2017 SENATE INDUSTRY, BUSINESS AND LABOR

SB 2258

2017 SENATE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

SB 2258
1/31/2017
27652

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Eva Liebelt

Explanation or reason for introduction of bill/resolution:

Relating to pharmacy claim fees and pharmacy rights

Minutes: Attachments 1-3

Chairman Klein: Opened the hearing.

Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association: Written testimony, see attachment #1. (:10-12:21)

Senator Casper: Why sign the contracts?

Mike Schwab: For example, Blue Cross Blue Shield and Pharmaceuticals have 75-85% of the market, you don't sign the contract you don't serve 75-85% of the market in the state.

Senator Burckhard: As one of the 78 million baby boomers, this makes me nervous is this going to help us or is this going to scare us, this kind of legislation?

Mike Schwab: Does it scare you from what is happening in the industry I would agree. Should it scare you from what we are trying to actually bring about in terms of trying to bring more balance in how contracting is done and transparency in the market place, I would say it should not.

Senator Poolman: Are there any insurers that are not using PBM's? It doesn't seem like a choice for a pharmacist to say no I am not going to deal with a PBM because where would all the customers go if that happened.

Mike Schwab: That would be correct, in order to provide service, you must contract with a PBM.

Chairman Klein: Are we taking a huge step, is this going to put a burden on pharmacist if the big folks who really call the shots, the 75 percenters say they will figure this out without you?

Mike Schwab: That would be correct. We definitely have three of them that are in 75-85% of the market in North Dakota. We have nothing to hide, we are tired of the take it or leave it contracts and the gap clauses and some of the things that are happening to the patients and things happening with the employer groups. We would be more than happy to show you the information but are bond from our contracts from doing so.

Senator Casper: Are the pharmacists in any way allowed to negotiate those contracts at all?

Mike Schwab: Some pharmacies are able to negotiate but that obviously depends on your location. If you fall outside of the access that means the PBM's have no choice but to contract with some of the rural pharmacies.

Dan Churchill, Pharmacist from Bismarck: Written testimony, see attachment #2. (18:30-21:05

Chairman Klein: You're not worried about retribution by the passage of this, that it will curb your ability to continue to work with a lot of these companies?

Dan Churchill: We try to do things to plug loopholes and holes but it's kind of a shell game. If we plug these loopholes, I am sure in future legislation we will be dealing with new loopholes that have opened up. I would hope that some of these things would be resolved. The people this hurts is the patients in North Dakota.

Shane Wendel, Pharmacist: In support. I am a rural pharmacist in Carrington and New Rockford. I have a couple of other business partners and we have bought some rural stores where the existing pharmacist was retiring and the store was going to close. As a group we bought it and we are recruiting young pharmacists to go into these rural markets those that want to own rural pharmacies. We are getting them started, so we have a group of stores and I do almost all of our contracting. We have a regulated body, pharmacies are very heavily regulated and insurers are very heavily regulated and then you have this no passage PBM and you are supposed to control cost. They have almost no regulation and they control the money. They were invented to be the pass through to pay the pharmacy, to take the insurance money, keep track of everything and give it to the pharmacist. Now they have become the major profit center of the whole thing. (22:45-29:10)

Senator Roers: Do you think these two bills do what you want them to do?

Shane Wendel: They are setting guidelines for conduct, yes.

Chairman Klein: Called for opposition.

Abigail Stoddard, Pharmacists with Prime Therapeutics: In opposition. Written testimony, see attachment #3. (30:00-35:58)

Senator Poolman: I do believe a reimbursement issue is a consumer issue because those costs do get passed on somewhere. Can you talk about the four-hundred-dollar fee and why any pharmacist would be forced to fill a prescription at a loss under a PBM contract?

Abigail Stoddard: The fee is charged by the Medicare part D program. I can't speak to that individual four hundred dollars. I can tell you that in the Medicare part D program pharmacies are paid for performance. They are risk sharing contracts both sides, up or down. All of our performance measures are spelled out in the contract for Medicare part D. I am not here to argue that pharmacies could fulfill a prescription at a lost, drugs are a commodity that is how the commodity market works. (36:45-39:36)

Senator Casper: Does a PASO matter if the PBM's can, without regulation expand the list of specialty drugs?

Abigail Stoddard: I am seeing this as two different issues. The PASO can help negotiate the contract but the PASO is not involved in the specialty pharmacy benefit, which is dictated by the employer union health plan. The PASO does not tell the employer what drugs to cover at which pharmacy. (40:34-41:04)

Senator Casper: But you do, the PBM does?

Abigail Stoddard: The health plans and employers do.

Senator Casper: On one side you have the health plan and employers working through the PBM's. On the other side you have the PASO representing the pharmacists and the PBM's and the PASO's are coming together. To me in that negotiation if one party has the opportunity to expand what their contracting over and chipping away at what is left of the other party, that gives you a great deal of leverage.

Abigail Stoddard: Respectfully you are comparing apples to oranges. When we talk about a contract and when we talk about a specialty benefit that an employer dictates a PBM administer. I don't think I can answer your question.

Senator Poolman: You talked about the fees just being all federal Medicare part D fees. Then why do we read in the bill that it talks about fees that are imposed by a third party payer related to a performance metrics? We are scoring metrics that are determined by the PBM. Why wouldn't we want to pass that, that has nothing to do with the federal fee that sounds like something the PBM's are imposing upon the pharmacists. Would you talk about those fees for me?

Abigail Stoddard: I would agree with the first part of why we would need that in here, I don't think we do, it wouldn't solve the problem that they articulated because they articulated a problem with the federal program.

Senator Poolman: You're not charging them any fees or determining any metrics where they fall into the place where they need to be paying additional fees based on where they fall on a scale that you are deciding?

Abigail Stoddard: It's all Medicare part D.

Chairman Klein: A lot of discussion in Washington. Isn't this turning into a national issue?

Abigail Stoddard: I don't know the answer.

Emily McGann, Regional Director for State Government Affairs for CVS Health: In opposition. I just wanted to add a couple of quick comments. I think Abigail Stoddard's first major point is very valid one and one that would be helpful to have, more like a stockholder's discussion and not in a form like this. The issue with PSAO and sharing what they contract with their pharmacies, I think would solve a lot of other problems. The whole refusal to fill in mandatory profits, one analogy I like to make is that drugs are a commodity market and everyone knows you don't make money every time you take an action. (46:00-48:55)

Chairman Klein: I think Danielle, as I recall her letter, she could no longer get her prescriptions through her husband's employer for that short period of time. She had to either go seventy miles and get the 90 days, it wasn't available locally. What is the difference day and why would she be forced to 90 instead of the 30?

Emily McGann: I think what I would say about that, the appeal of 90-day mail service is that they are far less expensive because you have one dispensing fee instead of 3.

Chairman Klein: Closed the hearing.

2017 SENATE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

SB 2258
1/31/2017
27662

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Era Liebelt

Explanation or reason for introduction of bill/resolution:

Relating to pharmacy claim fees and pharmacy rights

Minutes: Attachments 1-5

Chairman Klein: We are going to come back to order. We are going to go back to those in support of 2258.

Harvey Hanel, Medical Services and Pharmacy for Director Workforce Safety and Insurance: Written testimony, see attachment #1. (2:00-5:23)

Chairman Klein: This morning there was a lot of discussion on what this bill does but your only concern relates to number seven?

Harvey Hanel: That's correct. With our PBM we have a fully transparent model in that pharmacies reimburse based upon a fee schedule which we establish so there are none of these additional fees. Are only concern being that section that refers to the ability to refuse services. We don't want to get into that situation where we have a pharmacy out there that is going to start picking and choosing. That isn't in the best interest in treating our injured workers.

Chairman Klein: What I am hearing is your PBM is open and transparent and understands what the pharmacists job is and what your job is, to manage benefits. You're not the group they are targeting.

Harvey Hanel: That is what we have tried to establish with our PBM when we did our contracting to make sure it is a transparent model.

Senator Roers: What PBM do you use?

Harvey Hanel: We currently use Involve Pharmacy Services, it used to be called US Script. They are a small PBM based out of Fresno, California.

Senator Roers: You're not experiencing the problem with access and coverage that was demonstrated this morning?

Harvey Hanel: We do not experience those issues.

Gary Boehler, Pharmacist Consultant for Dakota Drug, Inc.: Written testimony, see attachment #2. (8:25-23:58)

Chairman Klein: Called for opposition.

Patrick Ward, Express Scripts: Written testimony, see attachment #3.

Jack McDonald, Prime Therapeutics: I would just say, while prime is still opposed to these two bills, we would like to have a chance to talk to some of the stakeholders on this bill to see if there are any areas where there might be some accommodations.

Chairman Klein: You would like to work with them at least on 2258 but 2301 you are throwing up your hands?

Jack McDonald: We are still opposed to that.

Chairman Klein: Closed the hearing. Jack McDonald has asked to visit with the parties involved, let's see if there are any solutions. I am hoping something can be worked out and that they will spend some time and give each other a few minutes.

Also handed out: **Mark J. Hardy, PharmD, R.Ph., Executive Director, Board of Pharmacy:** Written testimony, see attachment #4.

David. A. Balto: Written testimony, see attachment #5.

2017 SENATE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

SB 2258
2/7/2017
Job Number 28003

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Era Liebelt

Explanation or reason for introduction of bill/resolution:

Relating to pharmacy claim fees and pharmacy rights

Minutes: Attachment 1

Chairman Klein: Opened the meeting. He went over the amendment. Amendment, see attachment #1.

Senator Poolman moved to adopt the amendment, 17.0924.01001.

Senator Casper seconded the motion.

Roll Call Vote: Yes-7 No-0 Absent-0

Senator Casper moved a do pass as amended.

Senator Roers seconded the motion.

Roll Call Vote: Yes-7 No-0 Absent-0

Senator Klein will carry the bill.

CL 2/7/17

17.0924.01001
Title.02000

Adopted by the Industry, Business and Labor Committee

February 7, 2017

PROPOSED AMENDMENTS TO SENATE BILL NO. 2258

Page 1, line 15, after the underscored semicolon insert "or"

Page 1, line 16, replace "; or" with an underscored period

Page 1, remove line 17

Page 2, line 14, replace "may" with "shall"

Page 2, remove lines 26 and 27

Page 2, line 28, replace "8." with "7."

Page 3, line 1, replace "9." with "8."

Page 3, line 3, replace "10." with "9."

Page 3, line 6, replace "11." with "10."

Page 3, line 6, replace "A" with "Upon request, a"

Page 3, line 10, replace "12." with "11."

Page 3, line 14, replace "13." with "12."

Renumber accordingly

Date: 2/7/17
Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2258

Senate Industry, Business and Labor Committee

☐ Subcommittee

Amendment LC# or Description: 17.0924.01001

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Senator Poolman Seconded By Senator Casper

Senators	Yes	No	Senators	Yes	No
Chairman Klein	x		Senator Marcellais	x	
Vice Chairman Campbell	x				
Senator Roers	x				
Senator Burckhard	x				
Senator Casper	x				
Senator Poolman	x				

Total (Yes) 7 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2/7/17
Roll Call Vote #: 2

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2258

Senate Industry, Business and Labor Committee

☐ Subcommittee

Amendment LC# or Description: 17.0924.01001

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Senator Casper Seconded By Senator Roers

Senators	Yes	No	Senators	Yes	No
Chairman Klein	x		Senator Marcellais	x	
Vice Chairman Campbell	x				
Senator Roers	x				
Senator Burckhard	x				
Senator Casper	x				
Senator Poolman	x				

Total (Yes) 7 No 0

Absent 0

Floor Assignment Senator Klein

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2258: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2258 was placed on the Sixth order on the calendar.

Page 1, line 15, after the underscored semicolon insert "or"

Page 1, line 16, replace "; or" with an underscored period

Page 1, remove line 17

Page 2, line 14, replace "may" with "shall"

Page 2, remove lines 26 and 27

Page 2, line 28, replace "8." with "7."

Page 3, line 1, replace "9." with "8."

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Page 3, line 10, replace "12." with "11."

Page 3, line 14, replace "13." with "12."

Renumber accordingly

2017 HOUSE INDUSTRY, BUSINESS, AND LABOR

SB 2258

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

SB 2258
3/20/2017
29504

☐ Subcommittee
☐ Conference Committee

Kathleen Davies

Explanation or reason for introduction of bill/resolution:

Pharmacy claim fees and pharmacy rights.

Minutes: Attachments 1-11

Chairman Keiser: Opens the hearing of SB 2258.

Senator Klein ~ District 14: I'm prime sponsor on this bill. I will leave it to the experts to talk about the bill.

1:42

Mike Schwab ~ Executive Vice President of the ND Pharmacists Association: Attachment 1.

13:32

Rep Kasper: Page 2, line 30, is that what you foresee that is happening?

Schwab: That's correct.

Rep Dobervich: You talked about the direct and indirect remuneration fees. What are those fees for?

Schwab: They originally started out between drug manufacturers and the pharmaceutical industry. They've not been twisted and imposed upon the pharmacies. Maybe one of the pharmacists could answer that.

Chairman Keiser: The penalty for a violation, that means a maximize of 30 days and $1500, to me isn't a significant penalty. In this case it creates a problem for our jails and $1500 in the scope of this business is not very significant. If we have a repeat offender, shouldn't we be doing a whole lot more?

Schwab: It was in the previous bill (from Legislative Council on a previous bill in the prior session).

Chairman Keiser: If we're going to have a penalty section, we need to make sure it has some implications.

17:14

Gary Boehler ~ Pharmacist consultant Employed-Dakota Drug, Inc: Attachment 2 & 3.

34:00

Rep Kasper: I know there are a few PBM's that are out there that operate in a transparent way, is that correct?

Boehler: That is absolutely true. Where there is a 100% pass through on rebates, billing, where there is no spread pricing. Everything I see as a pharmacy provider, you will see as the employer buying the insurance. They are strictly and only charging an administrative fee for their service, much like how the PBM's started out in the 60's or early 70's.

Rep Lefor: Contract language states, that there are gag orders upon pharmacies on the PBMs, that there's language telling pharmacies they cannot mail prescriptions to patients, and pharmacies that try to negotiate this prohibition in their contracts are threatened with expulsion. Have you seen that in contract language?

Boehler: Yes, I have those letters back in my files.

Rep Lefor: What percent of PBMs that Rep. Kasper alluded to, deal fairly?

Boehler: I know of only one that deals fairly, openly and honestly.

Rep Lefor: We need to look at the 2015 law, the fiscal impact, and that the goal is to save employers money. What is it in the 2015 law previously stated, can you rebut that?

Boehler: I'd need a refresher exactly what was in the bill.

Rep Lefor: I don't have it in front of me but I try to have an open mind. The statement was made we really need to take a look at the negative fiscal impact to employers, etc. I won't ask if you're not familiar.

Rep Dobervich: The remuneration fees, is that clawback you refer to? Or exactly what are those fees?

Boehler: The DIR fees that are taken from the pharmacy. I associate the 2 as being different. A DIR fee is something assessed to the pharmacy by the PBM. The Called the committee to order on-pay may still be 3-4-5-20% of that prescription. A clawback happens when a cheaper and inexpensive drug is reimbursed at such a high rate, that co-pay is assessed to the patient, and then at the bottom you see a payment by the PBM of a negative

($47.69 as on Page 4 of my testimony- Exhibit 1). It's going through the pharmacy but from the patient. There the patient is being impacted. On top of that, there can be a retroactive DIR fee that's assessed against the pharmacy. Those DIR fees range from 3-9% and as high as $11 per. On this example the pharmacist would have been in the hole $8-$10.

Rep Dobervich: The DIR fees, why is it being accessed?

Boehler: That fee is being assessed by the PBM. With CMS requiring all the DIR fees the PBMs are receiving from the drug manufacturers for placing these drugs on special tiers, I believe it's another way the PBM's have twisted this whole DIR thing around, and thought, we can take more back from the pharmacy to make up for what we have to give to CMS.

Dan Churchill ~ Pharmacist from Bismarck: Attachment 4 and requested a Do Pass.

44:00

John Olson ~ : I just want to clear up a confusion. The chair asked a question about fines and penalties. You correctly stated a person can be charged with a B Misdemeanor, the penalty 30 days in jail and/or $1500 fine. There's an organizational fine in the Century Code that says an organization found guilty of a Class B Misdemeanor could be fined up to $20k.

Chairman Keiser: That just appears as a repeat, $20,000 for the organization with multiple violations?

Olson: I assume that could be multiple counts, yes.

45:10

Mark Hardy ~ PharmD-Executive Director of the ND State Board of Pharmacy: Attachment 5 in support.

48:05

Rep Kasper: Who regulates the PBM's in ND?

Hardy: Current the insurance department of ND has licensure of PBMs as a third party administrator. Also we have a couple provisions that have been passed in the last legislative session that fall under the section of century code that we have jurisdiction over as well. So we do make some issues especially on the audit provision and the mac provisions that the Board of Pharmacy has had to get involved with in ND.

