Comment Report

Commerce
Date: 03/01/2021
Time: 02:30 PM
Location: RM 103, Sup. Ct. Chamber

Name: Shane Austerman

Comment: Please hold a subcommittee meeting for HF50. All should go see the public outcry of support posted on Rep. Lundgren's Facebook. https://www.facebook.com/RepShannonLundgrenAlso please read the article listed here: https://www.telegraphherald.com/news/tristate/article73518e2f69cf5c588d63065d74ab82b2.html

Name: Shane Austerman

Comment: I should also note that a full subcommittee hearing would also bring to light that the grant that currently exists for PKU patients used to be $2000 in FY 2008 and slowly dwindled to $0 in FY 2018. For FY 2021, it is $675. In today's dollars, the $2,000 from FY 2008 would be about $2500. The grant should be increased immediately to match the inflationadjusted FY 2008 amount. The fact this has been reduced has put many people's brains at risk. Rep Lundgren has failed to understand that it took significant advocating to get the $675 back after FY 2018.HF 50 should be passed as well. It would ensure people would get access to Medical Foods that prevent brain damage. Rep Lundgren has shared with others this bill doesn't cover enough people to make it worthwhile. One amendment needs to be added to this bill, it also should cover Medicaid patients. Due to Medicaid's unique structure, this bill inadvertently didn't cover Medicaid patients, who were provided insurance coverage until July of 2020. This needs to be remedied immediately and could be done by this bill. Rep Lundgren understands that no state law can mandate ERISA plans to cover these Medical Foods, but that is why both Senators Grassley and Ernst support a National Bill called the Medical Nutrition Equity Act (MNEA) that would mandate all insurance cover these Medical Foods. This inability to regulate ERISA selffunded plans is no reason not to pass this bill. The MNEA covers the same conditions and items HF 50 would if enacted.Thank you for your attention to this matter.

Name: Connor Rose

Comment: Attached are PCMA's comments in respectful opposition to HSB 228

March 1, 2021

Madam Chair Shannon Lundgren
Members of the House Commerce Committee

Re: HSB 228: An Act relating to pharmacy benefit managers, pharmacies, and prescription drug benefits

Madam Chair Lundgren and Members of the Committee:

On behalf of the Pharmaceutical Care Management Association (PCMA), I am writing in respectful opposition to HSB 228, which will significantly impact the ability of employers and health plans to offer affordable and high-quality prescription drug benefits to their employees and enrollees. PCMA is the national trade association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plan for more than 2.5 million Iowans with health coverage through employers, health insurers, labor unions and federal and state sponsored health programs.

PBMs exist to make drug coverage more affordable and help consumers obtain lower prices for their prescription drugs through price discounts from retail pharmacies, negotiating rebates from pharmaceutical manufacturers, and offering lower-cost dispensing channels. Today, there is no federal or state law requiring employers, health plans, or government programs to hire PBMs, but they choose to do so in order to keep the cost of providing benefits low while still providing robust access to pharmacies and high quality care for their members.

PBMs are business-to-business vendors and administrators of prescription drug plans designed and implemented by plan sponsors. It is important to keep in mind that every limitation and restriction placed on the services PBMs offer ties the hands of small employers from utilizing proven market-based tools that they demand in order to contain the cost of providing high-quality prescription drug benefits at an affordable price.

Below you will find our concerns with several provisions outlined in HSB 228 that restrict the use of PBM tools which will lead to higher prescription drug costs for millions of Iowans:

Section 8(1) and (2): Pharmacy Networks and Section 9(4): Prescription Drugs-Point of Sale
Health plans and pharmacy benefit managers rely on selective contracting with independent, chain, mail-order, and specialty pharmacies to provide patients with robust access to high-quality pharmacies that provide consumer with significant savings at the pharmacy counter. By fostering competition on service, price, convenience, and quality, plan sponsors have a great degree of control over prescription fulfillment by incentivizing pharmacies to offer discounts or lower dispensing fees. These savings are passed onto patients in the form of lower cost sharing.[1,2] HSB 228 undermines this competition and will force PBMs and plan sponsors to contract with any pharmacy willing to accept its terms and conditions to participate in a network, thereby eliminating any incentive to offer discounts to patients. Put simply, if all pharmacies are required to be in a network, then there is no incentive to offer discounts for patients, resulting in lost savings opportunities.

