MICHAEL SCHRAA

P.O. Box 8953
Madison, WI 53708

STATE REPRESENTATIVE • 53RD ASSEMBLY DISTRICT

Office: (608) 267-7990
Toll-Free: (608) 534-0053
Rep.Schraa@legis.wi.gov

Senate Bill 737

Thank you, Chair Felzkowski and Members of the Senate Insurance Committee, for the opportunity to testify in favor of this Pharmacy Benefit Manager reform bill, which will make the purchase of prescription medications more affordable and accessible.

First, I'd like to provide some context on Pharmacy Benefit Managers (PBMs) and recent legislation.

Pharmacy Benefit Managers began in the 1960s to do the complex paperwork for insurance companies who began offering prescription drug coverage as part of health insurance plans.

This is a valuable service, but over time, certain business practices have crept in that make PBMs very profitable, yet they are not always in the best interests of patients.

Please keep in mind, that the 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 the vertical integration affects patient care. These vertical monopolies claim to keep costs down; yet in reality cost savings are often cost-shifting to competitors or to the consumer.

This bill continues the work to regulate Pharmacy Benefit Managers so that our constituents will receive improved care, with the correct medication, at the best price, and in a timely manner.

As you may recall, there were 104 cosponsors to 2019 AB 114/SB 100. The Assembly passed it as amended unanimously. Unfortunately, the substitute amendment removed many of the provisions that would have been most useful to our constituents. The Senate cancelled the final floor session, so AB 114 never came to a vote. A bill identical to the watered down substitute amendment was introduced and enacted as 2021 Act 9.

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

- PBMs are required to register with the Office of the Commissioner of Insurance and to report to OCI on the rebates (kickbacks) they retained and did not pass on to the health plan sponsors (insurers). 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 the 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 will do much to accomplish affordability. All network providers will have the same co-pay, so patients will not be paying more at some pharmacies than at others. Patients who use manufacturer copay assistance will be able to count it toward deductibles. Patients will also receive higher quality care, since

they can choose to 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, that medication will be available to them. Formulary stability is essential. Under the bill, the formulary and the copay 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.

Another key component of accessibility is simply having a pharmacy nearby. I've heard from a number of pharmacists and pharmacies who are on the verge of closing up shop because of shady practices by the PBMs. They are convinced that PBM's vertical monopolies are designed to put competitors out of business. This is especially troublesome in small rural areas where the elderly and infirm may have difficulty traveling to access pharmaceuticals.

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

Currently, PBMs who have a vertical monopoly with their own pharmacy chain will often offer lower copays for customers and higher reimbursements to their own pharmacies. In fact, pharmacies are sometimes reimbursed less than the cost of the drug. This is the most urgent concern of pharmacies. They cannot stay in business when they repeatedly lose money on sales. It's as simple as that.

The Maximum Allowable Cost (MAC price) will be based on clearly defined criteria. If the reimbursement is less than the cost of the pharmaceutical, 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, along with related supplies and services. The bill requires a dispensing fee equal to the current amount that the state pays for Medical Assistance dispensing fees.

With both an equivalent reimbursement and a reasonable dispensing fee, at least we will not be losing pharmacies because they are losing money to serve our constituents.

The bill also protects from these unfair practices by an appropriate appeals process for inadequate Maximum Allowable Cost (MAC) lists, allows the pharmacist to inform the patient of their loss, or even to decline to fill a prescription where they would suffer a loss.

Another unfair practice is predatory audits of pharmacies. 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 the pharmacy. 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.

In closing, I appreciate the bipartisan group of legislators who have cosponsored this bill to make sure our constituents can access the medications they need. I will be happy to answer any questions after the other authors have completed their testimony.

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.

MARY FELZKOWSKI

STATE SENATOR • 12TH SENATE DISTRICT

Testimony on SB 737: Pharmacy Benefit Manager Accountability

Senate Committee on Insurance and Small Business
Senator Mary Felzkowski
12th Senate District
December 6th, 2023

Good morning Fellow 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 who will speak after me, 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.

Capitol Office: P.O. Box 7882 • Madison, WI 53707-7882 • (608) 266-2509 • **Toll-Free:** (800) 334-8775
Cell: (715) 966-3366 • Sen.Felzkowski@legis.wi.gov

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.

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.

I'd like to turn it over to Representative Rozar who will further discuss why we're concerned for our constituents if PBM practices continue unchecked.

DONNA M. ROZAR

STATE REPRESENTATIVE • 69TH ASSEMBLY DISTRICT

Office: (608) 267-0280
Toll Free: (888) 534-0069
Rep.Rozar@legis.wi.gov

P.O. Box 8953
Madison, WI 53708-8953

Testimony before the Senate Committee on

Insurance and Small Business

Senate Bill 737

December 6th, 2023

Thank you, Chair Felzkowski, Vice-Chair Hutton, and members of the Senate Committee on Insurance and Small Business for holding this hearing on Senate Bill (SB) 737, 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!"***

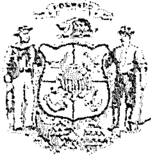
A secondary issue that needs to be considered with medication affordability is a patient's treatment plan. Patients who are worried about affording their medication are more likely to find ways to make their medication "stretch." This can result in reducing or skipping critical dosages of their medication. 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.



ANDRÉ JACQUE

STATE SENATOR • 1ST SENATE DISTRICT

Phone: (608) 266-3512
Fax: (608) 282-3541
Sen.Jacque@legis.wi.gov

State Capitol · P.O. Box 7882
Madison, WI 53707-7882

Testimony before the Senate Committee on Insurance and Small Business

Senator André Jacque
December 6, 2023

Madam Chair and Committee Members,

Thank you for the opportunity to testify in support of the "All Copays Count" provision within Senate Bill 737. I am proud to have introduced this vital patient assistance over last few legislative sessions, including Senate Bill 100 this session, to support patient access to life-saving and essential medication.

I've heard from many constituents and patients across Wisconsin about the vital role that copay assistance plays in allowing them to access critically important treatments. For patients with conditions that require specialty medications, copay assistance from pharmaceutical manufacturers has become even more crucial, because patients are increasingly bearing the burden of higher out of-pocket costs for their health care due to unfair policies.

Heath plans and pharmacy benefit managers (PBMs) essentially move the goal posts on patients just when they think they've reached their deductible. The plans refuse to count "copay accumulator adjustment program" assistance towards patients' deductibles or out-of-pocket maximums, leaving patients footing additional unexpected costs at the pharmacy counter – costs that have already been paid by the copay assistance.

I'm sure you will hear heart-wrenching stories today from those who have been hit by this unfair policy. Excluding this copay assistance from their deductible puts many patients in an impossible position where they must choose between their physical health and their financial stability. As a result, many patients are forced to disrupt their treatment regimens, or forego treatment altogether - all because of a provision in their health plan that they weren't even aware existed. As you can imagine, this unfair practice puts added strain on the health care system overall, as individual health outcomes worsen, and patients require higher, more intensive levels of care.

Incorporating the language from Senate Bill 100 is a simple fix that directly addresses these concerns. It helps patients afford their prescription medicines by ensuring that amounts paid for prescription drugs by or on behalf of a person covered under a policy or plan apply to any calculation of an out of-pocket maximum, or to any cost-sharing requirement of the policy. This language is similar to nearly unanimous bipartisan legislation that has been enacted recently in 16 other states, and there's no reason why Wisconsin shouldn't join them. It should be noted that this language as SB 100 has broad bi-partisan cosponsorship from over a third of the legislature and support from a coalition of nearly 50 national and Wisconsin-based patient, provider, and physician groups serving the interests of patients with chronic and serious health conditions that rely on copay assistance to access critical medications.

Again, on behalf of countless patients and their families across our state, I am elated that this crucial reform has finally received the opportunity to be heard in committee, allowing advocates a chance to have their stories heard. Allowing co-pay assistance for prescription drugs to count toward a patient's out-of-pocket maximum or cost-sharing requirement will help keep health care costs down.

In the interest of all our constituents, family, and friends with a complex or chronic condition and our state as a whole, I urge this committee to take action to protect copay assistance for patients across the state. While I certainly would not be opposed to the All Copays Count provision becoming law by enactment as part of larger legislation alongside other components, I ask that this crucial life and health-saving, common sense safeguard be further allowed to simultaneously proceed independently as standalone legislation (SB 100/AB 103) yet this session to maximize the chance that it is enshrined in law as soon as possible, before adjournment next year.

Thank you, and I'm happy to answer questions.

The Wisconsin Independent Pharmacy Association (WIPA) asks for your support of **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.

Pharmaceutical Companies (Drugmakers)

Sell drugs to pharmacies

Pharmacy

A formulary is a list of drugs covered by a health insurance plan.

Pay rebates to keep drugs on formulary

Pay back the difference on the actual drug cost and negotiated cost

Pharmaceutical companies often offer discounts to PBMs to gain more favorable formularies.

PBMs

Pay copay the PBM sets or Out-of-Pocket cost

Contract with PBMs to decide copay or drug cost amount

Health Insurers/ Employers

Buy insurance to cover some of the cost of prescriptions

Patients

Since the majority of PBMs are connected to large chain pharmacies, independent pharmacies struggle to stay open and are unable to provide low cost drugs to patients.

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

The Truth about Pharmacy Benefit Managers

Patients can be affected by PBMs due to the lack of transparency and complex drug pricing. Independent pharmacies suffer negative impacts due to reimbursement disparities, limited network access, unfair pricing, burdensome administrative requirements, and lack of transparency.[1] Independent pharmacies suffer losses, lose customers, and struggle to stay in business. Losing a neighborhood pharmacy affects the health and well-being of the members of our communities.

$633.5B amount the U.S. spent on prescription drugs in 2022.[7]

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

266M Americans' pharmacy benefits are controlled by PBMs[2]

Despite efforts at the state and federal level to regulate PBMs, they have continued to gain power and money, while prescription drug prices are going up and pharmacies are closing.

Calls for increased transparency and oversight of PBMs have grown louder.

A Closer Look:

Lack of Transparency — Leads to higher drug costs and financial burden on the healthcare system and patients.[3]

Monopolization — PBMs concentrate power to negotiate better terms for themselves while also hurting patients.[3]

Conflict of Interest — PBMs set reimbursement rates to benefit their own pharmacies but not independent pharmacies.[3]

Administrative Burden — Independent pharmacies often do not have the resources to execute complex tasks that are required by PBMs.[3]

Sources

1 https://www.economicliberties.us/our-work/the-pharmacy-benefit-mafia-the-secret-health-care-monopolies-jacking-up-drug-prices-and-abusing-patients-and-pharmacists/
2 https://content.naic.org/cipr-topics/pharmacy-benefit-managers
3 https://www.sanabenefits.com/blog/health-insurance-101-what-is-a-pbm/
4 https://content.naic.org/sites/default/files/inline-files/NCPA%208-29-19.pdf
5 https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf
6 https://ncpa.org/sites/default/files/2022-05/PBM-Storybook-12pg.pdf
7 https://www.pharmacist.com/Publications/Pharmacy-Today/Article/drug-expenditures-expected-to-increase-in-2023#:~:text=2023%20predictions,between%201%25%20to%203%25.

Prepared by The Welch Group, 2023

Previous Legislation

2021 Act 9:

Requires PBMs be licensed by the Office of Commissioner of Insurance (OCI).

Requires PBMs submit an annual report to OCI.

Requires 30 day advanced notice to a patient for any formulary changes.

Prohibits "gag clauses"- allows pharmacists to let the patient know the drug costs if they choose to not use their coverage.

Provides parameters for audits.

2023-25 Legislative Session

SB 737

Pharmacy Protections: Safeguarding pharmacies from burdensome dispensing fees and prohibiting retaliation against reporting pharmacies, fostering an environment that encourages reporting and compliance.

Fiduciary Responsibility: Ensures PBMs prioritize the health plans they serve, aligning their interests with optimal patient care. The bill establishes fiduciary responsibility to the hiring insurance company.

Patient Freedom: The bill protects patients from unnecessary penalties, allowing them the freedom to choose their preferred pharmacy within the PBM network. It also allows pharmacies to join preferred or non-preferred networks.

Copay Accumulator: The bill will require commercial health plans and PBMs in Wisconsin to count the value of copay assistance toward patient cost-sharing requirements while still allowing insurers to retain plan design flexibility.