Rep Kasper: On the scope of the PBM's do, what percent does your board have the ability to look at?

Hardy: The board works on a complaint basis as far as the issues. So it depends on what situation is brought to the board by patients.

Rep Kasper: Would it be more appropriate to move the licensure and total regulation of PBMs to the Board of Pharmacy compared to where it is right now?

Hardy: The board hasn't looked at that but I can understand why you would want to do that. Rep. Anderson we defer to the legislature to make that decision.

Rep Boschee: Are you seeing complaints, at who is at fault?

Hardy: Yes we do deal with complaints with that original from services provided by a pharmacy benefit managers pharmacy or their mail order operation they may have just as we would with other pharmacy that provide traditional services as well. Yes, we do deal with complaints on both sides.

Rep Boschee: Do you feel the consumers are informed it's not their pharmacist, that it's another entity? Are they bring the complaint against the other entity or their pharmacist?

Hardy: Usually the patient knows where they're getting their services from whether their hometown pharmacy or maybe a mail order pharmacy that may be shipping their medications.

Rep Boschee: Have any states regulated PMBs at this point?

Hardy: Yes, there are many states that have this provisions like this. There are a couple that have looked to license PBMs through their Board of Pharmacy. That's more something talked about nationally, whether that happens, time will tell.

Chairman Keiser: Anyone else here to testify in support, opposition of 2258.

52:39

Abigail Stoddard ~ Pharmacist with Prime Therapeutic: Attachment 6.

1:02:21

Rep Lefor: Number 11, it's simply saying that PBM's cannot require more accreditation than is already in federal or state statute. It seems from the testimony I've heard, is that PBM's set up the accreditation, they pick the specialty drugs and control a lot of the pricing and compete with the pharmacies. Why should there be accreditations that are additional to federal and state requirements?

Stoddard: We don't set up the accreditation bodies. Those are independent organizations similar to a hospital getting accredited by the joint commission. My own facilities must be accredited.

Rep Lefor: But the PBM's require them to be accredited through these entities correct?

Stoddard: If they wish to participate in our specialty network, yes.

Rep Lefor: If they wish to participate. So you're making the decision for them correct?

Stoddard: They may choose one accreditation of several available. We don't tell them which one or that they have to do more than one.

Rep Lefor: Your saying, #11, unless I'm misunderstanding you, has a tremendous negative fiscal impact? It seems really vague to me. We should check the fiscal impact. Don't you have any documentation or what that might be? If you do would you share that with us?

Stoddard: In the Senate hearings, Mr. Ward, brought forth a fiscal note from Minnesota. We've seen bills to this similar affect in MN for the past 3 years. The last time the state had a fiscal note done was 2016. This portion for that state of Minnesota, was estimated to cost the state $7.8 every 2 years and increasing. I could share that.

Rep Kasper: You talked about no gag orders with patients. You have a gag order in your contract with Pharmacist A talking to Pharmacist B if they've been able to see their contact, about their contract with you.

Stoddard: Yes, the contract is proprietary. Yes, similar to if you were any other provider of a service and you had a contract, that contract is proprietary, you can't share that with other members of your industry. I would also think that pharmacies wholesalers would have a problem with pharmacies sharing prices with their wholesaler for the price they get on toilet paper and on greeting cards. That pricing information is proprietary to members of the industry because to disclose that is tacit collusion. They can discuss with the member any cost information relevant to the member but they can't call up the neighboring pharmacy and say, "hey, Prime is paying me $2 for this drug, what are they paying you? I want to get your rate."

Rep Kasper: So the 1st amendment of the US Constitution has no bearing in your contract. You said you are most concern with number 6. We heard testimony about the fact that does exist. If they're part of a purchasing group on contracting group, there's a lot of small pharmacies, that don't have the time to negotiate these complex contracts but they're being negotiated on their behalf, and they're saying they're being prohibited from looking at those contracts. You said earlier you do not prohibit that.

Stoddard: Correct. I would not say I'm not concerned about Section 6 of this bill, I think Section 6 is indicative of other players in this market, the PSAO's, holding contracts and causing issues. If we explore those issues, we potentially would not need additional legislation to solves these problems.

Rep Kasper: You talked about the ongoing mail order problems. Number 8 Page 2, when you mail your drugs from PBM headquarters, where's your PBM headquarters?

Stoddard: Minneapolis.

Rep Kasper: When you mail something from MN to ND, do you pay the shipper a fee to mail it?

Stoddard: We absorb that cost. That's accounted for in our fees to our clients.

Sen. Kasper: So you're getting it one way or another.

Chairman Keiser: Several sections of this bill weren't a problem. Why do you object to being included in the bill if it's not a problem?

Stoddard: Some we don't have a problem with but to date the proponents have not been willing to discuss with us and take out the sections of the bill that are a problem.

Robert Harms ~ lobbyist for CVS Health, introduced Emily Meegan

Emily Meegan, CVS Health: I will echo the comments of Miss Stoddard. We would like to sit down with the proponents but they haven't not been able to do so. There are some provisions we are seriously concerned about, but others where we think there can be common ground for the betterment of the industry.

1:10:50

Chairman Keiser: I will hold this bill until Wednesday. We haven't talked about prohibiting class action lawsuits. Do you have an issue with that?

Meegan: We've never seen that provision before. Our legal department is still looking at. It's my understanding that arbitration is a first step, more informal, less expensive and that litigation could commence at the finality of arbitration if there's not an agreement reach.

Chairman Keiser: Does it state that in the contract? Does it prohibit class actions suits in the contract?

Meegan: I don't know if our contracts specifically do but I can look into that for you.

Rep Kasper: I would like that information by Wednesday.

Chairman Keiser: There is a great disconnect in the testimony. We're given examples from the pharmacists showing DIR. It is happening. The principle is a policy question, even if you're not doing it at least have the discussion.

Meegan: I do agree with that and I don't know how to answer that but we are more than willing to work with whoever is having an issue with us.

Rep Kasper: Don't your contracts prohibit the pharmacist from having a discussion openly either with this committee or with other pharmacists, so how can they discuss when your contracts prohibit them?

Meegan: I meant to come to CVS or CVS Caremark specifically if they're having an issue.

1:14:12

Robert Harms ~ Representing CVS: Attachment 7.

1:20:24

Rep Kasper: You mentioned the negotiation between a PBM and a Bobcat. This doesn't have anything to do with the Bobcat contract. It addresses the negotiation of the contract between the PBM and the pharmacists, do you agree?

Harms: I agree completely. My point was that's there's an assertion that when a PBM goes to the retail pharmacist, and he has no negotiating power and I'm saying that's not true. I've had retail tell me they have had success negotiating.

Rep Kasper: Do you have any idea of the population of Minnesota?

Harms: I don't.

Rep Kasper: I think it's about 7 million. Your citing of the MN fiscal note of $12 million would be equivalent to $800,000-$900,000 in ND. You mentioned that we heard antidotal evidence in testimony. It's obvious we're hearing antidotal because the PBM's put a gag order on the pharmacists from speaking. You've made some bold statements in your handout. PBMs will save $650 billion in drugs costs over the next decade. You've asked for evidence. I asking for your substantiation for making that claim, would you provide that to our committee?

Harms: I would be happy too.

Pat Ward ~ Represent Express Scripts: Attachment 8 & 9. I'm going to echo what others have said. A couple things I want to mention. The organizational fine for an individual is $1500, for a corporation it's max of $20k.

Chairman Keiser: We're going to give both sides an opportunity to bring the best bill forward whether compromise or not. Further opposition to SB 2258? Neutral testimony? Closed the hearing.

Testimony received without giving oral testimony:

10) Andy Peterson, GNDC
11) Laura Bright, handwritten

2017 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

SB 2258
3/22/2017
29542

☐ Subcommittee
☐ Conference Committee

Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Pharmacy claim fees and pharmacy rights.

Minutes:

Chairman Keiser: Reopens the hearing of SB 2258.

Rep Kasper: I like the bill the way it is. Moves a Do Pass.

Vice Chairman Sukut: Second.

Chairman Keiser: Discussion?

Roll call was taken on SB 2258 for a Do Pass with 12 yes, 1 no, 1 absent & Chairman Keiser is the carrier.

9:00 AM

Date: Mar 22, 2017

Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 2258

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description: _____

Recommendation

☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐ _____

Motion Made By _____ **Seconded By** _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	X		Rep Laning	X	
Vice Chairman Sukut	X		Rep Lefor	X	
Rep Beadle	X		Rep Louser	X	
Rep R Becker	X		Rep O'Brien	X	
Rep Bosch	X		Rep Ruby	~~Ab~~	
Rep C Johnson	X		Rep Boschee	X	
Rep Kasper	X		Rep Dobervich	X	

Total (Yes) 12 No 1

Absent 1

Floor Assignment Rep Keiser

REPORT OF STANDING COMMITTEE

SB 2258, as engrossed: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **DO PASS** (12 YEAS, 1 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2258 was placed on the Fourteenth order on the calendar.

2017 TESTIMONY

SB 2258

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

SB 2258
Senate Industry, Business and Labor Committee
January 31, 2017 – 10:00 am
Senator Jerry Klein – Chairman

Chairman Klein and members of the committee, for the record, my name is Mike Schwab, the Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of SB 2258.

I would like to start by turning your attention to Page 1 – Line 12 – Number 2.

Recently, Pharmacy Benefit Managers (PBMs) have started to access a "fee" on claims submitted by a pharmacy. This legislation would rein in abusive retroactive direct and indirect remuneration (DIR) fees imposed by pharmacy benefit managers (PBMs). Retroactive DIRs, often assessed weeks or even months after a prescription has been filled, prevent pharmacies from knowing at the time of dispensing what their true reimbursement will be for that prescription. Such lag time creates an unnecessary burden on pharmacy operations and makes it very difficult to make decisions for the future. Furthermore, the magnitude of these fees, often force pharmacies to make tough decisions to cut back on community contributions or to reduce employee hours, or in some cases laying off employees. Such actions have a ripple effect through local economies. This common-sense legislation would bring greater transparency to pharmacy payments by informing pharmacies at the point of sale what their reimbursement will be for clean claim prescriptions and allow for better business planning. There are a few states that have already passed similar legislation with additional states introducing legislation to address these fees this year. Federal legislation has also been introduced to address this concern under Medicare Part D plans (senior plans).

A recent report by the Centers for Medicare and Medicaid (CMS) that was released on January 19, 2017 shows these DIR fees are having an impact on the federal government and the taxpayers paying the bill. CMS has observed a notable growth in DIR fees collected by the PBMs. DIR fees have gone from $8.7 billion in 2010 to over $23 billion in 2015. This coincides with the rapid growth of Medicare Part D net drug costs which have gone from $77.5 billion in

2010 to over $137 billion in 2015 with most of the growth taking place between 2013 to the present.

CMS identified three main trends taking place regarding these kinds of fees. These fees have caused (1) higher out of pocket spending for beneficiaries, (2) beneficiaries reach the catastrophic phase of Medicare Part D benefit quicker and federal government then picks up 80% of the total drug costs and (3) claim fees that are implemented after the point-of-sale lessen PBM plan liability and increase plan liability for the federal government. Pharmacy is also now starting to see these fees implemented on the commercial side or non-federal government plans as well.

It is not unreasonable to request the PBM tell the pharmacy at the point-of-sale the amount of the "fee" that will be taken from the pharmacy. This provision allows the pharmacy to know what fees will be imposed upon the pharmacy at the point-of-sale or time of processing the claim and not done weeks or months later. Examples of this "fee" will be shared with you by others wanting to testify.

<u>Starting on Page 1 – Line 18 – Number 3 and subsection A-C.</u>

Currently, pharmacies are assessed "performance scores or metrics" based on each pharmacy's performance in addressing medication adherence measures. The performance measures are established by an unbiased nationally recognized entity called "EQUIPP" – Electronic Quality Improvement Platform for Plans and Pharmacies. Basically they identify a range or percentage that a pharmacy performance measures should fall into. The issue is that the PBMs are now establishing their own range or percentage that a pharmacy should be falling into. If a pharmacy does not fall into the range or percentage identified by the PBM, the PBM will assess a fee upon the pharmacy. In some recent cases, a pharmacy can be meeting all the ranges or percentages established by EQUIPP but the PBM will still assess a fee upon the pharmacy.

This section simply states, that each PBM cannot make up their own ranges or percentages and they need to use EQUIPP or another unbiased nationally recognized entity aiding in improving pharmacy performance measures. It further states that a PBM cannot

assess a fee on the cost of goods sold by a pharmacy and can only asses a fee on the professional dispensing fee established in the PBM and pharmacy contract.

Page 2 – Line 12 – Number 4.

This provision prohibits a PBM from charging a patient a copayment that actually exceeds the costs of the medication. It also prevents the PBM from "clawing back" part of the copayment paid to the pharmacy provider which we strongly feel is illegal and misrepresentation to the patient. Examples will be shared with you today by others waiting to testify.

Page 2 – Line 16 – Number 5.

Currently, PBMs have started to require pharmacies sign contract language that states the pharmacy agrees to not participate in class action lawsuits. They want the pharmacy to agree to arbitration and it has to be done in a state of the PBMs choosing and done on a claim by claim basis. This provision allows the pharmacy just like any other business the opportunity to exercise their rights as a business owner.

Page 2 – Line 22 – Number 6.

This reassures a pharmacy who belongs to a Pharmacy Service Administration Organization (PSAO); they have a right to see the contract details that the PSAO has entered into on the pharmacy's behalf. Others will speak to this provision as well today.

Page 2 – Line 26 – Number 7.

This provision is self-explanatory. However, we anticipate that ND Medicaid and ND Workforce Safety and Insurance will be opposed to this one provision. We understand their concern but we felt we needed to have a discussion as to why this provision is included. Currently, because of PBM contract language, pharmacies are forced to fill some medications at a loss. Pharmacies are for-profit businesses and are forced to sell products at a loss and these losses have increased in recent years. Basically every single pharmacy in this state has had to implement software systems that turn the pharmacy computer screen "RED" when they are being forced to fill medications at a loss. This used to happen to pharmacies a few times a month, then a few times a week and now it happens daily. I am sure pharmacists here today

can attest to the fact that they have had to implement these kinds of computer software systems and can also speak to the frequency this is taking place at their respective pharmacy.

Page 2 – Line 28 – Number 8.

This provision removes gag orders placed upon pharmacies by the PBMs, where the pharmacy is not supposed to tell a patient if there is a cheaper alternative available for the patient.

Page 3 – Lines 1-5 and Numbers 9 and 10.

This prohibits a PBM for telling a pharmacy they cannot mail prescriptions to patients or provide home delivery services to patients. Chairman and members of the committee, pharmacies have been providing this ancillary services since before ND was even a state. Maybe if the PBMs didn't own their own pharmacies and weren't in the business of pharmacy directly setting the competing pharmacy's reimbursement and competing for their patients, this wouldn't even be an issue. Pharmacies who try to negotiate this prohibition in their contracts are threatened with expulsion from the PBMs pharmacy network.

Page 3 – Line 6 – Number 11.

This provision would provide the pharmacy with necessary information so the pharmacy can make an informed contracting decision. Right now, some PBMs will not provide this information to a pharmacy when the pharmacy is trying to determine if they should sign a specific PBM pharmacy network contract.

Page 3 – Line 10 – Number 12.

PBMs have taken it upon themselves to now require pharmacies become "accredited" to be in the PBMs specialty pharmacy network and to be allowed to dispense specialty drugs to patients. The accreditation requirement is only one aspect of some PBMs attempt to carve pharmacies out of the supposed "specialty" market or other pharmacy networks for that matter. On top of accreditation, some PBMs are also requiring pharmacies adhere to a slew of reporting requirements as well as certain assurance measures. Reporting requirement and assurance measures are one thing. However, a number of the reporting and assurance measures have egregious "fines" attached to them. A pharmacy is already regulated by State

and Federal laws and rules and authorized to dispense any and all drugs their licenses and certifications allow.

We would like to offer two short amendments to this bill.

Amendment One

Page 1 – Line 15 – b. That is not reported on the remittance advice of an adjudicated claim; or

Page 1 – Line 16 – c. After the initial claim is adjudicated at the point of sale. ~~or~~

Page 1 – Line 17 – d. ~~To which a pharmacy did not clearly agree in a writing signed by both parties.~~

Amendment Two

Page 2 – Line 14 dispensing provider or pharmacy ~~may~~ shall retain the adjudicated cost and the pharmacy

Thank you for your time and attention. I would be happy to try and answer any questions. I know there are additional people her to testify in support of SB 2258.

Respectfully Submitted,

Mike

Mike Schwab

NDPhA EVP

SB 2258 1/31/17 #2

Senate Industry, Business, and Labor Committee

Chairman – Sen. Jerry Klein

SB 2258 Testimony (Claims Fees)

01/31/2017

Chairman Klein and members of the Committee. I am Dan Churchill, a pharmacist from Bismarck. I am here today to urge you to issue a DO PASS recommendation on SB 2258.

