurer is collecting the additional revenue but penalizing the patient for needing and utilizing assistance.

It is important to note, this legislation only applies to prescription medications if there is not a medically appropriate generic equivalent available to the patient. Accordingly, this legislation removes the argument that financial assistance drives patients toward higher cost medications.

This proposed ban on copay accumulators has been adopted in 19 other states, red and blue states, by overwhelming margins.

Thank you for your kind consideration of this Bill. I am happy to answer any questions you have.

Wisconsin Independent Pharmacy Association (WIPA)

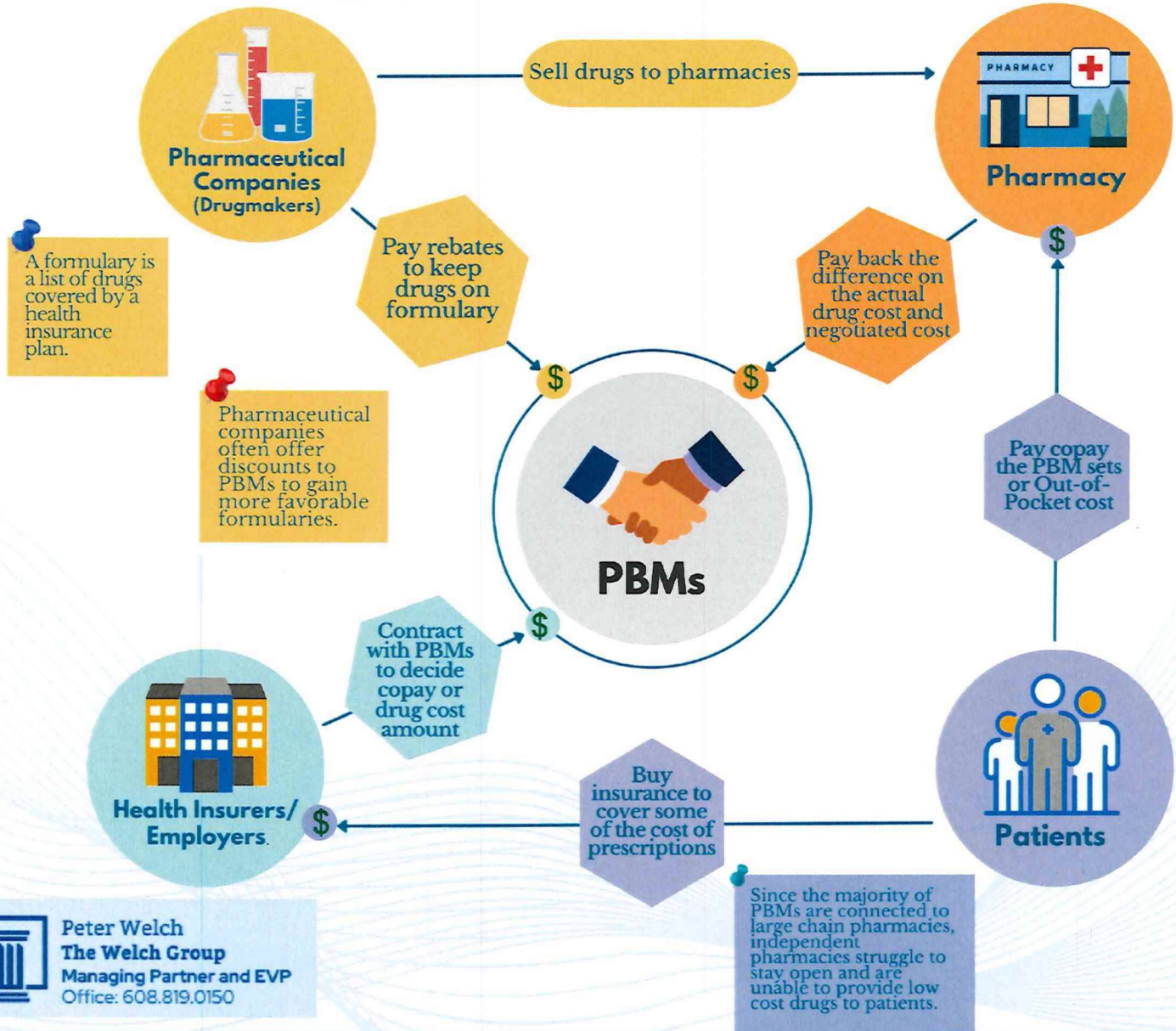
Educate Activate Advocate

The Wisconsin Independent Pharmacy Association (WIPA) asks for your support of **AB 773/SB 737 relating to: Pharmacy Benefit Manager Accountability.**

WIPA represents the hundreds of independent pharmacies who prioritize patient's access to care, cost transparency, and healthcare affordability in Wisconsin.

What is a PBM?

Pharmacy Benefit Managers (PBMs) were originally created to help health insurance companies handle the prescription drug programs they offered in their plans. PBMs now act as middlemen between drug makers, health insurers, and pharmacies. The negotiations between PBMs and these parties are growing more complex and less transparent. PBMs also have significant influence over which drugs get covered by insurance (being on the formulary list) and decide which pharmacies are in the insurance network. The top three PBMs (Express Scripts, Optum RX and CVS Caremark) manage 89% of drug claims. Concerns have been raised about PBM practices, and there have been calls for government oversight.



Peter Welch
The Welch Group
Managing Partner and EVP
Office: 608.819.0150

TO: Assembly Committee on Health, Aging, and Long-Term Care

FROM: Dan Strause

RE: Support of AB 773

DATE: February 14, 2024

Dear Chairman Moses and Members of the Committee:

My name is Dan Strause – co founder of Hometown Pharmacies of Wisconsin and former CEO. I retired and transitioned my CEO role – with purpose – one is to educate our communities and legislators of the negative impacts PBMs have affected. Today I am testifying on behalf of the Wisconsin Independent Pharmacy Association.

Please note the following:

1) Attached "Humalog" infographic – testimony from Eli Lilly – a pharmaceutical manufacturer – to the United States Senate Health committee – on the reason why the costs to patients and payors are so high.
2) We have a "greedflation" infographic - that that "translates" the Humalog infographic to better understand the "shell game" AND THE KEY PIECE – LEGISLATIVE PRESSURE WAS NECESSARY TO BRING THE NEEDED CHANGE – that recently occurred due to PUBLIC OUTRAGE.

These two infographics rebut the PBM's testimony that they are the only one in the supply chain incentivized to lower cost.

It also rebuts that PBMS only take $0.06 of every dollar. We find this a significant dereliction of truth telling.

Also – please find attached the "buckets" of PBM tactics that impact prices – also clearly rebutting the 6 cents per RX.

Also – please find 3 separate States who did analysis of PBM's paying their pharmacies and chains significantly more than independent pharmacies – thereby clearly practicing anti-competitive strategies for their own gain.

Also – please find attached a court ruling from respected Wisconsin judge that a PBM contract with independent pharmacies with "take it or leave it contracts" and "unconscionable!"

Finally – all of the PBM practices above are creating pharmacy deserts – and in a time where health care access points are needed most – they are shrinking due to "Corporate profit goals" at the inflated expense of everyone else. Please find the attached document showing the rapid decline of independent pharmacies since 2013.

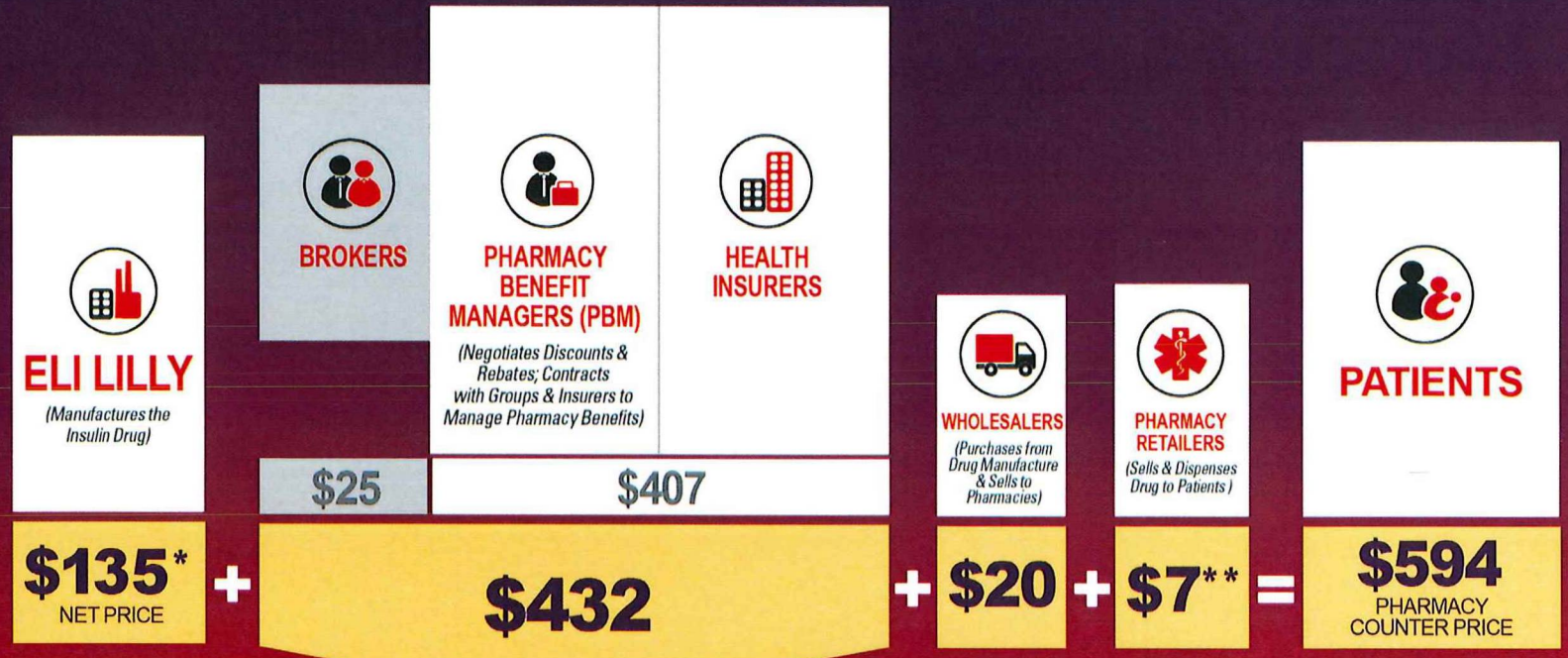
Regards,

Dan Strause

HUMALOG

Where the Money *Really* Goes

Pharmacists United for TRUTH & TRANSPARENCY



DEMAND TRANSPARENCY

*As reported by Eli Lilly 3/24/2019.

**Conservative estimate, actual price may be closer to $1. Most pharmacies in contact with PUTT have reported losses on all insulin dispensed due to below-cost reimbursements.

TruthRX.org

HUMALOG

GREEDFLATION: WHERE THE MONEY REALLY GOES

Wisconsin Independent Pharmacy Association (WIPA)

Educate
Activate
Advocate

	Eli Lily	Brokers	Health Insurers	Pharmacy Benefit Managers	Wholesalers	Pharmacy Retailers	Patients
	Manufacturer Original Patent sold for $1			Is Supposed to Negotiate lower rates	Purchases from Drug Manufacturer, Warehouses, and Sells to Pharmacies	• Buys & Dispenses Product to Patients • Consults & Connects with Patients • Monitors issues • Only Touch Point With Patients in this Process Patient Access • Pharmacy 30 + times a year, physicians only 3	
Profit Calculation – Cost	$6	$0	$0	$0	$20	$587	
Profit Calculation – Sales Price	$135	$25	$407	$432	$567	$594	
Profit Calculation – Margin	$129	$25	$407	$432	$587	$7	
Profit Calculation – Margin %	2150%	250000%	407000%	Infinity	4%	1%	

Cost to Patient

$135* Net Price + **$25** + **$407** = **$432** Total for Middleman + **$20** + **$7** = **$594** Pharmacy Counter Price

RECENT PUBLIC OUTRAGE AND LEGISLATIVE PROCESSES CAUSED THE CHANGE TO THE COST OF INSULIN!

PBMS FAILED THE AMERICAN PUBLIC, THEY DID NOT ACT IN THE BEST INTERESTS OF PATIENTS OR PAYORS, THEY ONLY ACTED AS FIDUCIARIES OF THEIR SHAREHOLDERS!

Don't be misled by the notion that pharmaceutical companies independently set their prices. They are actually compelled to comply with Pharmacy Benefit Management (PBM) requests for proposals, which demand various fees - including rebates, formulary fees, marketing fees, administrative fees, data fees, and each year, new inventive revenue channels. These escalated fees benefit PBM shareholders. Consequently, pharmaceutical manufacturers are forced to increase their costs. However, they also gain an advantage as they can incorporate these inflated costs, which insurance will cover, thus creating a win-win situation for both entities in commercial plans and many other types of insurance. The companies footing the bill remain oblivious to this process as neither the broker, the health plan, nor the PBM act as fiduciaries to the payer!

*Sources: Eli Lilly on 7/24/20, PLITT TruthRX.com

EPIGATE

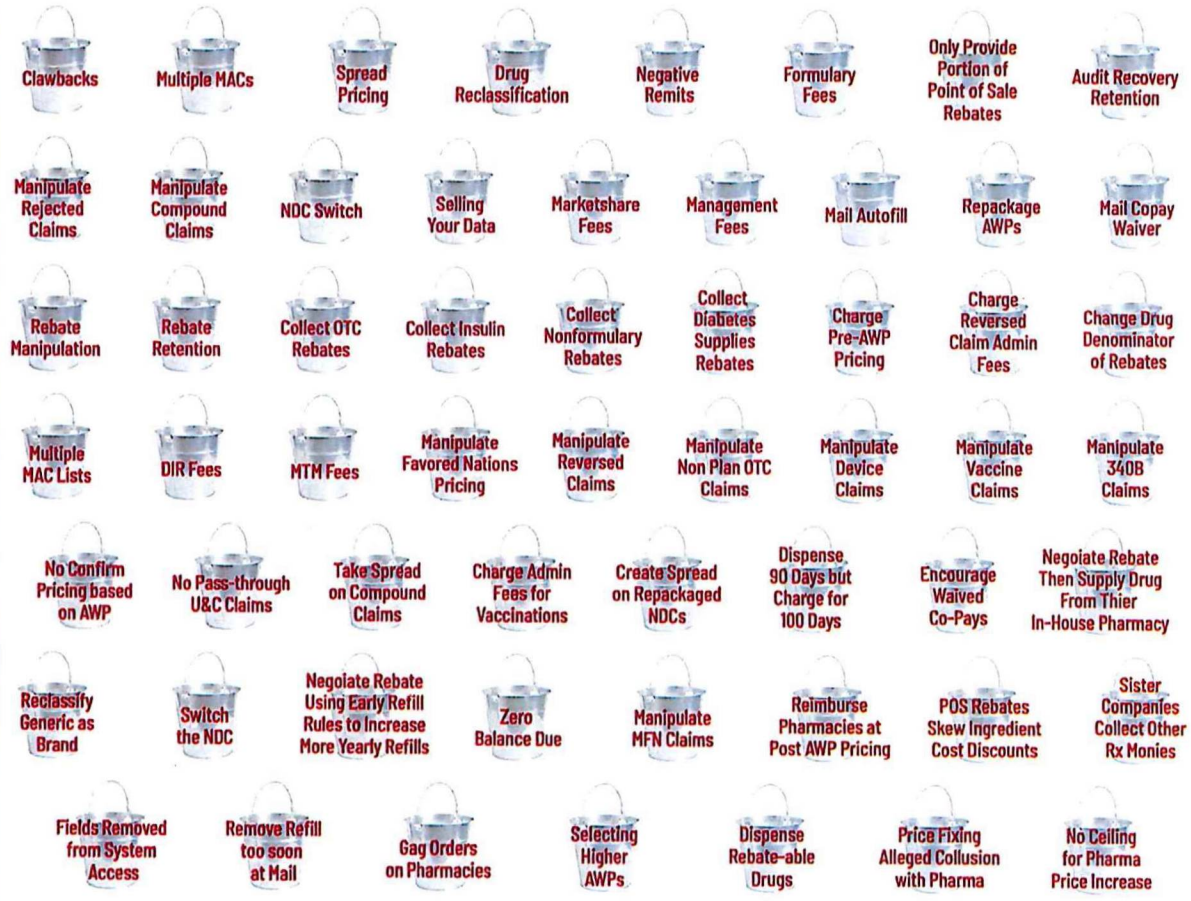
Where the Money *Really* Goes

Pharmacists United for TRUTH & TRANSPARENCY

DEMAND TRANSPARENCY

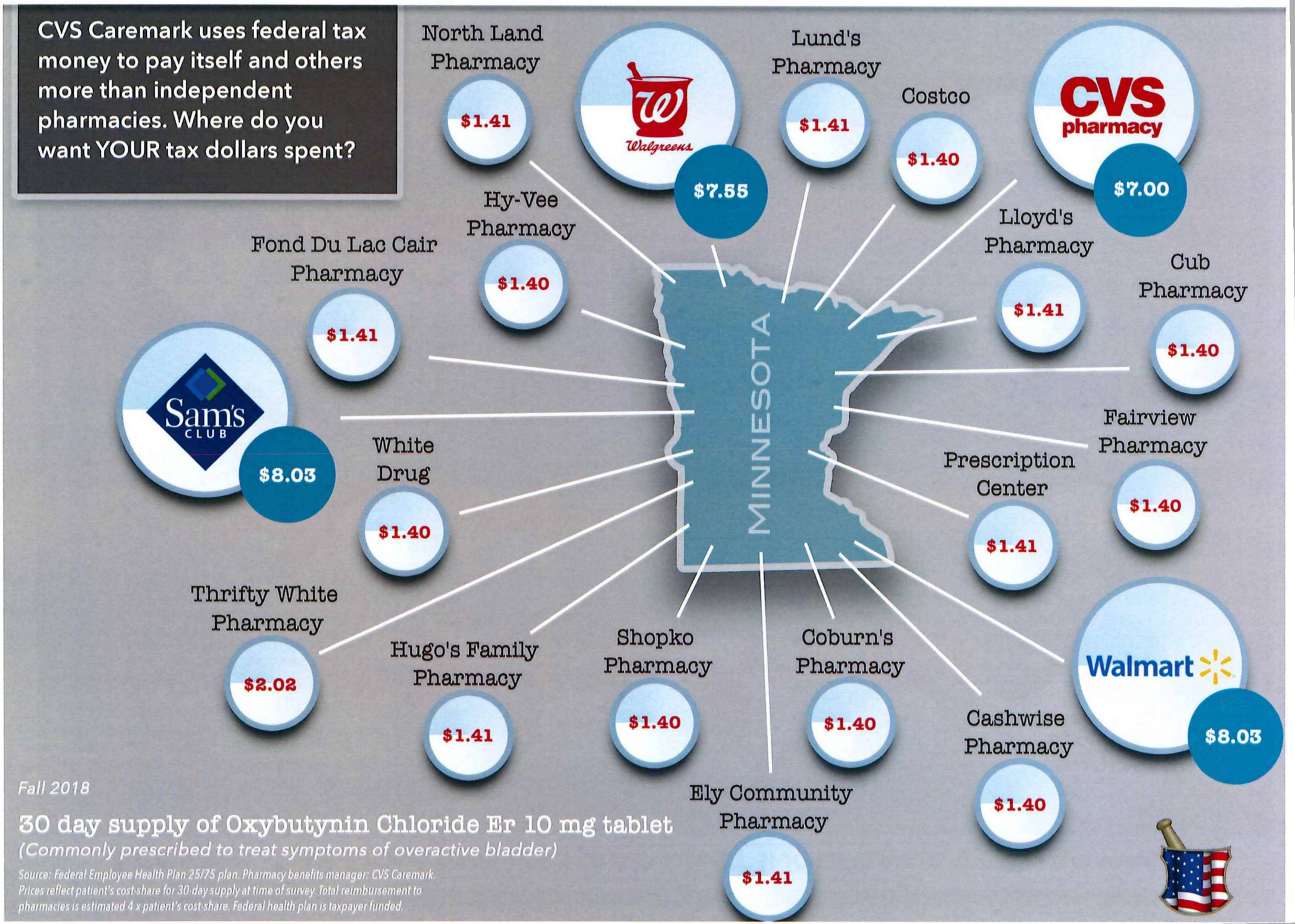
TruthRX.org

Traditional PBMs



Federal Tax Dollars Used Against Independent Pharmacies

CVS Caremark uses federal tax money to pay itself and others more than independent pharmacies. Where do you want YOUR tax dollars spent?



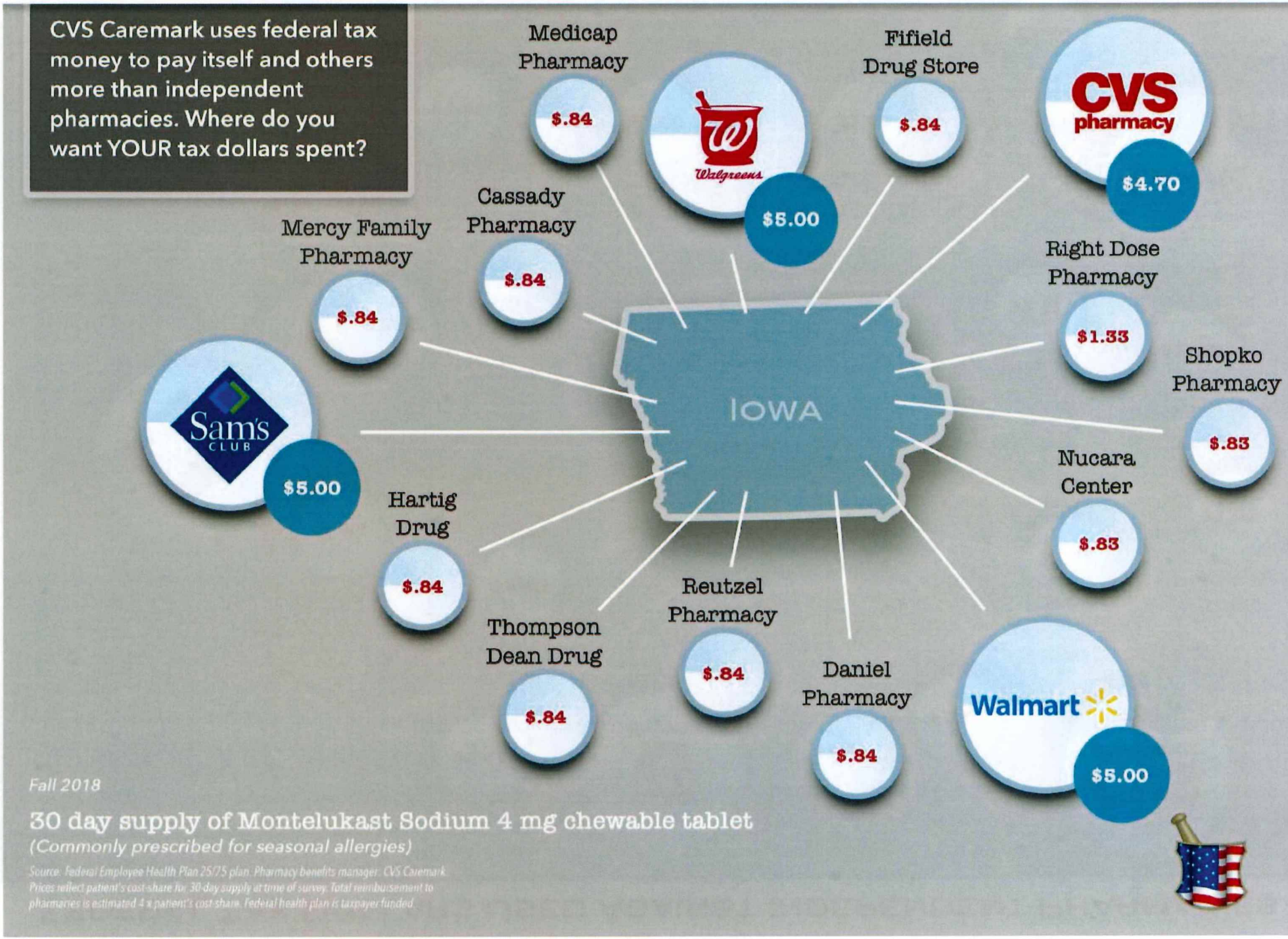
Fall 2018

30 day supply of Oxybutynin Chloride Er 10 mg tablet

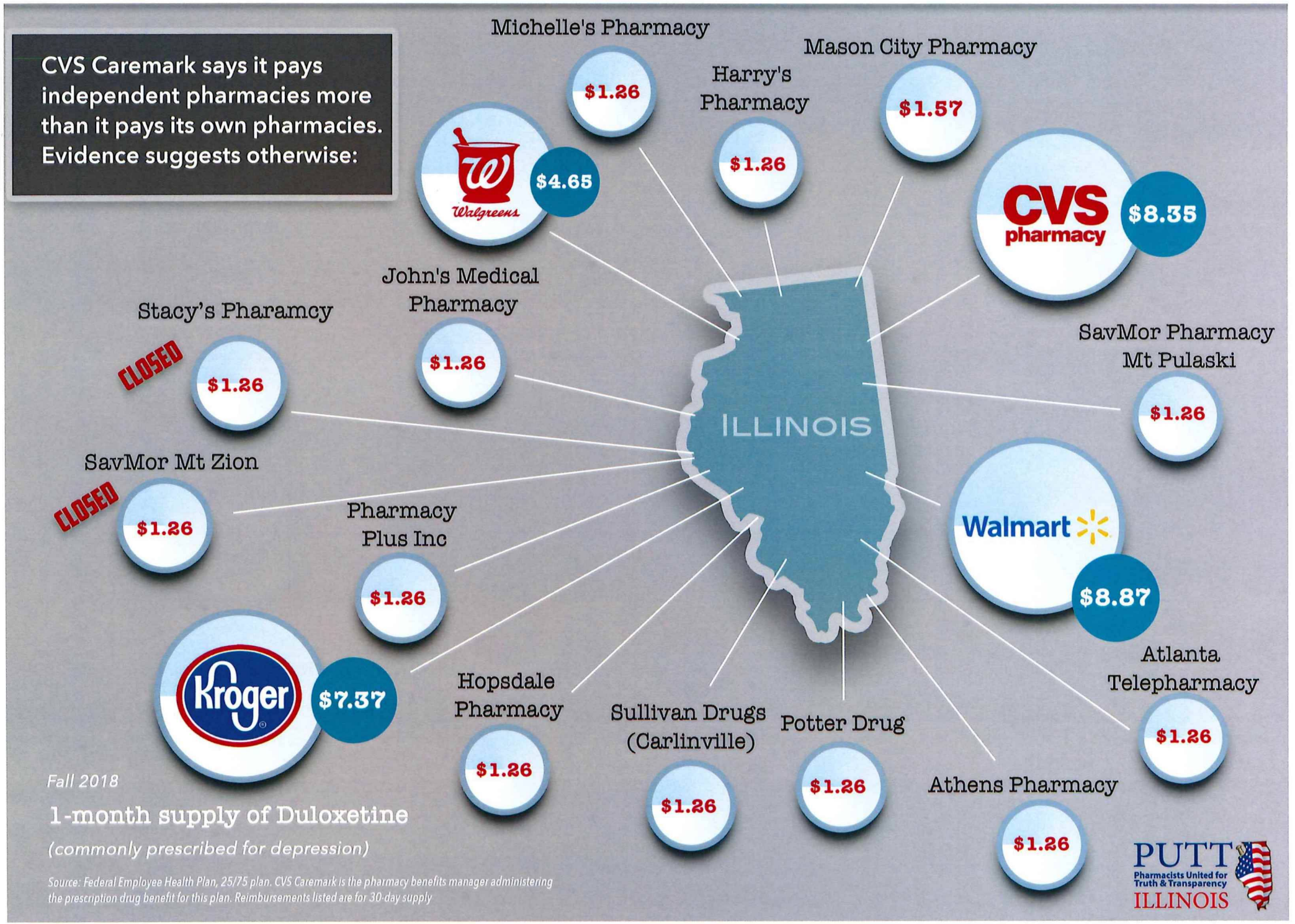
(Commonly prescribed to treat symptoms of overactive bladder)

Source: Federal Employee Health Plan 25/75 plan. Pharmacy benefits manager: CVS Caremark. Prices reflect patient's cost-share for 30-day supply at time of survey. Total reimbursement to pharmacies is estimated 4 x patient's cost-share. Federal health plan is taxpayer funded.