340 B: Prevents PBMs from discriminating against hospitals and clinics that participate in the federal 340B program, which provides discounted prescription drugs provided by manufacturers for high-need patients.

December 6, 2023

To: Chair Felzkowski
Senate Committee on Insurance and Small Business

From: Wisconsin Primary Health Care Association

RE: In Support of Senate Bill 737

Chair Felzkowski and members of the Senate Committee on Insurance and Small Business:

On behalf of the 19 Community Health Centers in Wisconsin, WPHCA supports Senate Bill 737 as a crucial step forward to address predatory practices such as discriminatory pricing and overly burdensome audits by Pharmacy Benefit Managers (PBMs) and increase access to affordable health care for Wisconsinites.

WPHCA is the membership organization for the 19 Federally Qualified Health Centers (FQHCs or Health Centers) in Wisconsin. Community Health Centers are non-profit, community-directed medical, dental, and behavioral health providers. Provision of pharmacy services is also an essential component of the primary care model. In 2022, Community Health Centers served nearly 300,000 patients in communities throughout the state, including patients from every county. One in five patients lack insurance, and 70% of patients are at or below 200% of the Federal Poverty Level, which is $30,000 for a family of four. WPHCA appreciates this opportunity to provide comments in support of SB 737 and appreciates the continued leadership of Sen. Felzkowski and Rep. Schraa on this issue.

Community Health Centers work with PBMs to meet the needs of patients utilizing private insurance or Medicare for prescriptions. Half of the state's Community Health Centers operate in-house pharmacies, some rely strictly on contract pharmacies, and several use both methods for prescription distribution or supplement with mail order options. Community Health Centers report that PBMs implement unfair auditing practices mired in non-value add administrative burden and unfairly targeted entities participating in the federal 340B Drug Pricing Program through discriminatory contracting.

Established in 1992, the 340B Drug Discount Pricing Program enables "covered entities" to purchase outpatient drugs (prescription drugs and biologics other than vaccines) at reduced prices, allowing them to expand access to affordable prescription drugs for patients. Covered entities include Federally Qualified Health Centers, tribal clinics, certain hospitals, and others that disproportionately provide care for individuals with limited resources, such as low-income individuals or the uninsured. In addition, covered entities receive savings through the program on certain prescriptions covered by commercial insurance and Medicare.

2810 Crossroads Dr Suite 2700, Madison, WI 53718
608-277-7477 wphca.org

Administered by the Health Resources and Services Administration (HRSA), the program goal is to "stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services" and extend reach for entities that serve large populations of low-income and uninsured patients. Drug manufacturers must offer 340B discounts to covered entities in order to have their drugs covered under Medicaid. HRSA calculates a 340B ceiling price for each covered outpatient drug, which represents the maximum price a manufacturer can charge a covered entity for the drug. This is based on a formula; if manufacturers raise prices too steeply there are penalties and price reductions for 340B purchases.

The 340B program allows Community Health Centers to purchase outpatient medications at significantly reduced costs, enabling them to provide affordable discounted or free medications to uninsured and underinsured patients. By law and statute, Community Health Centers, are required to invest every penny of 340B savings into activities that expand access for their patients. The 340B program generates savings that are reinvested in the Community Health Center to meet the unique needs of their communities like dental care, behavioral health, chronic disease management, translation services, food access programs, and co-pay assistance programs.

SB 737 provides various protections to 340B covered entities like Community Health Centers in regard to PBM contracts and operations. It prohibits PBMs from:

- Refusing to reimburse a 340B covered entity or contract pharmacy from dispensing 340B drugs;
- Imposing requirements or restrictions that are not applied to other entities;
- Reimbursing 340B entities at a different rate relative to non-340 entities; and
- Applying network restrictions to 340B entities.

At least 16 states have passed laws protecting Community Health Centers from discriminatory 340B pricing in PBM contracts. Without these protections, the benefit of the program towards patient care is essentially transferred from the intended non-profit, local community-based entities to for-profit organizations.

One Wisconsin Community Health Center example demonstrates the key issue that SB 737 would address in which a PBM contracts with the pharmacy for a *lower* dispensing fee as a 340B covered entity than it would for a non-340B entity. Through this practice, the PBM unfairly targets the health care entity simply on the basis of its participation in the 340B program, intended to benefit patients and health care organizations that disproportionately provide care for medically under-served populations. "Discriminatory contracting from PBMs is a real concern related to the 340B Program, both as a financial issue and for the potential of steering patients to non-preferred pharmacies as well as pickpocketing Health Center savings, as intended by Congress. One of the PBMs we contract with recently provided a contract with a $2.00 dispensing fee for generic drugs. When they realized that Lakeshore participates in the 340B Program, the PBM reduced the dispensing fee to $1.00 for generic drugs and added a requirement to identify drugs purchased through the 340B program. This reduces Lakeshore's savings on every single drug covered under the program. Correcting

administrative errors from PBMs, identifying appropriate alternative therapies for patients, and responding to an ever-changing 340B landscape costs time and money, and diverts our attention from our core mission of providing excellent care for under-served patients," shared Kristin Blanchard Stearns, CEO, Lakeshore Community Health Care.

PBMs also disrupt Community Health Center operations and needlessly force clinics to jump through hoops during auditing processes. We appreciate this bill's efforts to address unfair auditing process. For example, a recent PBM audit required individual faxes for individual documents requiring dozens of hours of administrative time from clinic staff, including a pharmacy student intern, to comply with the request.

Thank you for the opportunity to share information regarding the impacts of PBM practices on Community Health Centers and our patients, and for your consideration of SB 737.

Richelle Andrae

Richelle Andrae
Government Relations Specialist
Wisconsin Primary Health Care Association
randrae@wphca.org | 608-571-6168

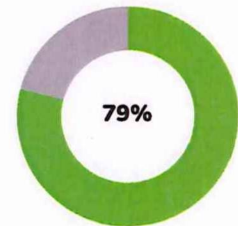
January 2023

WHAT IS A COMMUNITY HEALTH CENTER?

There are 19 federally-designated Community Health Centers in Wisconsin with more than 200 service delivery sites, serving nearly 300,000 patients.

DID YOU KNOW?

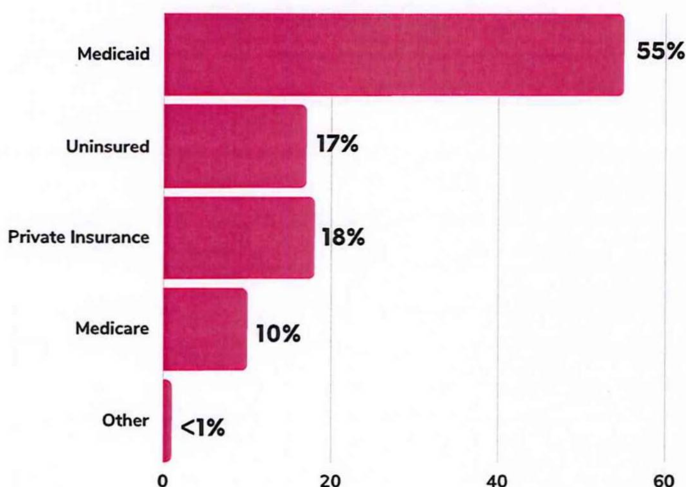
- Community Health Centers are clinics that provide **primary care services, including check-ups, behavioral health, dental care, substance use disorder treatment,** and enabling services like care coordination and community referrals.
- Wisconsin's 19 Community Health Centers are part of a national network of clinics that serve as the medical home for over **29 million people** of all ages in over 12,000 communities.
- Community Health Centers provide services to everyone **regardless of insurance status,** with fees adjusted based on a patient's ability to pay.
- Because of their special federal designation, Community Health Centers participate in unique programs like the **National Health Service Corps,** a program to place providers in areas without enough providers to serve the population.
- Community Health Centers receive **limited funding from public investments** to provide care for uninsured individuals and high-need populations (approximately one-third of revenue is state or federal grant funding).
- Every $1 in federal investments generates $7 in economic activity across Wisconsin, delivering over **$652 million in economic activity annually.**



79% of Community Health Center patients live below 200% of the Federal Poverty Line.

The Federal Poverty Line in 2021 is $26,500 for a family of four.

Insurance Status of Wisconsin Community Health Center Patients



WHAT MAKES COMMUNITY HEALTH CENTERS UNIQUE?

Community Health Centers are:

- Dedicated to filling gaps in traditional health care systems by serving under-resourced communities
- Private or public not-for-profit organizations
- Located in or serving high need communities, based on federal requirements, which may be urban or rural areas
- Governed by a patient-majority Board of Directors
- Responsible for meeting performance and accountability requirements and publicly reporting clinical and financial data to the federal government

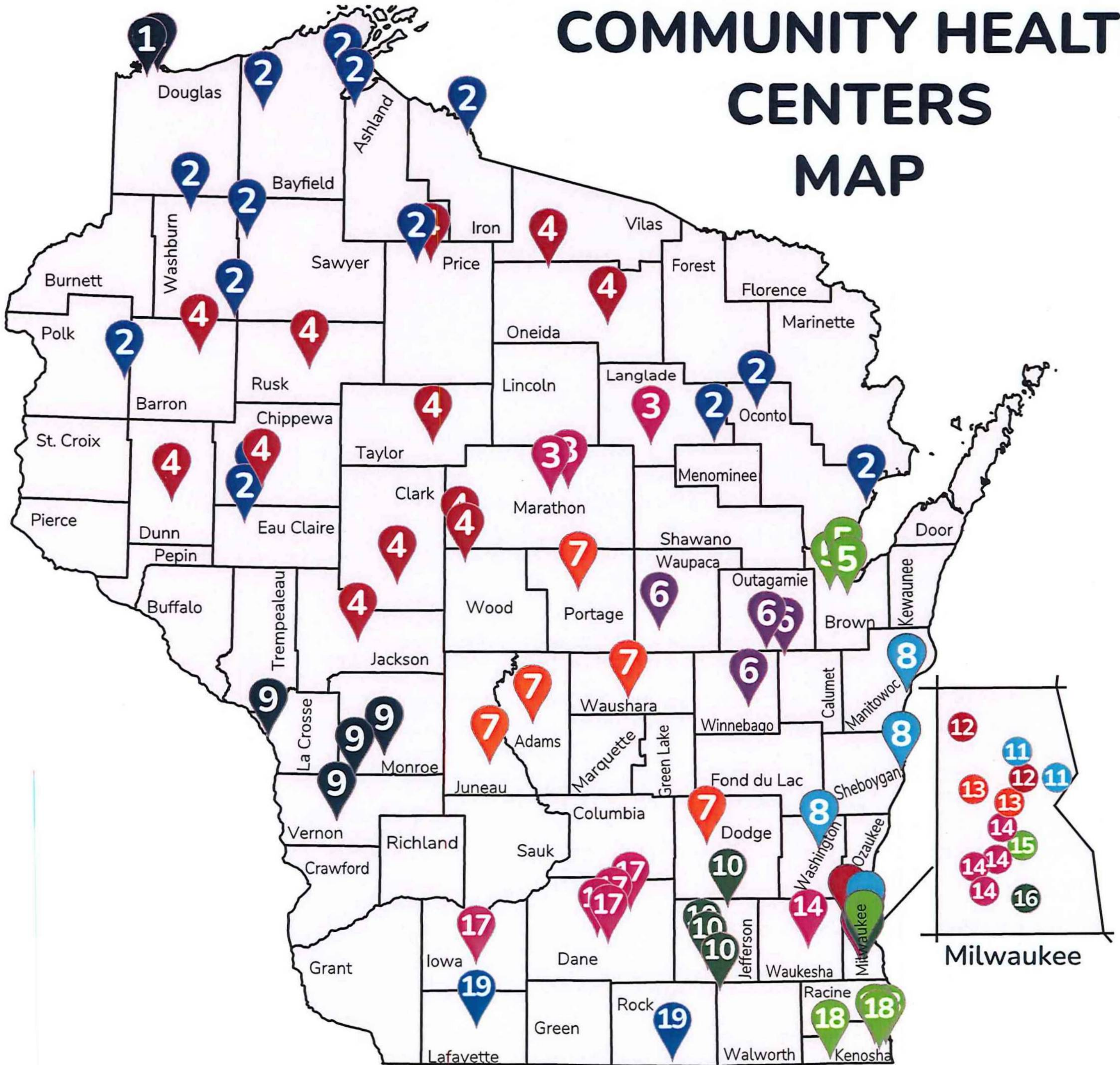
Community Health Centers sit at the crossroads of health care and public health. They are not:

- Hospitals or health systems
- Free and charitable clinics
- Local public health departments

Richelle Andrae
e: randrae@wphca.org
p: 608-571-6168

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,123,023. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

WISCONSIN COMMUNITY HEALTH CENTERS MAP



1. Lake Superior Community Health Center
2. NorthLakes Community Clinic
3. Bridge Community Clinic
4. Family Health Center of Marshfield
5. N.E.W. Community Clinic
6. Partnership Community Health Center
7. Family Health La Clinica
8. Lakeshore Community Health Care
9. Scenic Bluffs Community Health Centers
10. Rock River Community Clinic
11. Outreach Community Health Centers
12. Milwaukee Health Services, Inc.
13. Progressive Community Health Centers
14. Sixteenth Street
15. Gerald L Ignace Indian Health Center
16. Muslim Community & Health Center
17. Access Community Health Centers
18. Kenosha Community Health Center
19. Beloit Community Health Systems

WPHCA
Wisconsin Primary Health Care Association

Updated January 2023

wphca.org

HUMALOG

Where the Money *Really* Goes

Pharmacists United for TRUTH & TRANSPARENCY

ELI LILLY
(Manufactures the Insulin Drug)
$135* NET PRICE

\+

BROKERS — $25

PHARMACY BENEFIT MANAGERS (PBM)
(Negotiates Discounts & Rebates; Contracts with Groups & Insurers to Manage Pharmacy Benefits)

HEALTH INSURERS

PBM & Health Insurers — $407

$432

\+

WHOLESALERS
(Purchases from Drug Manufacture & Sells to Pharmacies)
$20

\+

PHARMACY RETAILERS
(Sells & Dispenses Drug to Patients)
$7**

=

PATIENTS
$594 PHARMACY COUNTER PRICE

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.*

FEDERAL TAX DOLLARS USED AGAINST INDEPENDENT PHARMACIES

CVS Caremark says it pays independent pharmacies more than it pays its own pharmacies. Evidence suggests otherwise:

Walgreens $4.65

Michelle's Pharmacy $1.26

Harry's Pharmacy $1.26

Mason City Pharmacy $1.57

CVS pharmacy $8.35

John's Medical Pharmacy $1.26

Stacy's Pharamcy CLOSED $1.26

SavMor Pharmacy Mt Pulaski $1.26

ILLINOIS

SavMor Mt Zion CLOSED $1.26

Pharmacy Plus Inc $1.26

Walmart $8.87

Kroger $7.37

Hopsdale Pharmacy $1.26

Sullivan Drugs (Carlinville) $1.26

Potter Drug $1.26

Athens Pharmacy $1.26

Atlanta Telepharmacy $1.26

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

To:	Members, Senate Committee on Insurance and Small Business
From:	Rebecca Hogan, on behalf of the Alliance of Health Insurers
Date:	December 6, 2023
Re:	Testimony on SB 737

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 category and will consistently outpace that of other health spending.

In response, 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 manufactures 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

10 East Doty Street, Suite 500 • Madison, WI 53703 • 608-258-9506
R.J. Pirlot, Executive Director, pirlot@hamilton-consulting.com
www.allianceofhealthinsurers.com

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

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 by the groups representing health plans.

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

Thank you for this opportunity to testify.

[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

10 East Doty Street, Suite 500 • Madison, WI 53703 • 608-258-9506
R.J. Pirlot, Executive Director, pirlot@hamilton-consulting.com
www.allianceofhealthinsurers.com

AHIP Testimony to the Wisconsin Senate Insurance and Small Business Committee re: SB 737
Wednesday December 6, 2023

Madame Chair, my name is Patrick Lobejko and I'm with America's Health Insurance Plans, better known as AHIP.

I'm testifying today to respectfully oppose SB 737, legislation which imposes substantial requirements on prescription drug benefits provided by health insurance providers and pharmaceutical benefits managers.

Everyone should be able to get the medications they need at a cost they can afford. But drug prices are out of control, and hardworking Wisconsin families feel the consequences every day. In response, employers, HMOs, health insurance providers, and various government entities have turned to PBMs as partners to administer efficient and effective prescription drug benefits. PBMs are the primary lever available to health plans to ensure their enrollees can obtain the medications they need at the lowest possible cost; and that providers and pharmacies are providing quality care.

Legislation such as SB 737 will disrupt this partnership by imposing government mandates that will increase costs for Wisconsinites and remove vital safety measures developed through private market innovations. Now AHIP has strong concerns with several provisions in the bill, I want to focus my testimony on 2 sections, 10 and 12.

Section 10: Section 10 impedes necessary formulary changes that keep patients safe and provide greater options to consumers. Health insurance providers and PBMs use various utilization protocols and methods to ensure that patients receive safe, effective, timely, and cost-efficient care, such as formulary benefit design. Proposals that limit or take away such management tools stifle the flexibility and innovation which currently allows health plans and PBMs to provide value to consumers.

Our members use nationally recognized care criteria, the input of clinical experts – including pharmacists and physicians – who serve on our pharmacy and therapeutics committee, and consideration of the latest medical evidence and literature reviews to create and mange formularies. Formularies often require updates during the plan year and prior to the renewal date due to circumstances this proposed legislation does not take into consideration.

Health plans and PBMs need flexibility to immediately react to changes in the market such as new information about the efficacy and safety of both new and old prescription drugs. And equally important, health insurance providers need flexibility to foster competition amongst drug manufacturers to control costs.

Section 12: Section 12 exploits Big Pharma's bait and switch copay coupon game that distorts the prices of prescription drugs. Everyone should be able to get the medications they need at a cost they can afford, without having to use a coupon. On top of high list prices, Big Pharma uses copay coupon schemes to price gouge patients.

Employers and health insurance providers have worked hard to develop programs that attempt to better reflect patients' actual out-of-pocket spending on drugs and to shed light on these pricing schemes. It is critical to have guardrails in place against this kickback system to ensure transparency and affordability in drug pricing for every American. Accumulator programs help restore balance in the

system by allowing the patient to use manufacturer coupons, but not counting the coupon towards the deductible – since the drug manufacturer is paying the amount of the coupon.

Legislation like SB 737 which attempts to ban accumulator programs will eliminate incentives for drug companies to lower prices, as they can continue to replace real price reductions with coupons as a work-around to health plan cost-sharing. As a result, drug companies will make more money while consumers and businesses will continue to foot the bill through higher premiums, out-of-pocket expenses, and federal insurance subsidies.

Health insurance providers and PBMs work tirelessly to keep up with Big Pharma's market distorting price tactics. A novel approach that has recently been developed allows prescription drug purchasers to maximize the benefit obtained from copay coupons. Maximizer programs enable PBMs to distribute coupon assistance across the benefit year and lower costs for everyone.

Madame Chair, thank you for your time and consideration of AHIP's concern and opposition to SB 737. We stand ready to partner together in making health care more affordable and accessible for the residents of Wisconsin.

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

---

[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

---

[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.

---

[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

[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

[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*

[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)

---

[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

---

[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.

Senate Bill 737
Senate Committee on Insurance and Small Business
December 6, 2023

Chair Felzkowski, members of the Committee, thank you for the opportunity to provide testimony today regarding Senate Bill 737 (SB 737). 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.

Yesterday, our Association joined several other trade associations in circulating a memo to the Legislature detailing our significant concerns with and opposition to SB 737. 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 SB 737 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 SB 737—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. SB 100, as incorporated into SB 737, 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. SB 737 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 SB 737. I am happy to answer any questions you may have at this time.

Coalition of Wisconsin Aging & Health Groups

Financial Empowerment – Personal Advocacy – Victim Rights

"Advocating for all Generations"

The Coalition of Wisconsin Aging and Health Groups is a nonprofit, nonpartisan, statewide membership organization that was founded in 1977.

December 6, 2023

Senate Committee on Insurance and Small Business: SB 737 Testimony

Good morning, Chair Felzkowski and members of the Committee, thank you for holding this hearing today. I'm Rob Gundermann, President and CEO of the Coalition of Wisconsin Aging and Health Groups. My organization is proud to lead the Wisconsin All Copays Count Coalition, comprising more than 40 national and Wisconsin-based patient and provider groups serving the interests of patients with chronic and serious health conditions that rely on copay assistance to access critical medications.

On behalf of the Coalition, I'm here to express our strong support for Senate Bill 737, especially the copay accumulator provisions in the bill, and urge the Committee to support this legislation. Copay assistance programs were first created by manufacturers in response to efforts from health plans to shift the cost burden of prescription medications on to patients. As a result, countless patients with chronic and complex conditions that require specialty medications depend on copay assistance to access life-saving treatments and manage their health. In response, health plans began implementing "copay accumulator adjustment programs", which don't count the value of copay assistance towards patients' cost-sharing responsibility.

Copay assistance is a critical lifeline for many patients across our state, many of whom I've heard from first-hand. With me today is Madiline Rettmann, a Certified Pharmacy Technician at Aurora Health who in her work sees on a daily basis how copay accumulator programs impact patients. Also with me today is Denise Seyfer. Denise is living with Pulmonary Arterial Hypertension and will tell you how accumulator programs affect people like her.

We and many others in this room are here on behalf of all Wisconsin patients who are looking to you to take action to protect copay assistance for patients and ensure that those in greatest need of treatment are able to access consistent, effective care. These copay accumulator programs are spreading. Two different insurance plans have recently sent letters to patients receiving copay assistance saying that accumulator programs will be added to their plans in 2024. One of those patients who is at the Mayo Clinic today or would be here, asked me to share the letter she received with you. You will find a copy of that letter with my testimony.

On behalf of the Wisconsin All Copays Count Coalition and the countless patients and providers we represent, I thank you for holding this hearing and listening to us today, and urge you to support Senate Bill 737, which includes a simple solution to a devastating problem and would alleviate a great deal of pain and fear for patients across Wisconsin. Thank you.

30 West Mifflin St. Suite 406 ■ Madison, WI 53703
Telephone: (608)224-0606 ■ Fax: (608) 244-4064 ■ Toll Free: 800-488-2596 ■ www.cwag.org
CWAG is an equal opportunity service provider.

Optum Rx®

P.O. Box 510941
Livonia, MI 48151-6941

SUN PRAIRIE, WI 53590

Important copay card information

October 2, 2023

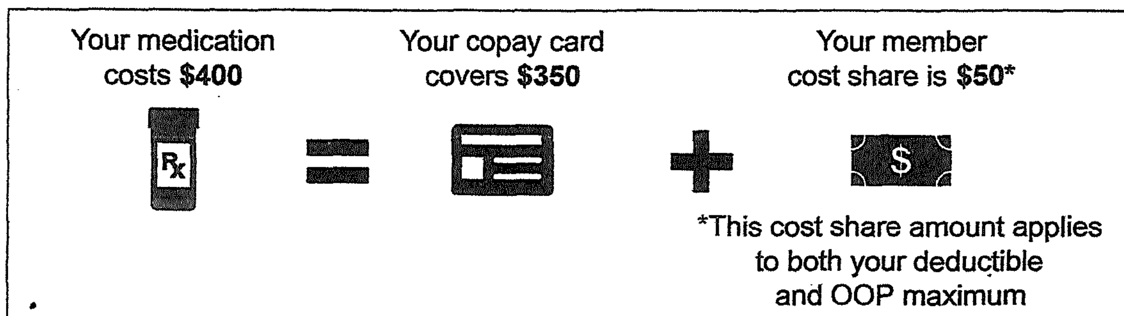
Dear [redacted]

Many people look for ways to help save on high-cost brand-name medications. One way is to use copay cards from drug manufacturers. Copay cards can lower your prescription drug out-of-pocket (OOP) costs, but there may be limits on how much you can save each year.

Starting January 1, 2024 if you use a copay card to pay for your prescription(s), the amount covered by the copay card will not count toward your deductible or OOP maximum. Only your OOP costs will be applied to your deductible and OOP maximum.

In the example below, your copay card covers $350 of your medication cost of $400. Your member cost share of $50 is the only amount that counts toward your deductible and OOP maximum.

How it works:



Questions? We're here to help.
Call the number on your member ID card. Thank you for letting us serve you and to help you make the best use of your pharmacy benefits.