Today in the pharmacy world each PBM is coming at us with a different strategy of fees that they charge us for this, that, and everything. It's a claims transmission fee, an out-of-network fee (when you are an in-network pharmacy), an in-network fee, a Transaction resolution fee, Direct and Indirect Remuneration Fee (DIR) and clawbacks, amongst other fees too numerous to mention. The majority of these fees are not apparent at the time of the prescription dispensation. The pharmacy only finds out what the fees are sometimes months later. The names and reasons for these fees are intentionally fuzzy and hard to understand. Some are tied to difficult to understand "performance metrics" which are often nearly impossible to achieve and usually are moving targets.

Even Medicare has said in a recent analysis (dated 01/19/2017) that many of these fees (specifically the DIR fees) are responsible for increasing out-of-pocket costs for patients and increasing overall costs for the Medicare Drug program. Medicare has come out with this type of information before but we have been unable to get any traction on this issue in Washington. Fortunately here in Bismarck we can come to our Legislature and at least get heard on the issues.

[redacted]my practice some of the fee shenanigans that we have witnessed: One prescription for an expensive monthly [redacted]aintenance medication processed through for about $600 dollars. Looked good, it covered our costs and everything was fine and dandy. A month later when examining the remittance advice that $600 prescription had a $400 fee assessed on it. So that prescription now was a several hundred dollar loss for the pharmacy. And let's look at the implications for the patient. The net price of that prescription was about $200. However $600 is what it is going to look like on that patient's Medicare Part D plan and they are going to go into the "donut hole" or "coverage gap" after about 6 months vs. not going into that donut hole at all without the post transaction fees.

Just yesterday filled a prescription on another monthly maintenance medication. The Rx processed thru for about $45. However here the PBM attached a "clawback" of $10. Meaning they expect the pharmacy to collect the $45 from the patient and then send $10 back to the PBM. The essential price of this Rx is $35. But the PBM is over charging $10 and pocketing it. This doesn't seem like much but extrapolate it by 12 fills a year and multiply by thousands of patients and you start to get very large numbers. This particular claim in this example was from a government funded payor, not Medicare.

There are many more examples. Most people don't believe me when I talk about this stuff, but it's true and it's huge and we need to do something about it

I urge you to issue a DO PASS recommendation on SB 2258 and put a stop to the foggy fees that are being assessed, at the end of the day, to the citizens of North Dakota.

Thank you,

[redacted]

Daniel M. Churchill, Pharm.D., R.Ph

SB 2258 – Senate Industry, Business & Labor Committee – January 31, 2017

Good morning Mr. Chairman and members of the committee. My name is Abigail Stoddard, I am a pharmacist with Prime Therapeutics, and I am here to respectfully oppose SB 2258.

SB 2258 covers huge portions of our business as a pharmacy benefit manager - quality-based contracting, member copayments, pharmacy reimbursement, pharmacist refusal to dispense, mail order networks and pharmacy credentialing. The testimony on this bill has been equally broad and we have not heard how and whether specific language in this bill will address the root cause of problems and complaints.

It is also clear to me from the proponents testimony and from the text of SB 2258 that there is a disconnect between a pharmacy's expectation of working with a PBM and the contracts they enter into with that PBM. Pharmacies have two options when contracting with PBMs – to contract with the PBM directly as an individual or to contract with a PBM through a group called a pharmacy services administrative organization (PSAO). The vast majority of our independent network pharmacies contract with us through a PSAO. These PSAOs negotiate contract terms and enter into contracts on behalf of their pharmacy members.

Most sections of this bill – section 2, 3, 4, 5, 8, 9 and 10 are items contained in PBM contracts. Based on the testimony today it appears that either pharmacies are not aware of contracts that are being signed on their behalf, or they are attempting to use the state legislature to release them from their contract obligations.

Section 6 of the bill leads me to believe it is the former. Section 6 states:

> *6. A pharmacist or pharmacy that belongs to a pharmacy service administration organization may receive a copy of a contract the pharmacy service administration organization entered with a pharmacy benefits manager or third-party payer on the pharmacy's or pharmacist's behalf.*

I hope what I've just highlighted illustrates that this bill raises more questions than answers and needs further study and discussion. I welcome any follow up from the sponsor or proponents on these issues, but today I can only oppose SB 2258 as written.

2017 Senate Bill No. 2258
Testimony before the Senate Industry, Business and Labor Committee
Presented by Harvey Hanel, Medical Services and Pharmacy Director
Workforce Safety and Insurance
January 31, 2017

Mr. Chairman and Members of the Committee:

My name is Harvey Hanel, Medical Services and Pharmacy Director for Workforce Safety and Insurance (WSI). I am here today to provide testimony regarding SB 2258. The WSI Board supports this bill with one amendment. Without that change, it is anticipated the WSI Board will oppose this bill.

WSI pays all medical benefits associated with a work related injury. Included in these benefits is all related pharmacy, without co-payment or deductibles. WSI fully supports the fair and equitable reimbursement of all medical providers. These providers include pharmacies, pharmacists, and pharmacy technicians who help to provide much needed medications and supplies to treat workers who have sustained an injury. Without them, our injured employees would have diminished access, which in turn would compromise care. That is the reason why WSI supports the majority of this piece of legislation.

Our single objection is found on page 2, lines 26 and 27, which states, "A pharmacy or pharmacist may decline to provide pharmacist services or products on behalf of a pharmacy benefits manager or third-party payer."

Currently, almost all North Dakota pharmacies, as well as thousands more nationwide, have entered into agreements with WSI's pharmacy benefit manager (PBM) to accept WSI reimbursement levels for dispensed medications. This reimbursement amount is based upon the WSI fee schedule and is administered by our PBM. The fee schedule includes maximum allowable cost or MAC pricing which is compiled and monitored by our PBM. WSI's reimbursement for medications, particularly those medications that fall under the MAC pricing structure, is established from a price at which the pharmacy can purchase those medications.

In the event there is a dispute over the reimbursement for a prescription, the pharmacy has the ability to enter a pricing dispute with WSI's PBM. This ensures overall fair reimbursement, and guarantees injured employees access to prescribed medications. Subsection 7 undermines this system. It would allow pharmacies to choose only to fill those medications where profits are maximized and refuse to fill medications where reimbursement may be lower. This will force injured employees to fill prescriptions in a piecemeal fashion, based upon the vagaries of any particular pharmacy.

While WSI believes the vast majority of pharmacies and pharmacists will continue to provide the type of service WSI has come to expect and rely on in treating injured employees, it does leave open the possibility a certain pharmacy or pharmacist could selectively choose to refuse services to injured employees.

Furthermore, there is nothing in this proposed legislation that would place the onus on the pharmacy or pharmacist to ensure they are being prudent purchasers of pharmaceuticals as a prerequisite to denial of services.

Attached you will find proposed amendments, and WSI requests your consideration in adoption of them.

This concludes my testimony and I will be happy to answer questions you may have.

Proposed Amendment to Senate Bill No. 2258

Page 2, remove lines 26 – 27

Page 2, line 28, replace "8." with "7."

Page 3, line 1, replace "9." with "8."

Page 3, line 3, replace "10." with "9."

Page 3, line 6, replace "11." with "10."

Page 3, line 10, replace "12." with "11."

Page 3, line 14, replace "13." with "12."

Renumber accordingly

Senate Industry, Business, and Labor Committee
SB 2258 – 9:30 A.M.
01/31/17
Chairman Senator Jerry Klein

Chairman and members of the committee, for the record, my name is Gary Boehler, a pharmacist consultant employed by Dakota Drug, Inc., a regional drug wholesaler based in North Dakota , and serving many independent pharmacy owners in North Dakota and surrounding states. I am here today to speak today in support of SB 2258.

I have been asked to comment on SB 2258 given my knowledge and past experience with PBM practices throughout the industry and to comment on language contained within SB 2258.

Since the 1960s when PBMs first became relevant in the prescription drug scene as processors of prescription drug claims for various health plans, their involvement has become far more intensive to act as the "middleman" between health care plan sponsors and the pharmacy provider network, while at the same time, creating a veiled shroud of secrecy that by design has created a lack of transparency neither understood by the plan sponsor paying the bill, the patients who receive their prescription drug benefits, or the pharmacy provider networks that take care of the patients. Our purpose today is to unravel some of these "secrets" that are pervasive throughout the industry and shed more light on the currently embedded practices that raise the cost of prescription drug benefits instead of having them be more realistic and following more closely rates of inflation.

We are all familiar with the rapid rise of prescription drug benefits rising by rates

that far exceed annual inflation rates. I firmly believe one of those reasons which is shrouded in secrecy is the "pay to play" schemes devised by PBMs which force the drug manufacturers to pay huge rebates to the PBM industry if that manufacturer is allowed to place their drug(s) on the PBM formulary and various tier levels. PBMs show drug savings to plan sponsors, but much of those savings are eaten up by the manufacturers being forced to raise their drug prices to be able to maintain their levels of profitability those manufacturers have had over the past years. It becomes a vicious cycle that never ends, creating even higher drug costs!

My reasons for supporting SB 2258 are multi-fold:

Quality metrics (commonly referred to CMS 5-Star Ratings) are being taken by PBMs and quantified to their own standards instead of the guidelines established by CMS. A pharmacy provider who might well achieve a 5-Star CMS rating is subject to funds taken from his PBM remittance if that provider does not meet the "new standard" as established by the PBM. 5-Star ratings are a measure of service for our patients; the PBMs choose to apply their direct and indirect remuneration fees (DIRs) against the reimbursement by the PBM for the products itself AS WELL as the dispensing fee. This bill will only allow DIR fees to be assessed against the service level and not the reimbursement for the product goods dispensed. For that reason I support this Senate Bill 2258.

Pharmacies using an outside service to negotiate their contracts (pharmacy service accounting organizations, or PSAOs) are NOT allowed to see the prescription drug contract that has been negotiated on their behalf by the PSAO. So, in essence, the PBMs have a contract that the pharmacy provider has not seen and may not know

the details therein. Senate Bill 2258 changes that to allow the PSAO to provide any contracts that the PSAO has negotiated on behalf of a participating pharmacy. For that reason I support this bill (removing a slice of the lack of transparency).

A common occurrence today is known as a patient claw back, wherein a patient's copay at the point of sale is raised to an egregious level, and then that excess is taken back from the pharmacy by the PBM. This is tantamount to charging the patient an additional premium for what that patient has already paid for a drug benefit. I view that as illegal and only a means for the PBMs' self-enrichment. SB 2258 prohibits that kind of egregious activity in North Dakota and for that reason I support this bill.

Pharmacists are not allowed to tell a patient when a cash price is less costly than the copay as determined by the PBM (gag orders). Disobeying those mandates by the PBM can result in a pharmacy being expelled from a PBM's network. This bill, which eliminates those gag orders and saves our patients money eliminates any/all gag orders. For that reason I support SB 2258.

PBMs are increasingly sending out letters to pharmacies threatening local owners of pharmacies against delivering or mailing out of prescriptions to patients with expulsion from their network(s). These services are part of the history of pharmacy and an expectation or need for certain patients. This bill prohibits these types of threats, and for that reason I support SB 2258.

Every pharmacy in the state is required to meet the standards of operation as set by the North Dakota Board of Pharmacy. PBMs are now establishing their own set of credentialing standards that are not consistent, simply cost a local pharmacy more

out of pocket expense, and are merely attempts by the PBM industry to restrict a local pharmacy's participation in varying types of dispensing, e.g. specialty drugs, vaccinations, etc. SB 2258 removes these unnecessary accreditation standards imposed by PBMs. For that reason I support SB 2258.

Senate Bill 2258 allows all pharmacies, regardless of practice setting (retail, long term care, or hospital) to participate in a class action lawsuit. Those actions are disallowed in contracts today, merely an effort by the PBM industry to prevent a united front by pharmacists to eliminate egregious actions that are in the industry today. For that reason I support SB 2258.

Thank you Mr. Chairman and committee members for allowing me to present this testimony on behalf of North Dakota pharmacists.

Gary W. Boehler

Gary W. Boehler, R.Ph.

SB2258NDSENATE2017

Testimony of Pat Ward in Opposition to SB 2258
Senate IBL – Tuesday – January 31, 2017 – 10:00 a.m.

- Good morning, Mr. Chairman and members. My name is Patrick Ward, and I am here on behalf of Express Scripts – one of the nation's largest pharmacy benefit managers – in opposition to SB 2258.

- As a pharmacy benefit manager, it is our goal to make prescription drugs safer and more affordable for both our clients, as well as their beneficiaries. We do this in a variety of ways: by negotiating discounts from brand drug manufacturers, designing retail pharmacy networks, promoting generics, operating specialty pharmacies, providing formulary management, performing drug utilization reviews, etc.

- We perform these services for tens of millions of Americans through our clients -- including Fortune 500 employers, health plans, labor unions and government entities of all sizes.

- Our clients design their pharmacy benefits to meet the unique needs of their respective workforces. We, then, as a PBM, administer that benefit. The details of how that benefit is structured, including the pharmacy network, are determined by the plan sponsor/client.

- Before delving into specifics, I would like to highlight for the committee that we, as an industry, have met with Mr. Schwab from the Pharmacy Association to better understand their concerns, as well as relay ours. It is our hope that we can find some mutual ground. I would also like to mention that many of the provisions in this measure relate to private contract terms between private sector clients, and that many of these issues can be resolved through the contracting process – and not legislation. Also, one of his main concerns seemed to be DIR payments. Fees in commercial health programs often get confused with "DIR," (Direct and Indirect Remuneration), which is a technical term unique to the federal Medicare Program that refers to discounts and charges exchanged between pharmacies and payers. DIR payments based on performance metrics hold pharmacies accountable for activities such as generic and cost-effect dispensing, improving adherence, and reducing inappropriate drug use. **States do not have regulatory authority over Medicare or the DIR program.**

- Among other things, SB 2258 would prohibit a pharmacy benefit manager from charging a fee to their contracted pharmacies for processing claims. These fees support key claim processing functions and without them the cost will be shifted to consumers.

- **Fees Are Part of Contractual Arrangements between PBMs and Pharmacies** – Pharmacies agree to certain fees in their contractual arrangements with PBMs. These fees are not unlike those paid by retailers to credit card companies in exchange for the risk of consumer fraud and for immediate payment for purchases, or the fees that banks charge consumers for ready access to cash through ATMs. Pharmacies freely enter into contracts with PBMs, agreeing to pay these fees in return for access to PBM services that enhance their own business practices.

- **Fees Maintain Pharmacy Access to Convenient Systems and Drive Business –**

Pharmacy benefit managers (PBMs) maintain robust IT systems to allow them to administer benefits. PBMs also contract with pharmacies to enable patients to fill prescriptions through their chosen benefit plan. For decades, pharmacies have agreed to contractual arrangements in which—for access to a PBM's health plan and employer clients' members and other services—they pay a fee. This allows pharmacies convenient and timely access to the business of hundreds of millions of consumers.

- **Fees Support Robust Information Systems That Help Pharmacies** – Specifically, the fees help support access to the PBM's IT systems that allow pharmacies to fill prescriptions from nearly any benefit plan. This system essentially assists in streamlining the process for pharmacies that would otherwise have to contract with individual employers and plans in order to provide services to their beneficiaries. Additionally, these fees also support maintaining help lines, benefit manuals, and other services provided to the pharmacy by the PBM.

- There are numerous other services identified that support PBM fees. Some examples are:
    - Real time POS adjudication services
    - Pharmacy audit/reporting
    - Help Desk
    - Consolidated credentialing (Pharmacy credentials once with ESI, as opposed to hundreds of times with various payors)
    - Consolidated remittance
    - Consolidated contracting (contracting with a single entity as opposed to various payors)
    - Education/Communication
    - Training webinars, email blasts regarding compliance issues/adjudication updates
    - Concurrent Drug Utilization review – online, real-time Drug Utilization Review analysis at the point of sale
    - Automated prior authorization processes to reduce calls to pharmacy
    - Compliance with CMS requirements

- Section 7 of this bill allows a pharmacist to refuse to refill a prescription. The reason that pharmacies enter into agreements with PBMs and plan sponsors is so that beneficiaries can have access to prescription drugs. We are unclear as to the need for this type of provision in law – other than arbitrarily denying patients access to their medications.
- Finally, section 12 removes important accreditation standards for dispensing certain types of drugs – particularly specialty products, similar with our concerns today with SB 2301. Specialty drugs are used to treat rare diseases and may not be stocked at typical brick-and-mortar drug stores. Given the sophisticated handling and distribution requirements of specialty drugs, the number of facilities equipped to handle the needs of specialty patients is lower still. Of the 69,000 pharmacies in the United States,

relatively few qualify as specialty pharmacies. Since not all pharmacies provide the same level of clinical care and product support to ensure that patients have access to the right medications at the right time, *payers must differentiate which pharmacies provide comprehensive specialty care versus those unable to achieve similar service levels and outcomes.*

- The legislation would hamper plan sponsors' abilities to create and utilize unique networks of highly qualified pharmacies to dispense specialty drugs, because it would open specialty services to all pharmacies licensed in the state, even those without specialty accreditation.
- We are willing to work with the Committee and proponents on mutually satisfactory amendments to this bill. We do respectfully request that any legislation that moves forward on this issue be prospective and not retroactively apply to existing contracts.
- **We ask for a Do Not Pass recommendation on SB 2258. I will try to answer any questions you may have.**

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SB 2258 1/31/17 #4

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Mark J. Hardy, PharmD, R.Ph.
Executive Director

SB 2258 – Pharmacy Claims Fees
Industry Business & Labor Committee
10:00 AM– Tuesday – January 31, 2017 – Roosevelt Room

Chairman Klein, members of the Senate Industry Business & Labor Committee, for the record I am Mark J. Hardy, PharmD, Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today about Senate Bill 2258.