FEDERAL TAX DOLLARS USED AGAINST INDEPENDENT PHARMACIES



Federal Tax Dollars Used Against Independent Pharmacies



FILED
06-30-2023
Clerk of Court
Marinette County
2022CV000068

BY THE COURT:

DATE SIGNED: June 29, 2023

Electronically signed by Judge James Morrison
Circuit Court Judge

STATE OF WISCONSIN CIRCUIT COURT BRANCH II MARINETTE COUNTY

OPTUM, RX, Inc.
Plaintiff,

DECISION AND ORDER

v.

Case No.: 22-CV-68

MARINETTE-MENOMINEE PRESCRIPTION CENTER, LTD, et al.
Defendants.

This case involves a request by Optum, RX (hereinafter "Optum") and a number of pharmacies (hereinafter collectively "the pharamcies") in which Optum seeks to enforce arbitration provisions with respect to disputes between Optum on the one hand and the pharamcies on the other. The matter has been exhaustively briefed and argued and the Court has considered carefully all of the arguments. Based upon the foregoing the Court is denying the motions of Optum to stay these proceedings and order the pharmacies to submit to binding arbitration. Strictly for purposes of explanation, this involves a request on the part of Optum to require arbitration and a defense on the part of the pharmacy that the arbitration clauses sought to be enforced are unconscionable. The pharmacies argue that the formulation of the clauses, their imposition in the first place, was unconscionable and the arbitration scheme as applied is likewise and independently substantively unconscionable. A key aspect of the position of the pharmacies is that the scheme of arbitration which requires each individual pharmacy separately arbitrate its disputes, that

is bilateral arbitration, and the terms of that arbitration, combine to make the entire scheme unconscionable.

Optum argues that the parties have agreed to arbitration in the Provider Agreement (with the exception of one pharmacy, Elevate) and that all parties are bound by the arbitration scheme as a result of the Provider Manual and that any consideration of unconscionability based upon the fact that multilateral arbitration is a matter which this Court is precluded from considering at all based upon a recent Supreme Court case, Viking River Cruises, 142 S. Ct. 1906 (2022).

The Court will turn to that issue first.

Optum relies on the *Viking River Cruises* case 142 S. Ct. 1906 (2022) to support the proposition that this Court cannot consider the fact that the arbitration clause at issue here requires individual, that is bilateral, one on one, arbitration as a factor in and of itself, to find an arbitration clause either procedurally or substantively unconscionable. This Court believes that this a misplaced reliance or a misreading of that case.

Because *Viking River* is the most recent statement of the United States Supreme Court with respect to the Federal Arbitration Act (FAA) this Court believes it is important to distinguish that case from the facts and circumstances applicable here.

As the Court understands the arguments made by Optum, they essentially come down to an argument that this Court cannot even consider the requirement of bilateral arbitration as a factor at all in this Court's analysis as to whether the arbitration clause sought to be enforced now which would require roughly fifty separate arbitration proceedings rather than allowing the consolidation of those proceedings is unconscionable. It is, as I understand the argument of the Optum to be that this Court cannot even consider the implications of bilateral as opposed to multi-party arbitration at all because that matter is resolved under *Viking River Cruises*. It was not.

Viking River involved an action brought by an employee of Viking River Cruises under the California Private Attorney General's Act (PAGA). The U.S. Supreme Court spends several pages of its opinion describing that the California legislature made a policy determination that California did not have adequate resources to individually monitor and enforce certain of its labor laws so it was, in effect, enlisting the assistance of individual litigants (as a private Attorney General) to enforce those laws and as a part of that scheme also allowed the litigant to aggregate the claims of others. The Supreme Court spends a good deal of time of writing about whether this is a Class Action in the classic sense or a representative action because PAGA included a provision that prohibited the enforcement of any "Class Action Waiver" in employment contracts in California; all very important to the resolution of that case but not controlling here.

The Supreme Court stated:

> "This Court's FAA precedents treat bilateral arbitration as the prototype of the individualized and informal form of arbitration protected from undue State interference by the FAA." (emphasis added)

Optum argues strenuously that this establishes the mandate that FAA, and the Supreme Court precedents interpreting it, establish that the very nature of arbitration is a bilateral, not multi-party arrangement (at least, at a minimum, unless the parties specifically agree to expand it to allow for multi-party litigation) and that therefore this Court is precluded from considering whether a claim that precludes multiparty arbitration can invalidate the agreements at issue here.

This Court believes that a proper reading of that Supreme Court precedent is that the Supreme Court indeed views arbitration prototypically as an informal, streamlined matter of dispute resolution and starts from the proposition that that is prototypically, that is usually, bilateral. There is nothing in *Viking River* ordering trial courts to mindlessly stop the inquiry as to whether a challenge to the fairness and reasonableness of a particular

arbitration provision based upon a multi-party challenge could be unconscionable. That is not the holding of *Viking River*.

Strictly, from a legal standpoint, the Supreme Court decision in *Viking River* dealt with the invalidation of a California law outlawing a class action waiver in contracts between employees and their employers. That is also not our case here at all, so it is not a binding precedent not should it be and it does not preclude the analysis here in any event. Speaking for the Court, Justice Alito stated:

> "The FAA was enacted in response to judicial hostility to arbitration. Section II of the Statute makes arbitration agreements 'valid, irrevocable and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." (emphasis added)

He goes on to say:

> "as we have interpreted this provision [of the FAA] contains two clauses:
>
> An enforcement mandate which renders agreements to arbitrate enforceable as a matter of Federal Law and a savings clause which permits invalidation of arbitration clauses on grounds applicable to any contract." (emphasis added)

He then goes on further to state:

> "A Court may invalidate an arbitration agreement based upon 'generally applicable contract defense like fraud or unconscionability, but not on legal rules that apply only to arbitration or derive their meaning from the fact that an agreement to arbitrate is at issue."

In other words normal contract defenses apply.

That is precisely what the pharmacies are asking this Court to do in this case; to consider whether standard contract law principles relating to unconscionability apply and there is nothing in *Viking River* that mandates that this Court must stop its inquiry as to reasonableness or fairness merely because the pharmacies are raising the issue of the alleged unfairness of mandatory bilateral arbitration. There remains, of course, the other issues about notice, the nature of the arbitration itself, three arbitrators, ten years of

experience, the limitations on discovery, etc. Those the Court will deal with momentarily but this Court rules that *Viking River* is not dispositive or controlling on the question of bilateral/multi-party arbitration as a prohibited inquiry.

Having decided that *Viking River* not only does not preclude this Court from considering normal questions of unconscionability but actually specifically ratifies that inquiry, the Court now turns to the argument that has been raised by the parties.

Optum argues that the parties agreed to binding arbitration, in fact, not once when they entered into the original Provider Agreement but, again every time a party submitted a claim or received a payment under that agreement or under the Provider Manual because all parties specifically agreed to follow the Provider Manual, even agreeing to allow Optum to unilaterally change the Provider Manual (and hence the Provider Agreement) from time and time and without notice.

The pharmacies argue that such an arrangement was unconscionable *ab initio* because it was an adhesion (take it or leave it) contract, and further that the actual operation of the arbitration clause, bilateral, three arbitrators, ten years experience in each case in the medical field, paper only, and ultimately very restricted discovery was separately unconscionable not only *ab initio* but as applied, substantively.

Parties should be free to make agreements which are not otherwise illegal whether they are wise or in the best interest of the parties or not. Parties should be held to the legal agreements which they make. Courts should enforce those legal agreements. In enforcing those agreements courts should look to the governing law and obviously follow both controlling law, statutory or common law, State or Federal. This is stating the obvious except that the application of this process is not entirely simple.

The parties appear to agree that with respect to the questions of unconscionability regarding arbitration that there is not substantial difference between the law under the Federal Arbitration Act or applicable statutory law in Wisconsin. There is an argument as to whether California or Wisconsin law should apply but this Court thinks that it is clear that with respect to contract formation issues such as those facing the Court today that Wisconsin law, statutory and decisional should apply. It is clear that under *Viking River* the United State Supreme Court holds that its precedent clearly empowers, indeed requires, Courts to decide contract formation issues and defenses (under normal contract law principles) at least in so far as they do not contradict the Federal Arbitration Act.

Both sides in this dispute request this Court to consider the decisions of other jurisdictions, California, Illinois and Florida in particular. On the questions of unconscionability, the Pharmacies wish this Court to follow the decisions of the California Court of Appeals which the pharmacies believe are favorable to their position notwithstanding that the controlling decision, Prescription Care, was not only not published, but that when Mr. Cuker, on behalf of the pharmacies specifically requested the Court to order publication of that Decision (so that it could be cited elsewhere) the California Court of Appeals declined to do so. The pharmacies also urged the Court that it consider the *Copper Bend* Decision where the Illinois trial court had found unconscionability and precluded arbitration but, lo and behold on April 14 of this year the Illinois Appellate Court reversed that Decision and specifically instructed the trial court to compel arbitration. No surprise Optum urges this Court to follow the Court of Appeals decision there and the pharmacies urge that this Court follow the dissenting opinion of that Illinois Appellate Court.

Optum urges this Court to accept the very recent trial court decision in the Florida case of *Optum v. South Miami Pharmacy*, 2022-005838-CA-01 where that trial court specifically found that a provision precluding multi-party arbitration was not unconscionable.

In fact, Optum argues that wherever a Court has been asked to look at this issue, with apparent exception of California, Courts have found that the preclusion of multi-party arbitration, a keystone of the arguments of the pharmacies in this case, is not a valid grounds to find procedural or substantive unconscionability. *Comity* is the principle that Courts in different jurisdictions should consider and give respect to the decision of "sibling" courts in other jurisdictions. The essence of Optum's argument is that all other courts that have looked at this question of multi-party arbitration have found, (whether *Viking River* requires it or not) that that should not be a factor in determining unconscionability.

This Court certainly has great respect for the decision of judges throughout the United States and no criticism whatsoever for the decision of courts in California, Illinois or Florida with respect to the issues before them and the decisions that they have recently made. This Court does not have a binding obligation, however, to follow the decisions of those courts for any number of reasons, one of which can be that the facts and circumstances in individual cases can bear on these issues. This is hardly the place to

engage in a law review article about the concept of the laboratory of democracy inherent in our Federal system. Different states take different approaches to comparable problems and then need to live with the consequences of those decisions.

It is apparently the position of the United State Supreme Court, with the exception of Justice Thomas, that if Congress chose to do so it could amend the Federal Arbitration Act to take away the role of individual States in determining whether particular contract formation issues remain within the discretion of the various States. As *Viking River* makes abundantly clear Congress has not done this so far and in fact the U.S. Supreme Court has made it abundantly clear in *Viking River* that considerations of contract formation/operation arising out of unconscionability claims remain an area for individual jurisdictions to apply their individual laws. It is, therefore, for this Court to decide whether and to what extent arbitration clauses in this case are or are not unconscionable either as adopted or applied.

The pharmacies claim that the arbitration provisions were unconscionable from the beginning both procedurally and substantively. The very nature of unconscionability is implicated when one party has superior, in this case, far superior bargaining position and the provision at issue is offered "on a take it or leave it" basis. The pharmacies further argue that the provisions requiring arbitration should be found by this Court to be procedurally unconscionable from the beginning, *ab initio*, but also that the Court should find the substance of the provisions to be unconscionable as implemented. With respect to substantive unconscionability the pharmacies argue several things. First, they claim that the whole purpose of arbitration is the simplification of process and reduction of expenses and time to decision but that these provisions are frustrated, in fact totally negated, by the specific requirements of three arbitrators (each of which has ten years of healthcare experience) conducting arbitration in California, extraordinarily limited discovery, interrogatories, etc. The pharmacies claim that these limitations together with the generally relatively small amount of money at issue in a particular dispute for each pharmacy (at least in the case of individual pharmacies) render it practically nonsensical and certainly noneconomical for a pharmacy to commence expensive, remote, arbitration so that in fact those pharmacies will simply abandon otherwise meritorious claims because the cost to arbitrate is simply too high - but this would not apply if pharmacies could aggregate claims.

Optum argues seriously and persuasively that the cases which this Court can and should consider all support its position that these provisions are not unconscionable either procedurally or substantively. Optum also argues, not surprisingly, that because the arbitration provisions which it claims binds the parties indicate that it is the arbitrator and not a Court that will decide questions of irritability that this Court's review should highly deferential for the power of the arbitrator at a minimum.

This Court asked the parties to provide a list of what the parties thought were undisputed facts. While there are even some disputes there I am advising the parties that I am relying on the following facts in making my determinations here. I am not ignoring the other facts that the parties have set forth but I am discounting their importance and advising both sides the facts upon which I rely to make the decisions I am making here.

1. All of the pharmacies who are respondents in this Wisconsin case, except Elevate, entered into Provider Services Agreements that contained a separate dispute resolution provision calling for binding arbitration, as well as an appropriate delegation clause delegating to the arbitrators the power to decide all questions relating to arbitration including the availability and scope of arbitration. The provider services agreement entered into by the parties also included a provision that empowered Optum to create and periodically update a Provider Manual, allowing Optum to change the manual from time to time, without notice and under which the parties agreed to be bound by the those changes.

2. All of the pharmacies assert, and I believe it is not contested, that none of the pharmacies actually negotiated their provider services agreement independently nor did any of the pharmacies have any direct contact with Optum or ever sign the Provider Services Agreement. Rather each of the pharmacies who are respondents in this action were represented by PSAOs and those organization actually, on behalf of the pharmacies negotiated and entered into and signed the Provider Services Agreements. While the pharmacies assert that they did not actually negotiate or physically sign the agreements they are not contesting that in each case the PSAO was acting as their agent with proper authority and that the pharmacy is ultimately bound under principles of agency to what the PSAO negotiated and signed on their respective behalf's.

2.a. *Elevate,* working through a PSAO negotiated a Provider Services Agreement that did not include binding arbitration. The Court understands that the desire to omit binding arbitration was intentional, certainly not a mere oversight. The Provider Services Agreement ultimately negotiated and signed on behalf of Elevate did not include a binding

arbitration provision. It is the position of Optum that the Provider Services Agreement bound Elevate to the terms of a Provider Manual, and changes to it, and that by accepting services, products and or payments Elevate was bound to exactly the same provisions with respect to arbitration, both existence and scheme as all of the other pharmacies.

3. From the beginning, Optum promulgated a Provider Manual which contained specific and detailed dispute resolution, binding arbitration, bilateral, and in many respects the same as exists now.

4. Two California cases, *Prescription Care Pharmacy v. Optum, Inc.* 2020 WL 4932554 (August 24, 2020) and *Platt, LLC v. Optum, Inc.* 2023 Westlaw 2507259 (March 15, 2023) found provisions of the Provider Manual unconscionable. In response to Prescription Care decided on August 24, 2020 Optum took steps to "correct" the deficiencies found in the California case by modifying the Provider Manual and placing those modifications in the online version of the Provider Manual. That occurred in September of 2020; however, those changes to the Operating Manual which addressed significant issues of unconscionability were not affirmatively communicated to any of the pharmacies until mid December 2020 when Optum sent an email to the pharmacies highlighting a number of changes in the Provider Manual at least one of which was a specific reference to changes in the dispute resolution/arbitration provisions of the manual. All of the parties agree that no later than December 31, 2020 all of the pharmacies would have had a reasonable opportunity to be aware of, examine and object to any of those changes. So that from and after January 1, 2021 any claim of lack of notice in and off itself would be waived going forward.

Each of the parties has provided sworn testimony that that pharmacy did not individually negotiate the provider services agreement and did not sign it. Each of the pharmacies admits that they followed the Provider Services Manual at least as to the day to day operations of their business with Optum, providing claim information, submitting claims, and receiving payments.

5. It is clear and appears to be uncontradicted that even though the PSAO acting on behalf of Elevate specifically negotiated a provider services agreement that did not include an arbitration provision at all, Elevate did receive and did follow the Provider Manual in exactly the same fashion as the other pharmacies.

6. The changes made subsequent to the Prescription Care decision included substantial limitations on discovery, limited interrogatories and depositions.

7. It is agreed that the number of customers potentially available to the various pharmacies as members of the Optum "group" would constitute between 20 and 25 percent of the universe of pharmacy customers fully available in those regions of Wisconsin where the pharmacies operated.

As the Supreme Court made clear in *Viking River*, an agreement to arbitrate a civil dispute is just that, an agreement, and it is enforced as it has been negotiated and agreed to between the parties. Agreements to arbitrate clearly constitute substantial limitations upon ones normal litigation rights, for example, choice of venue, bilateral or multi-party litigation potential, discovery, and undoubtedly most importantly, the right to judicial supervision review and appeal. As such, this Court needs to look at issues of the formation of that agreement in the first place to see if there actually was such a meeting of the minds limiting the rights of the parties in this fashion.

This Court must take a step back from the details of this dispute to state that the Court is aware that people sign things all the time which bind themselves to onerous provisions and in which they sacrifice important rights and remedies. For example, try adding an App to your cell phone and find that in the process you go through eighteen to twenty pages of fine print, legalese, identifying and limiting all of your privacy rights, ownership of content, etc. Open a brokerage account and find that you have specifically agreed that disputes with respect to that account will be settled by arbitration in New York City, most certainly by a panel of arbitrators friendly to the brokerage industry. Buy any vehicle in the United States and while the dealer touts its "warranty protection" understand what the manufacturer/dealer is actually saying is that your normal common law warranties of merchantability are being traded for a specific set of undertakings on the part of the manufacturer that actually and substantially limits their otherwise applicable common law liabilities.

This list could go on virtually forever. It is a regrettable but actual fact that many contracts containing arbitration provisions (and other surrenders of valuable rights) are almost always provided on a take it or leave it basis by an actor with far greater knowledge and often far greater bargaining position than the party agreeing to those surrenders. Courts must be mindful of that when Courts are asked to enforce such agreements especially where those agreements give up rights to have disputes decided in ones home jurisdiction, by a jury of ones peers, after full discovery and subject to judicial oversight and review. This is not to say that there are not legitimate reasons for arbitration but this

is to say that the imposition and implementation of these procedures needs to meet a test of minimal fairness and reasonableness.

This Court will take notice of the fact that organizations including Optum tend to be large and powerful purveyors of critically important prescription drugs. The products which Optum and others provide to pharmacies are critically and increasingly important to the health of virtually every American. The healthcare system in which we find ourselves today, for all its marvels and therapies, is increasingly characterized by mega-organizations of healthcare providers, drug and device manufacturers, medical care practice groups, large inter-state hospital systems, and huge HMO and other patient service groups. In fact, the vast majority of people in the United States who receive healthcare receive it through some sort of group, whether it is a large insurance plan, an HMO, an Affordable Care Act exchange, etc. The pharmacy industry is not exempt from any of these trends, in fact, the Marinette/Menominee Prescription Center, Ltd, a local "hometown pharmacy" apparently privately owned and operated is becoming increasingly a smaller and smaller percentage of the way Americans get their critically needed prescription medications and devices. More and more of these dispensaries are becoming parts of mega groups themselves. For example, in this case, the Wisconsin Hometown Pharmacy Group apparently has more than 50 such small pharmacies which have aggregated together in some fashion. On the other hand, Walgreens and CVS are two large pharmacy companies who command substantial portions of the market and wield comparable clout comparable to that of companies such as Optum. In order for a typical consumer to be able to get a prescription filled that consumer must increasingly do so through a plan which has been negotiated "for that consumer" by the consumer's healthcare provider, insurance company, employer, HMO, etc. Add to all of that the increasing consolidation of all of these entities and we have a situation where an individual pharmacy, even a pharmacy group such as Hometown, knows that for it to be able to compete in the market place it must make arrangements with pharmacy benefit providers such as Optum or its competitors.

This is all highly relevant to this circumstance because this Court must consider whether there was a meaningful bargained for exchange between the pharmacies on the one hand and Optum on the other hand. Regarding arbitration, the Court must look to the facts and circumstances as they existed at the time of the formulation of this contract not to how the drama has played out down the road. The pharmacies argue that if they wanted

to do business at all as a practical matter they needed to make a deal with Optum because Optum controlled something on the order of one-quarter of the pharmacy market, that is customers, available to pharmacies in Wisconsin. Those customers whose benefits are provided through the Optum pharmacy exchange can only go to those pharmacies that have made a deal with Optum and while it is true that 75 to perhaps 80% of the customers are not associated with Optum it is undoubtedly also true that most of those customers are associated with some other pharmacy group so as a practical matter, in the real world, pharmacies can make and have made a credible argument that they simply cannot do business if 20-25% of their total market is foreclosed to them because they have not been able to make a deal with Optum. This puts Optum in the driver's seat. As the Court understands it, indeed the product which Optum is providing is not drugs and other devices to pharmacies but pharmacy benefit customers.

This Court considers the situation with *Elevate* to be critical to the overall decision in this case because the PSAO for *Elevate* negotiated a Provider Agreement that did not provide for arbitration, but *Elevate* still finds itself subject to arbitration because the Provider Manual, not negotiated but simply applied, controlled that relationship. This is significant for two reasons. Elevate negotiated not to have to arbitrate and Optum was able to avoid that specific agreement by putting arbitration in the back door through the Provider Manual and that shows exactly how intransigent Optum was with respect to losing or for that matter modifying arbitration provisions.

It is true that some Courts, such as the Florida trial court have stated that pharmacies could simply go to different pharmacy benefit managers. Perhaps that is true but that is not how this Court understands this market. It is the customers that Optum delivers but by not contracting with Optum these pharmacies are precluded from a very statistically significant part of the market.

This is a motion on the part of Optum to enforce an arbitration provision which this Court finds was unconscionable in its inception and also in its unilateral modification; in the manner that it was imposed on a "take it or leave it" basis and on the substance of how the arbitration scheme actually works.

As to whether or not the provisions are also substantively unconscionable other Courts have found, Florida for example, the opposite of this Court's ruling that these provisions, (paper only, limited discovery, 3 arbitrators each of which as ten years of experience, arbitrations in Orange County, California) are reasonable and not

unconscionable. This Court is most influenced by the fact that when Elevate, through its PSAO, specifically negotiated a Provider Agreement that excluded arbitration and Optum agreed to that provision in the Provider Agreement but then immediately implemented a Provider Manual that imposed precisely that arbitration scheme on *Elevate* and from this Court must conclude that Optum was not dealing in good faith. This conduct causes the Court also to be seriously concerned about whether the entire arbitration scheme, as conceived and applied, and as amended, is unconscionable. Optum gets to decide the terms of an arbitration agreement even when they have agreed there will not be one, decides when and if it will change those terms, changes those terms without advance notice or negotiation, implements those terms for several months before it affirmatively notifies the pharmacies that substantial, unfavorable changes in the arbitration provisions are being implemented. This Court finds that conduct to be unconscionable as well. When the Court considers the cost of the arbitration (three arbitrators, ten years of experience, limited discovery, etc.) the Court can only conclude that in all but the most substantial disputes the cost of proceeding to arbitration will substantially outweigh any benefit that could be achieved in arbitration and that this will undoubtedly have a substantial chilling effect upon pharmacies presenting objectively meritorious positions. "You can't fight City Hall so why try" appears to be the result that this scheme creates. This is the product of a one sided agreement foisted upon pharmacies who need to make a deal with Optum or have a substantial part of a market closed to them and this is fundamentally unfair.

Based upon the foregoing the Court decides and Orders that the Optum Motion to Compel Arbitration is denied based upon the fact that the contract suffers from an unconscionable procedural defect in its formation, the take it or leave it nature of the contract and its subsequent amendments via the Provider Manual.