Sincerely,

The Optum Rx team

December 5, 2023

The Honorable Mary Felzkowski
Chair, Senate Committee on Insurance and Small Business
Room 415 South
State Capitol
PO Box 7882
Madison, WI 53707

Dear Chair Felzkowski Members of the Committee:

I am writing on behalf of the National Community Pharmacists Association (NCPA) in support SB 737, which would help control drug costs in Wisconsin, provide transparency for patients and employers regarding their prescription drug benefits programs, and establish greater oversight of the pharmacy benefit managers (PBMs) that administer those benefits.

NCPA represents the interest of America's community pharmacists, including the owners of more than 19,400 independent community pharmacies across the United States and nearly 255 independent community pharmacies in Wisconsin. These pharmacies employed more than 3,137 residents and they filled nearly 16 million prescriptions in 2021.

Community pharmacists have long known that opaque PBM practices not only hamper patients' ability to obtain pharmacy services from their trusted community pharmacists, but those practices can also lead to higher drug costs for both patients and plan sponsors. Due to the massive consolidation and vertical integration in the health insurance market[1], the three largest PBM's control 80% of the prescription drug market[2] giving them the power to engage in abusive practices which limit patient access, increase drug costs and threaten the viability of small business pharmacies.

NCPA strongly supports the bill's important provisions that protect patient choice, empowering patients to make their own healthcare decisions free from a PBM's conflict of interest. It is not uncommon for a PBM to require patients to utilize a PBM-owned or affiliated pharmacy, often a mail-order pharmacy. The PBM is then free to reimburse its pharmacy at higher rates, thereby forcing patients and plan sponsors to pay higher costs to the PBM. The bill's provisions will diminish the likelihood of PBMs steering a patient to a PBM-owned or affiliated pharmacy or mail order, preventing the PBM from charging artificially higher rates. These provisions ensure a patient can choose a pharmacy that's in the patient's best interest, not just what's in the PBM's best interest. Because the bill requires PBMs to make network access available to pharmacies only if they meet the same terms and conditions as PBM-affiliated pharmacies, there is assurance against the type of rising costs that opponents of the bill falsely suggest.

---

[1] https://ncpa.org/sites/default/files/2023-01/verical-bus-chart.jpg
[2] Drug Channels: The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger

100 Daingerfield Road
Alexandria, VA 22314-2888
703.683.8200 PHONE
703.683.3619 FAX

We appreciate the bill's protections against under-reimbursement to pharmacies. We support the bill's comprehensive provisions for establishing an administrative appeals process. It is excellent policy to have instances of corrected underpayment apply to all similarly situated pharmacists and pharmacies subject to the same applicable pricing information. We support the provision giving the pharmacist the right to decline to dispense when faced with below-cost reimbursement. We commend the author for these provisions.

NCPA strongly supports using a transparent reimbursement pricing model using cost-based reimbursement methodology as proposed in the bill. This is not a novel approach as both the states of West Virginia[3] and Tennessee[4] have enacted similar provisions. This transparent reimbursement approach will ensure that both the insured and plan sponsor know how their money will be spent. We support the proposal's use of transparent benchmarks such as the national drug acquisition cost (NADAC), which is updated on a weekly basis. We similarly support use of a regularly updated dispensing fee based on pharmacies' cost to dispense using the Centers for Medicare and Medicaid Services (CMS)-approved figure.

The bill would also prohibit retroactive fees that end up increasing out-of-pocket costs for patients. When a PBM has reimbursed a pharmacy for filling a prescription, it is not uncommon for the PBM to claw back a portion of the reimbursement days, weeks, or even months later, and often under the guise of effective rate reconciliations or "transaction fees." However, a patient's cost share is not similarly retroactively adjusted. This means that a patient's cost share is based on an arbitrarily inflated figure. By prohibiting fees and retroactive claim reductions, the bill will ensure patients' cost shares more accurately reflect the true cost of their health care services.

We also support the prohibition on accreditation standards and quality programs, which are often applied arbitrarily in PBM contracts. State boards of pharmacy are charged with protecting the health and well-being of the citizens in their state. When PBMs start making decisions regarding who can practice and how they can practice, they are stepping into the domain of the state board of pharmacy and restricting access to otherwise qualified pharmacists. This has negative consequences on patient access to care and patient choice.

Pharmacists understand that audits are a necessary practice to identify fraud, abuse, and wasteful spending, and they are not opposed to appropriate audits to identify such issues. Current PBM audits of pharmacies, however, are often used as an additional revenue source for the PBM. PBMs routinely target community pharmacies and recoup vast sums of money for nothing more than harmless clerical errors where the correct medication was properly dispensed and no financial harm was incurred. In many instances, the PBM not only recoups the money paid to the pharmacy for the claim in question but also recoups for every refill of that claim, even if all other fills were dispensed without error.

---

[3] West Virginia Code 33-51-9 (e)
[4] Tennessee Code 56-7-3206 (c)(1) and (f)

If NCPA has any constructive criticism to the bill, it would be to point out that the legislation has no terms for enforcement. States are increasingly authorizing stronger enforcement and oversight to the Office of the Insurance Commissioner, providing a range of tools such as authority to issue fines, to audit PBMs, and to potentially bar PBMs from doing business in the state after multiple violations. NCPA strongly encourages the addition of these provisions to the bill, offering Florida's SB 1550 from 2023 as a potential model.[5]

In closing, NCPA strongly supports this legislation and thanks Senator Felzkowski and Representative Schraa for their leadership on the bill. Thank you for receiving our perspective. If you have any questions, please do not hesitate to contact me at (703) 600-1186 or joel.kurzman@ncpa.org.

Sincerely,

Joel Kurzman
Director, State Government Affairs

[5] https://www.flsenate.gov/Session/Bill/2023/1550/BillText/er/HTML

Global Healthy Living Foundation
515 North Midland Avenue
Upper Nyack, New York 10960 USA
+1 845 348 0400
+1 845 340 0210 fax
www.ghlf.org

Dr. Robert Popovian, Pharm.D., MS
Chief Science Policy Officer, Global Healthy Living Foundation

Senate Bill 737 Proponent Testimony
Wisconsin Senate Insurance and Small Business Committee

December 15, 2023

Chair Senator Mary Felzkowski and members of Wisconsin Senate Insurance and Small Business Committee, my name is Dr. Robert Popovian; I am the Chief Science Policy Officer of the Global Healthy Living Foundation (GHLF).

GHLF is the umbrella organization for disease-specific patient communities. A full explanation of our activities, organizations, and funding sources is available on our homepage, and we invite all healthcare stakeholders to view our quarterly reports detailing the multitude of patient-centered innovations that GHLF has led over its 24-year history.

I am writing in support of SB 737. The passage of this legislation will ensure that patient support provided by any entity, including the biopharmaceutical manufacturers, is only utilized for the benefit of the designated patient and that all of the support counts towards a patient's health insurance deductible and maximum out-of-pocket liability. Our interactive tool demonstrates that state laws guaranteeing that all patient assistance benefits count towards a patient's deductible and maximum out-of-pocket liability have not increased the cost of health insurance. We have done inter and intra state analysis concerning premiums. In both cases, **absolutely no** statistical, numerical, or visual evidence suggests that such laws impact health insurance premiums in states that have passed laws protecting patients (19 states) versus those that have not yet done so.

It is essential also to note that two politically diverse states, New York and Texas, have passed similar laws guaranteeing that for-profit pharmacy benefit management (PBM) and insurance companies are not confiscating the manufacturer's support, while patients are saddled with high deductibles and out-of-pocket maximums. Patients in Wisconsin need similar protection. PBMs and insurers should not be allowed to collect assistance meant for patients and then punish patients and make them pay for the entire deductible or maximum out-of-pocket expenses. You need to stop this double-dipping scheme espoused upon Wisconsin patients needing life-saving medicines. It is time to stop middlemen from punishing sick patients for profit.

GHLF invites everyone to visit our free interactive site and transparently explore the data for themselves. All of the data utilized in calculating premiums has been captured through the HIX database, a program sponsored by the Robert Wood Johnson Foundation.

Thank You,

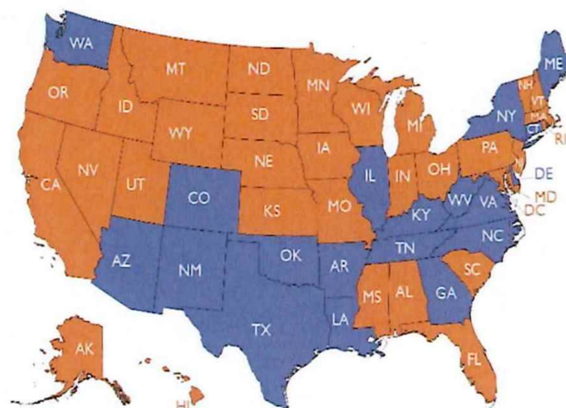
Dr. Robert Popovian, Pharm.D., MS
Chief Science Policy Officer, Global Healthy Living Foundation
Senior Health Policy Fellow, Progressive Policy Institute
Visiting Health Policy Fellow, Pioneer Institute

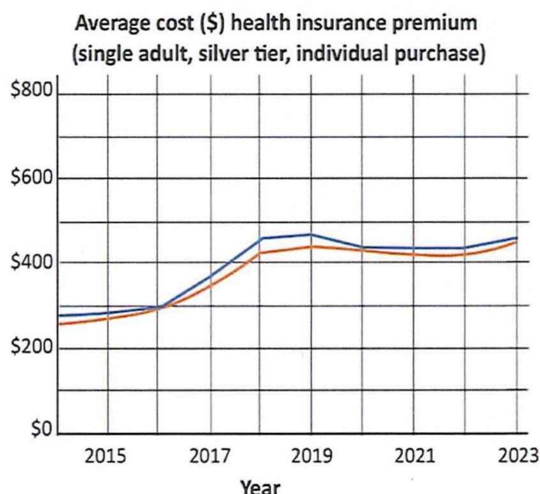
Cc: Louise Tharp, Executive Director, GHLF

GLOBAL HEALTHY LIVING FOUNDATION

Protecting Patient Assistance Programs Has Not Increased the Cost of Buying Health Insurance

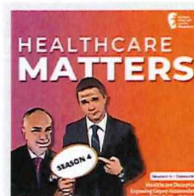
Nineteen states, shown in blue, have passed laws to protect patient assistance programs by banning **accumulator** and **maximizer clauses** in health insurance policies. Accumulators and maximizers stop patient assistance from counting toward a patient's out-of-pocket maximum and deductible. **This means the insurer is receiving the benefit of assistance, not the patient.**





Insurance companies and pharmacy benefit managers say banning these will increase the cost of health insurance, but our analysis shows this has not been the case. As shown on the graph, the rate of change in health insurance costs has been no different in states with vs states without laws banning accumulators and maximizers.

We have developed many other resources on our website to help make sense of this complex issue. Be sure to watch our educational webinar, read our curated articles and listen to our podcast episodes on this important topic.



You can use our free interactive tool to see the data for yourself, and access all of our resources at:

linktr.ee/law4pap or scan the QR code

For questions or to learn more, contact Robert Popovian at rpopovian@ghlf.org

To: **Chairwoman Mary Felzkowski and Members of the Senate Insurance and Small Business Committee**
From: **Employers for Advancing Free Market Healthcare**
RE: **Written Testimony on Senate Bill 737 as introduced**
Date: **December 6, 2023**

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 Senate Bill 737 and have concerns about many of the bill's provisions.

We are disappointed that the timing of the hearing did not allow employers to attend and share our concerns with you directly. As a result, we are submitting written testimony but 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, SB 737 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 driving up taxes in the process.

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 SB 737 not only shields 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 SB 737 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. SB 737 does nothing to address the very important issue of health industry consolidation, which is a concern for purchasers of healthcare across the spectrum. If SB 737 does not address the root causes of the problem, we must ask ourselves if the provisions of SB 737 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.

Testimony Opposing Senate Bill 737

Melissa Duffy, Government Affairs
December 6, 2023

Common Ground Healthcare Cooperative (CGHC) is a non-profit, member governed cooperative that provides health insurance to Wisconsin's early retirees, entrepreneurs, small employers and thousands of individuals working in jobs that do not offer employer-sponsored health coverage. We have been directed by our consumer-run Board of Directors to advocate for reducing the cost of care and coverage for our members wherever possible.