The Board of Pharmacy members have discussed **P**harmacy **B**enefit **M**anagers [PBM] and some of the issues created by PBMs in their practices. Often discussed are stories of pharmacists having to choose between losing money on a prescription due to the reimbursements set by the PBM being too low to cover the acquisition cost of obtaining the pharmaceutical product or choosing not to dispense. Often times our pharmacists will make the decision which is in the best interest of their patients, dispense the item and take the loss with the hope that they will be able to recover this cost in future claims. These situations appear to be happening with an increasing frequency, especially in the recent trend of increased drug prices and drug shortage issues occurring in the pharmaceutical marketplace. It would be best if these situations could be handled in a common sense fashion that would not only be fair to the dispensing pharmacy and does not get in the way of patient care decisions.

Pharmacy Benefit Managers have long been a source of conflict between pharmacies in their professional practice of providing patient care. More and more states are looking to regulate PBMs with legislation, even the National Association of Boards of Pharmacy [NABP], of which we are a member, have adopted model language to define PBMs and create a licensing structure for them. The ultimate reason is the PBMs not only participate in activities that encompass the practice of pharmacy, but also impose conditions that affect patient care.

The issue of direct or indirect charge backs to pharmacies addressed in #2 has been a contentious concern in the profession and has become an increased practice, to take back funds after the claim has been adjudicated. This practice has been brought to the Board of Pharmacy's attention to determine it this is a legal issue. Unfortunately, at this time there is not a clear violation of law with this type of practice.

We would expect our pharmacies to provide information on cost effective and clinical effective medication in an individual patient situation addressed in #8. Simply put, we need our medical professionals talking to the patient about how best to treat their conditions, while keeping in mind the cost effectiveness of that treatment. This is just common sense and good pharmaceutical care.

The Board has been informed by patients and pharmacies of the prohibition by a Third-Party Payer from mailing or delivering medications which appears to be the goal of #9. This type of restriction runs contrary to the expectation of deliverance of pharmaceutical care across all our rural areas of the state of North Dakota. Being able to deliver to homebound patients and mail medications to the rural areas is a trademark of high standards and how we deliver the best care possible in North Dakota.

It is the Board of Pharmacy's stance that any legally and appropriately licensed Pharmacy in the state of North Dakota should be able to dispense pharmaceutical product in accordance to the license issued by the State Board of Pharmacy. The Board of Pharmacy inspections assure the public that the pharmacy is acting in a lawful way. Therefore, we would also support the provision of #12.

I will be happy to answer any questions you may have, and do appreciate your time.

SB 2258 1/31/17 #5

WRITTEN TESTIMONY OF DAVID A. BALTO TO MEMBERS OF THE NORTH DAKOTA INDUSTRY, BUSINESS AND LABOR COMMITTEE CONCERNING S.B. 2258 AND S.B. 2301

January 31, 2017

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Members of the Industry, Business and Labor Committee, thank you for the opportunity to submit testimony on pending legislation S.B. 2258 and S.B. 2301 and the need increase enforcement and regulation with respect to Pharmacy Benefit Managers (PBMs). This testimony documents the compelling need for this legislation to protect consumers and health care providers, and regulate PBMs in North Dakota. As explained in this testimony, the proposed legislation includes policies that are needed to protect consumers and providers from inconsistent and unfair practices by PBMs and provide a more competitive marketplace.

The comments in this testimony are based on 30-plus years of experience as a private sector antitrust attorney and an antitrust enforcer for both the Department of Justice and the Federal Trade Commission ("FTC"). From 1995 to 2001, I served as the Policy Director for the FTC's Bureau of Competition and the attorney advisor to Chairman Robert Pitofsky. At the FTC, I helped direct the first antitrust cases against PBMs. Currently, I work as a public interest antitrust attorney. I have represented consumer groups, health plans, unions, employers, and even PBMs on PBM regulatory and competitive issues. I have testified before Congress, numerous state legislatures and three times before the Department of Labor on PBM regulation, and was an expert witness for the State of Maine on its PBM legislation.[1]

The following testimony explains why the proposed legislation is necessary to protect consumers, health care providers and competition.

I. Background

PBMs increasingly engage in anticompetitive, deceptive or egregious conduct that harms consumers, health plans, and pharmacies alike. In a nutshell, both consumers and pharmacies suffer as consumers are increasingly denied a choice in their level of pharmacy service by PBMs. PBMs exercise their power to restrict consumers to the PBM's own captive mail order and specialty pharmacy operations, reducing choice and quality for many. Consumers and their health plans also suffer when health plans are denied the benefits of the PBMs' services as an honest broker, which drives up drug costs, and ultimately leaves consumers footing the bill for higher premiums.[2]

Why do consumers care about restricted access to pharmacies? Because community pharmacists are the most accessible health care professionals; and in many markets, such as rural markets which are prominent in North Dakota, they may be the only accessible professional. Because community pharmacies provide consumers with valuable clinical services and counseling, often free of charge. Because some pharmacies offer drugs at lower prices than the PBMs. Egregious PBM conduct jeopardizes these types of programs that consumers highly value. As community pharmacies are already economically efficient and operate on very

[1] The views expressed herein are my own and do not necessarily represent the views of any individual clients.
[2] Often health plans and large employers are silent on complaining about the PBMs out of fear of retaliation since they must do business with PBMs. In response to criticism during the Express Scripts/Medco merger that employers did not publicly express concern over the merger, Senator Herb Kohl stated that "it is notable that no large employer who privately expressed concerns to us wished to testify at today's hearing, often telling us that they feared retaliation from the large PBMs with whom they must do business." Statement of U.S. Senator Herb Kohl on the Express Scripts/Medco merger (12.6.2011).

minimal margins, reduced consumer access to these pharmacies would, in the end, likely result in harm to other consumers who rely on these community pharmacies.

Similarly, consumers also care about rising health care costs, including out-of-pocket costs for prescription drugs. PBMs have a profound impact upon drug costs. If PBMs are unregulated they can continue to engage in conduct that is deceptive, anticompetitive, and egregious. For this system to work effectively, PBMs must be free of conflicts of interest that arise from owning their own pharmacies. What health plans and employers are fundamentally purchasing is the services of an "honest broker" to secure the lowest prices and best services from both pharmaceutical manufacturers and from pharmacies. When the PBM is owned by the entity it is supposed to bargain with or has its own mail order operations there is an inherent conflict of interest, which can lead to fraud, deception, anticompetitive conduct, and higher prices. The three major PBMs – Express Scripts, CVS/caremark and Optum Rx -- clearly face that conflict since they own mail order operations, specialty pharmacies, and in the case of CVS Caremark – the second largest retail pharmacy chain and the dominant long-term care pharmacy in the U.S.

In recent years, the major PBMs—including those with a clear conflict of interest in their cross-ownership with pharmacies—have engaged in a variety of anticompetitive and anti-consumer practices.

II. Chronic Anticompetitive and Consumer Protection Problems in the PBM Market

PBMs are like other healthcare intermediaries that manage transactions by forming networks and transferring information and money. As a former antitrust enforcer, I can tell you that there are three essential elements for a functioning competitive market: (1) transparency, (2) choice and (3) a lack of conflicts of interest. This is especially true when dealing with health care intermediaries such as PBMs and health insurers where information may be difficult to access, arrangements are complex and clouded in obscurity, and there may be principal-agency problems. On all three of these elements the PBM market receives a failing grade.

Why are choice, transparency, and a lack of conflicts of interest important? It should be obvious. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering fair prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire. In both of these respects the PBM market is fragile at best. There is certainly a lack of choice especially for those plans that are dependent on the top tier big three PBMs (Express Scripts, CVS Caremark and Optum) which have an approximate 80% share of the market. And PBM operations are very obscure and a lack of transparency makes it difficult for plans, including government buyers, to make sure they are getting the benefits they deserve.

When dealing with intermediaries, it is particularly critical that there are no conflicts of interest. A PBM is fundamentally acting as a fiduciary to the plan it serves. The service a PBM provides is that of being an "honest broker" bargaining to secure the lowest price for drugs and

drug dispensing services. When a PBM has an ownership interest in a drug company or has its own mail order or specialty pharmacy dispensing operations, it is effectively serving two masters and may no longer be an "honest broker."

Moreover, when a PBM has its own pharmacy operations there are a myriad of competitive problems. Who will effectively monitor and audit the company-owned pharmacies? A pharmacy chain can use its PBM affiliate to disadvantage rival pharmacies, reducing reimbursement, and excluding pharmacies from networks. What about competitively sensitive information such as prices and costs? Where a pharmacy knows its rivals costs and pricing, it does not have to compete as hard. Ultimately consumers lose through less choice and higher prices.

The rapidly increasing drug costs which effectively lead to higher drug rebates for the PBMs leads one to question which master the PBM is serving. It increasingly appears that PBMs profit from higher drug prices, because they lead to higher rebates.

Competition and choice are crucial for a market to work effectively. North Dakotans should have the choice in how they value pharmacy services. Some choose community pharmacies, others who value one-stop shopping choose their local supermarkets, and others choose chains. This choice is important because competitors have to respond to this choice by improving services and lowering prices.

The legislation presented to this Committee is vital to provide needed protections to consumers, community pharmacies and payors.

Who Speaks for the Consumer – The Community Pharmacist

One important aspect of pharmacy services is the service pharmacists provide in assisting consumers in dealing with insurance companies and PBMs. Too often consumers are lost in a system where the PBM says "we don't have any choice, it's the employer who refuses coverage" and the employer says "we just do what the PBM tells us to do." No one takes responsibility or provides an answer. Who is there to protect the consumer?

The pharmacist is the advocate for the consumer. When PBMs create barriers patients typically seek help from their pharmacist to navigate their pharmacy benefit. Consumers can not battle with the PBM or insurance company. For these consumers, pharmacists act as an advocate, guiding consumers to use the lowest price drugs, explaining co-pays, and determining access. When a particular policy is problematic, the pharmacist will often work through it with the patient, providing explanation and even advocating on behalf of the patient with the PBM—going far beyond the tasks for which the pharmacist is paid.

Moreover, not only are pharmacies not paid for such services, but pharmacies are assessed ancillary fees by the PBMs not provided them at the point-of-sale to consumers. Additionally, in some instances in which the cost of a consumer's co-pay for a drug exceeds the cost of the drug itself, PBMs will claw-back the additional amount from the pharmacy. These practices place pharmacies in a position of not knowing what true reimbursement will be until

months after they have dispensed the medications.[3] Such practices put pharmacies in peril of being able to continue servicing consumers.

S.B. 2258 provides protection for pharmacies from charges that are not apparent at the point-of-sale or at the time the claim for the dispensed drug is processed by the PBM. It also prevents a PBM from charging a patient a co-pay that exceeds the cost of the medication and prohibits the PBM from automatically clawing-back from the pharmacy the portion of the co-pay that has been patient by the patient. These provisions are necessary to allow pharmacists to continue advocating for patient coverage and protecting patients from egregious PBM practices.

III. A Broken Market Leads to Escalating Drug Costs and Rapidly Increasing PBM Profits

What is the result of this dysfunctional market? PBMs entered the health care market as "honest brokers" or intermediaries between health care entities. However, the role of the PBM has evolved over time and increasingly PBMs are able to — "play the spread" – by not fully sharing the savings they purportedly secure from drug manufacturers. As a result PBM profits have skyrocketed over the past dozen years. Since 2003, the two largest PBMs—Express Scripts/Medco and CVS Caremark— have seen their profits increase by almost 600% from $900 million to almost $6 billion.

If the market was competitive, one would expect profits and margins would be driven down. But as concentration has increased, the exact opposite has occurred.

There is tremendous concern over rapidly increasing drug prices which threaten our nation's ability to control the cost of health care. While PBMs suggest that they are there to control costs, these claims must be carefully scrutinized. The concern of a PBM is to maximize profits and that means maximizing the amount of rebates they receive. Since rebates are not disclosed, this is an incredibly attractive source of revenue. PBMs can actually profit from higher drug prices, since this will lead to higher rebates.

Would PBMs withhold their negotiating punch to secure higher rebates? We do not have to guess that this is occurring. PBMs have used similar strategies in the past. Indeed, as noted below state enforcers have attacked sweetheart deals PBMs arranged with drug manufacturers to force consumers to use higher cost, less efficacious drugs, in order to maximize rebates and secure kickbacks. They held back their negotiating muscle to allow prices to escalate to maximize rebates.

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[3] These practices also increase costs to the federal government. The Centers for Medicare and Medicaid Services (CMS) recently issued a report concerning the ancillary fees known as direct and indirect remuneration. CMS reported that compensation and rebates PBMs receive from transactions beyond the pharmacy point-of-sale is double the rate of gross drug spending by CMS on Medicare Part D prescriptions. Such ancillary charges to pharmacies place more burden on Medicare beneficiary cost-sharing and increasing Medicare's costs for these beneficiaries. CMS, Medicare Part D – Direct and Indirect Remuneration (January 19, 2017), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19-2.html.

Facing weak transparency standards, the largest PBMs frequently engage in a wide range of deceptive and anticompetitive conduct that ultimately harms and denies benefits to consumers. Some PBMs secure rebates and kickbacks from drug manufacturers in exchange for exclusivity arrangements that may keep lower-priced drugs off the market. PBMs may switch patients from their prescribed drug to a more expensive drug to take advantage of rebates that the PBM receives from drug manufacturers. PBMs often do not pass through rebates secured from drug manufacturers to payors, and instead are accounted for as a reduction in cost of revenues, allowing the PBMs to hide profits. In fact, Medco was the last PBM to publicly disclose rebates in 2012. In short, PBMs derive enormous profits at the expense of the health care system from the ability to "play the spread" between pharmaceutical manufacturers, pharmacies and health care plans.

No other segment of the health care market has such an egregious record of consumer protection violations as the PBM market. Between 2004 and 2008, Express Scripts and CVS were the subject of six major federal or multidistrict cases over allegations of fraud; misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. One of the most common forms of egregious conduct identified was PBMs switching consumers to higher cost drugs, that often were less efficacious, in order to maximize rebates. These cases appended to this testimony, resulted in over $371.9 million in damages to states, plans, and patients so far.

Unfortunately the provisions in the orders in each of these cases have expired, increasing the need for greater regulation and enforcement to ensure that the market functions with transparency, consumer choice, and free of conflicts of interest.[4] These problems are only getting worse. Case in point is the number of recent cases which are either ongoing or have recently settled. In 2014, CVS alone was responsible for over $30 million in penalties concerning violations of the False Claims Act and SEC violations.[5] In 2015, Express Scripts and CVS paid settlement fines to the federal government and to numerous states of over $129 million for illegal prescription dispensing and various violations of the false claims and anti-kickback laws.[6] Currently pending before the Delaware federal district court is a False Claims Act violation brought against Medco (now Express Scripts) on behalf of the U.S., California, Florida and New Jersey over claims the company defrauded state and federal health insurance programs by accepting undisclosed discounts from drug manufacturers and not passing on the savings to its clients, according to a recently amended complaint.[7]

Moreover, substantial private litigation is pending against major PBMs. For example, Optum Rx, has several separate suits filed against it. One by retail chain Kmart which alleged

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[4] For a more detailed analysis of the federal and state cases against the PBMs, *see* David A. Balto, *Federal and State Litigation Regarding Pharmacy Benefit Managers*. http://www.dcantitrustlaw.com/assets/content/documents/PBM/PBM%20Litigation%20Updated%20Outline%20-%201-2011.pdf.

[5] *See* Testimony of David A. Balto, "The State of Comeptition in the Pharmacy Benefits Manager and Pharmacy Marketplaces," before the House Judiciary subcom. On Regulatory Reform, Commercial and Antitrust Law, Appx. A (Nov. 17, 2015), http://dcantitrustlaw.com/assets/content/documents/testimony/PBM%20Testimony.Balto_November%2017%202015.Final.pdf.

[6] Id.

