NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
ATLANTA, GEORGIA
MARCH 4, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee met at The Whitley Hotel in Atlanta, Georgia on Sunday, March 4, 2018 at 8:45 a.m.

Assemblyman Kevin Cahill of New York, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Sam Kito (AK)
Rep. Deborah Ferguson (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Richard Smith (GA)
Rep. Matt Lehman (IN)
Rep. Bart Rowland (KY)
Rep. Joe Hoppe (MN)
Rep. Justin Hill (MO)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Asm. Andrew Garbarino (NY)
Sen. Bob Hackett (OH)
Rep. Glen Mulready (OK)
Rep. Tom Oliverson (TX)
Rep. Bill Botzow (VT)

Other legislators present were:

Rep. Paul Mosley (AZ)
Rep. Bryon Short (DE)
Rep. Darlene Taylor (GA)
Rep. Steve Riggs (KY)
Sen. Paul Wieland (MO)
Sen. Ed Buttrey (MT)
Rep. Ron Tusler (WI)

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded the Committee unanimously approved the minutes of its November 18, 2017 meeting in Phoenix, Arizona.

DISCUSSION ON STATE OPTIONS FOR RESPONDING TO CHANGES IN FEDERAL HEALTH POLICY

Heather Howard, Director of State Health and Value Strategies, and Lecturer in Public Affairs at Princeton University & former Commissioner of Human Services for the State of NJ, began by discussing some of the changes in Federal health policy that that are affecting the individual market, the first being the repeal of the individual mandate. The tax bill repeals the ACA's individual mandate penalty, effective January 1, 2019, by setting the amount of the penalty to zero. The CBO estimates that due to the repeal, there will be a 10% increase in premiums, and 13 million will lose coverage. Notably,

however, Massachusetts' individual mandate, started in 2007, is still in effect, and some states are considering introducing their own mandates. Cmsnr. Howard noted that state individual mandates are a good tool for states to combat the issuance of substandard plans, and stated that for states considering their own mandates, some key elements that any state legislation implementing a mandate must contain include: a definition of qualifying coverage; categories of exemptions; and a penalty amount. States must also create a mechanism for granting exemptions and create a system for providers to report coverage statistics. Notifying the uninsured about their coverage options could be an optional provision. Cmsnr. Howard also stated that reinsurance is an efficient mechanism for spreading the costs of high cost enrollees and noted that the temporary Federal reinsurance program kept premiums down for the first three years of the ACA.

Three states were approved for 1332 reinsurance waivers in 2017 (AK, MN, OR) and several others are considering submitting applications in 2018. Cmsnr. Howard stated that the elimination of the individual mandate penalties in 2019 will build pressure for premium relief, especially for unsubsidized individuals, and noted that Congress is considering a second round of Federal funding for reinsurance to help stabilize the individual market. Cmsnr. Howard also noted that reinsurance has a proven track record of reducing premiums by guaranteeing carriers don't face large losses. Reinsurance also correlates with increased insurer participation (insurer participation declined when Federal reinsurance ended) and reduced market volatility. Cmsnr. Howard then provided a brief overview of the three approved 1332 wavier applications (AK, MN, OR) and encouraged states to plan ahead on any waiver applications as early planning positions states to influence Federal policy and to respond successfully to shifts in Federal policy. Cmsnr. Howard noted that the latest state to submit a 1332 waiver application for a reinsurance program was Wisconsin, and stated that 1332 waivers have bi-partisan support.

Cmsnr. Howard then discussed the recently proposed regulations from the Departments of Health and Human Services and Treasury regarding short term limited duration health plans (STLDs). The regulations propose to allow the STLD duration limit to be extended from 3 months to up to 12 months and make it easier for consumers to renew such policies. The regulations also revise what disclosures the policies must make to consumers. Comments on the proposed regulations are due on April 23. Cmsnr. Howard stated that, if implemented, the STLD regulations' impact on the individual market could be substantial, particularly when compounded with the zeroing out of the individual mandate penalty. HHS estimates that between 100,000 and 200,000 individuals would leave the individual market for STLD plans, which would result in higher premiums for those left. Cmsnr. Howard also noted that those who purchase STLD plans will incur increased financial liability if they get sick and/or injured, and there is a history of deceptive marketing tactics surrounding STLDs. However, nothing in the proposed regulations changes or diminishes states' authority as the primary regulators of STLDs, and therefore, states have a broad set of options to consider when dealing with them. States could: ban them outright; require STLDs to comply with some or all individual market rules; limit the duration of STLDs; require STLDs to meet a minimum medical loss ratio (MLR); and require improved consumer disclosures and education about STLDs. Depending on the state, some of those options could be implemented administratively, while some would need legislation.