Declining Independent Pharmacy Numbers Across US and Wisconsin

YEAR	US	WISCONSIN
2000	24,811	
2001	24,602	
2002	----------	
2003	----------	
2004	23,956	
2005	24,358	
2006	24,500	
2007	23,348	
2008	23,318	
2009	23,117	
2010	23,064	
2011	23,106	
2012	23,106	410
2013**	23,029	---
2014	22,814	374
2015	22,478	381
2016	22,160	360
2017	22,041	273
2018	21,909	285
2019	21,767	272
2020	21,683	256
2021*	19,397	258
2022	19,479	255
2023	19,432	254

Pharmacy Shortage Areas – 2020

- **24% of neighborhoods in Wisconsin were pharmacy shortage areas affecting 1,244,588 residents.**
- **41% of pharmacy shortage areas were in rural neighborhoods, 45% in urban, and 13% in suburban.**
- **21% of rural neighborhoods in Wisconsin were pharmacy shortage areas affecting 484,566 rural residents.**
- **32% of the total Medicaid population lives in a pharmacy shortage area.**

This information is taken from the USC-NCPA Pharmacy Access Initiative.

The National Community Pharmacists Association (NCPA) is working with the University of Southern California School of Pharmacy and Leonard D. Schaeffer Center for Health Policy and Economics (USC) to tackle barriers to pharmacy access, including closures.

The Pharmacy Access Initiative seeks to generate real-time information for national, state, and local policy officials, health care academics, industry leaders, and others to identify communities lacking in pharmacy access.

*Starting with the 2021 NCPA Digest, the source of pharmacy counts reported changed from "NCPA analysis of NCPDP data and NCPA research" to "The store count data is reflective of the stores in the IQVIA Rx Universe as of June 2021.

**Individual state counts were not reported in the 2013 NCPA Digest

FROM THE DESK OF

FORMER STATE SENATOR JASON RAPERT (AR)

DATE: February 14, 2024

TO: Rep. Clint P. Moses, Chair
Committee on Health, Aging, and Long Term Care
Wisconsin State Assembly

FROM: Jason Rapert
Arkansas State Senate 2011-2023

RE: AB 773 and SB 737 - PBM Accountability Act

Dear Chairman Moses & Committee Members:

I am writing to personally express my support of AB 773 sponsored by Rep. Michael Schraa, and SB 737 sponsored by Sen. Mary Felzkowski, addressing the pressing need for Pharmacy Benefit Manager (PBM) reform, transparency, accountability, and oversight in the state of Wisconsin. Your state has the opportunity to join with other states around the country by passing these much needed reforms that will benefit and protect all consumers in Wisconsin. It is the right thing to do.

When I was recently briefed on your pending legislation and asked my opinion, I decided to send you my written support for this important legislation. Prescription medications are an import ant part of the American healthcare system and Wisconsin citizens deserve to have confidence that they can access low cost prescriptions for themselves and their families. I urge all members of the Wisconsin State Assembly and State Senate to vote for AB 773 and SB 737.

I served in the Arkansas State Senate from 2011 to 2023, served as chairman of the Arkansas Senate Insurance & Commerce Committee, and also served as president of the National Council of Insurance Legislators (NCOIL). During my tenure as president of NCOIL in 2018, I sponsored the NCOIL Pharmacy Benefits Manager PBM Licensure and Regulation Model Act - the first such national model bill calling for Pharmacy Benefit Managers to be licensed and regulated by state insurance departments in the nation. I have also spoken and presented nationally on the PBM issue by invitation from various organizations including the American Medical Association (AMA), National Association of Insurance Commissioners (NAIC), National Council of Insurance Legislators (NCOIL), Coalition Against Insurance Fraud, National Community Pharmacists Association (NCPA), Independent Pharmacy Cooperative (IPC), Arkansas Pharmacy Association, Coalition of State Rheumatology Organizations, Pharmacists United for Truth & Transparency, and the American Pharmacy Cooperative, Inc. just to name a few.

prescription medications. This harms citizens, harms insurance companies who pay for prescriptions, and creates tremendous stress on healthcare delivery in our nation. I reiterate, it is well documented that some of the largest PBMs in the nation have been bad actors. In state after state, investigations have shown that some of these PBMs have purposely undermined independent pharmacists, been guilty of dealing unfairly, intimidated pharmacists and threatened to cancel contracts when pharmacists have sought to intervene on behalf of patients, engaged in "rebate" demands which are effectively nothing more than "pay to play" schemes, and spent large sums of money lobbying state legislators to buy favor and escape regulation that would hold them accountable.

Lest you get the wrong impression, I do not oppose the operation and benefit of honest PBMs to contract with insurers to manage prescription drug benefits. I personally have a strong conservative legislative record. **I am all for free market capitalism as a conservative legislator - but I am NOT for a license to steal.** To use an old sports analogy, the big three PBMs have been playing street ball by their own rules for far too long. I would never advocate that they cannot play ball, but I believe every reasonable person should see that having a referee on the court to hold them accountable and ensure everyone plays fair is a good thing.

Think about this reality for a moment - in state jurisdictions all over this country insurance companies must answer to insurance departments, doctors must answer to medical boards, pharmacists must answer to pharmacy boards, hospitals must answer to state regulators, but PBMs have historically never had to answer to anyone. Why is that? It is no secret that many complaints have been filed about the unfair practices of PBMs, lawsuits have been filed, investigations have been carried out, and public policymakers have been called upon to address the problems. Millions of dollars in overpayments to PBMs have been documented and millions of dollars of fines or penalties have been imposed on the PBMs responsible. For over 150 years the business of insurance has been regulated by individual states through their own insurance departments. With the exception of cash pay, every prescription transaction in America involves insurance payments or taxpayer money to be expended through Medicaid or Medicare. The individual state insurance departments are the proper place for licensing, registration, regulation and enforcement authority to be established. NCOIL debated, discussed and passed model legislation calling for insurance departments to be equipped to help protect consumers and ensure PBMs are operating fairly in their states. History has shown that PBMs engage in unfair practices and have exhibited corporate greed that has harmed individual consumers, the pharmacy industry, and taxpayers.

which decide how much to pay themselves for these high-priced medications.

- Requires PBMs to **allow pharmacies to join their PBM provider network** if they agree to accept the same terms as other network pharmacies.
- **Prohibits PBM patient steering or coercion tactics** (premium or co-pay differentials).
- **Prohibits PBM gag clauses on pharmacy-patient information on drug price costs.**
- **Sets requirements for methodology, access to PBM MAC List information and appeals processes.**
- **Requires PBMs to reimburse themselves the same as all other network pharmacies.**
- **Requires uniform reimbursement rates for all preferred network pharmacies.**
- Gives **pharmacies the right to refuse to fill** a prescription with PBM below acquisition costs reimbursement.
- **PBM formulary lists requirements**:
    - Formulary list prior notices to potential plan sponsors and covered individuals.
    - Prevents drug removal from approved plan year formulary list.
    - 90 day advance written notice of formulary change
- **Strengthens Pharmacy audit protections.**
- Requires PBM **audit recoupments to be returned to patient and plan sponsor.**
- **PBM fiduciary and rebate disclosure mandates** back to plan sponsors.
- **340B Hold harmless protections from PBM abuses** against covered entities and contracted pharmacies and pharmacies.
- **Allows patient drug payment assistance (drug couponing) be applied to patient coverage cost sharing.**
- **Prohibits PBM retaliation against pharmacies for filing PBM complaints (includes injunctive relief).**

authorizing state insurance departments to license, register, regulate, and use enforcement authority to ensure citizens are protected and PBMs are held accountable. Now is the time for Wisconsin to pass AB 773 and SB 737 and put Wisconsin patients and consumers first when it comes to prescription drug costs.

Thank you for your time and consideration of my testimony in your proceedings. Please call on me whenever I may be of service.

Sincerely yours,

Jason Rapert
P.O. Box 10368
Conway, AR 72034

MEMORANDUM

To: Representative Clint Moses
CC: Members, Committee on Health, Aging and Long-Term Care
From: Bill Keeton, Chief Advocacy Officer

Re: Vivent Health Support for Healthcare Provider Protections Included in AB 773

Dear Chairman Moses and Committee Members:

On behalf of Vivent Health, please accept this written testimony in support of Assembly Bill 773.

Vivent Health is Wisconsin's largest provider of HIV prevention, healthcare and treatment services for people living with and vulnerable to HIV. Today, we provide these services to more than 4,900 people throughout the state of Wisconsin through locations in Appleton, Beloit, Eau Claire, Green Bay, Kenosha, La Crosse, Madison, Milwaukee, Superior and Wausau. Our unique model of care is delivering amongst the highest quality patient outcomes for a medically, socially and economically challenged patient population – many of whom are uninsured, underinsured and living in poverty – in the nation.

Today, the ability of Vivent Health to continue serving some of Wisconsin's most vulnerable is threatened by the nefarious practices of Pharmacy Benefit Managers (PBMs). PBMs were intended to help manage and reduce costs for insurers by serving a hybrid role of plan administrator and drug cost negotiator. These savings were to then be passed on to consumers in the way of premium cost containment, lower out of pocket costs for medications and enhanced healthcare outcomes.

Unfortunately, not only have consumers not realized the proposed benefits that PBMs were to create, but the business practices PBMs engage in with healthcare providers – including safety net providers like Vivent Health – create overly burdensome contracting environments and lost revenue. PBMs are creating a dire financial reality for health care providers like Vivent Health through their use of direct and indirect remuneration, post-adjudication fees, unfair and unattainable performance metrics that impact payment, discriminatory reimbursement against 340B Drug Pricing Program participants and anti-consumer patient co-pay accumulator policies.

Perhaps most concerning is that PBMs *know* the impact these policies are having on safety net healthcare providers and yet they continue to mandate them in their contracts. PBMs are not willing to negotiate the terms of their contracts, instead offering a 'take it, or leave it' approach for smaller community-based providers and pharmacies. This is why the reforms in SB 737 are necessary, and why more than 20 states have passed legislation banning discriminatory reimbursement and 19 have passed patient-focused co-pay accumulator legislation.

PRESS RELEASES

AMA examines PBM market competition and integration with insurers

OCT 13, 2022

CHICAGO – A new analysis (PDF) by the American Medical Association (AMA) finds a widespread lack of competition in local markets across the United States where prescription drug middlemen known as pharmacy benefit managers (PBMs) provide services to commercial health insurers. The AMA analysis is the first to shed light on variations in market shares and competition among PBMs at the state and metropolitan levels.

Based on 2020 data for individuals with a commercial drug benefit tied to a medical benefit and the PBMs used by insurers, the AMA's competition analysis presents national and local market insight on five different PBM services performed for insurers: rebate negotiation, retail network management, claim adjudication, formulary management, and benefit design. It presents the two largest PBM market shares and concentration levels for all states and metropolitan areas.

"The American Medical Association already has serious concerns (PDF) about PBM business practices that can have a detrimental impact on patients' access to and cost of prescription drugs," said AMA President Jack Resneck Jr, M.D. "PBM markets require careful scrutiny as less competition and more vertical integration can embolden anti-competitive business practices to the detriment of patients. The novel data presented by the AMA analysis is intended to help regulators, lawmakers, researchers, and policymakers better evaluate merger proposals in the future that may harm patients by raising prices, lowering quality, reducing choice and stifling innovation."

The analysis found significant portions (37%) of the national markets for two services, formulary management and benefit design, were managed in house by health insurers rather than buying those services from the PBM market. In contrast, commercial insurers largely use a PBM for three services: rebate negotiation, retail network management and claims adjudication, rather than conducting them in house. The analysis thus assessed market competition for those three PBM services.

At the national level, the analysis found that a handful of PBMs have a large collective market share for the three PBM services most used by insurers:

- The 10 largest PBMs had a collective share of 97%.
- The four largest PBMs had a collective share of roughly 66%.
- Six PBMs are used exclusively by one insurer or a set of Blue Cross Blue Shield affiliates.

At both the state and metropolitan levels, the analysis found a high degree of market concentration for each the three PBM services assessed by the study:

- More than three of four (about 78%) states had highly concentrated PBM markets.
- More than four of five (85%) of metropolitan areas had highly concentrated PBM markets.

The analysis also quantified the extent of vertical integration between health insurers and PBMs. An insurer is vertically integrated with a PBM when a PBM service is performed in house or supplied by a PBM that shares ownership with the insurer.

- Health insurers that were vertically integrated with a PBM covered 69% of all people with commercial drug insurance.
- Although the average vertical integration shares across states and metropolitan areas were slightly lower (63% and 65%), there was wide variation across states and metropolitan areas.
- Some states have almost no vertical integration between insurers and PBMs, while others are almost entirely vertically integrated. South Dakota has the smallest vertical integration share (6%) and North Carolina has the highest vertical integration share (97%).

According to the analysis, "even though the largest health insurers and PBMs are vertically integrated, there is still a significant portion of the market that remains not vertically integrated, particularly at the local level." Vertically integrated insurers may not allow non-vertically integrated insurer competitors to access their PBMs, or they could raise the cost of those PBM services. This could adversely affect non-vertically integrated insurers and ultimately patients through higher premiums.

The analysis of competition in commercial PBM service markets adds to the AMA's work to shine a light on market consolidation in the health insurance industry. Protecting patients and physicians from anticompetitive harm will continue to be a vital issue of public policy for the AMA, the federation of medicine, and the nation's physicians. The AMA website offers additional information on the AMA's efforts against anti-competitive mergers.

American Cancer Society
Cancer Action Network
608.215.7535
sara.sahli@cancer.org
fightcancer.org/wisconsin

February 14, 2024

To: Wisconsin Assembly Committee on Health, Aging and Long-Term Care
From: The American Cancer Society Cancer Action Network
Re: Testimony in Favor of Assembly Bill 773

Good morning, Chairman Moses, and members of the Committee,

My name is Sara Sahli - I am the Government Relations Director for the American Cancer Society Cancer Action Network in Wisconsin. ACS CAN, our board members, our volunteers, and our staff advocate for public policies that reduce the cancer burden for everyone.

Thank you for holding this hearing today and allowing me the opportunity to provide testimony in support of Assembly Bill 773 the Pharmacy Benefit Manager (PBM) Accountability bill that incorporates all provisions included in the All Copays Count legislation.

Like those that have told their stories today, many cancer patients and individuals living with chronic medical conditions have difficulty affording the cost of their prescription drugs. This is especially true for newer drugs – including cancer drugs – that do not yet have a generic equivalent. To help temper high prescription costs, many individuals living with cancer and other chronic medical conditions receives copay assistance offered through manufacturer programs and charitable patient assistance programs. Unfortunately for many, this copay assistance is increasingly not treated the same as copays that are paid with cash and therefore not applied to the patient's deductible and out of pocket financial responsibilities. This means patients using these copay assistance programs are still responsible for the entire deductible and out of pocket maximums as the assistance is not benefitting them in the intended way.

Like Krin from Westby, WI (story and link to video attached), who was diagnosed with stage three uterine cancer in 2020. After many months of treatment, she was cancer free. However, two years after her initial diagnosis, she received the news that her cancer had returned. Her new treatment plan included daily oral chemotherapy and immunotherapy – which kept the cancer from spreading and have allowed her to "still enjoy my life like I did before cancer".

For Krin, and so many others, taking medication every day to maintain their health comes with a steep price tag. Fortunately, Krin received copay assistance from the drug manufacturer. However, this assistance does not count towards her deductible and out-of-pocket maximum. Krin is not receiving the benefits of this charitable assistance.

This legislation would help Krin and so many others by removing these barriers to prescription drug access and allow patients to utilize the full benefit of copay assistance programs by ensuring all payments made by the patients - directly or on their behalf - be counted toward their overall out of pocket maximum payment or deductible.

I also want to make clear - this bill is not a coverage mandate and does not require that insurance companies cover any particular drug or class of drugs. Nothing in this bill prevents insurers from using their existing utilization management tools such as step therapy and prior authorization. We are addressing copay assistance that is being used by patients for drugs that their insurance company has already made the decision to cover, and their doctor has determined they need. Patients still have plenty of skin in the game when it comes to making and paying for their healthcare decisions, as they are still paying their insurance premiums and patients living with chronic illnesses don't have the luxury of forgoing certain health care treatments and services until they can more easily afford them.

The American Cancer Society Cancer Action Network is urging members of the Assembly Committee on Health, Aging and Long-Term Care to stand with patients and help those with chronic and complex conditions like cancer access the treatments they need to live a healthy and productive life by voting yes on Assembly Bill 773.

Thank you for your time.

Dear members of the Assembly Committee on Health, Aging and Long-Term Care,

Thank you for holding a public hearing on Assembly Bill 773. My name is Krin Stendalen, and I live with my husband Gary in Westby, WI. I'm writing to share my story because Assembly Bill 773 includes a provision to ensure that All Copays Count. This will help patients and families like mine access and afford lifesaving medication. In January 2020, I was diagnosed with stage three uterine cancer and began treatment with chemotherapy and radiation. After many months of treatment, I was cancer free. However, two years after my initial diagnosis, I received the news that my cancer returned.

My new treatment plan included daily oral chemotherapy and immunotherapy. Taking medication every day to maintain my health came with a steep price tag. Fortunately, I received copay assistance from the drug manufacturer. Before receiving this financial support, my husband and I had to dip into our retirement account to pay for the medication. Prior to 2023, my insurance plan did count copay assistance toward my out-of-pocket cost requirements. However, this year they removed this benefit for all patients increasing the burden of out-of-pocket costs.

I believe all patients who receive copay assistance should have it count towards their deductible and out-of-pocket maximum. The All Copays Count legislation will do just that, which is why I'm asking you to vote yes on Assembly Bill 773.

Thank you,

Krin Stendalen
S1486 Stenslien Lane
Westby, WI

Cc: Senator Brad Pfaff and Representative Loren Oldenburg

TO: Assembly Committee on Health, Aging & Long-Term Care

FROM: Thad Schumacher
Fitchburg Family Pharmacy
3050 Cahill Main #6
Fitchburg, WI 53711

DATE: February 14, 2024

SUBJECT: Testimony in Favor of Assembly Bill 773

Thank you Committee ChairPerson and Committee Members

I am here representing Fitchburg Family Pharmacy, a family owned and operated business in Fitchburg, WI.

I am unfortunately here to report to you the dismal state of pharmacy reimbursement in Wisconsin and America. The current structure of pharmacy reimbursement is unsustainable and will lead to the closure of pharmacies which will decrease access to pharmacy services across Wisconsin.

I present along with my testimony statistics from our pharmacy for the past 6 months. I am sad to report that nearly one-quarter of all the prescriptions that I fill are reimbursed below what our pharmacy was able to purchase the products for. I can report that pharmacies across Wisconsin are suffering from this same reimbursement dilemma.

Exhibit A. Total prescription filled Jun - Nov 2023: 24,346
Total prescriptions reimbursed at $0 dollars profit or less: 5,688 **(23%)**
These 5,688 prescriptions represent over a $100,000 loss

Over the past year the pharmacy industry has suffered from massive supply chain disruptions. Our store and many independent pharmacies are uniquely positioned to mitigate these disruptions with our daily ordering and multiple vendor relationships. This has meant that we have seen an influx of business for many expensive medications. Unfortunately, most of these medications are reimbursed to us at a loss. Our team knows that many of these patients have been to many pharmacies searching for these products and we are committed to providing patients what they need.

Our team will continue providing and expanding access to pharmacy care moving forward. It became clear to everyone during COVID testing and vaccinations that if you reimburse pharmacists with a sustainable model, they can accomplish extraordinary outcomes. The idea of a fair cost plus reimbursement model such as Wisconsin Medicaid gives me hope for what pharmacy services our profession could expand access to. The current reimbursement model is

one of the only things holding our small business back from producing more, hiring more employees and increasing wages.

If you fail to act, we will continue down an unsustainable path that will lead to decreased access for the people of Wisconsin.

Thad Schumacher PharmD
Fitchburg Family Pharmacy
tschumacher@fitchburgfamilyrx.com
608 886 7117

February 14, 2024

To: Honorable Members of the Assembly Committee on Health, Aging, and Long-Term Care

Re: Support for Assembly Bill 773 PBM Accountability Legislation to Protect Copay Assistance for Patients

Dear Chairwoman Moses and Members of the Committee,

On behalf of the ALS Association, thank you for the opportunity to submit written testimony in support of Assembly Bill 773, the "Pharmacy Benefit Manager Accountability" bill, which would protect local pharmacists and incorporates all the provisions included in the All Copays Count legislation (that would help Wisconsin patients access and adhere to their prescription medications.

Amyotrophic lateral sclerosis (ALS) is an always fatal progressive neurodegenerative disease that slowly robs a person's ability to walk, talk, eat, and eventually breathe. The cost of care for someone living with ALS is astronomical, with annual out-of-pocket expenses reaching upwards of $250,000 per year. As with many people living with complex medical conditions, those with ALS must take various drugs to maintain their health. The copays associated with acquiring them significantly add to this crushing financial burden.

One way that people with ALS afford their care is through copay assistance programs, where cards or coupons from nonprofit organizations or drug manufacturers help reduce the cost of drugs. However, insurers and pharmacy benefit managers increasingly use copay accumulator adjustment programs to prevent such assistance from counting towards patient cost-sharing, such as their deductible or annual out-of-pocket maximum. In effect, the insure0r is "double dipping" and is paid twice by demanding payment of out-of-pocket costs: first from copay assistance programs provided by drug manufacturers or nonprofits and then again from patients.

Copay accumulator adjustment programs do not just harm patients' finances; they undermine their access to life-saving prescription drugs, making it even more difficult for people living with ALS and other complex medical conditions to adhere to a treatment plan. With lower copays, consumers are more likely to take their medications regularly.

We strongly support the prohibition of copay accumulator adjustment programs. We believe that *all Wisconsin residents* should be able to afford necessary treatments by ensuring *all payments* – made by or on behalf of them – are counted towards their deductible and out-of-pocket maximums.

Thank you for your time and your consideration of this critical legislation. For all these reasons, we respectfully request your support for AB 773.

Sincerely,

Sarah Sanchez
Managing Director, Advocacy
The ALS Association
sarah.sanchez@als.org

CYSTIC FIBROSIS FOUNDATION®

February 14, 2024

The Honorable Clint P. Moses
Chair, Assembly Committee on Health, Aging and Long-Term Care
2 E Main St
Madison, WI 53703

Dear Chairman Moses, Vice-Chair Rozar, and Honorable Members of the Committee:

On behalf of the more than 700 people with cystic fibrosis (CF) in Wisconsin, we write to express our support for AB 773, which provides a number of accountability measures to protect patients' access to medication, including requiring insurers to apply third-party assistance to out-of-pocket maximums and other patient cost-sharing requirements. While copay assistance is not a silver bullet for systemic issues that face our health care system, solutions to address affordability and sustainability cannot come at the expense of patients' health and financial wellbeing. We ask for your support and co-sponsorship of AB 773.

About cystic fibrosis

Cystic fibrosis is a life-threatening genetic disease that affects nearly 40,000 children and adults in the United States. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. Cystic fibrosis is both serious and progressive; lung damage caused by infection is irreversible and can have a lasting impact on length and quality of life. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. While advances in CF care are helping people live longer, healthier lives, we also know that the cost of care is a barrier to care for many people with the disease.

Accumulator programs jeopardize access to care

Accumulator programs prevent third-party payments from counting towards deductibles and out-of-pocket limits and therefore increase out-of-pocket costs for patients—which can cause people with CF to forgo needed care and lead to adverse health outcomes. According to a survey conducted by George Washington University of over 1,800 people living with CF and their families, nearly half reported skipping medication doses, taking less medicine than prescribed, delaying filling a prescription, or skipping a treatment altogether due to cost concerns.[1] Because CF is a progressive disease, patients who delay or forgo treatment—even for as little as a few days—face increased risk of lung exacerbations, costly hospitalizations, and potentially irreversible lung damage.[2]

Accumulator programs also place additional financial strain on people with CF who are already struggling to afford their care. More than 70 percent of survey respondents indicated that paying for health care has caused financial problems such as being contacted by a collection agency, filing for bankruptcy, experiencing difficulties paying for basic living expenses like rent and utilities, or taking a second job to make ends meet.

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[1] https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1056&context=sphhs_policy_briefs

[2] Trimble AT, Donaldson SH. Ivacaftor withdrawal syndrome in cystic fibrosis patients with the G551D mutation. J Cyst Fibros. 2018 Mar;17(2): e13-e16. doi: 10.1016/j.jcf.2017.09.006. Epub 2017 Oct 24. PMID: 29079142.

Additionally, while three quarters of people received some form of financial assistance in 2019 to pay for their health care, nearly half still reported problems paying for at least one CF medication or service in that same year. One mother of an eight-year-old child living with CF who, like many families in Wisconsin, depends on financial assistance to access life-changing medications, shares that they "would have to consider the cost of such medications, our ability to pay for them, and our family's financial stability" if it weren't for co-pay assistance programs.

AB 773 would also require covered benefits to be considered essential health benefits (EHBs). Currently, private health plans are allowed to deem certain categories of prescription drugs as "non-essential." This determination allows plans to substantially adjust their cost-sharing for a particular drug or eliminate coverage for certain specialty medications altogether. In doing so, plans can require enrollees to seek free drugs from manufacturers or collect the maximum amount of copay assistance available through manufacturers and other third-party programs. These strategies include an accumulator component, which adds to the considerable costs and administrative burdens for people with CF. Cystic fibrosis treatments rarely have generic alternatives so when private plans exclude specialty CF medications or cover them while placing significant administrative and financial burden on the enrollee, people with CF face the difficult choice of foregoing these necessary treatments, changing to an often more costly insurance plan from the ACA marketplace, or in some cases seeking alternate employment.

This issue has unfortunately impacted many Wisconsin families and caused them financial hardship, significant administrative burden, and unnecessary barriers to accessing care. The mother of an 11-year-old living with CF reported facing a $24,000 monthly copay for one of her son's vital medications unless she was able to shuttle between a copay assistance program and a pharmacy benefit manager to negotiate additional assistance. She shared that "this resulted in a year where we had to use six different pharmacies to get my son's medications. It was a total nightmare. Hours on the phone, filling out paperwork and trying to navigate why the insurance we were paying for wasn't seeming to fill their end of the deal. We enlisted the assistance of the Cystic Fibrosis Foundation Compass program right away, and this still took months to navigate."