[7] *John Doe v. Medco Health Solutions Inc., et al.*, Case No. 1:11-cv-00684 (D. Del.).

failure to pay reimbursements for dispensed drugs equating to $38 million in damages;[8] another by 55 independent pharmacies alleging illegal conduct serving to inflate patient costs while simultaneously underpaying pharmacies;[9] and several others filed in 2016 alleging that Optum is overcharging patients for prescription drugs and pocketing the overcharge.[10] Express Scripts is currently facing a $13 billion lawsuit by its largest client Anthem for overcharges for prescription drugs.[11] Additionally, Express Scripts is facing several antitrust conspiracy suits in which plaintiffs have alleged Express Scripts engaged in a conspiracy with other major PBMs to exclude competing compounding pharmacies from their network, effectively forcing the competition to close and routing patients to the PBMs captive pharmacies. These cases have survived Express Scripts' motions to dismiss and one is set for a jury trial beginning in May 2018.[12]

IV. Legislation is Vital to Inform Payors and Protect Consumers

As a general matter it is essential to provide transparency for consumers, which helps them to adequately evaluate products carefully, to make informed choices, and to secure the full range of services they desire. In these respects the PBM market is fragile at best. PBM operations are very obscure and a lack of transparency makes it difficult for plan sponsors to make sure they are getting the benefits they deserve.

Responding to the numerous enforcement actions, both a handful of states and Congress have taken measures to enact transparency provisions by requiring some degree of disclosure of rebates and other revenue. In the multistate enforcement action against CVS Caremark, 30 state attorneys general required rebate disclosure. Additionally, the Department of Labor ERISA Advisory Council recommended PBMs be required to disclose fees and compensation to sponsors of ERISA health plans.[13] Finally, some large sophisticated health plans have negotiated for greater transparency.[14]

Although settlements from litigation and negotiations have helped to address some issues, without legislation, a lack of transparency allows PBMs to "play the spread" – the difference between a PBM's expenditure and the revenue it takes in – leading to higher costs for plan sponsors and patients. PBMs earn enormous profits by negotiating rebates and discounts with drug manufacturers in exchange for promoting certain drugs on their preferred formulary or

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[8] *Kmart Co. v. Catamaran Co.*, Case No. 2015-L-008290 (Ill. Ct. Cl. Aug. 31, 2015).
[9] *Albert's Pharmacy, Inc. et al v. Catamaran Corporation*, Case No. 3:15-cv-00290 (M.D. Pa. Feb. 9, 2015).
[10] *See, e.g, Stevens v. UnitedHealth Group, Inc. et al.*, Case No. 16-cv-03496 (D. Minn.).
[11] *Anthem v. Express Scripts*, Case No. 16-cv-2048 (S.D.N.Y.)
[12] *HM Compounding Services v. Express Scripts*, Case No. 14-cv-01858 (E.D. Mo.); *Precision RX Compounding, LLC et al. v. Express Scripts*, Case No. 16-cv-00069 (E.D. Mo.).
[13] *See* PBM Compensation and Fee Disclosure, Report by the ERISA Advisory Council, Department of Labor (2014), *available at* http://www.dol.gov/ebsa/publications/2014ACreport1.html.
[14] Linette Lopez, The companies you've never heard of are about to incite another massive drug price outrage, Business Insider (Sept. 12, 2016) (reporting that some of America's biggest employers including American Express, Macy's and Coca-Cola have created an organization called the Health Transformation Alliance with the aim of breaking with "existing marketplace practices that are costly, wasteful, and inefficient, all of which have resulted in employees paying higher premiums, copayments, and deductibles every year" including PBMs), http://www.businessinsider.com/scrutiny-express-scripts-pbms-drug-price-fury-2016-9.

engaging in drug substitution programs. PBMs also negotiate contracts with pharmacies to determine how much the pharmacists will be paid for dispensing medication and providing services. By paying a lower reimbursement rate to pharmacies, but failing to adequately disclose reimbursement rates and manufacturer rebates, PBMs can generate more revenue. In both respects, PBMs can "play the spread" by failing to disclose these forms of indirect compensation. The failure to disclose these payments denies purchasers important information that impacts their buying decisions. [15] As a result, this lack of information often results in higher costs for consumers, health plans, employers, and other plan sponsors.

PBMs are free to "play the spread" between manufacturers, pharmacists and plans because of a lack of disclosure. Unclear and inadequate disclosure of rebates and discounts undermine the ability of plan sponsors to compare competing proposals. Because rebates, discounts, and other fee structures remain undisclosed, plan sponsors cannot clearly identify and choose PBMs offering the highest value services. PBMs' promise of controlling pharmaceutical costs has been undercut by a pattern of conflicts of interest, self-dealing, deception, and anticompetitive conduct. The dominant PBMs have been characterized by opaque business practices, limited market competition, and widespread allegations of fraud.

Increased disclosures by PBMs have resulted in price decreases and significant savings for health plans. For example, in the corporate context, a recent report revealed that Meridian Health System discovered that its drug benefit increased by $1.3 million within the first month of contracting with Express Scripts for PBM services.[16] Meridian discovered that they were being billed for generic amoxicillin at $92.53 for every employee prescription; however Express Scripts was paying only $26.91 to the pharmacy to fill these same prescriptions.[17] The result was a spread of $65.62 going back to the PBM. Meridian canceled its contract and switched to a transparent PBM which saved Meridian $2 million in the first year of its contract.

The provision of S.B. 2301 which requires PBMs to provide more transparency for employers and requires the PBM to disclose if the PBM practices spread pricing is vitally important for the employer to make informed contracting decisions to better service its beneficiaries.

V. Protecting Patient Choice and Eliminating Conflicts of Interest

The legislation before this Committee serves to protect patient choice. As consumers and patients we all understand the critical importance of patient choice. Only where consumers have the full range of choices does the competitive market thrive. Unfortunately, because PBMs have their own pharmacy operations – through retail stores, mail order, or specialty pharmacy – they are increasingly engaging in conduct that restricts patient choice and leads to higher costs and worse health care.

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[15] Robert Restivo, Testimony before the Department of Labor ERISA Advisory Council at 15 (August 20, 2014) ("the [PBM] industry is beset with a lack of transparency that is difficult to deal with even for the largest employers."), *available at* http://www.dol.gov/ebsa/pdf/ACrestivo082014.pdf.
[16] Katherine Eban, *Painful Prescription*, Fortune Magazine (Oct. 10, 2013).
[17] Id.

Forcing Consumers to use Mail Order

The major PBMs make a large portion of their profits by forcing consumers to use mail order. The major PBMs often restrict network options to drive consumers to their operations. Mail-order may be more costly, may result in significant waste, and fails to provide the level of convenience and counseling that many consumers require. Consumers may have existing relationships with a community pharmacy and may not wish to leave the pharmacist they know and trust to be served by a mail order robot. Others simply enjoy the ability to one-stop-shop and prefer the convenience of their supermarket pharmacy. The bottom line is that consumers are left worse-off when they are unable to choose the level of pharmacy care they desire.

Preventing Vulnerable Consumers from Using Their Community Specialty Pharmacy

The ownership of specialty pharmacies exacerbates the conflict of interest problem. Restrictive networks raise significant concerns for the over 57 million Americans that rely on specialty drugs.[18] Specialty drugs are typically expensive treatments that require special handling or administration. These drugs provide treatment for our nation's most vulnerable patient populations who suffer from chronic, complex conditions such as hemophilia, Crohn's Disease, Hepatitis C, HIV/AIDS, and many forms of cancer. The leading PBMs – Express Scripts, CVS Caremark and Optum own their own specialty pharmacies and increasingly force consumers to use their specialty pharmacy. Specialty drugs are expected to be the single greatest cost-driver in pharmaceutical spending over the next decade. The cost of specialty drugs is rising rapidly, with a projected increase to $1.7 trillion in 2030.[19]

The dominant PBMs are able to force consumers to use their own specialty pharmacies through restrictive networks. These networks can be higher cost and can also disrupt the continuum of care degrading health outcomes and increasing healthcare costs.[20] Patients on specialty drugs often require regular contact and counseling from their pharmacist. For many disease states, the pharmacist and health care team regularly contact the patient to make sure the drug is properly administered, taken on time, and the drug is working effectively. Disrupting this patient-provider relationship in complex and expensive treatment of very sensitive health conditions imposes significant harm to both the consumer and the health plan. We all know there is a profound difference between the personal treatment of an independent pharmacy and dealing with the automated telephone approach of the large PBMs.

Laura Hines, *Soaring specialty drug prices leave patients seeking relief*, Houston Chron. (March 15, 2015).

[19] IMS Health, Overview of the Specialty Drug Trend (2014), *available at* https://www.imshealth.com/deployedfiles/imshealth/Global/North%20America/United%20States/Managed%20Markets/5-29-14%20Specialty_Drug_Trend_Whitepaper_Hi-Res.pdf.

[20] The vital service-related role of independent specialty pharmacies was described in my testimony before the United State Senate Judiciary Antitrust subcommittee concerning the Express Scripts-Medco merger. *See* David Balto, Testimony regarding "The Express Scripts/Medco Merger: Cost Savings for Consumers or More Profits for the Middlemen?" before the U.S. Senate Subcommittee for Antitrust, Competition Policy and Consumer Rights, December 6, 2011, *available at* http://dcantitrustlaw.com/assets/content/documents/testimony/SenateJudiciary.ESIMedci.Balto.pdf.

Moreover, restrictive networks and steering practices rob consumers of the choice to use their preferred pharmacy and method of distribution; and—with this important rivalry gone—consumers also miss out on the benefits of vigorous competition, including lower prices and improved service. These restrictive networks deny patients a choice in provider and, given the high-touch nature of services in this area, this choice is highly valued by many consumers. The PBMs' ability to impose restrictive networks harms consumers that depend on the high-cost products and services that are of great, and even life-altering, significance to these vulnerable patients.

Finally, there is the fox guarding the hen house problem. When a PBM has its own specialty pharmacy, it no longer clearly serves the plan – rather, its incentive is to increase profits by forcing consumers into the PBM's specialty pharmacy.[21] The New York Times poses the appropriate question: "pharmacy benefit managers like CVS and Express Scripts…are supposed to help health plans control drug costs. But will they have the zeal to do that if they are making money dispensing these expensive medicines?"[22]

Of critical importance here is the fact that North Dakota community pharmacists are not looking for a "handout" from the PBMs, the state or the federal government; they simply want the ability to compete on a level playing field. This further demonstrates the anticompetitive practices utilized by the PBMs. If a small business community pharmacy is willing to accept the same contract terms as, for example, CVS, but is denied the opportunity to contract, one of two things is happening: either CVS's contract is raising costs for consumers by not offering the lowest price true competition would yield, or consumers are needlessly suffering poorer pharmacy access and choice.

The provisions of S.B. 2258 and S.B. 2301 serve to help eliminate many of the conflicts of interest explained above. The legislation allows a pharmacy to mail or delivery medications as an ancillary service of the pharmacy. This is a practice that North Dakota pharmacists have been providing for over 125 years. Additionally, the legislation provides increase in patient access and choice for patients purchasing specialty medications. By preventing the PBMs to require standards more stringent than federal and state requirement for licensure in the state of North Dakota, and allowing a licensed pharmacy to dispense any and all drugs under that license, the legislation will help ensure adequate pharmacy access and choice for North Dakota consumers.

VI. Conclusion

S.B. 2258 and S.B. 2301 will have a significant, positive impact on North Dakota consumers, providers and employers. PBMs operate with little transparency and inherent conflicts of interest engaging in deceptive practices. Without transparency, PBM profits will

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[21] Katie Thomas, Specialty Pharmacies Say Benefit Managers Are Squeezing Them Out, New York Times (Jan. 9, 2017), *available at* https://www.nytimes.com/2017/01/09/business/specialty-pharmacies-say-benefit-managers-are-squeezing-them-out.html.

[22] Andrew Pollack and Katie Thomas, Specialty Pharmacies Proliferate, Along With Questions, New York Times (July 15, 2015), *available at* http://www.nytimes.com/2015/07/16/business/specialty-pharmacies-proliferate-along-with-questions.html?_r=0.

continue to rise exponentially at the expense of small business pharmacies and patients. Broadening transparency requirements on PBMs will allow pharmacies to better ably serve their patients by being able to receive fair reimbursement, and allow payors and employers to make informed contract decisions before it enters a deal with the PBM. Conflicts of interest in owning mail and specialty pharmacies significantly inhibit patient choice and access to their preferred providers. Allowing increased choice and access to community pharmacy will foster greater competition to the benefit of plans and ultimately to consumers. We urge you to vote to pass both S.B. 2258 and S.B. 2301.

SB 2258 2/7/17 #1

February 7, 2017

PROPOSED AMENDMENTS TO SENATE BILL NO. 2258

Page 1, line 15, after the semicolon insert "or"

Page 1, line 16, replace "; or" with an underscored period

Page 1, remove line 17

Page 2, line 14, replace "may" with "shall"

Page 2, remove lines 26 and 27

Page 2, line 28, replace "8." with "7."

Page 3, line 1, replace "9." with "8."

Page 3, line 3, replace "10." with "9."

Page 3, line 6, replace "11." with "10." And insert immediately thereafter "Upon request,"

Page 3, line 10, replace "12." with "11."

Page 3, line 14, replace "13." with "12."

Renumber accordingly

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

SB 2258
House Industry, Business and Labor Committee
March 20, 2017 – 8:30 am
Representative George Keiser – Chairman

Chairman Keiser and members of the committee, for the record, my name is Mike Schwab, the Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of SB 2258.

I would like to start by turning your attention to Page 1 – Line 12 – Number 2.

Recently, Pharmacy Benefit Managers (PBMs) have started to access a "fee" on claims submitted by a pharmacy. This legislation would rein in abusive retroactive direct and indirect remuneration (DIR) fees imposed by pharmacy benefit managers (PBMs). Retroactive DIRs, are often assessed weeks or even months after a prescription has been filled, prevent pharmacies from knowing at the time of dispensing what their true reimbursement will be for that prescription. Such lag time creates an unnecessary burden on pharmacy operations and makes it very difficult to make decisions for the future. Furthermore, the magnitude of these fees, often force pharmacies to make tough decisions to cut back on community contributions or to reduce employee hours, or in some cases laying off employees. Such actions have a ripple effect through local communities and economies. This common-sense legislation would bring greater transparency to pharmacy payments by informing pharmacies at the point of sale what their reimbursement will be for clean claim prescriptions and allow for better business planning. There are a few states that have already passed similar legislation with additional states introducing legislation to address these fees this year. Federal legislation was introduced in March of this year to address this concern.

A recent report by the Centers for Medicare and Medicaid (CMS) that was released on January 19, 2017 shows these DIR fees are having an impact on the federal government and the taxpayers are paying the bill. CMS has observed a notable growth in DIR fees collected by the PBMs. DIR fees have gone from $8.7 billion in 2010 to over $23 billion in 2015. This coincides with the rapid growth of Medicare Part D net drug costs which have gone from $77.5 billion in

2010 to over $137 billion in 2015 with most of the growth taking place between 2013 to the present.

CMS identified three main trends taking place regarding these kinds of fees. These fees have caused (1) higher out of pocket spending for beneficiaries, (2) beneficiaries reach the catastrophic phase of Medicare Part D benefit quicker and federal government then picks up 80% of the total drug costs and (3) claim fees that are implemented after the point-of-sale lessen PBM plan liability and increase plan liability for the federal government. Pharmacy is also now starting to see these fees implemented on the commercial side or non-federal government plans as well.

It is not unreasonable to request the PBM tell the pharmacy at the point-of-sale the amount of the "fee" that will be taken from the pharmacy. This provision allows the pharmacy to know what fees will be imposed upon the pharmacy at the point-of-sale or time of processing the claim and not done weeks or months later. Examples of this "fee" will be shared with you by others wanting to testify. There is currently a class action lawsuit going on due to this practice by PBMs.

Starting on Page 1 – Line 17 – Number 3 and subsection A-C.

Currently, pharmacies are assessed "performance scores or metrics" based on each pharmacy's performance in addressing medication adherence measures. The performance measures are established by an unbiased nationally recognized entity called "EQUIPP" – Electronic Quality Improvement Platform for Plans and Pharmacies. Basically they identify a range or percentage that a pharmacy performance measures should fall into. The issue is that the PBMs are now establishing their own range or percentage that a pharmacy should be falling into. If a pharmacy does not fall into the range or percentage identified by the PBM, the PBM will assess a fee upon the pharmacy. In some recent cases, a pharmacy can be meeting all the ranges or percentages established by EQUIPP but the PBM will still assess a fee upon the pharmacy.

This section basically states, that each PBM cannot make up their own ranges or percentages and they need to use EQUIPP or another unbiased nationally recognized entity aiding in improving pharmacy performance measures. It further states that a PBM cannot

assess a fee on the cost of goods sold by a pharmacy and can only asses a fee on the professional dispensing fee established in the PBM and pharmacy contract.

As outlined in a white paper released in February of 2017 by Frier Levitt Attorneys at Law: Fundamentally, performance based DIR fees imposed by PBMs have no basis in law. Nowhere in the Modernization of Medicaid Act of 2003, CMS regulations or any CMS guidance are PBMs authorized to charge pharmacy providers with percentage based DIR fees under the guise of "performance" or "quality". Additionally, in our opinion, these fees effectively alter the net reimbursement to pharmacy providers sufficient enough to trigger other provisions of law, including Any Willing Provider Laws requiring terms and conditions – including reimbursement – to be "reasonable and relevant" and federal Prompt Payment Law limiting the ex post facto recoupment of previously adjudicated amounts for clean pharmacy claims.

