Talking Points for Pharmacy Bill – SB 749, the PACT Act and Any Willing Specialty Pharmacy Provisions

Position on the Bill and Compromise Language

- MAHP worked closely with Health Care for All (HCFA) to reach agreement on proposed amendments to Senate Bill 749, which we are offered during our testimony during the June 6 HCF hearing in support of the bill.
- Our collaboration with HCFA signifies the importance of the issue and the priority we place on health care affordability, which remains a significant challenge for Massachusetts employers and consumers.
- The proposed amendments make important changes to the bill's Drug Access Program, to ensure that provisions relative to consumer cost sharing do not take away health plans' ability to negotiate lower prices for prescription drugs and effectively manage health care spending.
- Senate Bill 749 establishes a Drug Access Program and directs the Executive Office of Health and Human Services (EOHHS) to identify one generic and one brand name drug used to treat: Diabetes, Asthma, and Heart Conditions and then require commercial Group Insurance Commission (GIC), and MassHealth to cover the brand and generic drugs identified by the Drug Access Program.
- Each identified generic drug would be required to be covered with $0 cost sharing, and each identified brand name drug would be required to be covered with $0 deductible/co-insurance and co-pays would be capped at $25 for a 30-day supply.
- As currently drafted, Senate bill 749, would not only cap or eliminate cost sharing for the selected prescription drugs, but it would also grant the state the authority to select the drugs, thereby removing any incentive for manufactures to come to the table to negotiate reasonable prices. For this reason, manufacturers support this provision in the bill.
- Our proposed amendment would retain the bill's caps on cost sharing for the selected drugs, however, provide the health plans with the ability to select the drugs, pursuant to criteria outlined in the bill, thus incentivizing manufacturers to come to the table to lower their prices.
- Increases in the cost of prescription drugs are major drivers of health care spending and contribute to growth in health insurance premiums.
- Despite our concerns with these provisions in Senate Bill 749, we recognize the overall importance of the legislation to containing the rising cost of prescription drugs which continue to impact the affordability of health care in the state.
- With these proposed amendments, MAHP is able to support Senate Bill 749 to rein in spending on prescription drugs.

Elimination of Health Plan Tools

- Health plans have limited tools to direct members to safe, effective, and lower cost drugs. The pharmaceutical industry is focused on removing these tools in order to drive members to new, high cost and heavily marketed drugs when in fact, there are lower cost drugs on the market today that may be equally as effective.

- MAHP generally opposes efforts to restrict health plan tools, such as eliminating or capping cost sharing for prescription drugs as such proposals hamper the ability of health plans to effectively manage drug costs through the development of formularies and do nothing to address the underlying costs of prescription drugs.
- Moreover, health plans have effectively educated consumers on the use of equivalent generic drugs and how these products can save money for both the patient and the health plan or employer. Restricting the patient's out-of-pocket expense on all categories of drugs removes the patient's incentive to choose the lower cost alternative and masks the true underlying cost of the drugs.
- However, given that health care prices in Massachusetts continue to exceed the state's health care cost benchmark, it is imperative that we continue to bring attention to this issue, as we seek to make health care coverage more affordable.
- Health care cost containment and affordability are a shared responsibility among all players in the health care sector and it is essential that the pharmaceutical industry join providers and health plans in being accountable to the HPC for cost growth that contributes to rising premiums.
- SB 749 would ensure that drug manufacturers are called as witnesses before the HPC's Annual Cost Trends Hearing and are subject to the associated data collection requirements by the HPC, CHIA, and the state's Attorney General, just as health plans and providers are today.
- Requiring drug manufacturers to be part of the annual hearings would be an important step toward understanding the impact drug pricing has on the statewide cost benchmark, whether the costs associated with novel drug therapies offer value in comparison to other therapies and treatments, and whether they are improving patient care.
- For these reasons we support SB 749, with the proposed amendments, that would bring pharmaceutical manufacturers into the cost conversation and help ensure affordability for employers and consumers.

Specialty Pharmacy

- Last session, MAHP was supportive of the PACT ACT, however provisions were added that would establish an "any willing pharmacy" policy for specialty and mail order pharmacies.
- MAHP strongly opposed these provisions due to the impact on patient safety, quality of care, and health care costs.
- Health plans contract with specialty pharmacies because of their expertise in coordinating the often-complex delivery and treatment processes associated with these drugs that is unsurpassed in other settings, making them better suited than other pharmacies to handle the distribution of these drugs.
- Health plans and PBMs require network specialty pharmacies to be accredited by a national accrediting body, Utilization Review Accreditation Commission (URAC) to ensure that the pharmacy complies with strict quality and safety standards.
- Neither bill requires that specialty pharmacies obtain accreditation to operate in the state and the licensure requirements outlined in the legislation are less stringent than the national accreditation standards.

- The bills will also significantly add to health care costs
- Any willing pharmacy laws diminish the ability of health plans (and their PBMs) to drive value and provide lower costs options for their members.
- As the HPC has found, the cost of specialty drugs has risen significantly both in terms of individual price and demand for these expensive drugs.
- According to the HPC:
    - Total commercial spending on clinician-administered drugs exceeded $1.6 billion in 2020, representing 15.8 percent of all office and hospital outpatient department spending.
    - Similar markups are present in national data.
    - Costs per single treatment for drugs administered in hospitals between 2019 and 2021 were an average of $8,200 more than those purchased through specialty pharmacies.
- Specialty pharmacies have the scale to negotiate lower prices with the manufacturers of these specialty drugs.
- Clinician-administered drugs represent a large and growing share of medical spending, therefore mandating that health plan specialty pharmacy networks include hospital-based or clinic-based pharmacies would increase costs.
- Prohibiting health plans from utilizing exclusive specialty network pharmacies would undercut health plans efforts to contain rising prescription drug costs, while also endangering patient safety and the proper handling of expensive and complex drugs.