We understand the challenge insurers face in managing the rising cost of drugs. However, cost containment strategies that further burden patients are unacceptable. Accumulators are especially challenging for a disease like CF, which has no generic options for many of the condition's vital therapies. The situation has become even more dire as a company that manufacturers CF therapies recently reduced the amount of copay assistance available for people enrolled in accumulator programs.

By passing AB 773, you will help ensure continued access to quality, specialty care for people with CF. The Cystic Fibrosis Foundation appreciates the Committee's attention to this important issue for the CF community in Wisconsin and urges you to support AB 773.

Sincerely,

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President, Policy & Advocacy
Cystic Fibrosis Foundation

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Assistant Professor of Medicine
Division of Allergy, Pulmonary and Critical Care
Department of Medicine
University of Wisconsin-Madison

Rose Franco, MD
Associate Director, Adult Cystic Fibrosis Center
Froedtert & Medical College of Wisconsin

Michael J. Rock, M.D.
Professor Emeritus
University of Wisconsin School of Medicine and Public Health

February 13, 2024
Assembly Health, Aging and Long-Term Care Committee
(Sarah Phelan Written Testimony)

Re: Assembly Bill 773 to Protect Copay Assistance for Patients

Dear Representatives:

I hope this message finds you well. My name is Sarah Phelan, and I am writing to you today as a dedicated respite care worker at Gio's Garden, a facility in Middleton, Wisconsin that provides crucial respite support to children with various rare diseases and special needs. Through my work I have witnessed the daily challenges and expenses faced by families dealing with these conditions.

I am writing today to ask you to support AB 773 / SB 737. This legislation would ensure that the value of copay assistance counts for patients across Wisconsin. I fully support these bills and urge you to support these bills to lower out-of-pocket costs for patients and help them access their needed prescription medications.

One of the most pressing issues these families confront is the overwhelming financial burden associated with the necessary medical care. I have seen this firsthand while working at Gio's, as most of the children with Rare Disease required 24/7 caregiving, frequent hospitalization, and a long list of treatments, including regular administration of medication and the use of a feeding tube.

Many families at Gio's grapple with financial hardships that manifest in the condition of their vehicles – broken and taped up, representative of the sacrifices made to prioritize medical needs over material comforts. There is a family without a car, relying on Uber for transportation to and from Gio's for both pick-up and drop-off. Another family, facing financial constraints, resorts to diluting formula to stretch resources for more than one feed – an unfortunate reality that highlights the harsh choices families must make. Copay assistance, I believe, can provide a critical solution to alleviate the financial strains many of these family's face.

One family in specific has multiple children with a rare genetic disease that results in a slow decline in motor and speech functions. Unfortunately, I have witnessed first-hand the diminishing abilities of the older child. As of recently his walking ability has significantly, however, he continues to try with a smile on his face. This decline in abilities results in more reliance on medication and more frequent doctor visits and hospitalization. All while a definitive cure for this syndrome does not exist yet.

The burden for these families is immense. Added to it is the financial burden. Rare disease families already face three to five higher expensive than those of an average family. So having multiple kids with this disorder is an extremely tasking financial burden. The cost for medications is a significant component of these expenses. For many families, assistance with copays is a lifeline that ensures they can continue to provide the best possible care for their loved ones.

These policies hurt Wisconsin families, many who can least afford their medications and often have no idea insurers do not allow these copay assistance programs to be directed to help offset their out-of-pocket costs. Until they are told at the pharmacy counter that they must pay thousands of dollars to get the medications they rely upon. This can leave patients with few alternatives and none

that are in the best interests of their families. Stop taking medications they need? Reduce another expense like food or housing?

I strongly urge you to support these bills and stand with patients in helping those with chronic and complex conditions access the treatments they need to live healthy and productive lives. This will help the loving and dedicated Wisconsin families at Gio's Garden and so many others. Denying patients access to programs to assist in the costs for the medications they need will not reduce costs and will only lead to unnecessary hospitalizations and increased suffering.

Thank you for your continued commitment to Wisconsin patients and their families.

Sincerely,
Sarah Phelan
623 north lake street apt. 603, Madison, WI 53703
scphelan@wisc.edu

SUPPORT PBM REFORM IN WISCONSIN

PSW
Pharmacy Society of Wisconsin

Pharmacy benefit managers, or PBMs, manage plans for nearly 95% of Americans with prescription drug coverage by serving as a "middle-man" between health plans and pharmacies. Operating with limited government oversight, some PBMs have utilized tactics such as "gag clauses" and "copay clawbacks" to drive up costs for customers. Tactics such as "pharmacy steering," deceptive advertising, and mandatory mail-order have reduced patient access to pharmacy and complementary health care services at the pharmacies of their choice.

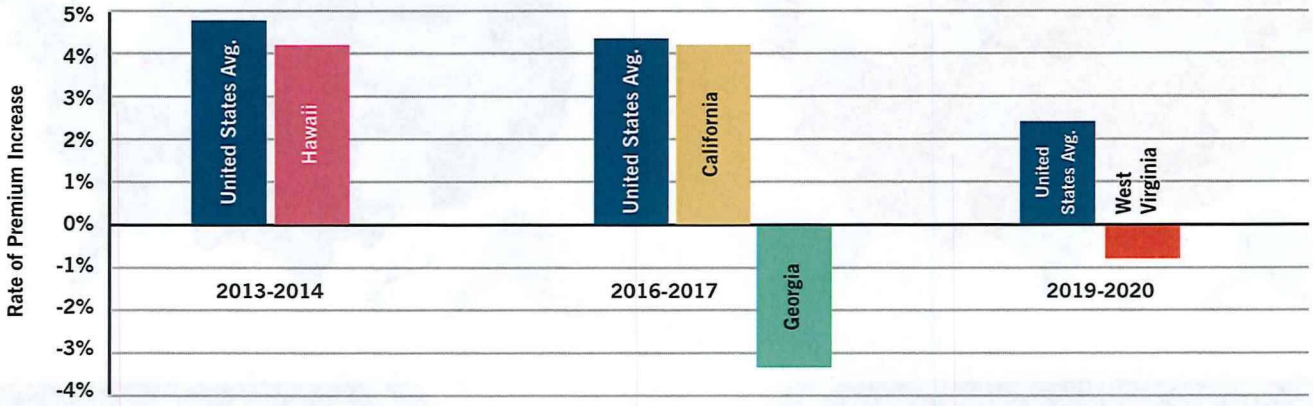
$633.5 Billion
amount the U.S. spent on prescription drugs in 2022[1]

89%
of the market is controlled by only 3 PBMs[2]

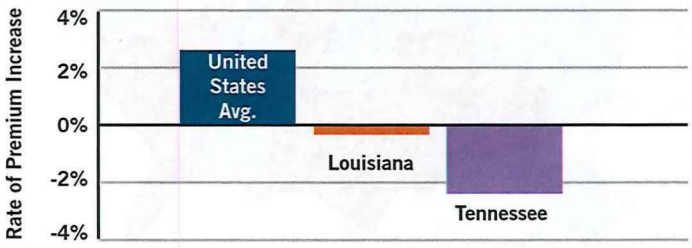
PBM REFORM HAS NOT RAISED COSTS FOR PATIENTS AND PAYERS

Rates of Premium Increases are LOWER in States with PBM Reforms

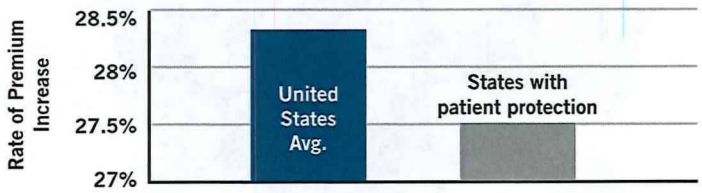
States that Protect Patients from Mandated Use of a Mail-Order Pharmacy[3]



States that Prohibit PBMs from Reimbursing PBM-Owned Pharmacies at Higher Rates than Non-Affiliated Pharmacies (2019-2020)



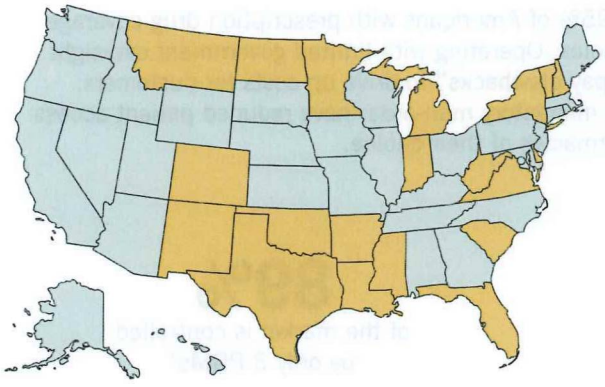
States that Protect Patients from PBM Penalties (e.g., Higher Copays) for Utilizing the In-Network Pharmacy of their Choice (2013-2020)



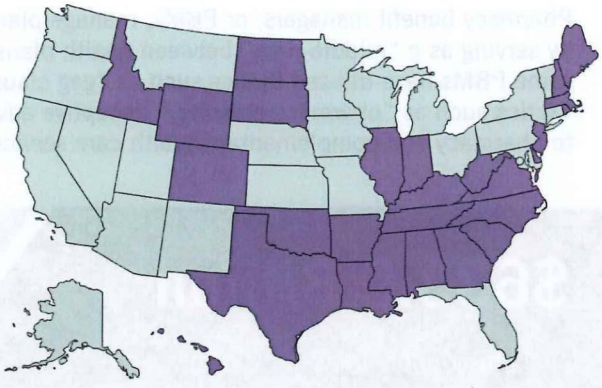
States include Delaware, Mississippi, North Carolina, and South Dakota.

STATES THAT HAVE PASSED PBM REFORM AS OF 2023

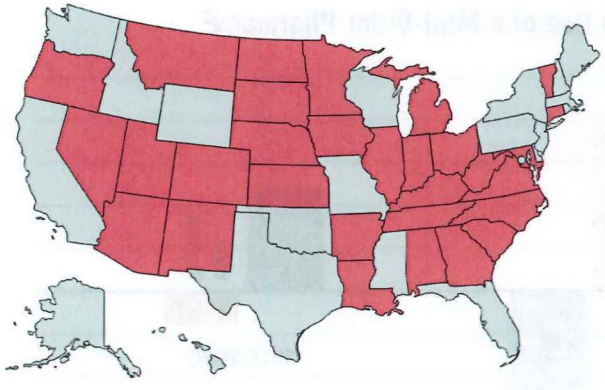
Accreditation Requirement Transparency



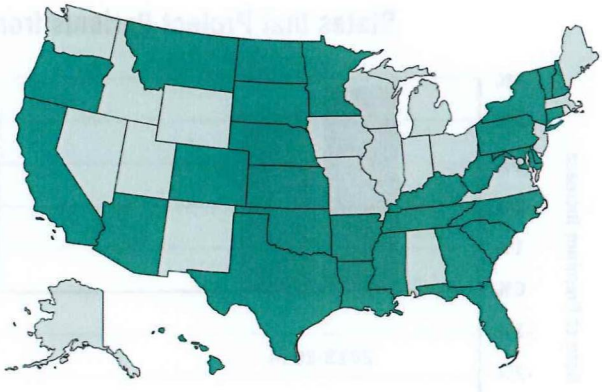
Any Willing Pharmacy (AWP)



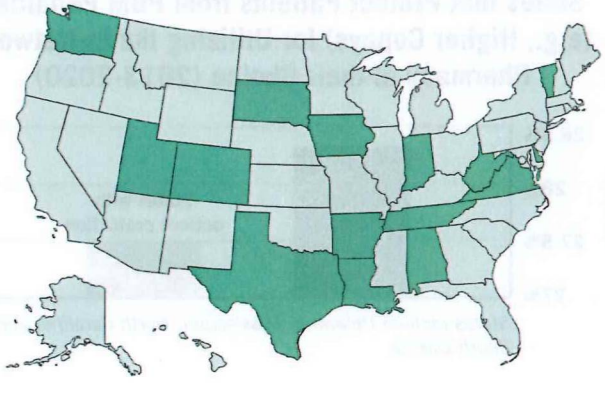
340b Non-Discrimination



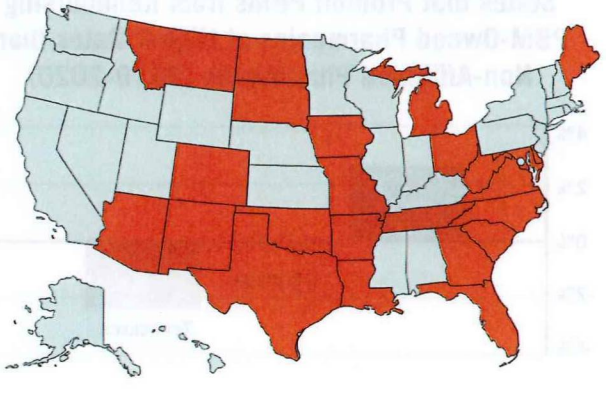
No Mandatory Mail Order



No Unequal Affiliated Reimbursement



No Adjudication Fees



1. https://www.pharmacist.com/Publications/Pharmacy-Today/Article/drug-expenditures-expected-to-increase-in-2023
2. https://content.naic.org/cipr-topics/pharmacy-benefit-managers
3. https://ncpa.org/sites/default/files/2022-03/pbm-regulations-one-pager.pdf

Pharmacy Society of Wisconsin

Pharmacy Society of Wisconsin

TO: Assembly Committee on Health, Aging & Long-Term Care

FROM: Sarah Sorum, PharmD, CAE
Executive Vice President / CEO
Pharmacy Society of Wisconsin

DATE: February 14, 2024

SUBJECT: **Testimony in Favor of Assembly Bill 773**

Thank you, Assembly Committee on Health, Aging & Long-Term Care members, for the opportunity to provide testimony in support of Assembly Bill 773. I am Sarah Sorum, a pharmacist and the CEO of the Pharmacy Society of Wisconsin. This bill takes several much-needed steps toward increasing transparency and accountability for Pharmacy Benefit Managers (PBMs).

Pharmacy benefit managers, or PBMs, manage prescription drug benefits for nearly 95% of Americans with prescription drug coverage[1]. Created initially to reduce administrative costs, validate patient eligibility, and negotiate costs between pharmacies and health plans, the role of PBMs has exploded due to their involvement in prescription claims at the point of sale for more than 200 million Americans.

At their best, PBMs can serve as an intermediary between health plans and pharmacies to create formularies of evidence-based, preferred medication lists. At their best, PBMs can negotiate with drug manufacturers and pharmacies to derive the most value from the investment in care.

However, recent studies have demonstrated that many PBMs operate without transparency and have taken advantage of their middleman position between the health plan and pharmacy provider. Three PBMs have evolved to control 89% of the market, which has led to the implementation of business practices that are unfair to employers, health plans, pharmacies, and patients. These vertically integrated, opaque oligopolies own and operate their own pharmacies, mail-order pharmacies, and specialty pharmacies and are driven by profit margin rather than bringing value to healthcare.

[1] AIS Market Data, Pharmacy Benefit Management, PBM Market Share, Top 25 Pharmacy Benefit Management Companies and Market Share by Membership. 2000-2011 Survey Results: Pharmacy Benefits Trends & Data.

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info@pswi.org www.pswi.org

Wisconsin is joining other states in pursuing needed policy intervention. The legislation we are talking about today includes several provisions that are in effect across the country[2]:

- Prohibitions on accreditation requirements are in effect in 20 other states.
- Allowances for pharmacies to join any network, if they agree to the contract terms, are in effect in 28 other states.
- 340b non-discrimination language is in effect in 30 other states.
- Prohibitions on mandatory mail-order are in effect in 30 other states.
- Prohibitions against adjudication fees are in effect in 24 other states.
- Prohibitions against reimbursing a PBM-affiliated pharmacy more than a non-affiliated pharmacy are in effect in 15 other states.

Today, you're hearing how this legislation's provisions will raise costs. In fact – the opposite is true[3]:

- In states such as Hawaii, California, Georgia, and West Virginia, which have provisions prohibiting mandatory mail-order (something this bill includes), premiums have increased LESS than the national average premium increases.
- In states such as Louisiana and Tennessee, which have provisions prohibiting PBMs from reimbursing PBM-owner pharmacies at higher rates than non-affiliated pharmacies, premiums have GONE DOWN – while the national average premium has gone up.
- In states such as Delaware, Mississippi, North Carolina, and South Dakota, which prohibit differential copays when using the in-network pharmacy of a patient's choice, premiums have increased LESS than the national average premium increases.

This legislation takes critical steps toward protecting patients and their access to pharmacies that provide critical healthcare services to the communities we serve. I urge your support of this legislation and thank you for the opportunity to provide testimony on Assembly Bill 773. I am happy to answer any questions you may have.

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[2] PBM Laws and Regulations by State. NCPA. https://ncpa.org/pbm-reform

[3] PBM Reform Has Not Raised Costs for Patients and Payers. https://ncpa.org/sites/default/files/2022-03/pbm-regulations-one-pager.pdf

AHI
ALLIANCE OF HEALTH INSURERS

Providing quality coverage to nearly 3 million Medicaid and private sector enrollees in Wisconsin.

To:	Members, Assembly Committee on Health, Aging, and Long-Term Care
From:	Rebecca Hogan, on behalf of the Alliance of Health Insurers
Date:	February 14, 2024
Re:	Testimony on AB 773

The Alliance of Health Insurers (AHI) is a nonprofit state advocacy organization created to preserve and improve upon consumer access to affordable health insurance in Wisconsin, both via the private sector and public programs.

Prescription medications are an important part of medical treatment. Over the past several decades, health plans' prescription drug benefits have provided access to needed medications for tens of millions of Americans. In addition, under the Affordable Care Act (ACA), every health insurance policy must include a comprehensive "essential health benefits" package covering ten categories of services, including prescription drug coverage.

Prescription drug costs in the United States are skyrocketing. In 2021, $378 billion was spent on prescription drugs.[1] CMS estimates that during this decade spending for retail prescription drugs will be the fastest growth health expense category and will consistently outpace that of other health spending.

In response, and increasingly over the past decade, employers, HMOs, health care insurers, and various government entities have turned to pharmacy benefit management companies (PBMs) as an efficient and effective way to administer prescription drug benefits. PBMs are the primary lever available to health plans to ensure that their customers can obtain the medications they need at the lowest possible cost; and that providers and pharmacies are providing quality care.

Our members and employers work with PBMs because they attempt to contain increasing costs by using their expertise and technology solutions to administer certain essential functions of a prescription drug benefit for health plans:

- Using clinically based services to reduce medication errors, achieve higher rates of medication adherence, and improve health outcomes.
- Negotiating directly with manufacturers and pharmacists to obtain discounts for their customers in the form of lower out-of-pocket costs. The level of comparable volume and cost reductions PBMs can generate cannot be achieved by many health plans, most employers, or individuals.
- Implementing of cost-cutting strategies that include discount pharmacy networks, incentives to use therapeutic alternatives, formulary management (including manufacturer rebates), mail-order pharmacies, drug-use reviews, and disease management.
- Educating their consumers about safe, effective, and lower cost generic drugs.

[1] https://www.cms.gov/files/document/highlights.pdf

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R.J. Pirlot, Executive Director, pirlot@hamilton-consulting.com
www.allianceofhealthinsurers.com

Today, more than 22 cents of every dollar spent on health insurance premiums goes to pay for prescription drugs – more than any other individual category.[2] PBMs have been found to save payers and patients nearly $1,040 per enrollee per year and reduce costs by $6 for every $1 spent on their services.[3] PBMs also pass rebates and savings through to their clients. 99.6% of prescription drug rebates negotiated by PBMs with drug manufacturers in Medicare Part D are passed through to drug plan sponsors.[4] 91% are passed through for the commercial market.[5]

This bill jeopardizes cost-cutting strategies PBMs and health insurers use to manage the costs of prescription drugs. This bill will eliminate or modify, amongst other provisions:

1. The current structure of pharmacy networks
2. Incentives to utilize mail order options for prescription drug delivery
3. The time frame insurers have to notify patients of a formulary change
4. When a drug can be removed from a formulary
5. The use of copay accumulators

This is a wide-ranging bill and for the purposes of this testimony I have only touched on the highlights. For a more comprehensive summary of the bill's provisions, please see the 18-page document shared with the committee and full legislature in December by the groups representing health plans and other interested parties.

Ultimately, the payers of health care - the employers of Wisconsin - simply cannot afford the bill presented today.

Thank you for this opportunity to testify.

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[2] AHIP, Know Your Health Care Dollar: Vast Majority of Premium Pays for Prescription Drugs and Medical Care, September 6, 2002

[3] The Return on Investment (ROI) on PBM Services, Prepared by Visante on behalf of PCMA, 2023

[4] Government Accountability Office (GAO), MEDICARE PART D Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization, July 2019

[5] The Prescription Drug Landscape, Explored, PEW Trust, March 2019

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Wisconsin
Association of
Health Plans

Assembly Bill 773
Committee on Health, Aging and Long-Term Care
February 14, 2024

Chair Moses, members of the Committee, thank you for the opportunity to provide testimony today regarding Assembly Bill 773 (AB 773). My name is Tim Lundquist and I am the Senior Director of Government & Public Affairs of the Wisconsin Association of Health Plans. The Association is the voice of 14 community-based health plans that serve employers and individuals across the state in a variety of commercial health insurance markets. Member health plans are also key partners in state-administered programs, including the Group Health Insurance Program and in Medicaid managed care.

In December, our Association joined several other trade associations in circulating a memo to the Legislature detailing our significant concerns with and opposition to the Senate version of AB 773. I have included a copy of that memo alongside my testimony today. For the sake of brevity, I will not cover in today's testimony the litany of issues raised in that memo. I will, however, summarize our conclusions: community-based health plans believe AB 773 has significant harmful and far-reaching consequences for the cost and quality of prescription drug management in Wisconsin. We respectfully urge committee members to take no further action on this bill.

I would like to focus my comments today on just one portion of AB 773—the inclusion of 2023 Senate Bill 100/Assembly Bill 103, relating to the application of prescription drug payments to health insurance cost-sharing requirements.

Association member health plans share the goal of the bill authors to make prescription drugs more affordable for Wisconsin patients. Drug prices set by pharmaceutical manufacturers are excessive and unreasonable, and prescription drugs constitute a significant and fast-rising portion of total health care spending. However, this proposal will not reduce this trend. AB 103, as incorporated into AB 773, constitutes state endorsement of bait-and-switch strategies used by pharmaceutical companies to encourage consumers to use more expensive branded drugs.

Specifically, this legislation purports to save patients money by prohibiting insurers' from managing the total cost of prescription drugs through the use of so-called copay accumulator programs. Drug manufacturers offer cost-sharing assistance, often in the form of copay coupons, and represent this assistance as being charitably designed. The reality, however, is that these programs are marketing tools used to drive sales of brand-name drugs. Copay coupons obscure a drug's true cost, incentivize the use of high-cost drugs, and make pharmaceutical manufacturers less accountable for both their prices and price increases, to the ultimate detriment of insured patients. AB 773 restricts use of a tool health plans may employ to better manage total drug costs for plan participants, and undermines health insurance provider efforts to negotiate lower prices for patients. The data bear this out: the prices for drugs with manufacturer coupons increase faster than those without. Imposing mandates on health plan benefit design <u>does not</u> address the root problem of drug manufacturers' high prices.

Committee members should also know that pharmaceutical manufacturer assistance programs are not permitted under federal programs like Medicare and Medicaid because they are considered a violation of federal anti-kickback laws. What's more, under state law, no health care provider in Wisconsin is permitted to offer the kind of copay waivers that pharmaceutical companies provide. The Office of the General Counsel of the Wisconsin Medical Journal has advised health care providers, "Do not offer routine waivers of copays and deductibles" and "Give only very small gifts to patients," to avoid violating state and federal law. Drug manufacturers' copay coupons certainly do not abide by this guidance.

For these reasons, we respectfully urge committee members to take no action on AB 773. I am happy to answer any questions you may have at this time.

To: Wisconsin State Legislators
From: AHIP
Alliance of Health Insurers
Pharmaceutical Care Management Association
Wisconsin Association of Health Plans
Date: December 5, 2023
Re: Opposition to Senate Bill 737 – PBM Legislation

Dear Legislators:

As advocacy organizations that are committed to market-based solutions that improve consumer affordability and access to high-quality, high-value health care in Wisconsin, we appreciate the opportunity to share our serious concerns with and opposition to SB 737, relating to pharmacy benefit managers (PBMs).

As drafted, SB 737 ("the PBM bill") does far more than provide "accountability measures" to protect independent pharmacies – it has significant harmful and far-reaching consequences for the cost and quality of prescription drug management in Wisconsin. Employers and their employees already bear the unreasonable and growing cost of prescription drugs through higher health insurance premiums and out-of-pocket costs. The Legislature should not make this problem worse by passing a suite of mandates that will cost Wisconsin employers millions of dollars annually, will do nothing to address the root causes of high drug costs, and will only serve to hamstring payer efforts to provide affordable access to prescription drugs.

The description of our many concerns with the bill begins on page 7 of this memo. However, before we outline the harmful effects of SB 737, we would like to provide background information on how prescription drugs are covered and accessed and how Wisconsin currently regulates PBMs.

How are Prescription Drugs Covered and Accessed?

Patients in Wisconsin generally access prescription drugs through a health insurance benefit, such as an employer-sponsored plan, an individual market plan, or via government programs like Medicaid and Medicare. The cost of prescription drugs and prescription drug coverage has increased over time.

According to the Centers for Medicare & Medicaid Services (CMS), in Wisconsin, annual per capita spending on drugs and other non-durable products by all payers has increased from $230 in 1991 to $1,040 in 2020 – an average annual growth of 5.3%.[1] National spending on retail prescription drugs has followed a similar trend, increasing from $101 per capita in 1960 to

[1] *Health Expenditures by State of Residence: Summary Tables.* Accessed November 22, 2023. Center for Medicare & Medicaid Services. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.