In theory, and as originally contemplated by CMS, these fees would provide pharmacy providers with additional reimbursement based on certain quality performance metrics. However, over the past couple of years or so, these fees have been twisted by the PBMs into overly-broad vehicle for clawing back additional monies and increasing their own profits at the expense of pharmacy provider, beneficiaries and taxpayers. These fees ultimately obscure drug pricing and the reconciliation process. It is important to note that PBMs have different terminologies for these fee charges, such as "network rebates", "pharmacy performance payments," or "network variable rates". In circumventing the adjudicated "negotiated price" through backend recoupments, DIR fees often allow PBMs to pay pharmacy providers below the acquisition cost of the drug products purchased by pharmacy providers.

Page 2 – Line 12 – Number 4.

This provision prohibits a PBM from charging a patient a copayment that actually exceeds the cost of the medication. It also prevents the PBM from "clawing back" part of the copayment paid to the pharmacy provider which we strongly feel is illegal and misrepresentation to the patient. Examples will be shared with you today by others waiting to testify. All of you should have received a few links to show you how this practice is being implemented by the PBMs as well.

Page 2 – Line 16 – Number 5.

Currently, PBMs have started to require pharmacies sign contract language that states the pharmacy agrees to not participate in class action lawsuits. They want the pharmacy to agree to arbitration and it has to be done in a state of the PBMs choosing and done on a claim by claim basis (prescription by prescription basis). This provision allows the pharmacy just like any other business the opportunity to exercise their rights as a business owner.

Page 2 – Line 22 – Number 6.

This reassures a pharmacy who belongs to a Pharmacy Service Administration Organization (PSAO); they have a right to see the contract details that the PSAO has entered into on the pharmacy's behalf. Others will speak to this provision as well today.

Page 2 – Line 26 – Number 7.

This provision removes gag orders placed upon pharmacies by the PBMs, where the pharmacy is not supposed to tell a patient if there are cheaper alternatives available for the patient.

Page 2 – Line 30 - Numbers 8 and Page 3 – Line 1 – Number 9.

This prohibits a PBM for telling a pharmacy they cannot mail prescriptions to patients or provide home delivery services to patients. Chairman and members of the committee, pharmacies have been providing this ancillary services since before ND was even a state. Maybe if the PBMs didn't own their own pharmacies and weren't in the business of pharmacy directly setting the competing pharmacy's reimbursement and competing for their patients, this wouldn't even be an issue. Pharmacies who try to negotiate this prohibition in their contracts are threatened with expulsion from the PBMs pharmacy network(s).

Page 3 – Line 4 – Number 10.

This provision would provide the pharmacy with necessary information so the pharmacy can make an informed contracting decision. Right now, some PBMs will not provide this information to a pharmacy when the pharmacy is trying to determine if they should sign a specific PBM pharmacy network contract.

Page 3 – Line 9 – Number 11.

PBMs have taken it upon themselves to now require pharmacies become "accredited" to be in the PBMs specialty pharmacy network and to be allowed to dispense specialty drugs to patients. The accreditation requirement is only one aspect of some PBMs attempt to carve pharmacies out of the supposed "specialty" market or other pharmacy networks for that matter. On top of accreditation, some PBMs are also requiring pharmacies adhere to a slew of reporting requirements as well as certain assurance measures. Reporting requirement and assurance measures are one thing. However, a number of the reporting and assurance measures have egregious "fines" attached to them. A pharmacy is already regulated by State and Federal laws and rules and authorized to dispense any and all drugs their licenses and certifications allow.

Thank you for your time and attention. I would be happy to try and answer any questions. I know there are additional people her to testify in support of SB 2258.

Respectfully Submitted,

Mike

Mike Schwab
NDPhA EVP

2

House Industry, Business, and Labor Committee

SB 2258 and SB 2301 – 9:00 A.M. & 9:30 A.M.

03/20/2017

Chairman Representative George Keiser

Mr. Chairman and members of the committee, for the record, my name is Gary Boehler, a pharmacist consultant employed by Dakota Drug, Inc., a regional drug wholesaler based in North Dakota, and serving many independent pharmacy owners in North Dakota and surrounding states. My sole purpose in consulting is to offer assistance to those pharmacies with third party (PBM) contracting and other pharmacy operational issues encountered routinely in pharmacy. I am here today to speak in support of both SB 2258 and SB 2301.

Attached is a letter written by a person I know who spent more than 10 years working for one of the biggest three PBMs. In the one page attachment, this individual, who wishes to remain anonymous, shares four examples of his/her experiences during his/her tenure. Although not specific, information shared with me points directly to similar comments we have all heard before from patients (paragraph 2) as well as an example I came across about six months ago where a negative adjustment made to one of the pharmacies I consult for could not be explained by the PBM. With some prodding and challenging, the several hundred dollar charge was reversed and a check issued for the amount in dispute. The pharmacist for whom I consulted was told there was no tracking capability to discern the reason for the negative adjustment.

This person who has written the attachment is willing to come into my office and speak to the chairman of this committee to validate what has been written.

Thank you Mr. Chairman and committee members for allowing me to present this testimony.

Gary W. Boehler

Gary W. Boehler, R.Ph.

PBMEMPTESTIMONY2017COVER

March 14, 2017

I worked for one of the three biggest PBMs for over 10 years. I am willing to share some experiences I encountered. My name and dates of services will not be revealed since I fear retaliation, recrimination, or libel suits. All statements below are accurate.

1. An Accounts Receivable system was written in-house and subject to multiple false starts and a difficult implementation. Part of the program allowed users to change dollar amounts for various transactions without any kind of audit trail, ignoring Generally Accepted Accounting Principles (GAAP) which requires an adjustment entry to be made documenting every change. Management was made aware of this on multiple occasions and requests made to simply eliminate that part of the program. Their response was changing it would make visible many programming errors in the software. Nothing was ever done.

2. During my tenure, co-workers complained that people wanted prescriptions discontinued that were no longer relevant to their treatment. The customer service group should have implemented those changes immediately, and upon reaching my department, I noticed that many of these requests were months old and prescriptions had not yet been discontinued.

3. Patient database information contained invalid state abbreviations; a query showed up to 5% were invalid. Equipped with a list of current zip codes from the USPS, we found that almost 10% of the patient addresses were invalid because of zip codes and/or invalid state abbreviations.

4. Undeliverable medications were returned to the dispensing pharmacy, and because there was no process to correct errant patient information, I made a request to validate state abbreviations and zip codes. The request was declined, even though the final figure of undeliverable prescriptions was around $20 million a year. I then checked to see how undeliverable scripts were handled and came to find out that they were all tossed into a large bin, emptied weekly, but nobody seemed to know the particulars. I contacted someone in supervision and was told there was no time to deal with such "foolishness" because of the already overflowing backlog of tasks. Later, senior management contacted me, having received an angry complaint from the person with whom I had met earlier. I was told very clearly NOT to bring this issue up again.

Thank you.

House Industry, Business, and Labor Committee

SB 2258 – 9:00 A.M.

03/20/17

Chairman Representative George Keiser

Chairman Keiser and members of the committee, for the record, my name is Gary Boehler, a pharmacist consultant employed by Dakota Drug, Inc., a regional drug wholesaler based in North Dakota serving many independent pharmacy owners in North Dakota and surrounding states. My sole purpose in consulting is in offering assistance to these pharmacies with their third party contracting and other pharmacy operational issues encountered routinely in pharmacy. I am here today to speak in support of SB 2258.

My 46 years in pharmacy spent in pharmacy operations and third party contracting have given me the experience to follow the PBM industry as it has changed with respect to contracting and responsibilities as a pharmacy provider. SB 2258 has many positive provisions for pharmacy providers and more importantly, patients who have also been impacted over the years by many of the transformations which have occurred, but never should have. I will expound on just a few of these positive changes in this bill.

A common occurrence that occurs today is called a "patient clawback" whereby a PBM artificially inflates the copay a patient is forced to pay at the time of dispensing; that excessive copay is then clawed back by the PBM from the pharmacy by a reduction in what is paid to the pharmacy. The patient ends up paying more than the regular copay should be and the PBM "pockets" that money. This pushes the patient who is on Medicare Part D into the donut hole sooner, hence hitting the patient with a "double whammy." HB 2258 eliminates clawbacks and for that reason I support SB 2258. See Exhibit 1 as an example.

Several PBM contracts I have read either disallow a pharmacy from mailing or delivering prescriptions to patients. Still others require the pharmacy to pay all postage related costs even where the patient has requested delivery, for example, with snowbirds who travel south for part of the winter. I have read letters

threatening expulsion from a network if a pharmacy does not stop mailing or delivering. SB 2258 makes these egregious activities illegal, and for that reason I support SB 2258.

Those pharmacies who use a pharmacy services accounting organization (PSAO) to negotiate third party contracts are oftentimes disallowed from even seeing THEIR OWN CONTRACTS THAT HAVE BEEN NEGOTIATED ON THEIR BEHALF! In essence, this forces a pharmacy to fill prescriptions without knowing what its reimbursement should be. I cannot name one other business where such an arrangement exists. SB 2258 uses language that says PBMs shall allow a pharmacy to see those contracts, and for that reason I support SB 2258.

Many third party PBM contracts prohibit a pharmacist from offering a less costly (usually generic) alternative when a patient is faced with a high cost brand name drug or as mentioned above, an excessively high copay which is then clawed back through pharmacy reimbursement. SB 2258 expressly prohibits these gag orders in PBM contracts, and for that reason I support this bill.

Direct and indirect remuneration fees (DIRs) have become a major source of revenue for the PBMs, all at the expense of the pharmacy provider network. These fees were originally set up by CMS in 2003-2004 during the advent of the Medicare Modernization Act to require PBMs to report any rebates, price concessions, discounts, free goods, or any other type of cost reduction in the cost of drugs meant to help keep prescription drug spending in check. In the past two or so years, PBMs have turned that around to take money from pharmacy providers as an added revenue stream to offset those rebates and price concessions that are given back to CMS. Frier Levitt Attorneys at Law from Pine Brook, New Jersey issued a 38 page white paper citing all of the fallacies and questioning the legality of these fees to begin with. *I have condensed the 38 pages down to three pages, taking direct quotes (with their permission) to provide a brief synopsis of their viewpoint*. For anyone interested, I do have the full white paper. SB 2258 prohibits DIR fees for North Dakota pharmacies except against the dispensing fee (which is the quality metric a PBM can only base a DIR fee, since pharmacies are already contracted on the cost of the goods being dispensed.

For that reason I support SB 2258.

To follow up on DIR fees, I received a list of 15 prescriptions (both brand and generic) where DIR fees were taken back by a PBM. I have attached a small spreadsheet which shows that DIR fees for these fifteen prescriptions accounted for 78.4% of the gross profit the pharmacy made. Because SB 2258 eliminates these egregious practices, I support this bill.

PBMs have established their own levels of ratings (5-star ratings as coined by CMS) which supersede those Originally intended when the Medicare Modernization Act was established. Stores are lumped together by network, PSAO, or chain and quality metrics averaged instead of each individual pharmacy being rated on its own merits. SB 2258 eliminates this, so for that reason I support SB 2258.

SB 2258 allows all pharmacies, regardless of practice setting (retail, long term care, or hospital) to participate in a class action lawsuit. Those actions are disallowed in contracts today, merely an effort by the PBM industry to prevent a united front by pharmacists to eliminate egregious actions that are in the industry today. For that reason I support SB 2258.

Thank you Mr. Chairman and committee members for allowing me to present this testimony on behalf of North Dakota patients and pharmacy providers.

Gary W. Boehler

Gary W. Boehler, R.Ph.

Attachments: 2

SB2258NDHOUSE2017

03/20/2017

[redacted]

Wednesday, February 15, 2017 6:35 PM

omission

This claims Submission was Accepted by the Primary Payer: CIGNA HELENA NO MAIL

Name: [redacted]
DOB: 12/26[redacted]
Address: [redacted]
City/St/Zip: [redacted]
Group No: ID: [redacted]
Product: Imiquimod Cream 5 %
Misc:

Rx No: [redacted]
Fill Date: 2/15/2017
Qty: 12.000
Days: 28
Auth: [redacted]
Plan: (800) 622-5579
Account Id:
Client Product Code:

Claim Info
Prior Authorization No:
Prior Authorization Type:
Authorized Qty: Auth. # Fills:
Auth. Dollar Amt: .00
PA Effective: 00/00/0000 PA Expires: 00/00/0000
PA Process: 00/00/0000

Submitted Amounts		Paid Amounts	
Total:	$416.18	Total:	$8.45
Retail/Cost:	$404.02	Retail/Cost:	$6.88
Patient Pay:	$0.00	Patient Pay:	$56.14
Sales Tax:	$8.16	Sales Tax:	$0.17
Incentive:	$0.00	Incentive:	$0.00
Fee:	$4.00	Fee:	$1.40
U&C:	$226.75	3rd Party:	$-47.69
Postage:	$0.00	Postage:	$0.00

DAW: 0 - No product selection indicated
Submitted Amount: 416.18
Submitted Copay Amount: .00 Incentive Amt: .00
Third Party (Payer): CIGNA HELENA NO MAIL
Eligibility Clarification:
Submission Clarification:
CLAWBACK
Other Coverage:
Other Payer Amt Paid Qual: 08 - Sum of All Reimbursement
Other Payer Amt/Date: .00 00/00/0000
Other Payer ID Type:
Other Payer ID:
Other Payer ID:
Other Payer ID:
Diagnosis Code:
Level of Service:
Cost Basis Determination: 01 - AWP (Average Wholesale Price)
Pharmacy Service Type: 1 - Community/Retail Pharmacy Services
☐ Service Billing

Patient Pay Breakdown

Amount Applied to Periodic Deductible:	$56.14
Amount Attributed to Product Selection:	$.00
Amount Attributed to Sales Tax:	$.00
Amount Exceeding Periodic Benefit Max:	$.00
Amount of Copay/Co-Insurance:	$.00

Plan Amounts

Accumulated Deductible Amount:	$56.14
Remaining Deductible Amount:	$5,943.86
Remaining Benefit Amount:	$.00

Messages:

DUR Codes Entered:

PATIENT CLAWBACK EXAMPLE

Prescriber Information:
Prescriber Name: [redacted]
Prescriber Address: [redacted]
Prescriber Phone:
Prescriber Fax: [redacted]

Fax Disclaimer: Documents accompanying this transmission contain cor
or entity to which it is addressed. The authorized recipient of this informa
If you are not the intended recipient, you are hereby notified that any di
you have received this information in error, please notify the sender imm

Exhibit 1

Brand vs. Generic DIR Fees

	A	C	D	E	F	G	H	I	J	K	L	M	N
1	Date of	NDC	Drug	Qty	AAC	Ingred.	Dispensing	Patient	$ Total	DIR Fee	Pharmacy	When DIR	Comments
2	Rx Fill		Name			Cost Pd	Fee	Copay	Reimbursed	Taken	Gross Profit	Taken	
3	1/4/2016	42858-0801-01	Morphine Sul 15 mg. CR	30	$ 12.09	$ 14.40	$ 0.50	$ 2.95	$ 17.85	$ 0.49	$ 5.27	EOB	DIR Fee 3.22%
4	1/4/2016	53746-0109-01	Hydrocodone/APAP 5-325	60	$ 8.11	$ 12.85	$ 0.50	$ 2.95	$ 16.30	$ 0.44	$ 7.75	EOB	DIR Fee 3.23%
5	1/5/2016	00088-2219-05	Lantus Solostar 100ml/per	30	$ 745.52	$ 759.53	$ 0.50	$ 3.60	$ 763.63	$ 25.82	$ (7.71)	EOB	DIR Fee 3.33%
6	1/5/2016	00173-0696-00	Advair 250/50 Diskus	60	$ 334.63	$ 7.74	$ 1.50	$ 345.02	$ 354.26	$ 7.92	$ 11.71	EOB	DIR Fee 2.25%
7	1/4/2016	49884-0466-65	Cholestyramine Light	90	$ 153.29	$ 191.31	$ 0.50	$ 1.20	$ 193.01	$ 6.40	$ 33.32	EOB	DIR Fee 3.32%
8	1/4/2016	00093-2049-56	Tolterodine 4 mg. ER	30	$ 95.02	$ 104.53	$ 0.50	$ 78.84	$ 183.87	$ 6.10	$ 82.75	EOB	DIR Fee 3.33%
9	1/5/2016	00173-0720-20	Flovent HFA AER 220mcg.	36	$ 990.27	$ 475.83	$ 0.50	$ 518.60	$ 994.93	$ 22.41	$ (17.75)	EOB	DIR Fee 2.25%
10	1/6/2016	00186-5040-54	Nexium 40 mg.	30	$ 250.97	$ 261.27	$ 0.50	$ -	$ 261.77	$ 8.69	$ 2.11	EOB	DIR Fee 3.33%
11	1/7/2016	00006-0221-31	Januvia 25 mg.	30	$ 345.23	$ 17.22	$ 1.50	$ 365.73	$ 384.45	$ 8.60	$ 30.62	EOB	DIR Fee 2.25%
12	1/7/2016	00310-0755-90	Crestor 5 mg.	30	$ 236.05	$ -	$ 1.50	$ 262.31	$ 263.81	$ 5.88	$ 21.88	EOB	DIR Fee 2.24%
13	1/7/2016	50458-0550-01	Invega 3 mg.	26	$ 769.02	$ 840.67	$ 0.50	$ 1.04	$ 842.21	$ 28.04	$ 45.15	EOB	DIR Fee 3.33%
14	1/9/2016	00002-3229-30	Strattera 40 mg.	30	$ 381.90	$ 380.54	$ 0.50	$ -	$ 381.04	$ 12.67	$ (13.53)	EOB	DIR Fee 3.33%
15	1/9/2016	00002-3239-30	Strattera 60 mg.	30	$ 381.90	$ 380.54	$ 0.50	$ -	$ 381.04	$ 12.67	$ (13.53)	EOB	DIR Fee 3.33%
16													
17	***Notes for 13 prescriptions:***												
18	1. Pharmacy gross profit per prescription = $14.46 on an average retail of $387.55, or 3.7%.												
19	2. DIR fees taken per prescription = $11.24, or an average of 2.90%, which is 78.4% of the GROSS profit the pharmacy made.												
20	Generic Prescriptions												
21	Brand Name Prescriptions												
22	3. Average retail for generic prescriptions: $102.75												
23	4. Average retail for brand name prescriptions: $514.13.												
24	5. Average DIR taken for generic prescription: $3.36 (3.27%).												
25	6. Average DIR taken for brand name prescription: $14.74 (2.87%).												
26													
27													
28													
29													
30													
31													
32													
33													
34													
35													
36													
37				Totals	$ 4,704.00	$ 3,446.43	$ 9.50	$ 1,582.24	$ 5,038.17	$ 146.13	$ 188.04		
38	Brand vs. Generic DIR Fees A5												