We believe Senate Bill 737 (SB 737) would increase costs to our enrollees, and therefore we oppose the legislation on behalf of our members that live in both rural and urban areas of Wisconsin, primarily due to the following harmful provisions:

- **Restrictions on mail order:** PBMs offer significant savings on medications distributed through mail order, and many individuals have come to rely on mail order for their maintenance medications which saves them time and money and helps them remain adherent to their medication regiment. SB 737 would keep us from passing those savings along to our members that are using mail order, much to the detriment of the families we serve that are using this service. It is not that many of our members do not also appreciate their hometown pharmacy which may bring other benefits, but it is not good policy to force our members to pay more for medicine that costs less. This is particularly true for our rural members who rely on medications through mail.

  Even more concerning is the possibility that the bill intends to restrict our use of specialty pharmacies. In our health plan, only about 2-3% of our members are using specialty medications at any given time, but these members account for about half of our total pharmacy spend. A previous analysis done during consideration of the 2019 version of the PBM showed that our members are saving almost $3 million due to our use of specialty pharmacies, not to mention the added safety measures and care coordination that specialty pharmacies provide through their teams of nurses, pharmacists and other clinicians working with patients with complex health needs.

- **Eliminating copay accumulator and maximizer programs:** Financial assistance programs offered by drug manufactures are designed to drive patients to take expensive medications, shielding consumers from the high cost of these drugs. CGHC will honor drug coupons for our members that qualify, but under our policy, only the amount the member pays out of their own pocket will count toward their deductibles and maximum out-of-pockets (MOOPs).

  Obamacare imposes caps on deductibles and MOOPs, but once an individual meets their MOOP all healthcare is "free" to that person for the remainder of the plan year. It is not free of course; these costs are simply being passed along to all enrollees in the insurance plan who are typically paying their full deductibles and MOOPs out of their own pockets when they need care.

  CGHC's member-run Board of Directors recognized this as a fairness issue for our entire membership. Years ago, they made the decision to put in place the policy we have today, which helps make medications more affordable for members using coupons but requires all members to meet their cost-sharing responsibilities. This saved our cooperative over a million dollars back then when we had fewer members and fewer drugs were subject to coupons. We project that SB 737 would cost our

cooperative millions should the legislature force us to reverse the policy. That money would come directly from the pockets of our members.

We further encourage committee members to consider the perverse incentives created by the language inserted in SB 737. The bill will allow drug manufacturers to pay consumers to take their medications by giving them money to satisfy their MOOPs. It enables them to collect very high prices from insurers once these MOOPs are satisfied. Consumers will not want to get off these medications that allows them to choose the lowest cost health plan with the highest deductible/MOOP plan knowing the costs will be covered by pharma anyway. And the consumers that are not taking drugs with coupons? They will pay more for coverage while satisfying their deductibles and MOOPs on their own. The incentive this creates for drug companies is to drive prices higher to maximize their coupons.

- **Accreditation Standards:** While this is not a cost issue as much as the previous two concerns, it is a quality issue that is unworkable as written. Federal law requires health plans to be accredited by a federally recognized accrediting agency such as URAC and NCQA to serve consumers on the marketplace. These accreditation standards require us to work with PBMs that are also accredited or that meet certain standards, and they in turn must have minimum standards in place for pharmacies. It is critical that PBMs retain the right to require standards of pharmacies that are necessary for health plans to meet URAC or NCQA accreditation.

There are many other provisions of this legislation that we are happy to address should you be interested in a meeting after the hearing. In the meantime, I hope this feedback on these three provisions is helpful to the Committee while considering this legislation. Please do not hesitate to contact me at mduffy@dcstrategies.org if you have any questions or wish to discuss these issues further.

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: December 6, 2023

RE: Concerns with Senate Bill 737, Pharmacy Benefit Manager (PBM) Legislation

---

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* taken in June of this year, making healthcare more affordable is tied for the top policy action state government can take to help businesses in Wisconsin[2]. In the same survey, almost 4 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

---

[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. Senate Bill 737 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

[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 cosponsor or 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.

Pharmacy Society of Wisconsin

TO: Senate Committee on Insurance & Small Business

FROM: Janet Fritsch, RPh
Board Chair
Pharmacy Society of Wisconsin

DATE: December 6, 2023

SUBJECT: **Testimony in Favor of Senate Bill 737**

Thank you, members of the Senate Committee on Insurance & Small Business, for the opportunity to provide testimony in support of Senate Bill 737. My name is Janet Fritsch, and I am a pharmacist, the owner of Corner Drug Hometown Pharmacy in Baraboo, and the Board Chair 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 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.

Wisconsin is joining other states in pursuing needed policy intervention.

The bill's authors have shared what this legislation does – but I want to share how it will impact my patients.

---

[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.

701 Heartland Tra
Madison, WI 5371
t: 608.827.9200 f: 608.827.929
info@pswi.org www.pswi.or

It's also important to note that 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 like mine 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 Senate Bill 737. I am happy to answer any questions you may have.

---

[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

SUPPORT PBM REFORM IN 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.

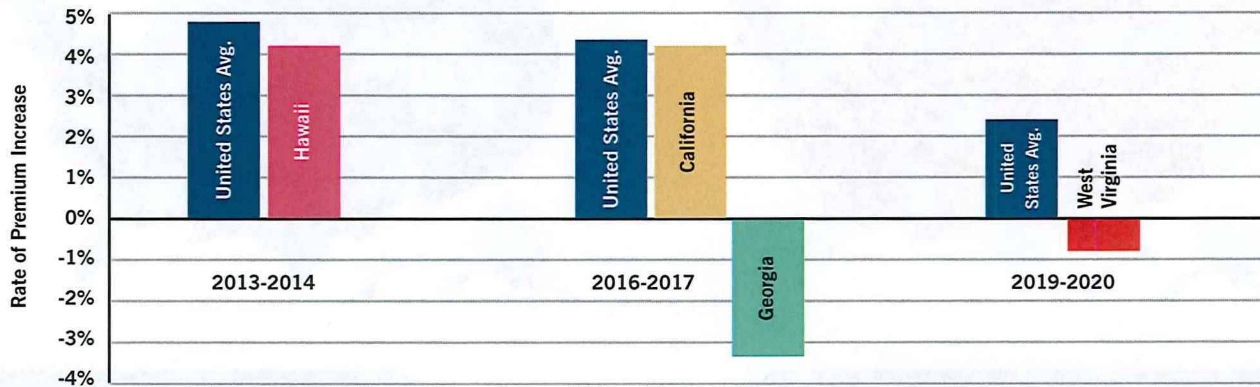
$633.5 Billion
amount the U.S. spent on prescription drugs in 2022[1]

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

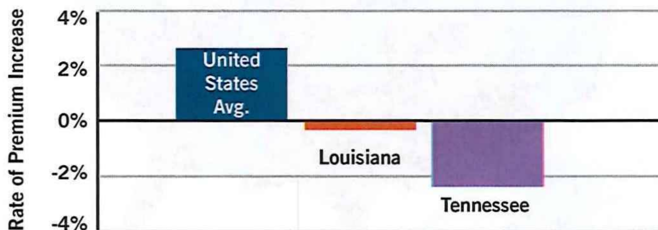
PBM REFORM HAS NOT RAISED COSTS FOR PATIENTS AND PAYERS

Rates of Premium Increases are LOWER in States with PBM Reforms

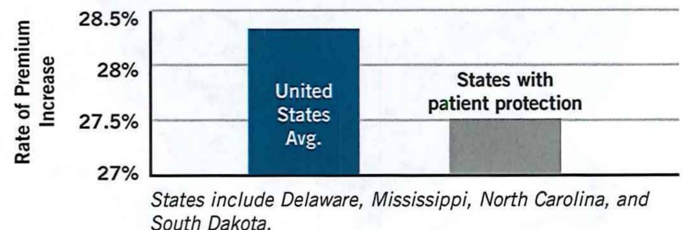
States that Protect Patients from Mandated Use of a Mail-Order Pharmacy[3]



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



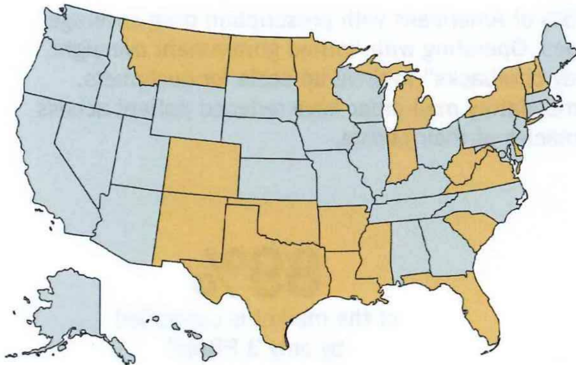
States that Protect Patients from PBM Penalties (e.g., Higher Copays) for Utilizing the In-Network Pharmacy of their Choice (2013-2020)



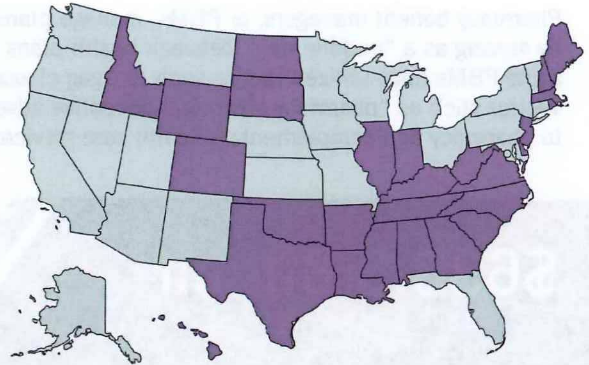
States include Delaware, Mississippi, North Carolina, and South Dakota.

STATES THAT HAVE PASSED PBM REFORM AS OF 2023

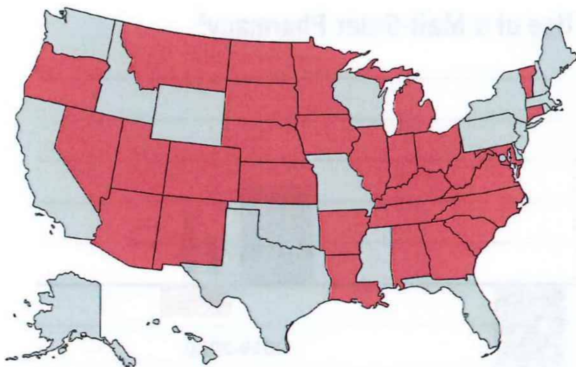
Accreditation Requirement Transparency



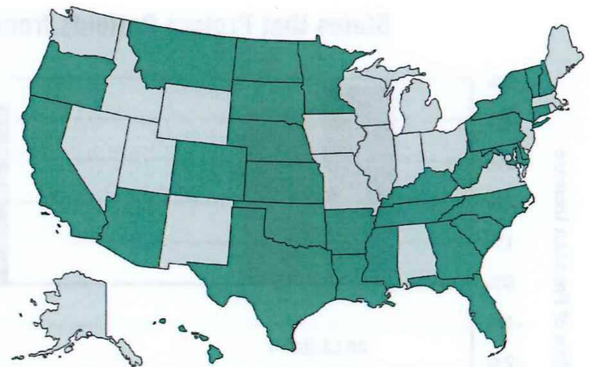
Any Willing Pharmacy (AWP)



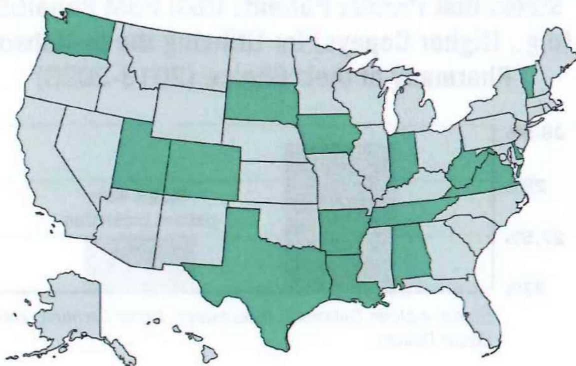
340b Non-Discrimination



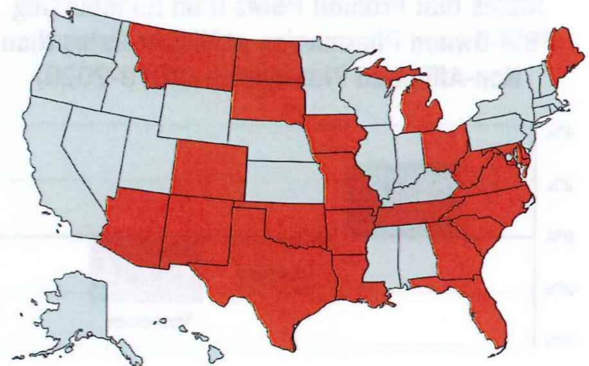
No Mandatory Mail Order



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

Senate Committee Testimony - Dec 6, 2023

Thank you Committee ChairPerson and Committee Members

I am here representing Fitchburg Family Pharmacy, a family owned and operated business in Fitchburg, WI. My testimony is on SB 737 - The Pharmacy Benefit Manager Accountability Act.