$1,147 in 2021, after adjusting for inflation.[2] In 2021, net of rebates, retail drugs accounted for about 16% of fully-insured private health plan premiums nationally.[3]

This increase in prescription drug spending has been driven by several key factors since the 1990s, including the introduction of numerous new drugs to the market, higher use of prescription drugs per capita, and increasing prices for brand-name drugs. Studies have shown that increasing prices for brand drugs largely reflect drug manufacturers setting higher launch prices for new brand drugs and increasing the prices of brand drugs already on the market.[4]

In this rapidly changing and increasingly expensive prescription drug environment, health insurance providers, employers, and government programs are responsible for balancing increasing prescription drug costs with affordability, access, and quality of care for individuals and families. Thus, private and public payers frequently contract with PBMs for their specialized expertise on prescription drug pricing and clinical issues.

What services do PBMs provide?

PBMs provide many services to drive access, value, efficiency, and effectiveness in the administration of prescription drug benefits, including:

- Negotiating directly with drug manufacturers to obtain discounts on prescription drugs, including volume-based discounts, that usually cannot be achieved by many health plans, most employers, or individuals.
- Negotiating directly with pharmacies for discounts and network design, including establishing value-based arrangements that incorporate clinical performance standards and metrics. This "value-based contracting" is increasingly common throughout the health care industry as a mechanism to drive higher quality care and better patient outcomes.
- Assisting with the development of formulary designs to help enrollees obtain safe and effective medications at the best value, including incentivizing the use of the high-value and clinically appropriate therapeutic options.
- Designing and implementing consumer-driven and data-supported medication management and other innovative pharmacy programs to prevent medication errors, increase adherence, and improve health outcomes.
- Offering enrollee education services around the drug benefit and prescription drugs generally, including the availability of safe, effective, and lower cost generic drugs.

How are prescription drugs covered?

The drugs covered under an insurance benefit, the patient's cost-sharing for the drug, and any specific requirements that might apply for a drug to be covered (e.g., prior authorization, step therapy) are specified via a formulary. PBMs negotiate with drug manufacturers to receive price concessions in exchange for a drug earning a certain formulary placement and/or coverage

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[2] *What are the recent and forecasted trends in prescription drug spending?* September 15, 2023. Peterson-KFF Health System Tracker. Available at: https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#Nominal%20and%20inflation-adjusted%20per%20capita%20spending%20on%20retail%20prescription%20drugs,%201960-2021.

[3] Ibid.

[4] *Prescription Drugs: Spending, Use, and Prices.* January 2022. Congressional Budget Office. Available at: https://www.cbo.gov/system/files/2022-01/57050-Rx-Spending.pdf.

criteria. Formularies deliver cost savings by making drug manufacturers compete on value, which we define as delivering the best outcomes for the lowest net cost.

Some drugs are required to be covered by federal law,[5] while other decisions about covered drugs are made by a Pharmacy and Therapeutics Committee (P&T Committee). A P&T Committee includes practicing physicians, pharmacists, and other licensed prescribers, and meets for the purposes of reviewing clinical, safety, quality, and cost-effectiveness evidence on various prescription drugs and discussing how specific drugs should be covered.

All commercial health plans are required under federal law[6] to provide enrollees a written summary of benefits and coverage (SBC) that includes a link to their formulary. Individual and small group qualified health plans (QHPs) are required under federal law[7] to keep their formularies up-to-date and publish their formularies in an easily accessible format that can be viewed by the general public.

Where do patients access prescription drugs?

Patients access prescription drugs through a variety of mechanisms, depending on the drug they have been prescribed and any special considerations for the shipping, handling, storage, and/or administration of that drug. Some drugs must be administered by a clinician, but many drugs can be safely taken at home. Patients who take their drugs at home may receive them from a chain pharmacy, independent pharmacy, other clinic/outpatient pharmacy, mail-order pharmacy, or specialty pharmacy.

The pharmacy industry is highly competitive, which has led the market to change significantly over the past several decades.[8,9] From 2010 to 2020, there was significant consolidation among retail pharmacy chains. Meanwhile, regional pharmacies have also experienced changes, with both large and small grocers (supermarkets that also have a pharmacy) undergoing acquisitions and mass retail pharmacies (large consumer goods retailers that also have a pharmacy) using their brand name and size to attract customers. Mail-order and direct-to-consumer online pharmacies have also grown, with established retail pharmacies and new entrants establishing a larger presence. Finally, since 2000, the number of independent pharmacies has leveled off at about 20,000 locations – and independent pharmacies have generally remained competitive by gaining scale through collaboration with other independent pharmacies and wholesalers.

As of 2019, of the 837 community pharmacies identified in Wisconsin, more than half (57%) were chain pharmacies, one-quarter (25%) were independent pharmacies, and about one-fifth

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[5] Individual and small group plans that are required to cover essential health benefits (EHBs) must cover certain drugs based on EHB rules (45 CFR 156.122) and the state's EHB benchmark plan (see more on the website of the Wisconsin Office of the Commissioner of Insurance).

[6] 45 CFR 147.200

[7] 45 CFR 156.122

[8] *Meeting changing consumer needs: The US retail pharmacy of the future.* March 17, 2023. McKinsey & Company. Available at: https://www.mckinsey.com/industries/healthcare/our-insights/meeting-changing-consumer-needs-the-us-retail-pharmacy-of-the-future.

[9] *Competition, Consolidation, and Evolution in the Pharmacy Market.* August 12, 2021. The Commonwealth Fund. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2021/aug/competition-consolidation-evolution-pharmacy-market.

(18%) were clinic/outpatient/HMO pharmacies.[10] This same analysis found that independent pharmacies have a larger presence in rural areas of Wisconsin than chain pharmacies, and 98.7% of Wisconsin's population lives within a 20-minute drive of a pharmacy.

In contrast to "brick and mortar" pharmacies, mail-order pharmacies and specialty pharmacies directly ship prescription drugs to patients' homes. Mail-order pharmacies can be lower-cost and more convenient for patients, including those with limited mobility or access to transportation. Mail-order pharmacies are especially valued by employers as both a matter of convenience for their employees and as a cost-saving tool.[11]

Specialty pharmacies dispense medications that are less commonly used, have serious side effects, and/or treat complex conditions. Specialty pharmacies are owned and operated by a variety of entities, including PBMs, wholesalers, providers, integrated delivery networks, and large chain pharmacies. Specialty pharmacies have evolved to meet the unique requirements for dispensing specialty drugs, such as sophisticated storage conditions and processes for drug handling and dispensing. In addition, specialty pharmacy staff coordinate a patient's care by providing close monitoring, collecting data, and sharing that information between the patient's health care providers. Drug manufacturers' pricing power and the unique features of specialty drugs have caused these drugs to be some of the most expensive available.

How Wisconsin Law Regulates PBMs

The federal and state laws that define and impact the management of prescription drug benefits are numerous, and the requirements that were mentioned previously are just a small sample of the parameters that health insurance providers must follow when administering these benefits. In addition to the many existing rules governing the administration of prescription drug benefits, Wisconsin also directly regulates PBMs under the framework established by 2021 Wisconsin Act 9.[12] Act 9 was enacted into law on March 26, 2021.

We recognize that the below summary of the provisions included in Act 9 is lengthy.[13] However, precisely because Act 9 established the many new statutory requirements outlined below, we believe including this description is important for legislators to understand current Wisconsin law with respect to direct regulation of PBMs and other consumer protections.

2021 Wisconsin Act 9

Requiring PBM Licensure & Reporting

- PBMs must be licensed by OCI, either as a PBM or as an employee benefit plan administrator.
- PBMs are subject to OCI's authority to examine or audit their records.

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[10] *Illustrating access to community pharmacies in Wisconsin.* February 17, 2021. Look, Kevin A. et al. Available at: https://www.japha.org/article/S1544-3191(21)00072-8/fulltext.

[11] *Concerns with LRB 1683, Pharmacy Benefit Manager (PBM) Legislation.* November 17, 2023. WMC & MMAC. Available at: https://media.wmc.org/wp-content/uploads/2023/11/17103240/WMC-MMAC-Memo-on-LRB-1683.pdf.

[12] We remind legislators that, while states can regulate fully-insured health insurance products, they are generally preempted from regulating self-funded ERISA plans. Accordingly, states do not have open-ended approval for pharmacy benefit regulation in general.

[13] The Legislative Council summary of 2021 Wisconsin Act 9 can be found here.

- OCI may revoke, suspend, or limit the license of a PBM for unprofessional conduct, based on a finding that the PBM:
  - Is unqualified to perform responsibilities.
  - Has repeatedly or knowingly violated an applicable law, rule, or order.
  - Has methods or practices that endanger the interests of the enrollees or the public.
  - Has inadequate financial resources to safeguard the interests of the enrollees or the public.
- PBMs must submit annual reports to OCI that contain, for contracted Wisconsin pharmacies:
  - The aggregate rebate amount that the PBM received from all pharmaceutical manufacturers but retained and did not pass through to health benefit plan sponsors.
  - The percentage of the aggregate rebate amount that is retained rebates.

Regulating Business Interactions Between PBMs & Pharmacies

- PBMs are prohibited from changing their pharmacy accreditation requirements more frequently than once every 12 months, and must, in response to a request from a pharmacy, provide any certification or accreditation requirements used as a determinant of network participation.
- PBMs (and health insurance providers) must follow the following statutory parameters for conducting audits of pharmacies:
  - Refrain from paying an auditor based on a percentage of the amount recovered in an audit.
  - Provide at least two weeks' notice for onsite audits.
  - Refrain from conducting an audit during the first five business days of the month, unless the pharmacy agrees otherwise.
  - Conduct an audit by or in consultation with a licensed pharmacist if the audit involves clinical or professional judgement.
  - Limit review periods to claims submitted within two years of the audit, unless required otherwise by state or federal law.
  - Limit the audit review to no more than 250 separate prescriptions.
  - Allow pharmacies to use other providers' records to validate the pharmacy's records relating to delivery of a drug and to use any valid prescription to validate claims in connection with a prescription.
  - Allow pharmacies to use either paper or electronic signature logs to document the delivery of drugs or services.
  - In the case of on-site audits, provide a complete list of records reviewed before leaving the pharmacy.
  - Deliver a preliminary audit report, which must contain certain information specified by statute, within 60 days.
  - Allow pharmacies, within the 30 days following receipt of the preliminary report, to provide documentation to address any discrepancies found in the audit.
  - Deliver a final audit report within 90 days of the preliminary report or the date of the final audit appeal, whichever is later.
  - Establish and follow a written appeals process for a pharmacy to appeal the final audit report and arrange, at their own cost, an independent audit.
  - Maintain the confidentiality of the results of an audit.
- PBMs (and health insurance providers) must follow the following statutory parameters for recouping funds from pharmacies:

- Refrain from assessing recoupments or penalties related to an audit until the appeal process is exhausted and a final report has been delivered to the pharmacy.
- Refrain from accruing or charging interest between the time the notice of an audit is given and the final report is delivered to the pharmacy.
- Exclude dispensing fees from calculations of overpayments.
- Refrain from seeking recoupment or recovery for a clerical or record-keeping error in a required document or record, unless the error resulted in an overpayment.
- Refrain from retroactively denying or reducing an adjudicated claim unless:
  - The claim was submitted fraudulently.
  - The payment for the original claim was incorrect.
  - The services were not rendered.
  - The pharmacy violated state or federal law in making the claim or performing the service.
  - The reduction is related to a quality program and is permitted by the contract between the two entities.

Establishing Consumer Protections

- PBMs and health insurance providers must allow an enrollee to pay at the point of sale the lower of: 1) their cost-sharing for the drug under their insurance plan, or 2) the cash price. This is a protection that PBMs and health insurance providers supported, and it was an industry best practice before being required by state law.
- Codifies a federal prohibition on so-called "gag clauses," by specifying that PBMs and health insurance providers may not restrict or penalize a pharmacy from informing an enrollee of the difference between the individual's cost-sharing for the drug under their insurance plan and the cash price.
- Pharmacies must disclose to consumers:
  - A pharmacist's ability to substitute a less expensive drug product equivalent or interchangeable biological product unless the consumer or prescribing practitioner has indicated otherwise.
  - A list of the 100 most commonly prescribed generic drug product equivalents.
  - Information on how to access the Food and Drug Administration's (FDA) list of all currently approved interchangeable biological products.
  - The retail price, updated no less than monthly, of the 100 most commonly prescribed prescription drugs available for purchase at the pharmacy.
- PBMs and health insurance providers must, with some narrow, common-sense exceptions, provide 30 days advance notice to patients if a prescription drug they are using will be removed from their plan's formulary or reassigned to a benefit tier with higher cost-sharing. The notice must include information on the procedure for the patient to request an exception to the formulary change.
- Pharmacists must notify a patient if a prescription drug they are filling or refilling is removed from their plan's formulary and the health insurance provider or PBM has added to the formulary either: 1) a generic alternative, or 2) another prescription drug with the same mechanism of action that has been assigned the same or lower benefit tier (i.e., with lower cost-sharing) as the original drug. The pharmacist can also extend the original prescription for a 30-day supply if the patient has had an adverse reaction to the new drug.

As noted above, Act 9 was enacted into law on March 26, 2021. Many of the provisions took effect on June 30, 2021, but others did not become effective until policy and plan years that began on or after January 1, 2022. In the case of disclosures that must be made by pharmacies, the Pharmacy Examining Board's final rule implementing this provision (CR 23-015) was just transmitted to the Legislature on October 2, 2023, and has not yet cleared the committee review process.

Put differently, the ink is barely dry on 2021 Wisconsin Act 9, and Wisconsin legislators are already proposing to add more regulations on PBMs and health insurance providers.

Payer Concerns with Senate Bill 737

The first iteration of the legislation that became 2021 Wisconsin Act 9 was introduced in the 2019-2020 Legislative Session. The original version of that bill proposed not just to establish state authority to directly regulate certain PBM activities, but to fundamentally and harmfully overhaul prescription drug management in Wisconsin. Organizations representing health insurance providers and PBMs – the entities responsible for providing access to prescription drugs at a cost that individuals and employers can afford – raised strong concerns with the bill as drafted because of its negative impact on the many important dimensions of: cost; patient access; patient safety; market competition; pharmacy quality and value-based contracting; fraud, waste, and abuse; freedom of contract; and government regulation. Other stakeholders also raised concerns about the impact of the proposed legislation.

Stakeholder representatives, including our associations, met in good faith with legislators over the course of many months to reach a compromise: the bill that became 2021 Wisconsin Act 9. Now, some of the same stakeholders who supported the original version of the previous PBM bill are back with many of the same ideas the Legislature declined to pass out of concern for their harmful impact.

Because of the strong similarities between this session's PBM bill and the initial version of the previous PBM bill, as well as the incorporation of other mandates that health insurance providers and PBMs also oppose, many of our concerns do not materially differ from what we have previously conveyed to legislators. In addition to these longstanding concerns, we also have concerns about new provisions proposed in this session's PBM bill.

The remainder of this memo is dedicated to outlining our concerns in detail, organized by the following themes: cost and competition; quality of care; patient safety; fraud, waste, and abuse; and freedom of contract. Within these themes, we identify provisions of concern and provide the rationale for our opposition. In most instances, a provision is listed under more than one theme due to its broad implications.

Cost & Competition Concerns

Individually and collectively, most provisions in the PBM bill invoke significant cost and competition concerns. Eliminating health insurance provider and PBM tools to promote high-quality, lower-cost care will make the drug cost problem worse, not better, for employers and patients.

Provisions: 632.861(3g); 632.861(3r)(a); 632.865(5h)(c)

These provisions are very similar to items that were proposed in the initial version of the previous PBM bill but were ultimately removed due to concerns about their impact. (In fact,

proposed 632.861(3g) is identical to a provision that was negotiated out of the previous bill.[14]) We oppose these provisions for the same reasons we opposed them several years ago.

Specifically, these provisions prevent health insurance providers and PBMs from providing patients with incentives (i.e., lower cost-sharing) to use lower cost pharmacies, including mail-order and specialty pharmacies. Mail-order pharmacies have introduced competition into the retail pharmacy setting, with an increasing number of entities entering this market. Mail-order pharmacies are especially valued by employers as both a matter of convenience for their employees and as a cost-saving tool.[15] Under the PBM bill, higher cost pharmacies would not be incentivized to provide lower prices because a market pressure to do so would be removed. In addition, some patients' out-of-pocket costs would increase because they could no longer financially benefit from using lower cost pharmacies. Providing a patient with lower cost-sharing is a **reward**—not a penalty.

Further, in addition to removing patient incentives to use lower cost pharmacies, these provisions would prohibit health insurance providers and PBMs from requiring specialty drugs to be dispensed by a specialty pharmacy. As described earlier in this memo, specialty pharmacies dispense medications that are less commonly used, have serious side effects, and/or treat complex conditions. Specialty pharmacies have evolved to meet the unique requirements for dispensing specialty drugs, such as sophisticated storage conditions and processes for drug handling and dispensing. In addition, specialty pharmacy staff coordinate a patient's care by providing close monitoring, collecting data, and sharing that information between the patient's health care providers. Because of the unique requirements for the handling and dispensing of specialty drugs, specialty pharmacies are more appropriately thought of as competitors to outpatient drug administration sites rather than competitors to "brick and mortar" retail pharmacies. Specialty pharmacies are owned and operated by a variety of entities, including PBMs, wholesalers, providers, integrated delivery networks, and large chain pharmacies.

On top of providing these valuable, tailored services, specialty pharmacies can provide drugs at a significant discount, including through volume-based discounts. Although specialty medications comprise a small proportion of total prescriptions, they account for an outsized share of drug spending. This means that the discounts offered by specialty pharmacies lead to significant cost savings.[16]

Provision: 632.861(3r)(b)
This proposal would require health insurance providers and PBMs to completely ignore the many important factors that underpin contracting with individual providers – like the underlying

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[14] The Department of Employee Trust Funds (DETF) specifically addressed this provision in its fiscal estimate for the bill, noting that "the use of specialty pharmacies increases the quality of clinical services provided to participants and provides costs savings to the state due to negotiated prices with the preferred specialty pharmacy."
[15] *Concerns with LRB 1683, Pharmacy Benefit Manager (PBM) Legislation.* November 17, 2023. WMC & MMAC. Available at: https://media.wmc.org/wp-content/uploads/2023/11/17103240/WMC-MMAC-Memo-on-LRB-1683.pdf.
[16] DETF also addressed a provision with similar intent to 632.861(3r)(a) in its fiscal estimate for the initial version of the previous PBM bill, saying "The required use of specialty pharmacies increases the quality of clinical services provided to participants and provides cost savings to the state due to negotiated prices with the preferred specialty pharmacy. Projected savings for implementing this program for the 2018 plan year were $1.2 million. The changes proposed in this bill may limit savings to the program."

costs of goods and services provided by a pharmacy, the volume of goods and services provided, the quality of services provided, local market conditions, patient demand, and competition – and instead reimburse all pharmacies in the same network at the same rate. This one-size-fits-all approach will lead to increased costs for Wisconsin employers and employees, with no additional value provided.

Provisions: 632.861(4)(a); 632.861 (4)(e))
These proposals revisit negotiated provisions of 2021 Wisconsin Act 9 and advance a similar "frozen formulary" concept that was removed from the initial version of the PBM bill due to concerns about its impact, especially from employers.[17,18] We oppose these provisions for the same reasons we opposed them several years ago – they assume a static drug market that does not exist, and render health insurance providers and PBMs unable to respond to the changing market in real time.

The prescription drug market is dynamic, which means the relative cost, value, and safety of drugs is constantly in flux. New drugs (which may be a generic/biosimilar drug, a competing brand drug, or an over-the-counter drug) come to market on an ongoing basis, drug manufacturers increase the cost of their products multiple times each year, and safety or efficacy information on a drug may be updated.

Formularies deliver cost savings by making pharmaceutical manufacturers compete on value, which is delivering the best outcomes for the lowest net cost. When drug companies increase their prices multiple times each year, health insurance providers and PBMs may be forced to revisit their formularies to ensure drugs are available at an affordable price. **Under this proposal, drug manufacturers could increase their prices mid-year, or decline to provide mid-year price concessions if there is new competition, without consequences.**

Furthermore, if a new drug comes to market that costs less and is at least as effective or has a better safety profile than an existing option, patients should get the benefit of accessing that new drug at a lower price. There are usually many equivalent drugs to treat a condition, which are evaluated for inclusion and placement on a formulary by P&T Committees[19] based on the best-available evidence. When a formulary is adjusted, it is because a group of experienced clinicians have determined it is clinically appropriate.

Health insurance providers and PBMs make good faith efforts to minimize the frequency of formulary changes that adversely impact patient cost-sharing and/or access, and to minimize the impact of formulary changes on patients when they do occur. However, statutorily taking away

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[17] *Concerns with LRB 1683, Pharmacy Benefit Manager (PBM) Legislation.* November 17, 2023. WMC & MMAC. Available at: https://media.wmc.org/wp-content/uploads/2023/11/17103240/WMC-MMAC-Memo-on-LRB-1683.pdf.

[18] DETF also specifically addressed a similar "frozen formulary" provision in its fiscal estimate for the initial PBM bill, saying, "The state's PBM makes periodic updates to the formulary throughout the year when, for example, new drugs are introduced to the market, brand name drugs lose their patent rights, or drug manufacturer costs significantly fluctuate. This provides the PBM and the state program the ability to manage the formulary and is a tool to contain costs for the state's group health insurance programs."

[19] See page 2 of this memo additional information about P&T Committees.

the option to respond to changing market conditions, as the PBM bill proposes to do, will lead to increased costs.[20]

Provision: 632.862
We oppose this provision, which is a direct incorporation of Assembly Bill 103/Senate Bill 100 and relates to the application of third-party (i.e., drug manufacturer) prescription drug payments to health insurance cost-sharing requirements.

Drug manufacturers offer cost-sharing assistance, often in the form of copay coupons, for certain brand name drugs under the guise of helping patients afford their medications. Copay waivers obscure a drug's true cost, incentivize the use of high-cost drugs, and make pharmaceutical manufacturers less accountable for both their prices and price increases. **Imposing mandates on health plan benefit design does not address the root problem of drug manufacturers' high prices.**

Drug manufacturers often represent their cost-sharing assistance programs as being charitably designed. The reality is that these programs are an anti-competitive marketing tool used to circumvent prescription drug benefit design and drive sales of their product over other, usually lower cost, alternatives. Industry estimates suggest drug manufacturers earn a 4:1 to 6:1 return on copay coupon programs.[21]

Copay coupons hide the real cost of a drug by creating a divide between the purchase price and the consumer's out-of-pocket cost. With coupons, drug manufacturers have an incentive to raise prices and offer coupons to offset consumer cost sharing. This means coupons have the perverse and undesirable effect of undermining health insurance provider and PBM efforts to negotiate lower prices for patients – thus resulting in higher premiums.[22,23] In fact, the prices for drugs with manufacturer coupons increase faster (12-13% per year) compared to drugs without coupons (7-8% per year).[24]

Drug manufacturer assistance programs are not allowed under federal programs like Medicare and Medicaid because they are considered remuneration offered to induce the purchase of specific items and therefore violate federal anti-kickback laws. In an advisory bulletin[25] regarding copay coupons, the U.S. Department of Health and Human Services Office of Inspector General said the following:

> *"Cost-sharing requirements for Federal health care program drugs serve an important role in protecting both Federal health care programs and their*

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[20] *Estimated cost of potential "frozen formulary" legislation.* January 25, 2021. Milliman. Available at: https://www.pcmanet.org/wp-content/uploads/2021/02/Milliman_Frozen-Formulary-Report_FINAL.pdf.
[21] *When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization.* October 2016. Dafney, L. et al. Available at: https://www.nber.org/system/files/working_papers/w22745/w22745.pdf.
[22] *Copay Assistance for Expensive Drugs: A Helping Hand That Raises Costs.* October 11, 2016. Ubel, P. & Bach, P. Available at: https://www.acpjournals.org/doi/abs/10.7326/M16-1334?journalCode=aim.
[23] *Eliminating Prescription Drug Copay Coupons.* Dafney, L. et al. Available at: https://onepercentsteps.com/wp-content/uploads/brief-epdcc-210208-1700.pdf.
[24] *When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization.* October 2016. Dafney, L. et al. Available at: https://www.nber.org/system/files/working_papers/w22745/w22745.pdf.
[25] *Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons.* September 2014. U.S. Department of Health and Human Services Office of Inspector General. Available at: https://oig.hhs.gov/documents/special-advisory-bulletins/878/SAB_Copayment_Coupons.pdf.

beneficiaries. These cost-sharing requirements promote: (1) prudent prescribing and purchasing choices by physicians and patients based on the true costs of drugs and (2) price competition in the pharmaceutical market. While copayment coupons provide an immediate financial benefit to beneficiaries, they ultimately can harm both Federal health care programs and their beneficiaries. The availability of a coupon may cause physicians and beneficiaries to choose an expensive brand-name drug when a less expensive and equally effective generic or other alternative is available. ***When consumers are relieved of copayment obligations, manufacturers are relieved of a market constraint on drug prices. Excessive costs to Federal programs are among the harms that the anti-kickback statute is intended to prevent*** *(emphasis added)."*

The prohibition on the use of copay coupons in Medicare, even for a drug that does not have an FDA-approved pharmacological treatment alternative (a scenario that would apply to commercial plans under Assembly Bill 103/Senate Bill 100 and the proposed PBM bill), was recently affirmed by the U.S. Court of Appeals in *Pfizer v. HHS*.[26]

Finally, no health care provider in Wisconsin is permitted to offer the kind of copay waivers that pharmaceutical companies provide. Doing so would constitute a violation of Wis. Stat. 146.905, as well as federal anti-kickback and civil monetary penalty laws. The Office of the General Counsel of the Wisconsin Medical Journal has advised health care providers, "Do not offer routine waivers of copays and deductibles" and "Give only very small gifts to patients," to avoid violating state and federal law.[27] Drug manufacturers' copay coupons certainly do not abide by this guidance.