Cmsnr. Howard stated that it is important to follow what Idaho is proposing by allowing the sale of plans that skirt ACA requirements. If the federal government does not step

in, other states will likely follow that process. Cmsnr. Howard also stated that at the end of this month, a Federal omnibus appropriations bill is expected to pass. Some members of Congress are trying to include state individual market reforms in the bill: Senators Alexander and Murray are trying to fund the CSR payments; and Senators Collins and Nelson are trying to provide for Federal grants to help states establish reinsurance programs. The timing is critical on those issues since carriers are in the process of deciding whether to stay or enter into the ACA market.

Rep. Matt Lehman (IN), NCOIL Treasurer, asked if we are witnessing the dismantling of the ACA state-by-state. Cmsnr. Howard stated that seems to the trend and it started with efforts to repeal the ACA outright but now there is a shift to administratively provide states with flexibility to innovate and experiment. It will be very interesting going forward to compare and contrast the results of what states are now doing.

Rep. Bill Botzow (VT), NCOIL Vice President, asked if more attention should be focused on the rural-urban divide as it pertains to healthcare and the age differences between the two. Younger people seem to be migrating more to cities, and the elderly to rural areas. Cmsnr. Howard stated that there is a particular stress on the healthcare delivery system in rural areas but to end on a hopeful note, Maryland is pioneering global budgeting which seems to provide rural areas with great hope going forward. In the other forty-nine states, hospitals are paid using fee-for-service, which results in a hospital prioritizing volume and filling beds instead of quality. Under the Global Budget Revenue system, hospitals receive a fixed sum payment for all Medicare patients for the year. Any money not spent on healthcare can be kept as profit, which reverses the incentives for hospitals. Instead of incentivizing hospitals to see as many patients as possible, hospitals are now incentivized to increase the quality of their care and reduce preventable illnesses.

PRESENTATION ON INITIATIVES TO PROMOTE SOLUTIONS ACROSS THE AUTISM SPECTRUM

Lorri Unumb of Autism Speaks began by stating that her son, Ryan, was diagnosed with autism at 22 months of age. Autism is a medical condition brought on through no apparent fault of the family – it is not yet known what causes it. Autism is diagnosed by a doctor or psychologist and often a developmental pediatrician. For reasons not yet known, autism is four times more common in boys than girls. There used to be three different “strains” – a.) autistic disorder; b.) Asperger’s syndrome; and c.) pervasive developmental disorder (a catch-all category). However, now autism is referenced on certain levels of “autism spectrum disorder.” The prevalence of autism is skyrocketing, and it is not certain why, although some is probably due to better diagnostics and an expanded definition. The Center for Disease Control (CDC) estimates that 1 in every 68 children is diagnosed somewhere on the autism spectrum.

Ms. Unumb stated that applied behavior analysis (ABA) is helpful in treating autism. It consists of a one-on-one intervention where they break down every skill that a human being needs to operate in life and train the child how to pick up any skills they are lacking through repetition, prompting, and positive reinforcement. Ms. Unumb stated that when doctors recommended that her son undergo 40 hours per week of ABA, the cost was $71,000 per year. At that time, insurance did not cover any of that amount which is what led her to start advocating for insurance coverage of autism treatment. Some of the reasons insurers gave for not covering ABA were: it was an experimental

line of treatment (it was not); it was being conducted by unlicensed providers (there were no licenses at the time); and that the schools could handle it. Motivated by that experience, Ms. Unumb wrote a piece of legislation in South Carolina in 2005 that requires insurance to cover evidence-based treatments as recommended by a physician. The bill passed in 2007 and became known as "Ryan's law."

Ryan's law requires coverage of autism treatment through age 16 with a $50,000 per year cap on ABA. Since that time, Ms. Unumb has been traveling across the country trying to get similar laws enacted. In 2001, only 1 state covered ABA (Indiana) but today, 46 states cover autism treatment. However, those 46 states vary dramatically in their levels of required coverage. Some states still lack coverage for ABA, and some states have made coverage distinctions for the individual and small group markets. Ms. Unumb stated that such coverage restrictions are a problem for families with autistic children and it often results in the family moving, or a change in employment with better coverage. Almost all states have autism insurance coverage in the state employee market, and all the 46 states have coverage in the large group market.

Rep. Paul Mosley (AZ) asked what Arizona's level of autism insurance coverage is. Ms. Unumb stated that Arizona's autism coverage mandate was one of the first to be enacted, and only applies to state employees and the large group market. However, after the ACA passed and states were given an opportunity to select a benchmark plan, Arizona selected the state employee plan as its benchmark. By virtue of that, autism coverage became part of the essential health benefit requirements and thus is available in non-grandfathered plans.