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

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

December 6, 2023

To: Wisconsin Senate Committee on Insurance and Small Business
From: The American Cancer Society Cancer Action Network
Re: Testimony in Favor of Senate Bill 737

Good morning, Chairwoman Felzkowski 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 is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society advocating for evidence-based public policies to reduce the cancer burden for everyone.

I appreciate the opportunity to provide testimony in support of Senate Bill 737 the newly introduced 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 receive 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.

This legislation would remove 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 Senate Committee on Insurance and Small Business 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 Senate Bill 737.

Thank you for your time.

KRIN STENDALEN

Cancer Story

Krin Stendalen is a cancer survivor living in Westby, WI with her husband Gary and their two children. In January 2020, Krin heard the devastating words, "you have cancer." She was diagnosed with stage three uterine cancer and began treatment with chemotherapy and radiation. After many months of treatment, she was cancer free.

Two years after her diagnosis, Krin received the heartbreaking news her cancer returned. Her new treatment plan includes daily oral chemotherapy and immunotherapy. Recently, Krin received the news her treatments are preventing her cancer from spreading. "I can still enjoy my life like I did before cancer," she said. However, taking medication every day to maintain her health comes with a steep price tag. Fortunately, Krin receives copay assistance through the drug manufacturer. Before the financial support, Krin and Gary had to dip into their retirement account to pay for the life-saving medication. Now their family has peace of mind knowing the cost of the drug keeping Krin alive is covered.

In Wisconsin, 8 out of 13 health insurance plans do not count copay assistance toward patients' out-of-pocket costs. Patients covered by these plans can use copay assistance, but those payments don't count toward their deductible or out-of-pocket maximum. Prior to 2023, Krin's insurance plan did count copay assistance toward her out-of-pocket cost requirements. However, this year they removed this benefit for all patients increasing the burden of out-of-pocket costs. 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.

For more information about All Copays Count and SB737, please contact Sara Sahli, Wisconsin Government Relations Director at Sara.Sahli@cancer.org

Dear members of the Senate Committee on Insurance and Small Business,

Thank you for holding a public hearing on Senate Bill 737. My name is Krin Stendalen, and I live with my husband Gary in Westby, WI. I'm writing to share my story because Senate Bill 737 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 Senate Bill 737.

Thank you,

Krin Stendalen
S1486 Stenslien Lane, Westby, WI

Cc: Senator Brad Pfaff and Representative Loren Oldenburg

MEMORANDUM

To: Senator Mary Felzkowski
CC: Members, Senate Committee on Insurance and Small Business
From: Bill Keeton, Chief Advocacy Officer

Re: Vivent Health Support for Healthcare Provider Protections Included in SB 737

Dear Chairwoman Felkowski and Committee Members:

On behalf of Vivent Health, please accept this written testimony in support of Senate Bill 737.

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.

1311 North 6th Street
Milwaukee, WI 53212

viventhealth.org
(800) 359-9272

Protection for 340B Providers from Discriminatory Reimbursement Practices

A key factor contributing to our successful model of care and our ability to provide care to everyone, regardless of their insurance status or ability to pay, is the 340B Drug Pricing Program (340B program). This federal program was created with bipartisan support in 1992 and allows certain safety net health care providers to purchase medications for the people we serve at a discount and reinvest the savings back into patient care and treatment. As a clinical organization receiving grants from the federal Ryan White program, Vivent Health is eligible to participate in the 340B program.

When Congress created the 340B program, it clearly intended the savings the program generates be used to help healthcare providers "stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." Except for minimal federal expenditures related to program oversight, the 340B program is not a cost to taxpayers and it is not a grant.

Discriminatory reimbursement is a practice by Pharmacy Benefit Managers and other health payors that negatively impacts 340B program covered entities by offering them lower reimbursement for medications simply because of the covered entity's participation in the 340B program. This practice runs counter to the established intent and purpose of the 340B program, namely, to help covered entities 'stretch scarce federal resources' to reach 'more eligible patients' and provide 'more comprehensive services.

Savings generated in the 340B program should be used to further patient care, not to pad the pockets of insurance companies or their PBMs. In fact, had Congress intended these savings to be given to PBMs and insurers, it would have expressly stated so in the legislation.

Other states have outlawed these discriminatory reimbursement practices for 340B drugs and Wisconsin should do the same.

Co-pay Accumulator Reform

Given the high price of medications and other out of pocket costs insured individuals face, many pharmaceutical manufacturers offer co-pay assistance programs to help low and moderate income individuals afford their medications, especially for the growing number of individuals covered by high deductible plans. Unfortunately, in 2018, PBMs and insurers started 'co-pay accumulator programs.' Under these programs, PBMs and insurers disregard third party payments made on behalf of insured individuals, often leaving patients with exorbitant out of pocket costs for their care.

Other states have put in place laws to require insurers to apply patient co-pay assistance toward meeting deductibles and out-of-pocket maximums on high deductible plans. To protect high risk patients with complex medical needs, Wisconsin should do the same.

Thank you for the opportunity to provide written testimony in support of PBM reform. Please do not hesitate to contact me if I can provide additional information on how PBMs negatively impact the ability of Vivent Health to achieve our shared goal of ending HIV as an epidemic.

Senate Bill 737
Proponent Testimony

Gary Dougherty
Director, State Government Affairs
American Diabetes Association®
Senate Insurance and Small Business Committee
December 6, 2023

Chair Felzkowski and Members of the Senate Insurance and Small Business Committee:

My name is Gary Dougherty and I am the Director of State Government Affairs for the American Diabetes Association® (ADA), the nation's leading voluntary health organization fighting to bend the curve on the diabetes epidemic. Founded in 1940, the ADA is made up of people with diabetes, healthcare professionals, research scientists, and other concerned individuals. The ADA's mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

I regret that I am unable to join you today; however, I want to thank the Chair for sponsoring Senate Bill 737 which, among other provisions, would ensure that the value of co-pay assistance programs is applied toward a patient's deductible, and urge your support for the bill.

Through policies known as co-pay accumulator adjustments, health plans will accept a patient's co-pay card or coupon but may not credit the amount toward the patient's deductible or out-of-pocket maximum. As a result, patients are forced to pay more out of their own pocket while health plans pocket both the assistance payment as well as the patient's co-pay. Blocking patient assistance can threaten the health of patients with chronic diseases like diabetes and lead to medication non-adherence or rationing. ADA research has shown that, for at least one in six insulin users, cost has impacted their use. Rationing or skipping doses of insulin is unsafe and can lead to costly and preventable emergency room and hospital visits.

For individuals living with rare and chronic conditions, like diabetes, the high cost of treatment has a direct impact on patient access. Many patients and their families rely on copay assistance programs from manufacturers and nonprofit organizations to afford the medications they need to manage their conditions - medications that rarely have generic alternatives.

Diabetes is a serious disease and must be managed according to the needs of each individual person. The ADA believes that every person living with diabetes should have access to the care, treatments, tools, and information they need to successfully manage their diabetes. It is vital that people with diabetes have the opportunity to work with their health care providers to choose the

Gary Dougherty
Director, State Government Affairs
1-800-676-4065 Ext. 4832
gdougherty@diabetes.org

1-800-DIABETES (342-2383)

most appropriate therapeutic option that best meets their individual needs at that particular time. To ensure their access to life-saving treatment, the practice of co-pay accumulator adjustments must be eliminated.

Ensuring all people with and at risk for diabetes have access to adequate and affordable health care is among ADA's principal policy priorities. SB 737 will help achieve that goal. Nineteen states have already enacted similar legislation to protect patients from this practice – all with overwhelming, bipartisan votes.

At a time when Wisconsinites are already struggling financially from high medical costs, we ask that you support and quickly pass SB 737 so patients can afford their medications, stay adherent to their treatments, and reduce the need for expensive hospitalization.

Thank you very much for your attention. If you have any questions, please direct them to me at gdougherty@diabetes.org and I will do my best to answer them for you.

Gary Dougherty
Director, State Government Affairs
1-800-676-4065 Ext. 4832
gdougherty@diabetes.org

1-800-DIABETES (342-2383)

December 6, 2023

Senate Committee on Insurance and Small Business
2 E Main St
Madison, WI 53703

Dear Chairwoman Felzkowski 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 SB 737, 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 SB 737.

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]

---

[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.

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. 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.

SB 737 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.

Once again, we want to thank Senator Felzkowski for introducing SB 737, which 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 SB 737.

Sincerely,

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

Nicholas J. Antos, MD, FAAP
Pediatric Pulmonologist
Co-Director, Cystic Fibrosis Center
Director, Pediatric Cystic Fibrosis Program
Children's Wisconsin
Medical College of Wisconsin

Christina Barreda, MD
Co-Center Director, UW Pediatric Cystic Fibrosis Program
University of Wisconsin School of Medicine and Public Health

Andrew T. Braun, MD, MHS
Director, UW Adult Cystic Fibrosis Program
Director, UW Advanced Pulmonary Service
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

Hara Levy MD
Director, UW CF Cystic Fibrosis Program
Co-Center Director, UW Pediatric Cystic Fibrosis Program
Division Chief Pulmonary and Sleep Medicine
Professor of Pediatrics
University of Wisconsin School of Medicine and Public Health

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

Testimony In Support of SB 737

Dear Wisconsin Legislators, Chairman Felzkowski, and Members of the Senate Committee on Insurance and Small Business:

I am a current resident of Appleton in Calumet County. I am a wife, and a mother to an 8 year boy who has Cystic Fibrosis. Our son was diagnosed through the state newborn testing when he was 5 days old and we currently treat with our CF Team at St Vincent hospital in Green Bay. On a daily basis, my son needs to go through an intense regimen of treatments and medications in order to keep him healthy to still participate in normal activities of an active 8-year-old. His treatments include two vest treatments; each treatment is 30 minutes long for each treatment. He also has two nebulizers that he inhales during his night routine. One of these inhalants is considered a specialty medication. Before every meal and snack, he also needs to take enzymes in order for his body to absorb nutrients. This medication is also considered a specialty medication. In addition, he also takes Trikafta, which is on the leading edge for CF patients as a CFTR modulator, which treats the underlying cause of the disease. This medication is also considered a specialty medication.

I am providing this background information to share why I am advocating on behalf of my son, other CF WI residents (and their families) and anyone else that relies on routine, costly specialty medication as part of their daily routine in order to maintain a lifestyle living as a resident of WI. I urge your support of SB 737, which would require insurers to apply third-party assistance to out-of-pocket maximums and other patient cost-sharing requirements.

As a mom, here is what the last 2 months of the calendar year have been and will continue to be if we do not act on this bill: I am counting how many enzyme pills he has left to see if I need to refill his prescription for when he eats. I am counting how many pills of Trikafta I have left to see if I can make our current inventory last until I can refill his prescription at the beginning of the calendar year. I am on the phone with both of his specialty pharmacies at least twice a week – on my lunch breaks and on my drive home – discussing the annual copay assistance maximums and understanding how many refills I will have before copay assistance has expired. With these specialty medications, I must call for each medication on a monthly basis to have them refilled as these medications can't be picked up at a local pharmacy.

These medications are contributing to my son to be a healthy, active 8 year just like his peers. He is on his way to a black belt in karate and is excelling in subjects in school. But in order for him to have these medications, there are numerous phone calls with the pharmacy companies, his CF medical team, health insurance company and the drug companies. As a full-time working parent, wife, mother and volunteer, time we have together is precious. While there are limitations to the copay assistance available to my family, my son is able to continue to take his life saving medication because of it, and we can afford the other costs (medical and other CF related items) and enjoy the time we have together.

