October 17, 2019

The Honorable Andrew M. Cuomo  
Governor of the State of New York  
Executive Chamber  
State Capitol  
Albany, NY 12224

RE: S6531 Breslin: To amend the public health law and to amend the insurance law in relation to pharmacy benefit managers

Dear Governor Cuomo:

The Pharmacists Society appreciates your leadership in recognizing the need to license and regulate pharmacy benefit management service providers in state law. As is well known, the Society has advocated for the state’s oversight for many years. We write in strong support of the above-captioned bill.

**Pharmacists are health care providers. PBM are not.**

Pharmacy benefit managers disturb established pharmacist-patient relationships. State oversight of PBM service providers cannot come quickly enough. Pharmacists are clinically trained to ensure that prescription drugs are safe, appropriate and therapeutically effective. Pharmacists check patients’ profiles before dispensing any medication to safeguard against duplication, contraindication, allergies or drug-drug interactions. Pharmacists are professionally liable for their patients, and they may lose their licenses in the case of patient harm. Pharmacy benefit managers, on the other hand, are businesses operating without any responsibility for patient care. This legislation creates appropriate and necessary statutory guardrails for PBM. They are to behave with “duty, accountability and transparency,” with business practices performed with “care, skill, prudence, diligence and professionalism and for the best interest primarily of the covered individual, and the health care plan or provider.”

**PBM disrupt patient care.**

Pharmacists are frontline providers. They interact with patients more often than any other licensed healthcare professional. Pharmacists in community practice are most accessible to the public, and they are particularly vulnerable to the interference of PBM. The nation’s three dominant PBM – Express Scripts, CVS-Caremark and OptumRx - own and operate mail order and so-called “specialty” pharmacies that beneficiaries are either mandated or financially incentivized to use. As a result, local pharmacists lose contact with patients who may
return sporadically or not at all. If a patient returns to the pharmacy for an urgent need, the patient’s profile is incomplete, inaccurate and out-of-date. Such disruptions do not serve patients well, diminish the role of the pharmacist and devalue the profession. This legislation does not deal directly with these problems, but it is a start.

Abusive practices undermine local businesses.

New York pharmacies have first-hand experience with PBM business practices. Abusive take-it-or-leave-it contacts, below-cost reimbursements, network restrictions, meaningless re-certification requirements, ill-defined charge-backs, additional fees and unfair recoupments threaten the financial stability of community pharmacies, particularly independents. In recent years PBMs have become more aggressive and today represent an existential threat to local pharmacies throughout the state, jeopardizing jobs and affecting local and regional economies. Although this legislation does not directly benefit pharmacies, authorizing the Department of Financial Services to license PBMs and establish reasonable standards in regulation is a clear step in the right direction.

Community pharmacists are front-line healthcare providers.

Licensed pharmacists behind the counter at a local pharmacy meet patients where they are and are in the optimal position to provide appropriate, timely care. Articles in peer-reviewed medical and pharmacy journals document that in-person pharmacist-patient interactions drive positive therapeutic outcomes. Gag orders, mandatory mail order contracts, unreasonable co-payments, prior authorization requirements, unworkable appeals procedures and restricted networks are regular features of pharmacy benefits designed to feed the financial bottom line of PBMs. This legislation, particularly disclosure of dispensing fees and other terms in PBM-pharmacy contracts will shed new light on real costs. Greater transparency leads to better business decisions by every entity, public and private, that pays for pharmacy benefits.

This bill is fully aligned with the goals of your administration.

Enacting this legislation into law represents another step toward achieving patient-centered healthcare that is accessible, consistent, fiscally responsible and value-based; local/regional economies that are sound and viable; and public health initiatives built on the continued presence of community pharmacies throughout New York.

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PBM drive up drug prices.

Pharmacy benefit managers are a factor in high prescription drug prices. In a 2016 congressional hearing, manufacturers stated publicly that demands from PBMs for higher and higher rebates is a driving force behind escalating manufacturer drug prices. 3, 4

PBMs themselves add cost.

It’s not just that drug prices are high. Engaging a PBM to manage the prescription benefit also adds to payers’ costs. In 2017 large employers began to realize they could save millions by eliminating PBMs altogether. 5 And recent state investigations into Medicaid managed care spending led to dramatic administrative decisions to eliminate PBMs completely in the West Virginia, California, and Michigan programs. West Virginia, the earliest state to change its policy, achieved Medicaid savings of $54 million in the first year, even while paying pharmacies at Medicaid fee-for-service rates. (Navigant Consulting report. April, 2019).

New York law prohibits spread pricing in Medicaid managed care.