[1] https://payorsolutions.cvshealth.com/programs-and-services/cost-management/network-strategies
[2] Joanna Shepherd. (2014). "Selective Contracting in Prescription Drugs: The Benefits of Pharmacy Networks." *Minnesota Journal of Law, Science & Technology.*

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

Additionally, Section 8(2) of HSB 228 inserts the state in the middle of business-to-business contracts eliminating several arrangements with pharmacies that are clearly outlined in the contracts they, or their PSAO agree to including:

- Nominal claims processing fees that go to maintain robust IT systems that allow pharmacies to administer benefits for employers, health plans, and many government programs across the country. These fees are not new and have been agreed to by pharmacies for decades.
- Performance based fees that are used for **all** providers in **all** parts of the healthcare system. These types of arrangements exist in Medicare, Medicaid, and commercial markets to give hospitals, physicians and other clinicians incentives to provide the most high-quality, cost-effective care. Government interference in private contracts as outlined in HSB 228 runs contrary to the progress made in healthcare and is a significant departure from the trend of payment for value.
- Accreditation fees that health plans and PBMs require for specialty pharmacies that demonstrate they are practicing the highest standards of best practices, including patient care and proper handling and distribution of specialty drugs. This legislation would now force plans to contract with pharmacies that do not meet basic quality and performance standards for storing, handling, and dispensing specialty drugs, putting patient safety at serious risk.

Section 9(2) and (6): Prescription Drugs-Point of Sale

Under this section, a PBM cannot prohibit a pharmacy from disclosing the availability of a lower-cost prescription drug or from selling a lower-cost prescription drug to a patient. PCMA and the PBM industry at large have supported federal and state legislation banning 'gag clauses' and wholly support patients paying the lowest possible price at the pharmacy counter for their prescription drugs. In fact, PBMs aggressively encourage the use of generic drugs, which cost a fraction of their brand counterparts.

This section also puts pharmacy profits ahead of a patient's health by allowing a pharmacist to decline to fill a prescription if they determine they will not earn an acceptable profit. This will lead to patients going without important medications, interrupting their regimens, and worsening their health outcomes. Additionally, it is a contractual requirement that they fill the prescription for this very reason. That is why PBMs have internal appeals processes in place for pharmacies so that what is most important, patients receiving the medications they need, happens first.

Section 10(1)(c), (2)(b), and (2)(c): Maximum Allowable Cost List and Section 13 (1)(b) and (3)(b)(1): Appeals and Disputes

Generic drugs are made by multiple manufacturers, which sell them at different prices to pharmacies. A maximum allowable cost (MAC) list specifies the most a PBM will reimburse a pharmacy for a particular generic drug. These lists are set and regularly updated to reflect a market based average acquisition cost of a well-run independent or chain pharmacy. MAC lists encourage pharmacies to purchase generic drugs at the lowest possible cost, which in turns create competition among wholesalers and generic drug manufacturers. However, these sections remove market incentives from pharmacies that encourage them to shop for the best available price through their PSAO or wholesaler. In fact, removing these incentives would then allow generic manufacturers and wholesalers to increase prices without recourse since pharmacies would continue to sell the drugs and be reimbursed above the level they paid using invoice prices that do not actually reflect the true cost of the drug to the pharmacy.

Additionally, Sections 10(1)(c) and 2(b) require PBMs to notify pharmacies of information regarding where they can obtain drugs at the 'pharmacy acquisition cost'. Simply put, there is no way a PBM could comply with these mandates. Independent pharmacies and chains buy drugs at different prices and terms from various wholesalers. PBMs are ***not*** involved in these transactions and have no insight into the prices that pharmacies pay. That information is only known to pharmacies, their PSAO, and drug wholesalers with which they contract.

Section 11: Pharmacy Benefit Manager Affiliates

This section of HSB 228 provides that plan sponsors or PBMs, "shall not reimburse any pharmacy located in the state, in an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy benefits manager affiliate for dispensing the same prescription drug as dispensed by the pharmacy." In 2018, the Ohio Department of Medicaid investigated this alleged preferential reimbursements and found that a PBM that owns mail order, specialty, or retail pharmacies reimbursed independent pharmacies 3.6% more for brand drugs and 3.4% more for generic drugs compared to its own reimbursement.[3] The Department "could not identify any preferential pricing paid to PBM owned pharmacies by the PBM that would create an anti-competitive advantage over independent pharmacies."[4] This makes sense because independent pharmacies and chain pharmacies buy drugs at different prices and terms from various wholesalers. PBMs are aware that independent pharmacies have different buying power than large chains.

Not only is this provision a solution in search of a problem, it undermines the free-market principles that have been consistently championed by the Iowa General Assembly and inappropriately inserts the government between two sophisticated parties negotiating private contracts.

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We appreciate your consideration of our concerns with HSB 228 and stand ready to work with the Iowa General Assembly towards solutions that promote access to affordable and effective prescription drugs for all Iowans.

Sincerely,

Connor Rose
Director, State Affairs
Pharmaceutical Care Management Association

[3] Ohio Department of Medicaid. (June 21, 2018). "Ohio Medicaid Pharmacy Benefit Manager Performance Review."
[4] Id.