PBM Licensure and Definition of PBM and ERISA Implications

- Health plans contract with PBMs to administer pharmacy benefits due to PBMs' expertise and capacity to administer pharmacy benefits in a cost-effective and efficient manner.
- PBMs negotiate directly with drug manufacturers and leverage scale to lower health care costs, due to their ability to leverage the covered lives of all their health plan clients.
- While MAHP and our member health plans see value in the role that PBMs play in containing rising health care costs, health care cost containment is a shared responsibility among all players in the health care sector.
- While we do not oppose additional transparency requirements on PBMs included in the bill, we have serious concerns with other provisions in the bill due to their impact on the ability of health plans to ensure access to safe, effective, and affordable prescription drugs.
- <u>The definition of PBM in the bill is extremely broad and would capture health plans that may perform some pharmacy management activities internally</u>.
- The language, as drafted, would require health plans that are licensed in the state to have to obtain a separate license with the Division of Insurance, subjecting the health plan to additional filing fees and costly administrative requirements, which are unnecessary.
- Therefore, any legislation to establish PBM licensure must exempt health plans that are already licensed by the DOI from having to re-license as a PBM.
- The bill attempts to regulate PBM practices impacting both fully insured and self-insured health plans, and the GIC, potentially triggering preemption under the federal Employee Retirement Income Security Act (ERISA). The sections imposing new requirements on

PBM functions will extend those requirements to self-insured plans, increasing costs for all Massachusetts employers rather than just full-insured health plans.

Anti-Steering

- SB 2492, as drafted, would prohibit health plans and their PBMs from using financial incentives, including co-payments and deductibles, to encourage the use of specific pharmacy providers, including specialty and mail order pharmacies, to incentivize utilization of high quality, more cost-effective network pharmacies.
- Disrupting health plan pharmacy networks will have a significant impact on health care costs in the state.
- Developing pharmacy networks is a tool that health plans use to control health care costs and provide access to quality prescription drugs and services.
- So-called anti-steering laws diminish the ability of health plans to drive value and to provide lower costs options for consumers.

MAC Pricing Restrictions

- SB 2492, as drafted, would impose restrictions on the use of maximum allowable cost (MAC) benchmarks for generic drugs that will impact the ability to secure fair reimbursement to pharmacies for generic drugs, thereby increasing costs for individuals, employers, and small businesses.
- MAC is the maximum allowable reimbursement by a pharmacy benefit manager (PBM) or health plan for a particular generic drug that is available from multiple manufacturers and sold at different prices.
- The purpose of MAC pricing is to standardize the reimbursement amount for identical products from various manufacturers, regardless of each manufacturer's price.
- A MAC list is a common cost management tool that is developed from a survey of wholesale prices existing in the marketplace, taking into account market share, existing inventory, expected inventories, reasonable profits margins, and other factors.
- State Medicaid programs originally developed MAC pricing lists after government audits showed that Medicaid reimbursements for generic drugs far exceeded pharmacy acquisition costs. Today, 45 Medicaid programs, multiple federal programs, and most private payers use their own MAC benchmarks to ensure that the pharmacy industry does not try to overcharge patients for generic medicines.
- While MAC pricing laws have passed in several states, none are as restrictive as this bill proposed in Massachusetts.
    - For example, the mandate to release proprietary pricing lists would have an anti-competitive effect on insurers and employers, as well as PBMs. Competing plans, wholesalers, pharmacies, and others would have access to others' pricing information. According to the Federal Trade Commission, this would drive up drug prices for employers and consumers.
    - Moreover, requiring PBMs or health plans to make retroactive adjustments would create difficult administrative burdens and add administrative cost.
    - A reasonable process for a pharmacy to appeal the listed MAC for a particular drug is appropriate, but these are individual appeals, and it is not appropriate to require

the PBM or health plan to also have to make that adjustment for other pharmacies in the network.

- While there may be anecdotal evidence of instances where a pharmacy, because of its purchasing decisions, was not reimbursed enough to make a profit on a particular prescription, no industry or company is guaranteed a profit on every sale and MAC pricing encourages pharmacies to negotiate low prices to earn profits on prescriptions.

Surcharge on health plans

- The language would require health plans to pay a significant surcharge to the DOI if their contracted PBMs engaged in spread pricing, steering, point of sale fees or retroactive fees in connection with the health plans.
- Health plans would be required to attest to whether their contracted PBM, a separate entity, is in compliance. Beyond including provisions prohibiting the practices, health plans cannot control the practices of a separate entity.

Spread Pricing

- SB, as drafted would impose restrictions on spread pricing and levy a surcharge on PBMs and health plans that utilize spread pricing.
- Spread pricing is one way a health plan may structure a contract and compensation terms with its contracted PBM.
- Drug prices go up year after year and often fluctuate multiple times during a single year.
- Unlike health plans whose premium rates are set prospectively for an entire year, drug manufacturers can change the price of a drug whenever and however often they choose during the year.
- Not all health plan and PBM contracts utilize spread pricing, however, we believe that this should remain a contracting option and that the state should not be mandating or prohibiting preferences for contract or compensation terms between two private parties.