PBM DIR FEES IMPACT ON MEDICARE BENEFICIARIES AND CMS
EXCERPTS FROM A WHITE PAPER DATED JANUARY 2017
BY FRIER LEVITT ATTORNEYS AT LAW
PINE BROOK, NEW JERSEY

Page 2: "One way in which PBMs have driven up drug costs are with murky "direct and indirect remuneration" fees (DIR Fees) charged to providers who dispense drugs such as specialty pharmacies and physician run medical practices that operate retail pharmacies....."

Page 3: "In theory – and as originally contemplated by CMS – these DIR Fees would provide Pharmacy Providers with additional reimbursement based on certain quality performance metrics. However, over the last year or so, DIR Fees have been twisted by PBMs into an abusive and overly-broad "backdoor" vehicle for clawing back additional monies and increasing their own profits – at the expense of Medicare and beneficiaries."

Page 4: "Fundamentally, performance-based DIR Fees imposed by PBMs have no basis in law. Nowhere in the MMA, CMS regulations, or any CMS guidance are PBMs authorized to charge Pharmacy Providers with percentage-based DIR Fees under the guise of "performance" or "quality."

Page 5: "DIR Fees cost Medicare, beneficiaries, and ultimately taxpayers more by obscuring the true net cost of drugs. The inflated upfront (point-of-sale) cost will result in higher cost sharing obligations, which in turn push beneficiaries into, and then out of, the Medicare Part D "donut hole" coverage gap faster.....This very concept was borne out of a critical report released by CMS on January 19, 2017. In the CMS Fact Sheet, CMS issues a rare public criticism of the PBMs' activities in contributing to the rise in DIR as a percentage of overall Medicare Part D spending.....However, the report only took into account DIR that was actually reported and returned to Medicare. Thus, CMS's findings would only be further pronounced if they included all such chargebacks – including DIR Fees – from the Pharmacy Providers that are not fully reported and returned to Medicare by the PBMs."

Page 6: "Additionally, DIR Fees effectively alter the net reimbursement to Pharmacy Providers sufficient enough to trigger other provisions under Federal law, including the Federal Any Willing Provider Law (requiring terms and conditions – including reimbursement – to be reasonable and relevant) and the Federal Prompt Payment Law (limiting the *ex post facto* recoupment of previously adjudicated amounts for clean claims."

Page 11: "The goal of DIR, as contemplated by CMS, is to account for after-the-fact, direct or indirect remuneration, paid out or received by PBMs and Part D plan sponsors from a variety of sources. However, with the regulatory backdrop, certain PBMs and Part D plan sponsors twisted and abused the concept of DIR to justify the concept of DIR to justify after-the-fact "fees" imposed on Pharmacy Providers, which ultimately obscure drug pricing and the reconciliation process."

Page 13: "Critically, a Pharmacy Provider that does not submit claims that fall within the purview of a PBM's quality metric categories, often will, nevertheless, be assessed a DIR Fee. In these cases, the DIR Fee charged back from the Pharmacy Provider **will be based upon the Part D plan sponsor's average performance scores, rather than the provider's actual performance.** This system lacks logic and can economically punish Pharmacy Providers.

Pages 13/14: "Performance metric DIR Fees can be based upon a flat fee or percentage basis.....with both types of DIR Fees a strongly performing Pharmacy Provider can only hope to minimize the amount clawed back by the PBM. In either case does the Pharmacy Provider stand to gain additional payment over the point-of-sale price.

Page 15: "PBMs attempt to justify the imposition of performance metric DIR Fees by referencing CMS's Star Rating System..... **However, it is important to note that the Star Rating System was designed by CMS to apply to Part D plan sponsors, not to Pharmacy Providers**.....Because PBMs and Part D plan sponsors are directly impacted financially by the CMS Star Rating System, PBMs have in turn sought to artificially pass along performance requirements to Pharmacy Providers, assessing them on these same criteria and justifying imposition of performance-based DIR Fees as "incentives."

Pages 17/18: "Importantly, not every PBM imposing a *post hoc "fee"* on providers refers to these charges as DIR Fees. In fact, many PBMs have different terminologies for these charges, such as "network rebates," "pharmacy performance payments," or "network variable rates.....There is little, if any, evidence that DIR Fees, however characterized, that are clawed back from the participating Pharmacy Providers, are **actually paid** back to Medicare through any formal reconciliation.....In essence, such DIR Fees are a hidden, profit-driven PBM tax, that are likely making a bad situation worse."

Pages 19/20: "A Part D plan sponsor owned by a PBM could utilize DIR Fees in the bidding process to overestimate anticipated spending by conservatively estimating the fees it will collect. Used in this way, DIR Fees may result in a bid with a prospective cost exceeding actual cost, allowing additional profits not contemplated by CMS in accepting that bid. While CMS is supposed to recoup a portion of the excess it has paid to the Part D plan sponsor based on the inaccuracy in estimated DIR Fees, the inflated bid is a determinant factor in beneficiary premiums, which are not recovered from beneficiaries. This means that by underestimating the value of anticipated DIR Fees Part D sponsors can exact higher premiums from beneficiaries, which do not need to be refunded once annual reconciliation occurs. By underreporting or underestimating expected DIR Fees that a Part D plan sponsor/PBM expects to take back from Pharmacy Providers, a Plan can submit a bid to CMS with inflated costs, resulting in not only higher beneficiary premiums, but also higher upfront reimbursement from CMS."

Page 21: **".....when PBMs and Part D plan sponsors characterize these chargebacks as something other than DIR (i.e., "network rebates," "pharmacy performance payments," or "network variable rates"), there is little evidence that the funds are reported and returned to Medicare."**

Pages 24/25: "By imposing DIR Fees on Pharmacy Providers retroactively, PBMs are able to reduce the ultimate "negotiated price" between Pharmacy Providers and PBMs through "backdoor" *post hoc* withholdings. PBMs design these withholdings to provide little quality incentive for Pharmacy Providers, while at the same time capturing the ever increasing "spread" differential between the reported "negotiated prices" and the "reconciled" negotiated price." This phenomenon creates a gap in the plan sponsor's reporting of costs to Medicare, as DIR Fees are necessarily imposed on Part D providers after the point-of-sale. In circumventing the adjudicated "negotiated price" through backend recoupments from providers, DIR Fees often allow PBMs to pay Pharmacy Providers well **below** acquisition cost of the drug products even though it appears to CMS and to the Pharmacy Providers themselves that negotiated reimbursement rates are otherwise reasonable. Percentage-based DIR Fees create a perverse financial incentive for PBMs to drive up the overall cost of medications. The higher the drug cost, the higher the percentage-based DIR Fee."

Page 30: "Based on the increasing impact of DIR Fees on consumers and providers, on September 8, 2016, the United States House of Representatives introduced the "Improving Transparency and Accuracy in Medicare Part D Spending Act" (H.R. 5951) and a companion bill in the Senate (S. 3308), which aim to prohibit the use of retroactive DIR Fees by Medicare Part D plan sponsors and PBMs.....Critically, the proposed legislation further serves to clarify longstanding congressional intent that DIR was never meant to encompass after-the-fact payments from providers to PBMs under the aegis of performance metrics, but instead, fully contemplated retroactive payment **increases** to providers, leaving such contractual incentive payments intact.....Despite the uncertainty with the measures pending from CMS and Congress, various ancillary laws and regulations exist casting doubt on retroactive PBM-imposed DIR Fees and standing for the conclusion that these fees remain a violation of the core intent of Federal law.

Pages 31/32: "The PBM industry's use of DIR Fees to retroactively clawback monies from providers is wholly impermissible under Federal law, both in terms of establishing an accurate negotiated price and in terms of the methodology employed by PBMs in calculating such fees (particularly as related to performance based fees). Indeed, not only are PBMs and Part D plan sponsors exceeding the authority provided to them by Congress, HHS, and CMS, but such PBM-imposed DIR fees are blatant violations of a variety of Federal laws, including the Any Willing Provider law as well as the Federal Prompt Payment law.....Importantly, nowhere in this section, or the whole of the MMA, does the law contemplate DIR Fees to be retracted from a Pharmacy Provider and certainly nowhere do the statutes expressly permit Part D plan sponsors or PBMs to impose a 3% to 9% per claim DIR Fee based on "performance." Rather, the overwhelming context of the MMA militates against after-the-fact recoupments from Pharmacy Providers."

Pages 35/36: "Critically, the Social Security Act includes the "Any Willing Provider law ("AWPL"), which relates directly to provider access and reimbursement in the Medicare program. The AWPL applies to all Part D plan sponsors and their downstream entities, such as PBMs.....Indeed, when a Part D plan sponsor enters into a contract with a PBM as a down-tier provider to provide drug coverage to Medicare beneficiaries, the Part D plan sponsor and the PBM must "agree to have a standard contract with reasonable and relevant terms and conditions of participation whereby any willing pharmacy may access the standard contract and participate as a network pharmacy.....While CMS has provided little guidance on what constitutes "reasonable" and "relevant" terms and conditions, importantly, CMS has expressly noted that pharmacy reimbursement rates are part of the terms and conditions that must also be "reasonable" and "relevant" in accordance with the Federal AWPL. CMS acknowledges that if reimbursement terms are unreasonably low in Medicare Part D networks, pharmacies throughout the country may not be able to afford participating in the networks, which would result in Medicare beneficiaries having a harder time accessing Medicare Part D services."

Page 36: "DIR Fees similarly violate the Federal Prompt Payment Act law. Generally under the Prompt Payment law, a Part D plan sponsor must issue or otherwise transmit payment on all clean claims to a network pharmacy within (i) 14 days after the date of an electronic claim is received, or (ii) 30 days after the date on which any other claim is received.....Flat fee performance-based DIR Fees are conducted in violation of the Prompt Payment law, as the PBMs assessing these fees are failing to remit full payment on clean claims within the timeframes outlined in the Prompt Payment law and similarly not alleging that the claims are not clean claims."

Page 37: "The PBM industry's imposition of unreasonable DIR Fees is another example of a policy implemented to increase PBM profits at the expense of the Medicare program, patients, and Pharmacy Providers. These DIR fees – particularly those based on provider performance – find absolutely no basis in Medicare regulation or law and may actually violate Federal law and guidance. In fact, the PBMs' use of DIR Fees actually increases the overall costs to patients and the Medicare program, which is ultimately paid for by taxpayers. DIR Fees obfuscate the accurate reporting of prescriptions drug reimbursement rates, leading to artificially inflated "negotiated prices" and subsequently higher administrative costs to the Medicare program upon reconciliation."

House Industry, Business, and Labor Committee

Chairman – Rep. George Keiser

SB 2258 Testimony (Claims Fees)

03/20/2017

Chairman Keiser and members of the Committee. I am Dan Churchill, a pharmacist from Bismarck. I am here today to urge you to issue a DO PASS recommendation on SB 2258.

Today in the pharmacy world each PBM is coming at us with a different strategy of fees that they charge us for this, that, and everything. It's a claims transmission fee, an out-of-network fee (when you are an in-network pharmacy), an in-network fee, a Transaction resolution fee, Direct and Indirect Remuneration Fee (DIR) and clawbacks, amongst other fees too numerous to mention. The majority of these fees are not apparent at the time of the prescription dispensation. The pharmacy only finds out what the fees are sometimes months later. The names and reasons for these fees are intentionally fuzzy and hard to understand. Some are tied to difficult to understand "performance metrics" which are often nearly impossible to achieve and usually are moving targets.

Even Medicare has said in a recent analysis (dated 01/19/2017) that many of these fees (specifically the DIR fees) are responsible for increasing out-of-pocket costs for patients and increasing overall costs for the Medicare Drug program. Medicare has come out with this type of information before but we have been unable to get any traction on this issue in Washington. Fortunately here in Bismarck we can come to our Legislature and at least get heard on the issues.

In my practice some of the fee shenanigans that we have witnessed: One prescription for an expensive monthly maintenance medication processed through for about $600 dollars. Looked good, it covered our costs and everything was fine and dandy. A month later when examining the remittance advice that $600 prescription had a $400 fee assessed on it. So that prescription now was a several hundred dollar loss for the pharmacy. And let's look at the implications for the patient. The net price of that prescription was about $200. However $600 is what it is going to look like on that patient's Medicare Part D plan and they are going to go into the "donut hole" or "coverage gap" after about 6 months vs. not going into that donut hole at all without the post transaction fees.

Just yesterday filled a prescription on another monthly maintenance medication. The Rx processed thru for about $45. However here the PBM attached a "clawback" of $10. Meaning they expect the pharmacy to collect the $45 from the patient and then send $10 back to the PBM. The essential price of this Rx is $35. But the PBM is over charging $10 and pocketing it. This doesn't seem like much but extrapolate it by 12 fills a year and multiply by thousands of patients and you start to get very large numbers. This particular claim in this example was from a government funded payor, not Medicare.

There are many more examples. Most people don't believe me when I talk about this stuff, but it's true and it's huge and we need to do something about it

I urge you to issue a DO PASS recommendation on SB 2258 and put a stop to the foggy fees that are being assessed, at the end of the day, to the citizens of North Dakota.

Thank you,

Daniel M. Churchill, Pharm.D., R.Ph

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BOARD OF PHARMACY
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Doug Burgum, Governor

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Mark J. Hardy, PharmD, R.Ph.
Executive Director

SB 2258 – Pharmacy Claims Fees
Industry Business & Labor Committee
8:30 AM – Monday – March 20, 2017 – Peace Garden Room

Chairman Keiser, members of the House Industry Business & Labor Committee, for the record I am Mark J. Hardy, PharmD, Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today about Senate Bill 2258.

The Board of Pharmacy members have discussed **P**harmacy **B**enefit **M**anagers [PBM] and some of the issues created by PBMs in their practices. Often discussed are stories of pharmacists having to choose between losing money on a prescription due to the reimbursements set by the PBM being too low to cover the acquisition cost of obtaining the pharmaceutical product or choosing not to dispense. Often times our pharmacists will make the decision which is in the best interest of their patients, dispense the item and take the loss with the hope that they will be able to recover this cost in future claims. These situations appear to be happening with an increasing frequency, especially in the recent trend of increased drug prices and drug shortage issues occurring in the pharmaceutical marketplace. It would be best if these situations could be handled in a common sense fashion that would not only be fair to the dispensing pharmacy and does not get in the way of patient care decisions.

Pharmacy Benefit Managers have long been a source of conflict between pharmacies in their professional practice of providing patient care. More and more states are looking to regulate PBMs with legislation, even the National Association of Boards of Pharmacy [NABP], of which we are a member, have adopted model language to define PBMs and create a licensing structure for them. The ultimate reason is the PBMs not only participate in activities that encompass the practice of pharmacy, but also impose conditions that affect patient care.

The issue of direct or indirect charge backs to pharmacies addressed in #2 has been a contentious concern in the profession and has become an increased practice, to take back funds after the claim has been adjudicated. This practice has been brought to the Board of Pharmacy's attention to determine it this is a legal issue. Unfortunately, at this time there is not a clear violation of law with this type of practice.