The Health Department is in the process of implementing provisions in the 2019-2020 budget prohibiting spread pricing in the NYS Medicaid program. Spread pricing is a financial shell game made possible by the lack of transparency in the PBM business model, a model that has increasingly come under attack in taxpayer-funded programs. Spread pricing is the difference between the low payment pharmacies receive from a PBM and the much higher price the PBM charges health plans or other payers. The practice first came to light in a series of exposes in the Columbus Dispatch 6 that led to a thorough investigation by the Ohio State Auditor who found that PBMs paid themselves $223.7 million more than they paid pharmacies for prescriptions dispensed to Medicaid managed care patients. The finding became the impetus for policy changes in other states, sending shockwaves throughout the country. Here in New York, developments in Ohio prompted the Society to commission a pilot study with results estimating the value of spread pricing in New York’s Medicaid managed care program to be at least $300 million. 7 The results from the NY Comptroller’s investigation are not in as of this writing, but they are eagerly anticipated.

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5 https://www.bloomberg.com/news/articles/2017-03-03/drug-costs-too-high-fire-the-middleman
6 http://www.gatehousenews.com/sideeffects/
New York law requires pass-through contracts in Medicaid managed care.

Several provisions in subdivision 10 of Section 4406-c of Public Health Law apply directly to financial arrangements between Medicaid managed care plans and PBMs. Payments to PBMs are limited to "the actual ingredient costs, a dispensing fee, and an administrative fee for each claim processed." The claims processing fee is limited to the maximum established by the Health Department. In addition, PBMs must disclose and pass through any additional income they derive. According to the operative language, PBMs must identify "all sources of income related to the provision of services to the managed care plan" and such income must be "passed down to the health care plan in full to reduce the reportable ingredient cost."

For pharmacies, broad state oversight of PBMs is an urgent need.

In 2017 you signed legislation to give pharmacies a well-defined appeals process to guarantee that PBMs reimburse network pharmacies at sustainable levels. Despite the law, PBMs still reimburse below cost for generics and don’t provide the mandated information to pharmacies when appeals are denied. New York’s Public Health Law (Section 280-a) is similar to laws in other states commonly referred to as "Maximum Allowable Cost" (MAC) appeals laws. Shortly after MAC appeal laws were enacted, PBM-pharmacy contracts began using the term "Generic Effective Rate" (GER). According to the October 9, 2019 blog posted by attorneys at FrierLevitt, pharmacies first became aware of GER clauses in PBM contracts in 2018. GER was not a meaningful term until pharmacies discovered significant shortfalls in anticipated remittance amounts, citing "GER" as the reason for given for clawbacks that occur weeks, even months after claims are adjudicated. GERs, therefore, offer a glaring example of the latitude PBMs have in their business dealings with local pharmacies. In the context of this letter, it is important to note that GERs are untouched by the new Medicaid managed care statutes described above. As such, GERs shine new light on the need for new state law that creates new robust state authority for the oversight of PBMs by the Department of Health and the Department of Financial Services.

Greater transparency is a public benefit.

In the bill, the mandatory disclosure of the terms of contracts between PBMs and pharmacies (new Article 29 of Insurance Law), will give state authorities the authority they need to understand, investigate and resolve problems that pharmacies, payers or patients bring to their attention. It should be noted that in addition to health plans, PBMs contract with large and small employers, unions, public employers such as school districts, municipalities, other local governments as well as the state itself. Because this legislation amends both Public Health Law and Insurance law, its reach is broad and it has the potential to deliver meaningful fiscal relief to private and public interests as well as to taxpayers at all levels.

Pharmacists and pharmacy owners and members of the public need relief from deceptive, anti-competitive, self-serving and abusive PBM business practices. Over time PBM contracts have become less favorable and more onerous with gag clauses, marginal, below-cost or vague reimbursement language, arbitrary fees/chargebacks and confidentiality and non-disclosure terms that are not tolerated in other circumstances. At the same time PBMs have consolidated, mail order and specialty pharmacies prospered, and local pharmacies have lost every ounce of their negotiating power.

**S6531 is comprehensive and well-crafted.**

The National Academy for State Health Policy (NASHP) and the National Conference of Insurance Legislators (NCOIL) are two prominent organizations that actively monitor actions in the states regarding the regulation of pharmacy benefit managers. It is important to note that the language in S6531 is comprehensive when compared to the NCOIL model bill adopted in December, 2018. Of particular interest, NASHP has very recently released an authoritative legal analysis of state efforts to regulate PBMs that includes this as a key point: “Due to a limited number of court decisions and courts’ inconsistent application of ERISA, states should not hesitate to pass PBM laws as another court may differ significantly in its legal analysis.” When the bill passed in June a NASHP spokesperson commented that the language in S6531 is remarkably comprehensive.

On behalf of the profession and our members who are practicing pharmacists and pharmacy owners, thank you again for your leadership on this important issue. For all the reasons stated above, the Society strongly supports this legislation and wholeheartedly recommends enactment into law.

Sincerely,

Steve Moore, PharmD, President

cc. Senator Neil Breslin
   Assemblyman Richard Gottfried
   Senator Gustavo Rivera
   Assemblyman Kevin Cahill

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