Copay coupons deliberately circumvent health insurance provider and PBM efforts to encourage equally effective, lower cost treatments. State law should not legitimize the use of copay coupons, nor force employers and employees to bear the increased costs that result from their use.

Provisions: 632.865(1)(an), (aq) & (at); 632.865(1)(bm); 632.865(1)(cr), 632.865(2); 632.865(2d)

Pharmacies are reimbursed by PBMs for generic drugs via maximum allowable cost (MAC) lists. Multiple drug manufacturers may make clinically identical generic products – but the price of the product, and thus a pharmacy's acquisition cost, can differ across manufacturers and wholesalers. MAC lists cap the amount a PBM will reimburse a pharmacy for clinically identical products and thus encourage pharmacies to buy their inventory as efficiently as possible. To purchase generic drugs at a greater discount, independent pharmacies may join larger buying groups and/or pharmacy services administrative organizations (PSAOs) to use their pooled purchasing power.

PBMs do not control how and from whom retail pharmacies purchase their drug inventory. But MAC reimbursement helps ensure that health insurance providers and PBMs – and, ultimately, employers and their employees – do not over-pay for drugs that are clinically the same. The MAC will change frequently in response to the complex and dynamic nature of market pricing

[26] The court opinion can be found here: https://cases.justia.com/federal/appellate-courts/ca2/21-2764/21-2764-2022-07-25.pdf?ts=1658759410.

[27] *Five Things Every Physician Needs to Know About Freebies and Discounts.* 2010, Volume 109, No. 4. Wisconsin Medical Journal. Available at: https://wmjonline.org/wp-content/uploads/2010/109/4/233.pdf.

for generic drugs. MAC prices are driven by competitive factors, including how long the drug has been generic, how many manufacturers are making generic versions, how available the generic drug is for purchase, and whether there have been manufacturing challenges like access to basic ingredients or product recalls. To determine a fair and up-to-date reimbursement rate for generic drugs, PBMs frequently survey market data to calculate the average acquisition cost for those drugs.

Since 2015, PBMs have been required under Wisconsin law[28] to include certain pricing transparency practices in their contracts with pharmacies, including:

- Updating MAC pricing information at least every 7 business days and providing a means for contracted pharmacies to promptly review pricing updates in a readily available and accessible format.
- Reimbursing pharmacies subject to MAC pricing that has been updated at least every 7 business days.
- Eliminating prescribed drugs or devices from the MAC or modifying the MAC in a timely fashion, consistent with drug availability and pricing changes.
- Providing a process for a pharmacy to appeal, investigate, and resolve disputes regarding MAC pricing that includes all of the following:
    - A 21−day limit on the right to appeal following the initial claim.
    - A requirement that the appeal be investigated and resolved within 21 days after the date of the appeal.
    - A dedicated phone number at the PBM for the pharmacy to speak to a person responsible for processing appeals.
    - A requirement that a PBM provide a reason for any appeal denial and the FDA's national drug code for the drug that may be purchased at or below the MAC price.
    - A requirement that a PBM make a pricing adjustment no later than one day after the date of the final determination of the appeal.

The PBM bill abandons the current market-driven framework, which balances competition with parameters for fair pricing and disclosure, and instead creates an environment that actively discourages pharmacies from being efficient purchasers of generic drugs. Most notably, the proposed legislation mandates that PBMs reimburse pharmacies at-cost in certain circumstances. If a pharmacy is guaranteed reimbursement at or above their acquisition cost, no matter what that acquisition cost is and if a lower-cost option could have been purchased instead, employers and their employees will bear the unnecessary expense of a higher price for an identical product. We oppose proposals that will result in this negative outcome.

We are also concerned about the impact 632.865(2d)(e) would have on patient access by allowing pharmacies to decline to dispense a drug if the pharmacy would be reimbursed less than its acquisition cost. As described previously, MAC lists cap the amount a PBM will reimburse a pharmacy for clinically identical products and thus encourage pharmacies to buy their inventory as efficiently as possible. Patients should not be penalized because a pharmacy did not purchase a drug efficiently.

Provisions: 632.865(1)(cg); 632.865(2d)(d)

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[28] Wis. Stat. 632.865 (2)

This session's PBM bill revisits a concept negotiated out of 2021 Wisconsin Act 9, which is a prohibition on PBMs reimbursing a pharmacy less than the amount the PBM reimburses an affiliate for providing the same product. The bill specifies that a PBM is required to compare the amounts calculated on a per unit basis based on the same generic product identifier or generic code number.

We oppose this proposal for the same reasons we opposed a similar provision in the initial version of the previous PBM bill – because contracts differ between pharmacies due to private negotiations and they are not always readily comparable at the drug level. Pharmacy contracts also differ by the method of determining "discounts." Without the ability to have different payment terms, PBMs would need to resort to pricing calculations that would fail to take into account all of the nuances of different pharmacies, resulting in higher overall prices for the sake of comparability. Further, this proposal effectively eliminates negotiations by requiring all contracted payments to be the same. A robust, competitive pharmacy market cannot exist under this provision.

Provision: 632.862(2h)
Dispensing fees are designed to cover reasonable costs associated with the dispensing of a drug. The PBM bill would require PBMs to pay a dispensing fee that is no less than the dispensing fee paid under Wisconsin's Medicaid program, which is currently $15.69 for a total annual prescription volume of 34,999 or less and $10.51 for a total annual prescription volume of more than 35,000.[29] Because of differences in how pharmacists are reimbursed in Medicaid versus the commercial market, these amounts are well above the average commercial market dispensing fee of $2.[30] Mandating minimum dispensing fees, especially at such a significantly higher amount than is currently negotiated in the commercial market, will result in millions of dollars in increased costs to Wisconsin employers and employees, with no additional value provided. We oppose this provision.

Provisions: 632.865(1)(ab) & (ac); 632.865(5d)
The federal 340B program was designed for drug manufacturers to provide discounts on outpatient drugs to qualifying safety net providers – such as federally qualified health centers, Ryan White HIV/AIDS Program Grantees, Medicare/Medicaid Disproportionate Share Hospitals, and children's hospitals – so they can stretch their resources and offer services to low-income and uninsured populations. The PBM bill prohibits PBMs from taking certain actions with respect to 340B covered entities, pharmacies and pharmacists contracted with 340B covered entities, and patients who obtain prescription drugs from 340B covered entities.

Because drugs are purchased by providers at a steep discount under the 340B program, claims for those drugs do not qualify for additional price concessions that would otherwise be provided to health insurance providers and PBMs by a drug manufacturer. This means that health insurance providers and PBMs sometimes pay more than their usual contracted price for drugs purchased through the 340B program. Health insurance providers and PBMs should not be

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[29] See ForwardHealth website: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=48&s=5&c=30&nt=Covered+Outpatient+Drug+Reimbursement%3A+Professional+Dispensing+Fees.

[30] *Mandating Pharmacy Reimbursement Will Increase Prescription Drug Spending.* August 31, 2021. PCMA. Available at: https://www.pcmanet.org/mandating-pharmacy-reimbursement-increase-spending/.

required to pay higher than their usual rates, especially when the drugs are being purchased at a discount, as would be required under the PBM bill. Rather, health insurance providers and PBMs should be able to continue to manage networks and reimbursement models to reduce the overall cost of prescription drugs.

Provisions: 632.865(5h)(a) & (b); 632.865(5t)
This session's PBM bill revisits the "any willing provider" concept that was negotiated out of 2021 Wisconsin Act 9 in response to concerns about its impact, especially from employers.[31]

PBMs create networks of pharmacies that offer savings to employers and their employees by securing discounted rates in exchange for higher patient volume. Nationally, 76% of employers report using some type of narrowed pharmacy network, and their employees can save 38% out-of-pocket using the in-network pharmacies versus out-of-network pharmacies.[32] The PBM bill requires PBMs to contract with any pharmacy that can meet the contract terms, interfering both with the freedom of contract and PBMs' ability to secure cost savings for employers and employees. For these reasons, we oppose "any willing provider" proposals.

Quality of Care Concerns
Health insurance providers and PBMs play an important role in facilitating high-quality patient care through accreditation standards, quality standards, and network design. The proposed PBM bill takes several steps to remove health insurance providers and PBMs from this role.

Provision: 632.865(4)(b)
This session's PBM bill revisits a concept negotiated out of 2021 Wisconsin Act 9, which is a prohibition on PBMs requiring a certification or accreditation that is inconsistent with or more stringent than federal and state requirements for pharmacy licensure. We oppose this proposal for the same reason we opposed a similar provision in the initial version of the previous PBM bill – because health insurance providers and PBMs should be free to require higher standards for their patients, rather than being statutorily required to accept the lowest common denominator.

Health insurance providers and PBMs often voluntarily seek or are required by government programs to obtain accreditation from independent entities such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC). These entities measure quality across many dimensions, including clinical performance (e.g., quality management and improvement, population health management, health equity) and consumer experience. To achieve the high standards of care required by these entities, health insurance providers and PBMs may in turn require pharmacies to adhere to certain practices and standards. The PBM bill would impede these quality improvement efforts and cause health insurance providers and PBMs in Wisconsin to fall behind their peers nationally.

We are especially concerned about the impact of this proposal on the dispensing of specialty drugs. Again, drug manufacturers' pricing power and the unique features of specialty drugs have caused these drugs to be some of the most expensive available. Specialty pharmacies have arisen in response to these pressures and have further evolved to adopt standards that improve quality

[31] See WMC and MMAC's November 17, 2023, memo to members of the Wisconsin Legislature, "Concerns with LRB 1683, Pharmacy Benefit Manager (PBM) Legislation."
[32] *Unlocking an Affordable Future*. January 2023. PCMA. Available at: https://www.pcmanet.org/wp-content/uploads/2023/01/PCMA-Affordable-Future-whitepaper_FINAL.pdf.

of care and safety for patients. Simply being licensed to operate a pharmacy does not demonstrate the level of operational capability and quality of service that is required for the handling and dispensing of specialty drugs. Specialty pharmacy accreditation programs established by independent entities like NCQA and URAC set important standards for best practices for patient-centered care and help pharmacies be equipped to enter value-based payment arrangements that reward quality.

Finally, whether to meet accrediting body standards or to voluntarily drive better patient outcomes, health insurance providers and PBMs currently can negotiate with pharmacies to establish quality programs or performance-based contracting. Such programs and contractual arrangements are common across the entire health care system as a means to encourage high-quality, high-value services. Health insurance provider and PBM arrangements with pharmacies may include disease state or medication-specific pharmacist training for high-cost and rarely used medications, or patient outcomes management programs and quality metric reporting. These activities indicate a consistent commitment to safe, coordinated, and quality patient care.

Provision: 632.861(3r)(a)
This provision would prohibit health insurance providers and PBMs from requiring specialty drugs to be dispensed by a specialty pharmacy. As we have described throughout this memo, specialty pharmacies dispense medications that are less commonly used, have serious side effects, and/or treat complex conditions. Specialty pharmacies have evolved to meet the unique requirements for dispensing specialty drugs and coordinate a patient's care, and often meet quality standards set by independent entities. We oppose this provision out of concern that it will lead to lower quality care for patients who need specialty drugs.

Provisions: 632.865(5)(e); 632.865(6r)
These provisions repeal a statutory parameter that was agreed to in negotiations over 2021 Wisconsin Act 9, and reverse course from that language to prohibit a PBM from basing "any criteria of a quality program…on a factor for which the pharmacy does not have complete and exclusive control." We oppose these changes.

As mentioned above, health insurance providers and PBMs are held to high quality standards by national accrediting bodies, not to mention the expectations set by employers and government programs for the quality of care their enrollees receive. Health insurance providers and PBMs must work with all their contracted providers, including pharmacies, to meet these standards and deliver the high-value care that patients deserve. Health insurance providers, PBMs, and many types of health care providers are routinely evaluated on – and held financially accountable for – quality factors over which they do not have "complete and exclusive control." Quality programs should be fair, achievable, and oriented toward delivering high-value care – but it is disingenuous to suggest that it is appropriate or desirable for quality programs to only include measures that are completely controllable by a single entity.

Provisions: 632.865(1)(cg); 632.865(2d)(d)
This session's PBM bill revisits a concept negotiated out of 2021 Wisconsin Act 9, which is a prohibition on PBMs reimbursing a pharmacy less than the amount the PBM reimburses an affiliate for providing the same product. We oppose this proposal for the same reason we opposed a similar provision in the initial version of the previous PBM bill – because it would

interfere with innovative pay-for-performance contracting, which rewards high-performing pharmacies for activities such as improving patient medication adherence or reducing gaps in patient treatment. These value-based activities benefit patients by ensuring safety, improving outcomes, and reducing costs. Value-based, quality-driven contracting focuses on improving patients' health outcomes and should be supported—not obstructed like it is under this bill.

Patient Safety Concerns

In addition to playing a role in promoting high-quality patient care, health insurance providers and PBMs also routinely take steps to help ensure patient safety. The proposed PBM bill inhibits these efforts in several ways.

Provisions: 632,861(4)(a); 632.861 (4)(e))

These proposals revisit negotiated provisions of 2021 Wisconsin Act 9 and advance a similar "frozen formulary" concept that was removed from the initial version of the PBM bill. We oppose these provisions for the same safety concerns we opposed them several years ago – because the known risks and benefits of a drug change over time, and health insurance providers and PBMs need to be able to respond to prescription drug safety and efficacy data in real time.

For example, additional safety concerns can emerge after a new drug is brought to market and used on a broader, more diverse population than was tested in clinical trials. Based on new data, a drug can be labeled with new safety warnings or even pulled from the market. Health insurance providers and PBMs take safety concerns seriously, and should be able to expeditiously change their formularies when new data emerge in order to favor drugs that have less dangerous side effects or are comparatively more effective. The PBM bill gives no consideration to and no exceptions for these kinds of circumstances.

Provision: 632.861(3r)(a)

This provision would prohibit health insurance providers and PBMs from requiring specialty drugs to be dispensed by a specialty pharmacy. As we have described throughout this memo, specialty pharmacies dispense medications that are less commonly used, have serious side effects, and/or treat complex conditions. Specialty pharmacies have evolved to meet the unique requirements for handling and dispensing specialty drugs, typically help coordinate a patient's care, and often meet quality standards set by independent entities. Typical retail pharmacies are often not equipped to meet the higher-than-normal standards for specialty drugs to ensure patient safety. Because of the unique requirements for the handling and dispensing of specialty drugs, specialty pharmacies are more appropriately thought of as competitors to outpatient drug administration sites rather than competitors to "brick and mortar" retail pharmacies. We oppose this provision out of concern for its potential impact on patient safety.

Provision: 632.865(4)(b)

This session's PBM bill revisits a concept negotiated out of 2021 Wisconsin Act 9, which is a prohibition on PBMs requiring a certification or accreditation that is inconsistent with or more stringent than federal and state requirements for pharmacy licensure. Again, we are concerned about the impact of this proposal on the dispensing of specialty drugs. Simply being licensed to operate a pharmacy does not demonstrate the level of operational capability and quality of service that is required for the handling and dispensing of specialty drugs. Specialty pharmacy accreditation programs established by independent entities like NCQA and URAC set important standards that play a role in helping keep patients who take specialty drugs safe.

Fraud, Waste & Abuse Concerns
This session's PBM bill revisits several of the same provisions that were negotiated out of the initial version of the previous PBM bill, as well as expands upon the audit requirements that were included in 2021 Wisconsin Act 9 (as a reminder, page 5 of this memo describes the audit requirements PBMs must follow under current law). Health insurance providers and PBMs raised concerns about the audit requirements proposed in the last PBM bill because extremely prescriptive parameters on audit procedures detract from efforts to safeguard individual, employer, and government program dollars from fraud, waste, and abuse. We have similar concerns with this session's PBM bill *(provisions: 632.865(6)(bm); 632.865(6)(c)3; 632.865(6)(c)3m; 632.865(6g); 632.865(8)).*

For example, the bill prohibits funds from being recouped for errors that have no "actual financial harm" (which is not defined under the bill) to the enrollee, policy, or plan unless the error is the result of failure to comply with a corrective action plan. We oppose this provision because it would prohibit PBMs from holding pharmacies responsible for common errors, not complying with applicable laws and rules, and/or contributing to waste or abuse. All health care organizations, including pharmacies, are held responsible for errors through audits and recoupment.

As another example, the bill prohibits the use of extrapolation to calculate recoupments. We oppose this provision because extrapolation can benefit everyone by avoiding the resource- and time-intensive alternative of auditing **all** claims. Auditing a sample of claims and projecting those findings saves all parties significant time and money. Furthermore, this provision effectively absolves pharmacies from the financial consequences of their errors, because the circumstances under which a recoupment or penalty can be applied are significantly narrowed. This provision would likely result in higher costs from fraud, waste, and abuse.

Finally, the bill introduces a new legal avenue through which pharmacies can claim "retaliation" from PBMs if they engage in normal business practices like terminating or refusing to renew a contract or requiring additional audits. This not only raises freedom of contract concerns, but also increases the chances for frivolous lawsuits by bad actors, who could levy a "retaliation" charge against PBMs when they take necessary steps to investigate and/or address fraud, waste, or abuse.

Freedom of Contract Concerns
As did the initial version of the previous PBM bill, this session's PBM bill inappropriately imposes requirements on contracts that are freely negotiated between private parties. We oppose the following provisions for other reasons mentioned elsewhere in this document, and we also oppose these provisions because they represent government interference with freedom of contract:

- 632.861(3r)(b)
- 632.862(2h)
- 632.865(1)(ab) & (ac)
- 632.865(1)(an), (aq) & (at)
- 632.865(1)(bm)
- 632.865(1)(cg)
- 632.865(1)(cr)

- 632.865(2)
- 632.865(2d)
- 632.865(2d)(d)
- 632.865(2p)
- 632.865(4)(b)
- 632.865(5d)
- 632.865(5)(e)
- 632.865(5h)(a) & (b)
- 632.865(5t)
- 632.865(6)(bm)
- 632.865(6)(c)3m
- 632.865(6g)
- 632.865(6r)

Conclusion

We appreciate the opportunity to share our perspective on the many harmful impacts of the PBM bill. Prescription drugs are a vital and increasingly expensive component of health care benefits, which means payers must carefully balance costs, affordability, access, and quality of care. Through this memo, we have attempted not only to convey our concerns with the PBM bill, but also describe the complexity of the prescription drug supply chain and management of prescription drug benefits. Many interdependent market forces – not just PBMs, as bill proponents claim – make the prescription drug industry generally and the pharmacy industry specifically a competitive, and at times challenging, business environment. Legislative mandates imposed in the name of protecting a specific market player – in this case, independent pharmacies – are a blunt and ineffective approach that always have spillover effects. In this case, those effects would be felt directly by Wisconsin employers and employees who already struggle to afford their health care costs.

WMC
Wisconsin's Chamber

MMAC
METROPOLITAN MILWAUKEE
ASSOCIATION OF COMMERCE

TO: Members, The Wisconsin Legislature

FROM: Rachel Ver Velde, Senior Director of Workforce, Education and Employment Policy, Wisconsin Manufacturers & Commerce
Andrew Davis, Vice President of Governmental Affairs, Metropolitan Milwaukee Association of Commerce

DATE: February 14, 2024

RE: Concerns with Assembly Bill 773, Pharmacy Benefit Manager (PBM) Legislation

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The high cost of health care has consistently been a top concern of our organizations' membership over the years – and for good reason. Wisconsin's healthcare costs are higher than the national average[1]. According to WMC's most recent *Wisconsin Employer Survey* from January of this year, making healthcare more affordable is the top policy action state government can take to help businesses in Wisconsin[2]. In the same survey, almost 3 in 10 employers saw health care costs increase by more than 10% in the last year alone.

A large driver of increased health care costs are prescription drugs, particularly for employers. Prescription drugs account for 16.1% of fully insured private health plan premiums after rebates[3]. Our members are taking innovative approaches to control the costs of health care and prescription drugs for their employees. Unfortunately, we have concerns that this legislation will have the opposite effect for employers and their employees.

In particular, we are concerned with a few provisions contained within the proposed pharmacy benefit manager (PBM) legislation:

> **Any Willing Provider**. Any-willing-provider (AWP) mandates require health plans to contract with any health provider or pharmacy group willing to meet the plan's contract terms. Besides going against the basic right to contract, these mandates would make it nearly impossible to negotiate favorable payment rates with a pharmacy in exchange for guaranteed patient volume. Requiring health plans to contract with any willing provider greatly diminishes employers and health plans' ability to obtain price discounts. The cost of the drugs will only go up under any-willing-provider

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[1] RAND Corporation, Prices Paid to Hospitals by Private Health Plans: https://www.rand.org/pubs/research_reports/RRA1144-1.html

[2] Wisconsin Manufacturers & Commerce, Wisconsin Employer Survey, Summer 2023: https://www.wmc.org/wisconsin-employer-survey/

[3] Peterson-KFF, Health System Tracker: https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#Retail%20drugs%20as%20a%20share%20of%20national%20health%20spending%20and%20as%20a%20share%20of%20fully-insured%20private%20health%20plan%20premiums,%202021

mandates. We've seen this play out in the worker's compensation system. If you limit a payer's ability to bargain based on volume, prices rapidly increase.

Restricting Mail Order Pharmacies. Mail-order pharmacies are often lower-cost and more convenient for patients, especially those with chronic conditions or who live in rural areas. Every employer wants to offer the best and most comprehensive health care and prescription drug benefit plans they and their employees can afford, and mail order pharmacies are often utilized to help drive costs down. Restricting mail order pharmacies would make access to prescription drugs more expensive, resulting in workers and their families losing their prescription drug benefit.

Frozen Formulary. Assembly Bill 773 contains a "frozen formulary" provision. At first glance this may seem good for patients, but in reality, it will increase costs. According to a 2021 study by Milliman, a frozen formulary provision would increase prescription drug costs in the fully insured commercial health insurance market by about $4.3 billion to $7.1 billion over five years[4]. Marketplace events occur throughout the year that impact the price of prescription drugs. By implementing a frozen formulary, payers and plans will be limited in their ability to take advantage of new reduced prices, generic drug launches, new medications, new over-the-counter medications, or manage utilization to the best of their abilities. Freezing costs is the failed idea that the Affordable Care Act was centered on, and it should not be replicated in the prescription drug marketplace.

Drug Manufacturing Coupons. Drug manufacturers offer "coupons" to patients to encourage usage of their name brand, higher cost drugs instead of lower cost alternatives. This legislation would require PBMs and health plans to apply drug coupons to satisfy patients' deductibles and out-of-pocket maximums. This will put in place a pricing scheme that allows drug coupons to cover high prices for consumers until the full costs are shouldered by health plans and employers. This drives up the cost of health care benefits for employers and employees, including for employees that do not utilize these high-priced drugs.

ERISA Plans. Self-funded health plans make up 68% of employer-sponsored coverage. The federal Employee Retirement and Income Security Act (ERISA) regulates these plans. This bill applies to ERISA plans due to the restrictions it places on PBMs. This is concerning for self-insured employers that are trying to innovate and control costs for their employees.

The first three provisions mentioned above were initially included in PBM legislation that was proposed in the 2019-2020 legislative session. A compromise bill was passed in the 2021-2022 legislative session (2021 Act 9) that removed these provisions at the request of employers. These provisions were removed because employers were concerned that they would raise costs for them and their employees.

Employers want to provide affordable, high quality health care to their employees and their families, including pharmaceutical benefits. PBMs are a part of the employer solution to manage the costs. PBMs negotiate price discounts, saving employers and their employees millions on their annual prescription drug spend. In order to do so, however, they must be free to work in the marketplace without unnecessary government regulation. PBMs need to be able to contract with providers willing to negotiate the best

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[4] Milliman Report, Estimated Cost of Potential "Frozen Formulary" Legislation: https://www.pcmanet.org/wp-content/uploads/2021/02/Milliman_Frozen-Formulary-Report_FINAL.pdf

price and adjust their pricing structure in real time in response to marketplace conditions that may move drug prices up and down.

WMC and MMAC are very concerned with the addition of these provisions to this legislation. We ask that you do not support this legislation.

Wisconsin Manufacturers & Commerce (WMC) is the largest general business association in Wisconsin, representing approximately 3,800 member companies of all sizes, and from every sector of the economy. Since 1911, WMC's mission has been to make Wisconsin the most competitive state in the nation to do business.

The Metropolitan Milwaukee Association of Commerce (MMAC) has been serving area businesses as a private, not-for-profit organization for more than 150 years. Today the MMAC represents 1,800+ member businesses with more than 300,000 employees in Milwaukee, Waukesha, Washington and Ozaukee counties and beyond.

NAVITUS

February 13, 2024

Chair Clint P. Moses, Vice-Chair Rozar,
& Members of the Health, Aging and Long-Term Care Committee
Room 12 West
State Capitol
PO Box 8953
Madison, WI 53708

RE: 2023 ASSEMBLY BILL 773

Dear Chair Moses, Vice-Chair Rozar, and members of the Health, Aging and Long-Term Care Committee:

Thank you for the opportunity to provide written comment on Assembly Bill 773. In December, we had the privilege of testifying before Chairwoman Felzkowski and members of the Insurance and Small Business Committee on this matter. Unfortunately, due to scheduling we are not able to attend the hearing so we appreciate your acceptance of these written comments.

We appreciate your dedication to the citizens of Wisconsin. As a transparent PBM who returns 100% of manufacturer rebates and fees that we receive directly to our plan sponsors, has never engaged in pharmacy spread, and focuses on health outcomes and affordability, we know the complicated landscape that is health care. We at Navitus have had the privilege of serving Wisconsin for over 20 years. We currently provide pharmacy benefits for nearly 621,000 citizens of Wisconsin, including:

- The Wisconsin Employee Trust Fund
- Universities
- Fully insured health plans
- Exchange plans
- Self-funded plans
- Cities, towns, and school districts

NAVITUS

Although many of our comments are in opposition of this bill in its current form, we express our sincere desire to collaborate with the Committee, Legislature, and interested parties, to achieve meaningful improvements and access to quality healthcare in Wisconsin. We are supportive of some of the provisions in this bill, in particular:

- The audit provisions; and,
- The transparency provisions - including payments to consultants or brokers.