We would expect our pharmacies to provide information on cost effective and clinical effective medications in an individual patient situation addressed in #7. Simply put, we need our medical professionals talking to the patient about how best to treat their conditions, while keeping in mind the cost effectiveness of that treatment. This is just common sense and a standard of pharmaceutical care.

The Board has been informed by patients and pharmacies of the prohibition by a Third-Party Payer from mailing or delivering medications which appears to be the goal of #8. This type of restriction runs contrary to the expectation of deliverance of pharmaceutical care across all our rural areas of the state of North Dakota. Being able to deliver to homebound patients and mail medications to areas while maintaining consultation standards is how we need to deliver the best care possible to North Dakotans.

It is the Board of Pharmacy's stance that any legally and appropriately licensed Pharmacy in the state of North Dakota should be able to dispense pharmaceutical product in accordance to the license issued by the State Board of Pharmacy. The Board of Pharmacy inspections assure the public that the pharmacy is acting in a lawful way. Therefore, we would also support the provision of #11.

I will be happy to answer any questions you may have, and do appreciate your time.

Mar 20, 2017

Testimony on SB 2258

Good morning Mr. Chairman and members of the committee. My name is Abigail Stoddard, I am a pharmacist with Prime Therapeutics, and I am here to respectfully oppose SB 2258.

SB 2258 covers huge portions of our business as a pharmacy benefit manager - quality-based contracting, member copayments, pharmacy reimbursement, pharmacist refusal to dispense, mail order networks and pharmacy credentialing. The testimony on this bill has been equally broad and we have not heard how and whether specific language in this bill will address the root cause of problems and complaints.

It is also clear to me from the proponents testimony and from the text of SB 2258 that there is a disconnect between the pharmacy's expectation of working with a PBM and the contracts they enter into with that PBM. Pharmacies have two options when contracting with PBMs – to contract with the PBM directly as an individual or to contract with a PBM through a group called a pharmacy services administrative organization (PSAO). The vast majority of our independent network pharmacies contract with us through a PSAO. These PSAOs negotiate contract terms and enter into contracts on behalf of their pharmacy members.

Most sections of this bill – section 2, 3, 4, 5, 8, 9 and 10 are items contained in PBM contracts. Based on the testimony today it appears that either pharmacies are not aware of contracts that are being signed on their behalf, or they are attempting to use the state legislature to release them from their contract obligations.

Section 6 of the bill leads me to believe it is the former. Section 6 states:

6. A pharmacist or pharmacy that belongs to a pharmacy service administration organization may receive a copy of a contract the pharmacy service administration organization entered with a pharmacy benefits manager or third-party payer on the pharmacy's or pharmacist's behalf.

I hope what I've just highlighted illustrates that this bill raises more questions than answers and needs further study and discussion. I welcome any follow up from the sponsor or proponents on these issues, but today I can only oppose SB 2258 as written.

THE HARMS GROUP

March 20, 2017

OPPOSE SB2301 and SB 2258 (PBM bills) Specialty Drug bill and Pharmacy fees/training

PBM 101--Pharmacy Benefits Managers; third party expert who manages pharmacy benefit in a health plan to save the client money. PBMs represent and protect those who pay the bills—consumers/insurers/taxpayers. For every $1 spent, PBMs produce $6 in savings to the consumer.

- PBMs will **save $650 billion in drug costs over the next decade—$941 @ person annually.***
- Administer drug benefit for 266 million Americans for plan sponsors (insurers, employers etc.)

Specialty Drugs-expensive, fastest growing: (follow the money)

1% of prescriptions in US are specialty—but represent **29%** of drug spend
(Stated differently: 5.1% of population uses specialty; represent 34% of healthcare costs)
By 2018, specialty drugs will represent **50%** of the drug spend in US
By 2020, 9 of 10 best-selling drugs---by REVENUE will be specialty drugs

If SB 2301/2258 become law: Drug prices will go up, costing ND-PERS, ND general fund, ND consumers

Minnesota fiscal note $12 million (killed in Mn. because of cost)
Why will drug prices go up?

- Loss of cost savings through network buying power (key driver)
  (PBM network can negotiate better price than single retail pharmacist).
- Loss of clinical management and drug adherence; reduced patient health (↑ costs)

SB 2258 misses the mark: DIR fees complaints—required by CMS/Medicaid. (Bill won't address)

Risks patient safety---bills prohibit additional training/credentials by manufacturer, health-plans. "If I have a law license then I am qualified to handle any case in ND". NOT true for lawyers; not true for Docs, not true for Rx.

No data----all anecdotal complaints about an industry that processes millions of prescriptions annually – We are guessing at the cost to insurers, employers, and consumers---for their health care.

ND Pharmacies have enormous bargaining power with PBMs----(CMS requirements + network coverage)

Inserts government into private contracts (contrary to ND Constitutional law)
Successfully challenged in 8th Circuit Court of Appeals for Iowa.

PBMs are good for consumers/Taxpayers—studied by FTC, GAO and private sector, PBMs are consistently proven to save consumers money.
Regulated by NDCC/ ND Insurance Department (NDCC 26.1-27.1)

*PCMA, Visante, Pharmacy Benefit Managers, February 2016

Robert W. Harms Box 895 Bismarck, North Dakota 58502 (701) 255-2841 (701) 258-7733 fax

Testimony of Pat Ward in Opposition to Engrossed SB 2258
House IBL – Monday – March 20, 2017 – 8:30 a.m.

- Good morning Chairman Keiser and committee members. My name is Patrick Ward, and I am here on behalf of Express Scripts – one of the nation's largest pharmacy benefit managers – in opposition to SB 2258.

- As a pharmacy benefit manager, it is our goal to make prescription drugs safer and more affordable for our clients as well as their beneficiaries. We do this in a variety of ways: by negotiating discounts from brand drug manufacturers, designing retail pharmacy networks, promoting generics, operating specialty pharmacies, providing formulary management, performing drug utilization reviews, etc.

- We perform these services for tens of millions of Americans through our clients -- including Fortune 500 employers, health plans, labor unions and government entities of all sizes.

- Our clients design their pharmacy benefits to meet the unique needs of their respective workforces. We, then, as a PBM, administer that benefit. The details of how that benefit is structured, including the pharmacy network, are determined by the plan sponsor/client.

- Before delving into specifics, I would like to highlight for the committee that we, as an industry, have met with Mr. Schwab from the Pharmacy Association to better understand their concerns, as well as relay ours. It is our hope that we can find some mutual ground. We offered reasonable amendments in the senate but Mr. Schwab, though he did meet with us, would not really negotiate.

- Many of the provisions in this engrossed bill relate to private contract terms between private sector clients, and that many of these issues can be resolved through the contracting process – and not legislation. Also, one of his main concerns seemed to be DIR payments. Fees in commercial health programs often get confused with "DIR," (Direct and Indirect Remuneration), which is a technical term unique to the federal Medicare Program that refers to discounts and charges exchanged between pharmacies and payers. DIR payments based on performance metrics hold pharmacies accountable for activities such as generic and cost-effect dispensing, improving adherence, and reducing inappropriate drug use. **States do not have regulatory authority over Medicare or the DIR program.**

- Among other things, Engrossed SB 2258 would prohibit a pharmacy benefit manager from charging a fee to their contracted pharmacies for processing claims. These fees support key claim processing functions and without them the cost will be shifted to consumers.

- **Fees Are Part of Contractual Arrangements between PBMs and Pharmacies** – Pharmacies agree to certain fees in their contractual arrangements with PBMs. These fees are not unlike those paid by retailers to credit card companies in exchange for the risk of consumer fraud and for immediate payment for purchases, or the fees that banks

charge consumers for ready access to cash through ATMs. Pharmacies regularly enter into contracts with PBMs, agreeing to pay these fees in return for access to PBM services that enhance their own business practices. ***Now they want you to legislatively rewrite these cntracts.***

- **Fees Maintain Pharmacy Access to Convenient Systems and Drive Business –** Pharmacy benefit managers (PBMs) maintain robust IT systems to allow them to administer benefits. PBMs also contract with pharmacies to enable patients to fill prescriptions through their chosen benefit plan. For decades, pharmacies have agreed to contractual arrangements in which—for access to a PBM's health plan and employer clients' members and other services—they pay a fee. This allows pharmacies convenient and timely access to the business of hundreds of millions of consumers.

- There are numerous other services identified that support PBM fees. Some examples are:
    - Real time POS adjudication services
    - Pharmacy audit/reporting
    - Help Desk
    - Consolidated credentialing (Pharmacy credentials once with ESI, as opposed to hundreds of times with various payors)
    - Consolidated remittance
    - Consolidated contracting (contracting with a single entity as opposed to various payors)
    - Education/Communication
    - Training webinars, email blasts regarding compliance issues/adjudication updates
    - Concurrent Drug Utilization review – online, real-time Drug Utilization Review analysis at the point of sale
    - Automated prior authorization processes to reduce calls to pharmacy
    - Compliance with CMS requirements

- .

- Finally, *and most importantly*, section 11 **removes important accreditation standards for dispensing certain types of drugs – particularly specialty products, similar with our concerns today with SB 2301.** Specialty drugs are used to treat rare diseases and may not be stocked at typical brick-and-mortar drug stores. Given the sophisticated handling and distribution requirements of specialty drugs, the number of facilities equipped to handle the needs of specialty patients is lower still. Of the 69,000 pharmacies in the United States, relatively few qualify as specialty pharmacies. Since not all pharmacies provide the same level of clinical care and product support to ensure that patients have access to the right medications at the right time, *payers must differentiate which pharmacies provide comprehensive specialty care versus those unable to achieve similar service levels and outcomes.*

- The legislation would hamper plan sponsors' abilities to create and utilize unique networks of highly qualified pharmacies to dispense specialty drugs, because it would open specialty services to all pharmacies licensed in the state, even those without specialty accreditation.
- We are willing to work with the Committee and proponents on mutually satisfactory amendments to Engrossed senate bill 2258.
- We also respectfully request that any legislation that moves forward on this issue be prospective and not retroactively apply to existing contracts.
- **We ask for a Do Not Pass recommendation on Engrossed SB 2258.** I will provide the committee with some proposed amendments,
- **I am introducing Dave Dederichs and Andy Behm, from ESI, who can answer your specific questions.**
- I will try to answer any questions you may have. Thank you for your time.

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House – IBL
Patrick J. Ward
March 20, 2017

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2258

Page 1, line 13, after "claim" insert "that is not outlined in the pharmacy's contract with the pharmacy benefits manager or third-party payer"

Page 1, line 16, insert "d. To which a pharmacy did not clearly agree in a writing signed by both parties."

Page 1, line 20, after "measures" insert ", or pursuant to the terms otherwise agreed to in the pharmacy's contract with the pharmacy benefits manager of third-party payer"

Page 2, line 13, after "medication" insert "to the plan sponsor"

Page 2, line 27, after "cost" insert "to the patient"

Page 2, line 30, after "A" insert "retail"

Page 2, line 30, replace "mail or deliver" with "engage in limited/local mailing or delivering"

Page 3, line 4, replace "shall provide" with "will make available to"

Page 3, line 6 through 7, replace "for each pharmacy network established or administered by a pharmacy benefits manager" with "to enable the pharmacy to make an informed contracting decision"

Page 3, remove lines 9 through 12

Page 3, line 15, replace "in effect on and" with "entered into"

Renumber accordingly

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GNDC
Greater North Dakota Chamber

3-20-17

Testimony of Andy Peterson
Greater North Dakota Chamber of Commerce
SB 2258
Industry, Business & Labor Committee
Honorable George Keiser - Chair
March 20, 2017

My name is Andy Peterson and I am representing the Greater North Dakota Chamber. The GNDC works on behalf of our members to support building a strong and vibrant business climate in North Dakota. The GNDC stands today in opposition of SB 2258.

The GNDC recognizes the importance of having a business environment that allows businesses and industries to find the most effective and efficient way to perform services and produce goods. One way this is done is by allowing for party to party negotiations regarding the terms of agreements. As far we can ascertain, SB 2258 contains provisions which can and should be part of the negotiations between pharmacies and the pharmacy benefits managers (PBM). It is the position of GNDC that those terms should be left to the parties to negotiate and not be dictated by state law. In a sense, by incorporating the conditions of a contract as outlined in SB 2258, the state is imposing mandates on how a business relationship should be managed.

The GNDC realizes that it is important for a business to know the rules and costs for them to be successful. Yet, it is imperative that the business do its part by understanding the rules and costs for a business inherent in that relationship and not to expect the state or any outside entity to manage the terms of their business. The GNDC believes that the most successful business climate is one in which competition is allowed to grow and thrive. To that end, SB 2258 makes that more difficult by placing the conditions on how contracts are structured between PBMs and pharmacies.

Chairman, members of the committee GNDC urges a Do Not Pass on SB 2258 and I would stand for any questions you may have.

Champions for Business

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Mar 20, 2017

SB 2258

- 12 MAR 17 -

1. I AM A BLUE CROSS BLUE SHIELD MEMBER AND HAVE BEEN TAKING HUMIRA ADALIMUMAB FOR ABOUT FIVE YEARS. A FEW YEARS AGO, MY RHEUMATOLOGIST HANDED ME A PHONE NUMBER AND SAID I WAS TO CALL THAT NUMBER TO FILL MY PRESCRIPTION. UNTIL THAT TIME, I WAS ABLE TO GET THE MEDICINE FROM MY LOCAL PHARMACY.

3. CURRENTLY WHEN I CALL FOR A REFILL, I MUST HAVE 15-20 MINUTES AVAILABLE BECAUSE THAT IS HOW LONG IT TAKES TO PROCESS. THIS EATS INTO MY LUNCH HOUR AND LEAVES ME FEELING FRUSTRATED BECAUSE I PREFER RESTING DURING MY BREAK FROM WORK. THE REPRESENTATIVES ARE COURTEOUS AND FRIENDLY AND THEY OFFER 24/7 ASSISTANCE IF I HAVE ANY QUESTIONS ABOUT THE MEDICINE, BUT I WOULD MUCH RATHER PREFER SPEAKING TO MY LOCAL PHARMACIST WITH ANY QUESTIONS OR CONCERNS REGARDING MEDICINE. HE IS A PROFESSIONAL AND I FEEL COMFORTABLE ASKING HIM QUESTIONS ABOUT MEDICINE. HE IS AN EXPERT AND I TRUST HIS KNOWLEDGE.

4. DELIVERY OF THE MEDICINE HAS BEEN WITHOUT FAIL, HOWEVER THE PACKAGING IS IMMENSE! EVERY MONTH, I RECEIVE A LARGE STYROFOAM CONTAINER WITH GEL ICE PAKS INSIDE A LARGE CARDBOARD BOX WITH TWO INJECTABLE PENS. I USED TO BE ABLE TO RECEIVE 6 PENS AT ONCE, BUT

INSURANCE ALLOWS A 28 DAY SUPPLY ONLY. IT SICKENS ME TO HAVE TO PUT THESE STYROFOAM CONTAINERS INTO LAND FILLS.

5. "SPECIALTY" PHARMACY IS NOT CONVENIENT FOR ME. CONVENIENT ONCE WAS - A SIMPLE PHONE CALL TO MY LOCAL PHARMACY AND A COUPLE HOURS LATER, I PICKED UP 6 INJECTABLE PENS. NOW, I HAVE TO MAKE THE 20 MINUTE PHONE CALL - 12 TIMES PER YEAR. PREVIOUSLY, IT WAS ONLY FOUR CALLS TO MY LOCAL PHARMACY.

6. I FEEL COST HAS REMAINED RELATIVELY THE SAME FOR ME - BUT WHAT ABOUT MY LOCAL PHARMACIST? HE IS NOT RECEIVING FUNDS FROM MY PRESCRIPTION BECAUSE I HAVE BEEN TOLD BY MY BLUE CROSS OF ND THAT I CAN NOT SUPPORT THE LOCAL BUSINESS OF MY SMALL TOWN.

7. IF BLUE CROSS OWNS PRIME SPECIALTY, THEY ARE GOING TO PUT THE SMALLER PHARMACIES OUT OF BUSINESS. I BUY LOCAL TO SUPPORT THE LOCAL BUSINESSES. IF INSURANCE COMPANIES ARE ALLOWED TO DO THIS - THEY WILL SHUT DOWN THE LOCALS COMPLETELY. BIGGER IS NOT BETTER. IT IS STILL COMFORTING TO ME TO KNOW I CAN ASK MY LOCAL PHARMACIST QUESTIONS, FACE TO FACE.

I DON'T WANT TO HAVE TO CALL A 1-800 NUMBER, PRESS 1 FOR ENGLISH AND BE ON HOLD 35 MINUTES FOR THE NEXT AVAILABLE "REPRESENTATIVE" TO ANSWER MY QUESTIONS.

SAVE THE LOCAL PHARMACIES.

PROTECT THEM.

DO NOT OBLITERATE THEM!

Laura Bright

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