My son and our family is just one example of the impact of these bans as there are others that have routine, specialty medications that are also on the phone trying to get these medications while trying to understand how they are going to be able to afford them.

I appreciate your consideration of SB 737 and thank you hearing our family's story. I urge you to support this important bill.

Yours Truly,

Elaine
Appleton, WI

December 6, 2023

To: Honorable Members of the Senate Insurance Committee

Re: Support for Senate Bill 737 PBM Accountability Legislation to Protect Copay Assistance for Patients

Dear Chairwoman Felzkowski, Vice-Chairman Hutton and Members of the Committee,

On behalf of the ALS Association, thank you for the opportunity to submit written testimony in support of Senate Bill 737, 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 insurer 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 SB 737.

Sincerely,

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

Testimony of

Michael Semmann

On Behalf of the

Wisconsin Grocers Association

Before the

Senate Committee on Insurance and Small Business

Senate Bill 737

December 6, 2023

Chair Felzkowski and members of the Committee, thank you for the opportunity to testify today in support of Senate Bill 737 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 have difficulty affording staff levels 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.

Frustrated by unpredictable fees and performance measures, WGA members appreciate the attention being provided to this issue. Under the current system PBMs often claw back fees from pharmacies retroactively, weeks, or even months after prescriptions are filled. The audit and appeal process provides similar challenges, with the arbitrary measures utilized to penalize pharmacies for minor errors (i.e., typos) which bear no financial impact.

WGA members ask for reasonable standards, providing rate floors and reimbursement transparency. Standardizing these measures will help pharmacy teams focus on patient care versus devoting time to finding access to medications at reasonable prices. Some PBMs also insert network and contract barriers when requiring the use of a "specialty" or mail-order pharmacy for medications to treat rare and/ or complex diseases. By increasing access to these medications locally, pharmacy patients would be able to gain access to the personalized care provided within miles from home by their local care team.

PBMs often under-reimburse pharmacies for the cost of drugs, rarely offer sufficient professional dispensing fees to cover pharmacies' operational costs and offer preferential treatment and reimbursement terms to their affiliate pharmacies – resulting in pharmacies big and small absorbing significant financial losses each time they fill a prescription. *Therefore, we support a fair reimbursement* model using standard, widely recognized drug cost metrics such as the national average drug acquisition cost (NADAC) plus a professional dispensing fee to – at minimum – cover a pharmacy's cost to acquire a drug and operate the pharmacy. "Cost-plus" is becoming increasingly common across the country, and even aligns with one major firm's recently announced approach to reimbursement for its own pharmacies.

Pharmacies can spend a great deal of time in consultations encouraging patients to make healthier choices and educating about the importance of their medications, but in rural or low-income communities these pharmacies have difficult achieving a benchmark that results in the 90% compliance that PBMs use to measure patient's adherence.

The retail food industry operates on razor thin profit margins and WGA member-affiliated pharmacies have virtually no ability to absorb these unexpected costs. Greater fees for pharmacies can translate to patients who are less adherent to or may potentially ration their medications. 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.

I'll be happy to answer any questions that surface in the future. 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).

From: Alaafia <ethleen@alaafiaafrc.org>
Sent: Wednesday, December 06, 2023 11:23 AM
To: Sen.Felzkowski <Sen.Felzkowski@legis.wisconsin.gov>; Ivanov, Stamena <Stamena.Ivanov@legis.wisconsin.gov>
Subject: Testimony copay accumulator

My name is Ethleen Peacock, the CEO of Alaafia Women's Corporation and I live with Sickle Cell disorder. Originally from Sierra Leone, West Africa, I moved to the United States seeking better healthcare and opportunities.

Living with a chronic illness has been challenging. On one occasion at the pharmacy, when I tried to use my copay card, I was informed it wouldn't count towards my deductible. At that time, my health prevented me from working a full-time job, leaving me in a tough financial situation.

Sometimes, the pharmacist suggested I use only the copay card instead of my insurance, which would be less expensive.
This situation left me questioning the purpose of paying insurance premiums if I couldn't use it for the essential medications I needed.

I urge the Wisconsin Senate to thoroughly examine and pass the proposed bill's copay accumulator aspect. This action would greatly assist individuals like myself, who are currently burdened with the stress of medication costs while simultaneously coping with the challenges of illness and pain.

Regards

Ethleen

Date: December 6, 2023

To: Members of the Senate Committee on Insurance and Small Business

From: Sean Stephenson, Director of State Affairs for the Pharmaceutical Care Management Association (PCMA)

RE: Testimony in opposition to Senate Bill 737

Chairwoman Felzkowski, members of the committee, my name is Sean Stephenson and I am the Director of State Affairs for the Pharmaceutical Care Management Association (PCMA) here to testify in opposition to Senate Bill(SB) 737. I appreciate the opportunity to provide testimony before you today.

PCMA is the national association representing America's pharmacy benefit managers also known as PBMs. PBMs administer prescription drug plans and operate mail-order and specialty pharmacies for more than 275 million Americans with health coverage through large employers, health insurers, labor unions, and federal and state-sponsored health programs.

If there are three things I want you to remember from me today, it is this; one, the PBM industry is the only stakeholder in the drug supply chain dedicated to seeking lower costs, two, no one is ever mandated to use a PBM; and three, in the total dollar drug of a prescription drug, 65 cents goes to the drug manufacturer, 25 cents to the pharmacist, 6 cents to the PBM and 4 cents to the wholesaler.

The core mission of PBMs is to reduce prescription drug costs for employers, governments, and union health plans so that they may provide their employees affordable access to needed prescription drugs. To that end, PBMS are third-party administrators that simply execute the plan the employers call. PBMs offer a variety of services to their health-plan-sponsor clients and patients that improve prescription adherence, reduce medication errors and manage drug costs. SB 737 will seriously undermine the ability of PBMs to control drug costs, and as a result, drug spending in Wisconsin will soar. Although some of the provisions are subject to interpretation, enacting two of the bill provisions, fiduciary mandate, and any willing provider, could cost the state of Wisconsin $319 million in excess drug spending in the first year alone, and more than $3.7 billion over the next 10 years[1]

Fiduciary

SB 737 would require a PBM to act as a fiduciary. Requiring PBMs to become a fiduciary would limit the use of cost-saving PBM tools, increase the costs of liability insurance, and increase overall costs. According to the Department of Labor, PBMs "who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform [certain] administrative functions for an employee benefit plan…are not fiduciaries of the plan."[2] Likewise, PBMs have no "discretionary authority" over plan assets as defined by DOL, which is an essential threshold requirement for fiduciary status under federal law.

The imposition of a fiduciary duty may reduce the flexibility that a plan sponsor has with regard to structuring their financial arrangement with their PBM and could lead to one-size-fits-all solutions. There may be only one way of contracting that would meet the definition of a fiduciary without some potential for incurring legal liability. Additionally, it could restrict payers' ability to

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

uniquely design their benefits to meet their beneficiaries' specific needs while implementing ways to provide cost savings, including formulary preferences, exclusions, and utilization management techniques. The reality of the marketplace is that one-size-fits-all plan designs would not work for everyone because not all payers have the same level of economic resources or the same size and type of patient population.

The Importance of Independent Pharmacists

A strong independent pharmacy marketplace is important in ensuring consumer access to health services and prescription drugs. In addition, PBMs need to ensure broad access to rural community pharmacies in order to remain competitive. PBMs would not be able to compete for the business of plan sponsors in rural areas if they did not include robust pharmacy access for their plan enrollees. In addition, both Medicare and TRICARE require explicit convenient access to pharmacies in urban, suburban, and rural areas.

It remains important that the independent pharmacy market remain stable and profitable, as it has over the last several years. Data from the National Council for Prescription Drug Programs (NCPDP) shows that over the last ten years, the number of independent retail pharmacies nationwide increased by 1,638 stores or 7.5 percent.[3] Over the last five years, the number of independent pharmacies has increased 0.5 percent, indicating a stable marketplace. In fact, independent pharmacies' financials have also been stable. From 2016 to 2020, the average prescription gross profit margin for independent pharmacies ranged from 20.8 percent to 21.1 percent, showing little fluctuation.

Pharmacy Networks

As previously stated, SB 737 would also institute "Any Willing Provider" (AWP) rules and prevent the use of national accreditation standards and preferred pharmacy networks. PBMs create networks of pharmacies that offer savings to clients and beneficiaries. The creation of these pharmacy networks is popular with employers and helps save money on drug costs. 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. In addition, the bill also forces PBMs to eliminate their accreditation standards. PBMs often require pharmacies to gain specialty pharmacy accreditation as a condition of participating in the network as a specialty pharmacy. Accrediting bodies such as URAC or ACHC assess the pharmacy for its use of evidence-based practices and clinical decision support programs, patient counseling and benefits coordination, patient outcomes and quality of care, and other clinical and patient care factors. Accreditation is essential for demonstrating high expertise in caring for patients.

All pharmacies in a network negotiate contracts with the PBM acting on behalf of the plan sponsor, and these typically include performance measures to incentivize better patient service and quality in areas such as generic dispensing, adherence, and patient counseling. By leveraging the power of large pharmacy collectives to negotiate with PBMs on their behalf, independent pharmacies can secure favorable contract terms and, on average, higher reimbursements than chain drugstores. Pharmacy Service Administrative Organizations, or PSAOs, and PBMs also provide pharmacies with software, such as Pharmacy Quality Solutions' Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP), which allows pharmacies to access their contracted pharmacy measures, track their own performance against those measures, and compare benchmark measures of their contracts across plans and against other pharmacies

Eliminating this puts patients at risk and increases costs as they reduce the usage of cost-efficient specialty pharmacies and preferred pharmacies that previously provided the deepest discounts as they can no longer count on getting added volume in exchange. The Federal Trade Commission (FTC) has noted that "requiring prescription drug plans to contract with any willing pharmacy would reduce the ability of plans to obtain price discounts based on the prospect of increased patient volume and would thus impair the ability of prescription drug plans to negotiate the best prices with pharmacies [4].

Dispensing Fees

Page 19, lines 6-16, creates a guaranteed dispensing fee. This provision is nothing more than an automatic cost driver that will increase prescription drugs prices for patients and payers. According to an October 10, 2023 audit report from the State of Wisconsin's Department of Employee Trust funds, exclusively for state employee benefit, there were 1,772,212 commercial pharmacy claims. A provision in the bill creates a dispensing fee on each of these claims in the amount of either $10.51 or $15.69. The range of the mandated dispensing fee is between $18.6 to $27.8 million and will cost the Wisconsin Group Insurance Board those amounts to administer the same amount of claims.

Maximum Allowable Costs

The market for generic drugs is incredibly dynamic and is akin to a commodities market wherein prices fluctuate daily. Pharmacies are reimbursed for generic drugs via maximum allowable cost ("MAC") lists. To determine a fair reimbursement for generic drugs, PBMs survey market data to calculate the average cost for those drugs including information from nationally recognized pricing reference services, wholesalers, and drug manufacturers. The resulting reimbursement is established using that estimated market price while balancing the contractual requirements established by each unique pharmacy and plan sponsor.

MAC lists are important because network pharmacies purchase their supply of prescription drugs at different prices and terms from various wholesalers. MAC lists encourage pharmacies to buy their inventory as efficiently as possible and provide a reasonable, market-based reimbursement to provide patients and payers significant savings. Moreover, PSAOs, the largest of which is owned by wholesalers and contracts with PBMs on behalf of independent pharmacies use "off-invoice" discounting with pharmacies they are selling to such as purchasing volume discounts and others. These price adjustments are not typically included on the pharmacy's invoice and include various types of rebates and price concessions. PBMs are not involved in these transactions and have no insight into the prices that pharmacies pay. As a result, pharmacies may buy a drug cheaper than their submitted invoice reflects. Senate Bill 737 would upend the use of MAC lists as pharmacies are no longer encouraged to buy their inventory as efficiently as possible due to guaranteed reimbursement from the PBMs thus increasing the costs of prescription drugs for patients.