Our concerns are focused on cost to individuals paying premiums, employer/plan sponsors, and overall cost to taxpayers. The conservative estimates are more than $110 million dollars of increased costs to our clients and their members.

Choice of Provider

This provision appears to limit the ability of a plan sponsor - even one that is a health provider themselves - to limit its network or provide incentives to utilize preferred pharmacies, including their own in-facility pharmacies (think hospital plans). A plan sponsor whether they are a state, commercial employer, city or town, hospital, or university (among others) should be allowed the choice and ability to control quality and costs in a constructive manner. Additionally, plan sponsors rather than PBMs choose cost-sharing, network access and co-pays as part of their plan design.

Pharmacy Networks Provision

A requirement for to pay all pharmacies the same rate will increase plan costs. This provision does not take into account the cost differences experienced in rural or underserved areas versus larger chain pharmacy retailers who are likely to experience economies of scale. In essence, plan sponsors could be faced with limiting networks to larger retail chain pharmacies that agree to lower reimbursements and exclude independent pharmacies altogether; since Including them and paying a higher rate would force the employer to pay all pharmacies a higher rate. We suspect this is not the intention of this language. Furthermore, accommodation for additional patient management, enhanced precautions, and delivery of life saving drugs is not taken into account for specialty pharmacies.

NAVITUS

Minimum Dispensing Fees

Estimated financial impact of an established minimum dispensing fee is as follows:

- The Wisconsin Employee Trust Fund: between $18.8 million and $20.1 million
- Total among all Navitus clients, including cities, towns, and self-funded plans: between $47.6 million and $51.4 million.

Formulary

The notice requirement and restriction on changing formulary throughout the year prevents innovation and adaptability to the developing drug market that has been increasing the availability of biosimilar and generic drugs. Limiting formulary updates to renewal imposes significant costs for Wisconsin plan sponsors and more importantly members, who would not be able to take advantage of lower cost biosimilars or generics:

1) The estimated cost of this is $30 million for the entire book of Navitus business in the state due to delayed moves to generic or biosimilars; and,
2) Administratively, it forces plans to maintain 14 possible different formularies throughout the year. This could lead to confusion on behalf of pharmacies, members, and cause access issues for patients.

Continuity of Care – Amendment One

We oppose Amendment One. We believe that this will drive plan costs up, will not increase health outcomes, and is preempted by the Employees Retirement Income Security Act as it pertains to self-funded plans. We at Navitus have processes in place to grant medical exceptions to the formulary. This involves reviewing medical information, coordinating with physicians, and evaluating best outcomes for the patient. This process is a best practice that is governed by both the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Committee (URAC). Such a regulation would limit the plan sponsor's ability to take advantage of lower drug cost options after review. We have found that it is both clinically and financially responsible to require a trial of the lower cost agent provided there are no contraindications.

NAVITUS

Copay Assistance Aggregator/Optimizer Ban

Copay assistance provided by pharmaceutical manufacturers assists patients in paying high drug costs. However, instead of lowering the costs of these drugs for everyone, manufacturers seek to maintain an overall high drug cost and take advantage of citizens and plan sponsors by crediting the coupons to the overall high deductible or out of pocket maximum. This can often be met with one coupon or treatment. Subsequent treatments would be shouldered by the plan sponsor, taxpayers, and other members the following year as the cost for the plan is significantly increased. It is worth noting that as soon as the out of pocket or deductible is met, the patient no longer qualifies for the coupon and the overall cost of the drug is not lowered. Copay assistance optimizer programs seek to take full advantage of the generous marketing budget allocation for the benefit of both the patient and the employer. The numbers and impact are staggering. Further there is a disparate impact as patients who have significant conditions, need surgeries, or extensive therapy are denied the benefit of the allocation of an expedited deductible or out of pocket maximization. The result of crediting coupons to coinsurance would result in the following increased costs:

Fully Insured Health Plans	$21,755,015
Public Sector (counties, towns, and school districts)	$1,971,531
Self-Insured	$9,765,113
Total Impact	$33,491,659

During the Senate hearing there seemed to be confusion on what PBMs, plan sponsors and even pharmacists retain as far as these payments. The coupon simply lowers the cost paid by the patient and the plan sponsor or employer. Patients receive this benefit and are simply required to meet their deductible and/or out of pocket costs with payments made by them as any other member of that plan.

NAVITUS

Accreditation Requirements

Although we do not support unnecessary accreditation requirements that could be used as a barrier to entry for independent pharmacies, we do believe that meaningful accreditation requirements support high quality of care, particularly for patients with rare and difficult to treat diseases. Specialty pharmacy accreditation ensures a standard of care where enhanced pharmacist support and stricter storage/shipment/administration protocols should apply. We have discussed this with the Pharmacy Society of Wisconsin and are willing to work on amendments that support this goal.

Navitus does have a wholly owned specialty pharmacy with headquarters here in Madison called Lumicera. Similar to the Navitus PBM model, Lumicera is transparent and has operated as a cost-plus specialty pharmacy for nearly 10 years. Lumicera serves approximately 6700 patients in Wisconsin. Although these patients comprise less than 1% of the population, they are among the sickest, often suffering from rare and/or difficult to treat medical conditions. Lumicera provides critical care with compassion and expertise that yield better health outcomes due to higher adherence rates, clinical expertise, and patient copay support resulting in a best-in-class Net Promotor Score of 84. Lumicera also works to decrease costs to plan sponsors through innovative programs, clinical care coordination, the use of data analytics and insights, and our partnership through a cost-plus pricing approach.

Specialty pharmacies are able to provide the enhanced care necessary to save lives because they have the following, which are validated through the accreditation process:

- 24-hour access to pharmacists
- Clinical pharmacists and nursing staff who are trained and certified in care and even in specified diseases (allowing for tailored and compassionate care).
    - Complete care path explanation
    - Training on administration of medication and experience upon taking the medication, including contraindications and safety precautions
    - Storage and disposal instruction
    - Educations, community, and other resources available for patient advocacy
- Drug and disease state initial assessments with no time limit which-are comprehensive to ensure highest possible outcomes, the assessment focuses on overall health conditions, understanding of the medication and possible side effects and finally patient support access, including financial ability to acquire medication and possible options for support

NAVITUS

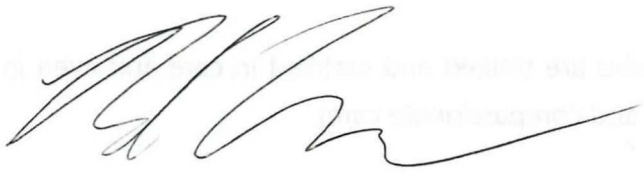
- Annual disease state reassessments
- Patients are supplied with supporting materials and items (free of charge) – swabs, bandages, sharps containers, syringes/needles.

We support meaningful accreditation that demonstrates expertise and commitment to the high level of quality care and the expertise to provide the necessary care required when dealing with rare and difficult to treat medical conditions. In specialty and rare disease pharmacy, quality and accreditation are essential. Clinical programs, service and quality metrics and the use of analytics are designed to ensure the best possible patient outcomes and the highest patient safety. An array of pharmacist clinicians certified in specialty pharmacy, oncology, and pharmacotherapy guide patients through therapy in conjunction with nurse clinicians and case workers. Patients seen by specialty pharmacies are 50% more likely to be adherent compared to those that use a retail pharmacy. Lack of adherence results in missed outcomes and wasted healthcare dollars, increasing the premiums for all of us.

We welcome any of the Committee members to tour our facility and would be pleased to discuss these important issues further.

Thank you for your time and commitment to the citizens of Wisconsin.

Respectfully submitted,



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COMMON GROUND
HEALTHCARE COOPERATIVE

Testimony Opposing Assembly Bill 773

Melissa Duffy, on behalf of Common Ground Healthcare Cooperative
Assembly Health Committee, February 14, 2024

Thank you Chairman Moses and members of the committee for allowing Common Ground Healthcare Cooperative submit testimony on Assembly Bill 773, which includes a number of provisions that would increase the cost of medications and overall coverage for consumers. While we are concerned about several of these provisions, we will narrow the scope of our testimony today to address only the drug coupon provisions that were originally introduced in separate legislation (AB 103) and that have now been rolled into AB 773.

Common Ground Healthcare Cooperative is a non-profit, member-governed insurance organization that does **not** have an ownership stake in a Pharmacy Benefit Manager (PBM). We primarily serve individuals who buy coverage for themselves because they do not have access to employer-sponsored, Medicaid or Medicare coverage. Affordability is our members' number one concern, and so we must stand up for our members when we see proposals like AB 773 that will impact what they pay for coverage.

Why Drug Coupons Exist

AB 773 includes a requirement on health plans and PBMs to count the value of drug coupons toward member deductibles and maximum out of pockets – an idea widely supported by drug manufacturers. Allow me to explain why drug manufacturers are pushing for this.

Drug manufacturers design copay coupons reduce or eliminate a patient's cost-sharing responsibilities, which doesn't simply make it easier to take expensive medications but incentivizes patients to get on and stay on these drugs. Importantly however, drug coupons do not lower the price that health plans pay for medications – the assistance effectively ends once a patient reaches their out-of-pocket maximum. So in essence, AB 773 allows drug manufacturers to spend a little money to make a lot more money. And while it is a benefit to the consumer taking the drug who no longer has any cost sharing responsibilities under their health plan, it is a costly proposition for everyone else covered by the plan. They are the ones that are paying more for these medications.

Drugmakers design coupons to drive utilization towards higher cost drugs when lower cost alternatives may be available, increasing overall costs that are ultimately passed onto ALL consumers in the form of higher premiums. Drug manufacturers will say they provide this assistance to help patients who cannot afford high-cost prescriptions. But Department of Health and Human Services' Office of Inspector General[1] says that the programs also are used to bolster prescription drug sales and prices and can increase costs for government and private payers. This is why they are considered an illegal kickback in federal programs.

If you read through the attached FAQ, you will find evidence that drugmakers see a rate of return on drug coupon assistance programs – they are a money-making scheme that should not be encouraged. We also include two visual representations of how drug coupons work, to help committee members better understand how coupons lead to higher priced health insurance coverage.

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[1] Office of the Inspector General Special Advisory Bulletin: https://oig.hhs.gov/documents/special-advisorybulletins/878/SAB_Copayment_Coupons.pdf

Why Copay Accumulator Programs Exist

Several years ago, our consumer-led board decided to implement a copay accumulator program across our plans, in part because it saved money for the cooperative which enabled us to offer lower priced coverage to all of our members. If legislation forces us to reverse this policy, our cooperative will have to raise its prices. This is not just a claim we make – we have the experience backed by actuarial science.

Copay accumulator programs enable health plans to count only the amount that an enrollee pays out of their own pocket for medications toward their deductibles and maximum-out-of-pockets, which are capped by federal law in most health policies today. Enrollees still benefit from the drug coupons or discount programs, but they must pay their fair share of their medical costs just like every other enrollee for every other covered benefit. Our members that receive a $60,000 knee replacement have to meet their deductible and out of pockets using their own funds. A member that has a heart attack and incurs a $220,000 emergency medical bill must do the same. A member that uses a coupon to pay for their $80,000 prescription still has to meet their deductible and out of pockets using their own funds under the copay accumulator program. This is an issue of fairness, which is another reason our consumer-led Board approved our current policy.

Pharmaceutical companies do not like copay accumulators of course, because they undermine a pricing scheme that has worked very well to promote the use of brand name, high-priced medications. AB 773 would eliminate a much needed cost saving tool for employers and health insurers, and remove all incentives for pharmaceutical companies to keep medications affordable.

It also removes incentives for consumers. Without cost sharing, what reason does a consumer have to seek the highest value health care possible, including medications that are just as effective as high-priced alternatives and available to consumers at a much lower cost?

Summary

Drug coupons and discount programs undermine consumerism by shielding consumers from the true cost of medications. Worse, they remove any motivation for drugmakers to lower prices, because higher prices actually make coupons more valuable to consumers, exacerbating the issue of unaffordable medications.

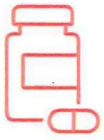
The provisions included in AB 773 will not protect consumers. Should this proposal be enacted, pharmaceutical companies stand to make more money. By limiting drug discount programs to a patient's out of pocket maximum, AB 773 limits the amounts that pharmaceutical companies have to spend. It will cost drugmakers less money to encourage consumers to take expensive medicines by helping them meet their maximum out of pocket's faster, at which time the drugmaker will stop offering discounts on the drug.

We urge you to think about the financial losses suffered by individual consumers who don't take these expensive medicines, as well as employers, employees and taxpayers that foot the bill for the ever-increasing cost of health care in the United States. They are the ones paying these costs, not health plans. We understand that many of you support this legislation to protect retail pharmacies, but you are not getting to the root cause of their financial woes with this legislation.

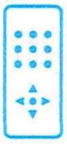
Please do not hesitate to contact me at mduffy@dcstrategies.org with any questions about this testimony or the attached visuals and FAQs.

Illustrating the Impacts of Drug Coupons on Patients and Health Plans

Scenario 1- Generics: Two individuals, Mark and Patty, enrolled in the same health plan that features a $3500 deductible, a $5000 maximum out of pocket (MOOP) and 20% coinsurance. After meeting the deductible, both have to contribute 20% of the cost of covered services until they reach their maximum out of pocket and pay nothing for covered services after that for that calendar year. Both have been diagnosed with leukemia and have been prescribed a drug called imatinib to treat it. Under the terms of their plan, they must satisfy their deductible before the health plan will begin to pay for covered services. The total premium for the plan is $450/mo, which is offset by ACA tax credits.



Mark fills his prescription for the generic version of imatinib which is priced at $765/mo. Mark pays a $30 copay and his health plan pays the remaining $735/mo. He does not use a drug coupon.



Patty sees an ad for Gleevec, the brand version of imatinib. The ad says she can get this drug for as little as $0/mo, even though the actual price of this drug is $10,031/mo.

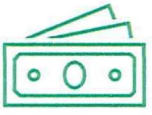
As a more expensive drug, Gleevec has a $100 copay under the terms of Patty's health plan – more expensive drugs get placed in a higher tier on the formulary. But with the coupon she will pay nothing, so she speaks with her doctor who writes a prescription for Gleevec.

The annual cost of the generic imatinib treatment is $9,180. The annual cost of the Gleevec is $120,372, minus the value of the drug coupon which we will calculate under two scenarios below.

IF AB 773 SHOULD PASS

Patty uses the coupon and pays nothing for all 12 months using Gleevec. The value of her first coupon is $4,806.20, which is her $3,500 deductible plus 20% of the remaining cost of the drug (coinsurance). The value of the second coupon is $193.80 - the amount remaining until Patty reaches her MOOP.

Mark pays $30 each time he fills his prescription, and after 12 months $360 has counted toward his deductible/MOOP.



Mark: Has contributed $360 toward the cost of his medication over 12 months. His health plan paid the remaining $8,820.

Patty: Has contributed $0 toward the cost of her medication. The drug coupon covered $5,000. Her health plan paid the remaining $115,372 plus the full cost of any other medical service she received.

WITH A COPAY PROGRAM IN PLACE

Patty uses the coupon and has to pay $93 for the third fill, as the drugmaker that offers the coupon limits the assistance to $30,000. After that, her copay for the medication is $100 under her health plan terms. Patty also has the option to switch to a generic at a lower $30 copay, but for this scenario we will assume she does not.

Mark pays $30 each time he fills his prescription, and after 12 months $360 has counted toward his deductible/MOOP.

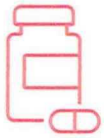
Mark: Has contributed $360 toward the cost of his medication over 12 months. His health plan paid the remaining $8,820.

Patty: Has contributed $993 toward the cost of her medication. The drug coupon covered $30,000, and her health plan paid the remaining $89,379.

Note the considerable difference in the cost to the health plan.

Illustrating the Impacts of Drug Coupons on Patients and Health Plans

Scenario 2 – Therapeutic Alternative: Two coworkers, Joe and Betty, are enrolled in their employer's health plan that features a $10,000 deductible with a $10,000 maximum out of pocket (MOOP) for families, which the employer offsets with contributions to an HRA for qualified medical expenses. Both Joe and Betty have narcolepsy and are prescribed two different medications to treat it. The employer and employee both contribute to the plan's $1,500/mo premium.



There are different approaches to treating narcolepsy. Betty's doctor prescribes modafinil which is a tier 1 generic available to Betty for a $10 copay. The total price of the drug is $43/mo.

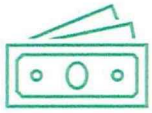
In discussing Joe's options for treatment, his doctor tells him that a drug company rep just dropped off several coupons for Xywav to treat narcolepsy. It's a fairly new therapeutic alternative to modafinil. Xywav's actual price is $15,298/mo. It is a tier 4 drug under the terms of the health plan, but Joe will get it for $10 with the coupon, which is limited to $16,000/year.

The total annual cost of the modafinil is $516. The total annual cost of the Xywav is $183,576, minus the value of the drug coupon which we will calculate under two scenarios below.

IF AB 773 SHOULD PASS

Betty pays $10 each time she fills her prescription, and after 12 months $120 has counted toward her deductible/MOOP.

The first fill for Joe's medication costs $15,298. Joe pays $10 and the drug coupon picks up $9,990 which satisfies Joe's deductible/MOOP. The employer plan pays the remaining $5,298. Joe pays nothing for subsequent fills nor any other covered health service for the remainder of the plan year. He decides to continue on this medication even though he still feels sleepy during the day – a known risk of taking this drug.



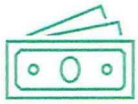
Betty: Has contributed $120 toward the cost of her medication and her employer plan paid the remaining $396.

Joe: Has contributed $10 toward the cost of his medication and gets all his subsequent medical care at no cost to him. The drug coupon covered $9,990 and his employer plan paid the remaining $173,576 plus the cost of any other care.

WITH A COPAY PROGRAM IN PLACE

Betty pays $10 each time she fills her prescription, and after 12 months $120 has counted toward her deductible/MOOP.

Joe pays $10 for the first fill of his medication, and the drug manufacturer coupon pays the remaining $15,288. He still feels sleepy during the day. When he goes to pick up his next prescription, he realizes he'll have to pay a lot more for Xywav going forward. He talks to his doctor about other options.



Betty: Contributed $120 toward the cost of her medication and her employer plan paid the remaining $396 for the year.

Joe: Contributed $10 toward the cost of Xywav. The drug coupon covered $15,288 for the first fill, then his doctor helped him find another option that worked better for him also for a $10 copay. Joe paid $110 and the employer paid $363 for 11 months of the alternative drug.

Note the considerable difference in the cost to the employer/employees

Drug Manufacturer Coupons FAQ

What are drug coupons, and why are they offered?

A drug coupon is an offer by a drug manufacturer to pay some or all of a patient's cost for the manufacturer's drug. By offering a coupon, a manufacturer can shield a patient from high prices, incentivizing patients to take those medications over other potentially less expensive generics or other lower cost substitutes.

Drug manufacturers say they provide this assistance to help patients who cannot afford a high-cost prescription. Others, including the Department of Health and Human Services' Office of Inspector Genera(OIG)l[1], say that the programs also are used to bolster prescription drug sales and prices and can increase costs for government and private payers.

How do drug coupons work?

Copay coupons reduce or eliminate the patient's cost-sharing responsibility under the patient's health insurance plan. Drug coupons do not lower the price that a health plan has to pay for the drug, and they are not available once a patient reaches their out-of-pocket maximum. Coupons are designed to drive utilization towards higher cost drugs when lower cost alternatives may be available, increasing overall costs that are ultimately passed onto consumers in the form of higher premiums.

Patients may access drug coupons through prescribers who receive them from pharmaceutical company representatives. Drug companies also pay millions of dollars to advertise them.

Can drug coupons be used if the patient has any type of health insurance?

As noted in the OIG report, the federal government considers them an illegal kickback in federal programs like Medicare and Medicaid, Tricare, and Veteran's Administration, so enrollees in these programs cannot utilize coupons. Some states, including Massachusetts and California, also placed limitations on drug coupons after studies[2] showed that drug coupons increase the use of branded medications over generics.

How do drug coupons increase costs?

Patients are induced to use the drugs that have a coupon because it saves them money, which on the surface sounds like a very good thing for consumers. However, when the costs of pharmaceuticals increase, so do premiums and cost sharing for consumers across the board. Health insurers typically offer lower co-pays on generic prescriptions because generics are less expensive for everyone on the plan. Drug companies strategically offer coupons to lower or eliminate the price a patient would have to pay for drugs that are very high cost even if they have generic equivalents or lower cost alternatives. In the end, consumers pay more for their health insurance while drug manufacturers increase their profits.

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[1] Office of the Inspector General Special Advisory Bulletin: https://oig.hhs.gov/documents/special-advisory-bulletins/878/SAB_Copayment_Coupons.pdf

[2] One study provided for example: https://www.aeaweb.org/articles?id=10.1257/pol.20150588

But have any studies shown that drug coupons lead to higher prices?

A research team from Harvard, Northwestern and the University of California, Los Angeles, reviewed brand-name drugs that also had generic equivalents.[3] They found that when drug manufacturers offered a coupon for the brand-name version, more patients stuck with the more expensive brand-name drug, and the drug manufacturer raised the prices on those drugs faster than it did for drugs for which no coupon was available.

Are health plans not allowing patients to use coupons?

Health plans allow patients to use coupons when legal under state or federal law. Many health plans are offering copay accumulator or copay maximizer programs that allow patients to use coupons to reduce their cost-sharing for a given prescription, while the value of the coupon does not count toward the patient's deductible or out-of-pocket maximum that applies to their plan.

Why isn't that "double dipping" by the health plan?

Remember that coupons do not reduce any costs for medications on the health plan side – only on the patient side. Once maximum out-of-pockets are met, health plans use premium collected from consumers to pay thousands or sometimes tens of thousands of dollars for these expensive medications. Insurers aren't "pocketing the money" because assistance isn't available to them, and keep in mind that it is actually consumer premiums that are being used to pay for medications.

What is an Out-of-Pocket Maximum and why is it important?

The out-of-pocket maximum is a cap on the amount a patient must pay out of pocket for covered medical items and services in a single plan year. Once an out of pocket is met, an individual pays nothing toward their healthcare for the remainder of the year – costs which are ultimately borne by other consumers. Federal law sets out-of-pocket maximums for many insurance plans. Drug coupons, if they are allowed to count toward the out-of-pocket maximums, are designed to help patients reach their out-of-pocket limits faster, sometimes without the patient paying anything out-of-pocket toward their medical costs. This creates an even stronger incentive for patients to choose and stay on expensive medications.

Has anyone researched how drug manufacturers are benefiting?

Yes, in 2021, members of Congress finalized a Majority Staff Report[4] after the US House Committee on Oversight and Reform conducted a nearly three-year investigation of the pharmaceutical industry and its drug pricing practices. The report found "all the companies the Committee investigated have employed anticompetitive strategies to suppress generic competition. Several companies have also used patient assistance programs and donations to third-party organizations—which were ostensibly intended to help patients afford expensive drugs— as tools to garner positive public relations, increase sales, and raise revenue."

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[3] *How do Copayment Coupons Affect Branded Drug Prices and Quantities,* https://www.nber.org/papers/w29735

[4] US House Oversight Committee Majority Staff Report, Drug Pricing Investigation https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf

Below is an excerpt that shows the return on investment for the drugmaker TEVA for the assistance program offered on their drug Capaxone (see page 154):

> "Teva's internal strategy documents emphasized the rate of return of its copay assistance program for commercial patients on Copaxone. For example, Teva's 2008 Copaxone Work Plan estimated that the company would spend approximately $70 million on "Private Insurance Financial Assistance" between 2008 and 2011 and that this expenditure would result in the sale of 198,930 units of Copaxone that otherwise would have been lost. Assuming a list price of $1,886 per unit (the price of Copaxone on the date of the presentation), these sales were worth over $373 million—a 433% return on investment."

Below is an excerpt that shows the return on investment for the drugmaker Novartis for the assistance program offered on their drug, Gleevec (see page 157):

> "Internal Novartis documents indicate that the company strategically used its copay programs to drive demand, particularly after the loss of exclusivity. While Novartis externally marketed its copay programs as ensuring that 'every patient who needs Gleevec has access to it,' Internal documents indicate that enhanced copay programs were a crucial piece of Novartis's loss-of-exclusivity strategy for Gleevec, encouraging patients to stay on the branded drug even after generic entry. A 2015 Gleevec Copay Strategy presentation noted, "Copay is an Important Component of the Gleevec LOE Strategy." Another set of slides described the company's copay promotion efforts as a way to "[h]elp to keep current customers on prescription by lessening the gap between Rx [Gleevec] and Gx [generic] costs."
>
> Internal company slides related to copay strategies before and after the loss of exclusivity proposed that enhancing the copay programs six months before the loss of exclusivity would result in the greatest return on investment by keeping patients on Gleevec before lower-cost generics entered the market. This document indicated that Novartis valued patient assistance programs starting six months prior to the loss of exclusivity as providing a return on investment of $8.90 for every one dollar spent on the program."

The Committee also investigated the level of patient assistance offered compared to the revenue brought in by drugmakers for drugs with coupons (see page 151):

- "Pfizer's reported expenditures on patient assistance programs from 2015 to 2017 accounted for less than one-tenth of 1% of Pfizer's reported Lyrica U.S. net revenue from the same period.
- Mallinckrodt, which has priced Acthar at approximately $123,000 per year, has touted the generosity of its patient assistance programs. Data obtained by the Committee reveals that the total cost of its programs was equivalent to approximately 2.5% of Mallinckrodt's $5 billion in Acthar net revenues from the same period.
- According to data provided by Celgene, the cost of its commercial copay program for its cancer drug Revlimid was equivalent to approximately 0.16% of its net U.S. revenue for Revlimid from 2011 to 2018."