Thanks to MAC pricing, multi-sourced generic medications are kept as affordable as possible in the U.S. MAC pricing is used by 79% of private employer prescription drug plans for retail generic prescriptions[6]. States adopted MAC lists after government audits showed that Medicaid reimbursements for generic drugs far exceeded a pharmacy's acquisition costs, and now 45 state Medicaid programs are using MAC lists to better control costs[7]. This legislation would allow pharmacies to dispense generic drugs while being paid brand drug rates. This bill guarantees pharmacies a profit on every drug they dispense, even if the pharmacy isn't a good purchaser of medications. These types of requirements counteract, if not eliminate, the incentive for pharmacies to look for and purchase competitively priced drugs. All of these proposals unfairly shift costs to plan sponsors and patients who need these medications.

Home Delivery
Many Americans rely on home delivery pharmacies because they provide convenient, safe, and affordable access to prescription drugs. Home delivery pharmacies offer many advantages, including improved health outcomes, by providing better adherence, greater access to care, and larger savings. Like other pharmacies, these home delivery pharmacies are licensed by state boards of pharmacy and the Drug Enforcement Administration (DEA) which regulate their safety and operations. SB 737 prohibits employers from choosing to encourage the use of home delivery pharmacies, which are safer and more affordable than retail settings, drive up drug costs and increase revenue for retail pharmacies at the expense of patients and health plan sponsors.

Frozen Formulary
Formularies are lists of recommended drugs eligible for coverage under a health plan benefit. A group of independent clinicians (convened but not controlled by a PBM) called a Pharmaceutical & Therapeutics (P&T) Committee evaluates clinical data and recommends a group of drugs for placement on the formulary. They look at safety, quality, and efficacy of the full range of FDA approved drugs when determining which drugs to add as a preferred status. The advice from the P&T Committee is evaluated by the PBM to help the health plan provide lower patient cost-sharing for high-value, alternative drug.

During any given year, new brand or generic drugs in a therapeutic class may be released, list prices may rise or drop, or safety and efficacy information on a drug may be updated. P&T Committees are responsible for staying up to date on new advances and updating the formulary to ensure it reflects the latest clinical guidelines and drug availability. Plans may adjust to these market changes by removing unsafe drugs from the formulary or by trying to capture savings due to new market competition, providing patients access to these new or newly affordable drugs. Restricting plan sponsors' ability to make changes to their formularies in all states would increase commercial prescription drug spending by $4.3 to $7.1 billion over five years[5]

Copay Accumulator
Copay accumulator programs are health plan programs designed to thwart drug manufacturers' efforts to force employers, unions, and public programs to pay for expensive, unnecessary brand medications through the use of copay coupons. Accumulators typically disallow the counting of the manufacturer's coupon towards the patient's out-of-pocket maximum and deductible because the patient hasn't actually incurred the cost. This ensures that the patient is incentivized to use the plan formulary and that the plan functions as it was designed.

Drug manufacturers encourage patients to disregard formularies and lower-cost alternatives by offering "coupons" to help the patient cover that higher cost. This ultimately steers patients away from cheaper alternatives and towards more expensive brand drugs (with higher cost-sharing obligations), completely undermining the formulary offered by a plan sponsor.

Here are the facts when it comes to manufacturer coupons:
- The prices for drugs with manufacturer coupons increase faster (12-13% per year) compared to non-couponed drugs (7-8% per year).[8]
- If Medicare's ban on coupons were not enforced, costs to the program would increase $48 billion over the next ten years.[9]
- For every $1 million in manufacturer coupons for brand drugs, manufacturers reap more than $20 million in profits (20:1 return).[10]
- A 2020 study by the Commonwealth of Massachusetts Health Policy Commission, estimates that coupons increased premiums in the Group Insurance Commission

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

program by $18 for a single premium and $52 for a family - increasing costs by over $44 million in excess spending.[11]

By definition, copay coupons target only those who already have prescription drug coverage (i.e., those who pay copays). Copay coupons are not means-tested or designed to help the poor or uninsured. Considered illegal kickbacks in federal health programs, copay coupons are still permitted in the commercial market.

Coupons only reduce short-term costs. Coupons are temporary—the individual patient likely pays more when the coupon goes away, instead of being started on the formulary drug from the start. It is the manufacturer who benefits by forcing the plan (indirectly the patient) to pay for the more expensive drug.

PCMA does not oppose true means-tested patient assistance programs that help individuals afford their prescription drugs. There is an important difference between means-tested patient assistance programs and copay coupons, which are targeted to individuals with health insurance.

I would also like to speak to the author's legislation that limits the use of coupons by excluding "… a brand prescription drug for which there is a generic equivalent." While this would likely lessen the utilization of coupons overall, coupons would still be allowed for costly name-brand drugs when a less-costly, competitive drug or therapeutic alternative is available, continuing to drive up total drug spend. As an example, weight loss drugs. Very popular discussion currently. An injection of Ozempic, which is a semaglutide, is approximately $936[12]. An injection of Wegovy, also a semigludtide costs $1,349. Under this bill a coupon could be allowed for the use of Wegovy, even those there is a less costly alternative available.

340B

340B Drug Pricing is a federal program originally created to support safety net providers but has morphed into a massive program that lacks transparency, has spurred complex litigation and has propped up for-profit companies. PBMs process claims for reimbursement for drugs that may have been purchased with a 340B discount, but at times it's unclear and PBMs are seeking more transparency. Overall, the 340B program is ripe for fixing, but by the federal government, not the states.

States should allow identifying language for modifiers in commercial claims, as an industry standard was developed by the National Council for Prescription Drug Programs (NCPDP). A minimum level of transparency, like in Medicaid, would help shine light on how 340B discounts are being used to help uninsured and low-income patients and help prevent fraud.

State-mandated inclusion of pharmacies in a plan network, solely on the basis that they contract with 340B hospitals, ignores safety and financial risks to patients, employers, and the government. Health plans should be able to contract with pharmacies on a variety of factors like the pharmacy's accessibility to plan enrollees, expertise, competitive rates, and compliance with fraud, waste, and abuse rules. State mandates bypass these types of common-sense network requirements.

Reporting/Transparency

Section 7 of the bill also mandates reporting requirements for prices PBMS. For the system to work, employers and plan sponsors have to be empowered not only with choice but with the information they need to make informed choices. At the beginning of the contracting process with the PBM, employers determine what information, disclosures, and audit rights they need. Our

industry supports open, transparent exchange of useful information. Our companies comply with the many transparency and disclosure obligations in place at the state and federal levels. But we do not believe the government should dictate private contract terms between two businesses. Employers should make the call on what information they want to receive.

PBMS already provides health plans, employer plan sponsors, and consumers with a broad array of accurate, actionable information on price and quality to make efficient purchasing decisions. As part of their requests for proposals when putting their pharmacy benefits out to bid, PBMs' customers lay out the terms of the transparency and information they want to receive, as well as their audit rights, and those terms are formalized in their contracts.

Transparency that helps patients and payers is necessary across the entire prescription drug chain. PBMs support and practice actionable transparency that empowers patients, their physicians, those sponsoring health coverage, and policymakers, so that each of these actors can make informed decisions that can lead to lower prescription drug costs. Actionable transparency encourages consumers to shop for coverage that best fits their health needs and budgets, and once covered, use the most cost-effective, highest-value healthcare goods and services. It enables prescribers and patients to avoid pharmacy counter-surprises and helps ensure that physicians can prescribe drugs that are affordable for patients.

To that end, PBMs provide patients and prescribers with Real Time Benefit Tools. The detailed cost-sharing information found in these tools includes information on exactly where the patient is with respect to progressing through a deductible or another benefit phase, what drugs are on the patient's formulary, and, as noted above, exactly what cost-sharing a patient should expect for a given drug at the pharmacy. PBMs also provide patients with information on in-network pharmacies, premiums, general cost-sharing, and benefits for their prescription drug coverage.

Audits

The National Health Care Anti-Fraud Association (NHCAA) estimates billions of dollars in annual financial losses due to healthcare fraud. Every dollar lost comes from the pocket of a consumer. Pharmacy audits are a crucial tool in combatting waste, fraud, and abuse (WFA) to protect patients, employers, unions, retirees, government programs, and other health plan sponsors. PBMs use pharmacy audits to help protect patients from dangerous medication errors and health plan sponsors from improper prescription costs and to ensure patients receive high-quality, proficient service from network pharmacies, identify evidence of WFA, and ensure compliance with regulatory requirements. These tools bolster patient safety and reduce health care system abuse.

Health benefit plans are required to audit all providers, including pharmacies, and they typically delegate pharmacy audits to PBMs. PBMs utilize varying types of audits, from in-person to completely remote, and use best business practices consistent with audits across the healthcare industry to minimize abrasion. Audits are required for virtually all federal, state, and private sector pharmacy benefit offerings, all of which are subject to regulatory constructs, and have specific parameters outlined in contracts. PBMs employ advanced analytics and predictive modeling to detect and predict high-risk, potentially fraudulent pharmacy scenarios. Many pharmacies delegate network contracting negotiations, including audit terms, to PSAOs. Contract terms may include scope of chart reviews, sample size, virtual vs. on-site audit activities, scheduled vs. non-scheduled audits, extrapolation of findings, timing, reporting, confidentiality, and outreach to patients and prescribers. Contracts also establish implications of adverse findings from audits (e.g., repayment, recoupment, termination of network participation, corrective action plans). PBMs return most funds recouped from audits to payors and receive appropriate market-based

compensation for their services. Audits are conducted as necessary due to the business environment and contract terms, and are staffed by appropriately trained, licensed, and certified pharmacy technicians and/or pharmacists.

Pharmacy audits have exposed inventory discrepancies, unwanted auto-refills and shipping of medications, claim submissions for medications not dispensed or prescribed, claims submissions for medications not requested by patients, and intentional billing for one product while dispensing another.

- In 2022, a Mississippi pharmacist was sentenced to 10 years in prison for his part in a $180 million insurance fraud scheme in which he paid kickbacks for referrals of medically unnecessary prescriptions—costing federal health care programs more than $50 million.
- In 2020, a large PBM identified and recovered over $300 million of FWA through annual audits.
- In 2019, an Oklahoma pharmacist, was found to have collected $1.09 million from fraudulent claims, including $338,481.81 from SoonerCare, Oklahoma's Medicaid administrator, and $753,334.13 from Medicare Part D.
- In 2017, the Texas Department of Health reported that annual audits of pharmacies conducted by two PBMs in the state recovered $450,157 and $1,215,675 respectively.

I started out by saying I want you to remember that we are the only entity in the drug supply chain that is dedicated to seeking lower costs and that no one is ever mandated to use a PBM. Restricting or placing mandates on the various tools I have talked about today, will hinder our ability to ensure that the end user, the patient, gets the lowest cost for their prescription drugs. Thank you to the members of the committee for the opportunity to testify today. I would be happy to answer any questions at this time.

CITATIONS:

1. January 2023 paper "Increased Costs Associated With Proposed State Legislation Impacting PBM Tools."
2. 29 CFR 2509.75-8 - Questions and answers relating to fiduciary responsibility under the Employee Retirement Income Security Act of 1974.
3. PCMA. 2023. https://www.pcmanet.org/the-independent-pharmacy-marketplace-is-stable-2023/
4. U.S. Federal Trade Commission. 2014. Letter to CMS re: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-centers-medicare-medicaid-services-regarding-proposed-rule/140310cmscomment.pdf
5. Estimated cost of potential "frozen formulary" legislation, Fully insured commercial payer impact, 2021–2025, Milliman, January 25, 2021. https://www.pcmanet.org/wp-content/uploads/2021/02/Milliman_Frozen-Formulary-Report_FINAL.pdf
6. https://www.pcmanet.org/wp-content/uploads/2017/06/MAC-Reimbursement-101-for-Cody-v2.pdf
7. https://www.macpac.gov/wp-content/uploads/2015/09/Medicaid-Payment-for-Outpatient-Prescription-Drugs.pdf
8. Leemore Dafny, Christopher Ody, and Matt Schmitt. When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. The National Bureau of Economic Research. October 2016.
9. Visante. Drug Manufacturer Coupons Raise Costs in Medicare Part D, Hurting Vulnerable Beneficiaries. May 2020.
10. Dafny et al. October 2016
11. https://www.mass.gov/doc/prescription-drug-coupon-study/download
12. https://www.healthsystemtracker.org/brief/prices-of-drugs-for-weight-loss-in-the-us-and-peer-nations/#List%20prices%20of%20drugs%20used%20for%20weight%20loss%20in%20the%20U.S.%20and%20peer%20nations

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org