But what about patients?

The legislature must recognize that the cost of medications has reached an unaffordable level. The same can be said for non-routine medical care. If it wasn't for health insurance, few people could afford to get sick.

Given that, policy solutions should take all necessary measures to avoid increasing health insurance costs which will lead to higher premiums, higher out of pocket costs and a higher number of people choosing to forgo coverage, exposing more people to medical debt and increasing uncompensated care for providers. Instead, policy solutions should take aim at the root causes of high pharmaceutical and medical prices paid by employers, employees and insurance consumers.

For their part, patients should look to purchase health coverage that has out-of-pocket cost features that they can manage. This is easier said than done, because a lower deductible and maximum out of pocket translates into higher monthly premium costs. But importantly, this is no different for a patient on an expensive drug than it is for a patient who needs surgery. That patient also has to meet their deductible. Patients should consider enrolling in a plan design that has lower out-of-pocket costs if they can afford it and have the ability to choose.

As a final reminder, the vast majority of health plans already support enrollees using drug coupons when a lower cost generic or substitute is not available. While the drug coupon scheme has detrimental impacts on prices, health plans understand that sometimes it is the only affordable option for patients. That said, we should not be further encouraging perverse incentives for patients to get on and stay expensive medications by allowing drug companies to also satisfy a patient's maximum-out-pocket.

Advancing
Free Market
Healthcare

To: **Chairman Moses and Members of the Assembly Health Committee**
From: **Employers for Advancing Free Market Healthcare**
RE: **Written Testimony on Assembly Bill 773**
Date: **February 14, 2024**

Advancing Free Market Healthcare is an advocacy organization founded by employers from across the state to amplify the voice of employers on health policy matters that impact employees, their families, and all healthcare consumers. We have reviewed the various provisions of Assembly Bill 773 and have concerns about many of the bill's provisions, and we would encourage all of you to discuss the bill with employers in your district before deciding to move this bill forward. We are happy to facilitate these discussions if needed.

By way of background, understand that just over 68% of Wisconsin's working-age population receives their healthcare coverage through an employer plan. Most of this population is covered via benefit plans offered by self-funded employers required to provide uniform benefits to employees across state lines, which is one reason the Employee Retirement Security Act of 1974 (ERISA) exists.

Unfortunately, AB 773 applies to PBMs that self-funded employers rely on but does not clarify an exemption for self-funded plans. This exposes employers to possible restrictions from PBMs who may interpret this bill to apply to them, resulting in potential legal expenses and court challenges should the bill pass as written. Our first request is a clarification that the bill does not apply to PBM contracts with self-funded plans, consistent with ERISA protections.

Secondly, we are strongly opposing the idea that medications purchased for less money via mail order pharmacies and specialty pharmacies should be sold at the same price to consumers as medications purchased at a higher cost and sold via brick and mortar pharmacies. This is not consistent with an idea that is central to our mission to seek free market solutions that enable the purchase of the highest value healthcare available which will in turn lower healthcare prices for consumers. These prices, whether they are related to drug costs or medical costs, are inflating copays, deductibles and premiums, at the same time depressing wages and increasing taxes.

We are also opposed to the provision of the bill that would require PBMs to count the value of drug copay assistance programs toward enrollee's cost-sharing requirements. This stands out as perhaps the most anti-free market provision of the proposal, as it removes all market forces that might otherwise encourage pharmaceutical companies to reduce their prices.

A relatively small number of our enrollees benefit from these medications, yet their costs consume an alarming and increasing percentage of employer health benefit budgets. The drug pricing scheme endorsed by AB 773 would not just shield consumers from drug company high prices but undermines patients' responsibilities to pay something toward their health expenses through copays and deductibles. It also exposes employers and the employees we serve to vastly increased plan expenses; all so pharmaceutical companies can make more money. It undermines competition because it allows higher priced drugs to be sold to consumers at an artificially discounted prices, and gifts patients money for deductibles and copays so they never want to stop taking the drug, even if it isn't helping. We strongly urge the committee to remove this provision from this bill and any legislation they consider.

The bill's provision that bars a PBM from removing a drug from a formulary mid plan year is also concerning from a cost perspective, especially if the change is a result of less expensive generics or alternatives coming to market. Purchasers need these flexibilities in their plan design to address the ever-changing costs of medications, which can increase significantly mid-year.

There are two provisions in AB 773 that Advancing Free Market Healthcare would support. The first involves clarifying fiduciary responsibilities for PBMS. Employers believe that PBMs have fiduciary obligations to health plans already and should be acting in their best interests with good faith and proper purpose. Legislation currently under consideration by Congress would require a study of this issue, but Advancing Free Market Healthcare would support Wisconsin joining a handful of other states in clarifying that PBMs are in fact fiduciaries for the health plans they serve.

We also support transparency in all forms, and therefore support the reporting requirements that are included in the bill.

In closing, we understand that a primary goal of this legislation is to protect brick and mortar pharmacies, which some consumers value while others prefer the convenience of mail order. We also recognize that a primary cause of pharmacies' struggle is the fact that the three of largest PBMs control about 80% of their market, increasing their leverage over pharmacies and making competition difficult. AB 773 does nothing to address the very important issue of health industry consolidation, which is a concern for purchasers of healthcare across the spectrum. If AB 773 does not address the root causes of the problem, we must ask ourselves if the provisions of AB 773 are worth the millions of dollars it would add to the total amount Wisconsinites spend on medications, which is already putting too many families in medical debt.

We stand ready to work with members of the committee on ideas to address the many facets of today's healthcare market that stymie competition and block the free market from working to lower costs. Please do not hesitate to contact Melissa Duffy at (608) 334-0624 or mduffy@dcstrategies.org if you would like to discuss these ideas in greater detail.

WISCONSIN GROCERS ASSOCIATION

Testimony of

Michael Semmann

On Behalf of the

Wisconsin Grocers Association

Before the

Assembly Committee on Health, Aging and Long-Term Care

Assembly Bill 773

February 14, 2024

Chair Moses and members of the Committee, thank you for the opportunity to submit written testimony today in support of Assembly Bill 733 related to regulation of pharmacy benefit managers (PBMs), fiduciary and disclosure requirements on pharmacy benefit managers, and application of prescription drug payments to health insurance cost-sharing requirements.

The Wisconsin Grocers Association, along with the pharmacies affiliated and owned by retail food stores support this legislation and believe it would provide a new transparent framework regarding PBM practices and create a more level playing field in the prescription drug market.

According to multiple sources, PBMs control nearly 80 percent of the prescription drug market and operate with little oversight by federal regulators and out of the view of consumers. PBMs influence prescription drug costs, determine which drugs are covered by an insurance plan, and change the balance of revenues that might otherwise be passed along as savings to consumers/patients.

These PBMs have created business structures to reduce reimbursement, claw back funds, restrict networks, and effectively force pharmacies to provide drugs below cost driving many retail food pharmacies, particularly in underserved, low-income and rural neighborhoods out of the business or preventing expansion into these important communities.

Historically, PBMs played an important role in the administration of prescription drug programs and were designed to take the paperwork burden away from pharmacists. However, in recent years, the PBM marketplace has transformed considerably, and they are doing just the opposite. As a result of

consolidation among PBMs, health insurance companies and acquired pharmacies, a small number of large corporations now wield nearly unbalanced power and influence over the prescription drug market for *260+ million Americans*. Among other things, PBMs negotiate drug costs, dictate which drugs will be included on plan formularies, and control how those drugs are dispensed. In other words, they control which treatments are prescribed to patients, which pharmacies patients can access, how much patients will pay at the pharmacy counter, and the amount pharmacies are ultimately reimbursed – decisions that are increasingly made after the patient leaves the pharmacy.

PBMs may require or tangentially incent mail order pharmacies, which equates to business and economic activity outside of WI. This can lead to unintended health outcomes from the reduced face to face interaction or direct consultation with the pharmacist to discuss the medication, openly ask questions, and prevent medication errors. Pharmacists connected to the retail food industry are most often nestled in the community and imperative to the health in rural or low-income communities. Because of PBMs there is an increased culture to dispense with little reimbursement which could lead to even less patient consultation. Pharmacies can't afford to staff to help patients and meet their demands because of the control PBMs have on their margins and some business practices.

Despite their outsized influence, PBMs are one of the least regulated sectors of the healthcare system and drug supply chain. There is almost no federal enforcement, oversight, or regulation.

WGA members have been frustrated by unpredictable fees the current system can cause which is seemingly unconnected to a pharmacy's performance and other standards. Under the current system, PBMs often claw back fees from pharmacies retroactively, weeks, or even months after prescriptions are filled. Greater fees for pharmacies have patients that are less adherent to their medications. For example, the less healthy a patient is or the more forgetful they are to take their medication, the pharmacy is penalized with larger fees. This is a vicious cycle. Pharmacies can make calls and consultations all day long to encourage patients to make healthier choices and understand the importance of their medications but in rural or low-income communities it never results in the 90% compliance that PBMs use to measure patient's adherence.

One of the practices that PBMs engage in is called "spread pricing", in which they charge health plans and payers more for a prescription drug than what they reimburse to the pharmacy, and then keep the difference – the "spread" – as profit. This practice can result in pharmacies being reimbursed less than their acquisition cost for a drug, and consumers may face higher health insurance plan premiums to cover these middleman costs. Another practice is the arbitrary, unfair, or deceptive clawing back of payments made to pharmacies, or the arbitrary, unfair, or deceptive increasing of fees or lowering of reimbursements to offset reimbursement changes in health plans.

These practices harm the pharmacies owned by grocery stores, as they reduce their revenues, increase their costs, and limit their ability to serve their customers/patients. Therefore, these pharmacies want to see new public benefits manager regulations at the state level of government that would prohibit these practices and mandate more transparency from PBMs.

The retail food industry operates on razor thin profit margins and WGA member-affiliated pharmacies have virtually no ability to absorb these unexpected costs. Therefore, they are forced to either pass those costs on to consumers in the form of higher prices, or worse, discontinue offering pharmacy services altogether at certain locations. WGA continues to work with stakeholders and the federal

government to end unequitable practices that hurt community and independent pharmacies and increase prescription costs for all Americans.

Please contact me at msemmann@wisconsingrocers.com to answer any questions that surface. Thank you.

The Wisconsin Grocers Association (WGA) is a non-profit trade association established in 1900 to represent independent grocers and grocery chains, warehouses & brokers, vendors, suppliers, and manufacturers before all levels of government. The WGA provides educational and networking opportunities, leadership training, public affairs, and compliance information for its membership.

WGA and its membership have a significant Economic Impact in the state of Wisconsin. The WGA represents nearly 350 independent grocers with multiple locations across the state, more than 200 retail grocery chain stores, warehouses and distributors, convenience stores, food brokers and suppliers. Wisconsin grocers employ over 30,000 people with over $1 billion in payroll and generate more than $12 billion in annual sales in Wisconsin resulting in approximately $800 million in state sales tax revenue. (Data provided by The Food Institute).

Dear Members of the Assembly Health Committee,

Thank you for your leadership on the Assembly Health, Aging and Long-Term Care Committee. As session wraps up, please stand with patients and remove barriers to prescription drug access.

Unfortunately, I can't attend the committee hearing on February 14th, but I urge you to please vote yes on Assembly Bill 773 to ensure all copays count for patients – as intended. By voting yes on AB 773, you can remove barriers to prescription drug access by requiring all payments made by patients, including copay assistance programs, to be counted toward their out-of-pocket maximum and deductible.

Please vote yes on AB 773.

Sincerely,
Deb Constien
3020 Craig Ln
Sun Prairie, WI 53590

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Please vote yes on AB 773.

Sincerely,
Mark Block
18125 W Plateau Ln
New Berlin, WI 53146

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Please vote yes on AB 773.

Sincerely,
Daniel Strause
PO Box 53
Rio, WI 53960

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Please vote yes on AB 773.

Sincerely,
Howard Haugstad
3974 Windemere Dr
Colgate, WI 53017

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Sincerely,
Benjamin Haugstad
3974 Windemere Dr
Colgate, WI 53017

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Please vote yes on AB 773.

Sincerely,
Katie Whitlock
N86W18106 Summit Dr
Menomonee Falls, WI 53051

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Please vote yes on AB 773.

Sincerely,
Scott Sidney
N40W6522 Jackson St
Cedarburg, WI 53012

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Please vote yes on AB 773.

Sincerely,
MJ Sidney
3780 S Hanson Ave
Milwaukee, WI 53207

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Please vote yes on AB 773.

Sincerely,
Heather Van Vonderen
3991 Agatha Christie Ave
De Pere, WI 54115

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Please vote yes on AB 773.

Sincerely,
Missy Dolan
14205 W Elmwood Dr
New Berlin, WI 53151

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Sincerely,
Maddie Petre
1009 W Juneau Ave Apt 404
Milwaukee, WI 53233

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Please vote yes on AB 773.

Sincerely,
Andrea Urban
1905 Mallard Pointe Cir Unit E
Waukesha, WI 53189

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Please vote yes on AB 773.

Sincerely,
Devin Schiesser
215086 Lakefront Dr
Hatley, WI 54440

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Sincerely,
Sandra Sidney
N40W6522 Jackson St
Cedarburg, WI 53012

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Please vote yes on AB 773.

Sincerely,
Kassie Martin
425 E Menomonee St
Milwaukee, WI 53202

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Please vote yes on AB 773.

Sincerely,
Sara Richter
1266 Kennedy Dr
Hartford, WI 53027

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Please vote yes on AB 773.

Sincerely,
Lacey ORourke
303 N Hamilton St
Madison, WI 53703

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Sincerely,
Naomi Gould
6296 State Road 144
West Bend, WI 53095

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Sincerely,
Tyler Stevenson
1931 Bay Mill Rd
Tomahawk, WI 54487

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Please vote yes on AB 773.

Sincerely,
Ryan Phillipsen
996 3rd St Apt 3D
Menasha, WI 54952

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Please vote yes on AB 773.

Sincerely,
Staci Rush
N9337 Carnot Rd
Algoma, WI 54201

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Please vote yes on AB 773.

Sincerely,
Mike Zagelow
3207 N Crystal Springs Rd
Janesville, WI 53545

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Please vote yes on AB 773.

Sincerely,
Abbie Milski
165 Ames St
Oregon, WI 53575

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Sincerely,
Keith Witt
W5445 US Highway 12
Elkhorn, WI 53121

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Sincerely,
Rick Conner
139 E Capitol Dr
Hartland, WI 53029

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Sincerely,
Erin Williams
102 Empire Dr
Beaver Dam, WI 53916

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Please vote yes on AB 773.

Sincerely,
Allison Witmer
333 Lowville Rd
Rio, WI 53960

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Please vote yes on AB 773.

Sincerely,
Adam Houtman
333 Lowville Rd
Rio, WI 53960

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Please vote yes on AB 773.

Sincerely,
Thad Schumacher
3110 Leyton Ln
Madison, WI 53713

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Please vote yes on AB 773.

Sincerely,
Chris Nielsen
1925 8th Pl
Kenosha, WI 53140

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Sincerely,
Jon Wilson
215 E Knollwood Way
Platteville, WI 53818

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Please vote yes on AB 773.

Sincerely,
Megan Schreck
4216 Downton Cir
Howard, WI 54313

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Please vote yes on AB 773.

Sincerely,
Michelle Rowe
PO Box 301
Rio, WI 53960

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Please vote yes on AB 773.

Sincerely,
Thomas Swanson
337 E La Salle Ave
Barron, WI 54812

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Please vote yes on AB 773.

Sincerely,
Reid Schwagel
7701 NE River Rd Ofc 105
Elk River, MN 55330

Dear Members of the Assembly Health Committee,

Thank you for your leadership on the Assembly Health, Aging and Long-Term Care Committee. As session wraps up, please stand with patients and remove barriers to prescription drug access.

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Please vote yes on AB 773.

Sincerely,
kevin melby
1549 200th Ave
New Richmond, WI 54017

Dear Members of the Assembly Health Committee,

Thank you for your leadership on the Assembly Health, Aging and Long-Term Care Committee. As session wraps up, please stand with patients and remove barriers to prescription drug access.

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Please vote yes on AB 773.

Sincerely,
Kim Abell
W759 Violet Rd
Genoa City, WI 53128

Dear Members of the Assembly Health Committee,

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Please vote yes on AB 773.

Sincerely,
Jonathan Haugstad
1022 W Johnson St Apt 304
Madison, WI 53715

Dear Members of the Assembly Health Committee,

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Please vote yes on AB 773.

Sincerely,
Aaron Montano
30825 Ketterhagen Rd
Burlington, WI 53105

Dear Members of the Assembly Health Committee,

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Please vote yes on AB 773.

Sincerely,
Ruth Beyer
2415 S Parkside Dr
New Berlin, WI 53151

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Please vote yes on AB 773.

Sincerely,
Shirley Thompson
4348 County Road B
Land O Lakes, WI 54540

Dear Members of the Assembly Health Committee,

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Please vote yes on AB 773.

Sincerely,
Kathleen Arntsen
5279 Tilden Hill Rd
Verona, NY 13478

Dear Members of the Assembly Health Committee,

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Please vote yes on AB 773.

Sincerely,
Sarah Bowker
6154 Blake Rd
Greenleaf, WI 54126

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Please vote yes on AB 773.

Sincerely,
Kim Kinner
735 Hunters Run
Hobart, WI 54155

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Please vote yes on AB 773.

Sincerely,
VERONICA DEVLIN
425 County Road Bb
Woodville, WI 54028

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Please vote yes on AB 773.

Sincerely,
Julie Kowalske
S66W12775 Somerset Dr
Muskego, WI 53150

Dear Members of the Assembly Health Committee,

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Please vote yes on AB 773.

Sincerely,
Jason Schwager
1617 Country Club Ln
Watertown, WI 53098

Dear Members of the Assembly Health Committee,

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Please vote yes on AB 773.

Sincerely,
Keri Radtke
3922 Jackson St
Mineral Point, WI 53565

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Please vote yes on AB 773.

Sincerely,
David Willink
345 Hillside Cir
Baldwin, WI 54002

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Please vote yes on AB 773.

Sincerely,
Tyler Wallenfang
1106 Bobby Ct
Appleton, WI 54915

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Please vote yes on AB 773.

Sincerely,
Phillip Dhein
N136W21104 Bonniwell Rd
Richfield, WI 53076

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Please vote yes on AB 773.

Sincerely,
Julie Hodgeman
140 E Cook St
Portage, WI 53901

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Please vote yes on AB 773.

Sincerely,
Alex Moreno
414 Edelweiss Cir
New Glarus, WI 53574

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Please vote yes on AB 773.

Sincerely,
Katie Moureau
319 Southing Grange
Cottage Grove, WI 53527

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Please vote yes on AB 773.

Sincerely,
Jeff Cushman
7057 Fahley Rd
Oshkosh, WI 54904

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Please vote yes on AB 773.

Sincerely,
Dan Phelan
753 Ashland Ave
River Forest, IL 60305

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Please vote yes on AB 773.

Sincerely,
Tim Dreier
N5750 Wolf River Ct
Shawano, WI 54166

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Please vote yes on AB 773.

Sincerely,
Matt Klieforth
N2345 Weatherhill Ct
Greenville, WI 54942

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Please vote yes on AB 773.

Sincerely,
Kathleen Callaghan
4422 Misty Valley Dr
Middleton, WI 53562

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Sincerely,
Donna Milne
W11428 Bay Dr
Lodi, WI 53555

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Sincerely,
Gary Boehler
4840 Harbor Ln N
Plymouth, MN 55446

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Please vote yes on AB 773.

Sincerely,
Ezra Gruszynski
W6332 Circle Dr
Crivitz, WI 54114

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Please vote yes on AB 773.

Sincerely,
Cheryl DeJong
1494 290th St
Glenwood City, WI 54013

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Please vote yes on AB 773.

Sincerely,
Joseph Riebe
4223 Tanglewood Dr
Janesville, WI 53546

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Please vote yes on AB 773.

Sincerely,
Laura Draper
5837 Marsh View Ct
Fitchburg, WI 53711

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Please vote yes on AB 773.

Sincerely,
Amy Kuhlman
W3569 W Neda Rd
Horicon, WI 53032

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Please vote yes on AB 773.

Sincerely,
Kaylynne Caffey
555 S Perry Pkwy Apt 7
Oregon, WI 53575

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Please vote yes on AB 773.

Sincerely,
Alexis Starosta
9824 S 35th St
Franklin, WI 53132

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Please vote yes on AB 773.

Sincerely,
Emily Hall
2320 N Booth St
Milwaukee, WI 53212

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Please vote yes on AB 773.

Sincerely,
Beth Knetter
215 N 28th Ave
Wausau, WI 54401

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Please vote yes on AB 773.

Sincerely,
Kelly Leibold
1824 Liberty St
La Crosse, WI 54603

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Please vote yes on AB 773.

Sincerely,
Lisa Conner
1260 Four Winds Way
Hartland, WI 53029

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Please vote yes on AB 773.

Sincerely,
Krista Lukes
124 Plummer Ct
Neenah, WI 54956

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Please vote yes on AB 773.

Sincerely,
Andrea Eake
761 Manchester Rd
Neenah, WI 54956

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Please vote yes on AB 773.

Sincerely,
Nic Smith
N4327 Murphy Rd
Freedom, WI 54130

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Please vote yes on AB 773.

Sincerely,
Erica Rodd
N87W27865 Perennial Ter
Hartland, WI 53029

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Please vote yes on AB 773.

Sincerely,
Debra Nevels
12023 W Lynx Ave
Milwaukee, WI 53225

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Please vote yes on AB 773.

Sincerely,
Philip O'Brien
5976 N Bay Ridge Ave WI53217
Whitefish Bay, WI 53217

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Please vote yes on AB 773.

Sincerely,
Kathryn Hansen
1240 Washington St
Wrightstown, WI 54180

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Please vote yes on AB 773.

Sincerely,
Monty Gilbertson
W605 Cherry St
Stoddard, WI 54658

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Please vote yes on AB 773.

Sincerely,
Jean-Luc Vanderheyden
375 Still Water Ct
Dousman, WI 53118

Dear Members of the Assembly Health Committee,

Thank you for your leadership on the Assembly Health, Aging and Long-Term Care Committee. As session wraps up, please stand with patients and remove barriers to prescription drug access.

Unfortunately, I can't attend the committee hearing on February 14th, but I urge you to please vote yes on Assembly Bill 773 to ensure all copays count for patients – as intended. By voting yes on AB 773, you can remove barriers to prescription drug access by requiring all payments made by patients, including copay assistance programs, to be counted toward their out-of-pocket maximum and deductible.

Please vote yes on AB 773.

Sincerely,
Michael Shult
647 Rinpoche Ln
Oregon, WI 53575

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Sincerely,
Kirby Davidson
1318 Woodgrove Way
Sun Prairie, WI 53590

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Sincerely,
Paul Westrick
6612 N Chickahauk Trl
Middleton, WI 53562

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Sincerely,
Lisa Patzer
W5880 Hackbarth Rd
Fort Atkinson, WI 53538

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Sincerely,
Linda DeGarmo
S958 Schultz Ln
Chaseburg, WI 54621

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Sincerely,
Nakeisha Payne
9315 74th St
Kenosha, WI 53142

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Sincerely,
Deb Dongarra
1726 Holly Dr
Janesville, WI 53546

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Sincerely,
Sarah Devine
2724 Hidden Dr
Saint Francis, WI 53235

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Sincerely,
Keeshia Jones
9627 70th St
Kenosha, WI 53142

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Sincerely,
TAMRA VAREBROOK
N100W14394 Sunburst Trl
Germantown, WI 53022

National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

February 14, 2024
The Honorable Clint Moses
Chair, Assembly Committee on Health, Aging, and Long-Term Care
Room 12 West State Capital
PO Box 8953
Madison, WI 53708

Dear Chairman Moses,

I am writing today on behalf of the National Association of Benefits and Insurance Professionals – Wisconsin Chapter (NABIP Wisconsin) – a member organization representing licensed agents and brokers who are engaged in the sale and service of health insurance and other ancillary products and serving employers and consumers in Wisconsin– to bring your attention to concerns regarding the dispensing fees being implemented in AB 773.

NABIP recognizes the need for lowering drug costs for patients and that the intent behind AB 773 is to increase accessibility of drugs and bring down costs, however, implementing dispensing fees will have the opposite effect. An additional dispensing fee on prescription drugs will cause pharmacy benefit managers to pass the cost of the dispensing fee on to employers and individuals, causing patients to pay exponentially more per prescription refill. A $10 to $15 fee may appear to be a low cost, but these costs add up for patients who rely on several prescriptions, especially among patients with health conditions including heart disease and diabetes, as well as low-income patients. Some patients who are prescribed inexpensive generic drugs may even pay more in dispensing fees than for their prescriptions. A drug that would normally be affordable without the imposition of an additional dispensing fee would become unaffordable very quickly, as individuals and employers would be forced to pay hundreds of dollars more per year in unnecessary fees for the drugs they rely on.

This cost increase is evident in other states where dispensing fees have been implemented. In 2023, Tennessee's law implementing professional dispensing fees for "low volume pharmacies", which are defined as a pharmacy that dispenses less than 65,000 prescriptions in a year, took effect. Since then, the average family is estimated to be paying an additional $680 per year on top of what they are already paying in medical expenses for the same level of care. In Tennessee, this has impacted residents in rural areas, who have fewer care options the most. Further, studies have found that a $10 price increase on prescription drugs would result in a 33% increase in death among patients, particularly those with conditions such as diabetes, asthma, and hypertension, as a result of these patients cutting back on their previously affordable medication that have been made unaffordable. NABIP is not opposed to AB 773 in its entirety but urges the committee to reconsider the dispensing fee being implemented in this bill.

On behalf of NABIP, I would like to thank you for your attention to this matter. While we all address the issue of drug affordability, it is critical to ensure that patients are not put in a position where they are forced to pay higher costs for drugs.

Sincerely,

Liz Dannenberg

President, NABIP Wisconsin