Ms. Unumb stated that some states have managed to get ABA coverage into their EHB package by including it in the "habilitative services." Also, the phrase "…including behavioral health treatment" was included in the ACA's list of EHB's specifically for ABA coverage. Ms. Unumb also noted that in states such as Ohio, Governor Kasich simply wrote to the Federal government requesting that ABA be included in their EHB and it now is. Accordingly, many families in Ohio can purchase a qualified health plan just for purposes of ABA coverage.

Ms. Unumb further stated that some states require autism coverage, but the coverage is impermissibly restricted. The Federal Mental Health Parity & Addiction Equity Act (MHPAE) prohibits financial requirements or treatment limitations on mental health benefits that are more restrictive than those on medical/surgical benefits. The term "treatment limitations" includes "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment."

However, many state insurance autism laws have dollar caps or age caps that are clearly quantitative treatment limitations that restrict coverage on a mental health benefit. As an example, Arizona has a $50,000 cap on treatment for children aged 0-9, and a $25,000 cap on children aged 9-17. Notably, Arizona's law was in place before MHPAE was enacted. Ms. Unumb closed by urging the committee members to look at the materials she provided that shows each state's level of autism insurance coverage and to work to ensure there are no impermissible restrictions. Ms. Unumb noted that in addition to improving the children's lives, autism insurance-coverage laws are important because the children can cost states a tremendous amount of money if they are not treated at an early age.

Asm. Kevin Cahill (NY), Chair of the Committee, asked if the MHPAE is broad enough to cover all autism treatment, and whether there are state mental health parity laws that have filled any gaps. Ms. Unumb stated that most states do have mental health parity laws but, in most instances, the MHPAE is broader and it aims to include autism treatment under the definition of "mental health benefit."

DISCUSSION ON REPORTING AND NOTIFICATION REQUIREMENTS FOR PRESCRIPTION DRUG MANUFACTURERS RELATED TO DRUG PRICING (SEE CALIFORNIA SB 17 (2017) AND VERMONT S.216 (2016)

Asm. Ken Cooley (CA), NCOIL Secretary, stated that California has tried a series of strategies to try to lower healthcare costs in general. In a recent survey conducted by the Journal of American Medicine, 25% of those polled stated that they did not pursue filling a prescription due to cost concerns. California SB 17 is an effort to improve transparency in the prescription drug market in order to have healthcare costs lowered. CA SB 17 requires pharmaceutical companies to notify public and private health insurers anytime the companies plan to raise the price of a drug by more than 16 percent over two years. Such notice must be provided at least 60 days prior to the planned effective date of the increase, and include a statement explaining the price increase. Additionally, CA SB 17 implements reporting requirements for certain health plans regarding: the 25 most frequently prescribed drugs; the 25 most costly drugs by total annual spending; and the 25 drugs with the highest year-over-year increase in total annual plan spending. This information is to be compiled into a report and submitted to the public and legislators demonstrating "the overall impact of drug costs on health care premiums."

Rep. Botzow stated that VT S.216 directed the Green Mountain Care Board, in collaboration with the Department of Vermont Health Access (DHVA), to identify annually up to 15 prescription drugs representing different drug classes "on which the state spends significant health care dollars and for which the wholesale acquisition cost (WAC) has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months, creating a substantial public interest in understanding the development of the drugs' pricing." The statute also requires that the manufacturers of the identified drugs provide a justification for the increase in the WAC, including all relevant information and supporting documentation, and provide that information to the Attorney General on a confidential basis.

Rep. Botzow stated that the latest report from the Attorney General was just released and he cited one of the DHVA's main observations from the data collected: "increasing WAC does not always result in more rebates for commercial payers, as rebates are not available on all drugs. Since rebates are sometimes based on a percentage of WAC, purchasers and payers may still pay more when WAC increases. In addition, uninsured and under-insured patients, such as those with high deductible health plans or limited coverage, often bear the full burden of price increases at the pharmacy." Rep. Botzow noted that the information in Vermont has been helpful but more needs to be done to see a meaningful decrease in drug pricing and healthcare costs in general. Rep. Botzow also noted that the Vermont Senate just recently passed a bill that contains elements of the CA SB 17 and other state drug pricing transparency laws.

Ed Silverman, Senior Writer at STAT News, stated that in the absence of any movement by the Trump Administration or Congress to directly address prescription drug prices, many states are taking some form of action in the area of transparency, the idea being

that transparency would get information out there that is not currently known, and it would better enable remedial action to be taken if an egregious drug price increase took place. Mr. Silverman noted that nearly two dozen states have introduced legislation that would demand transparency from drug makers and, in some cases, pharmacy benefit managers (PBMs). More than two dozen states have bills directed at PBMs specifically, some of which address incentives for mail order pharmacy and penalize pharmacists who discuss costs with consumers. Mr. Silverman noted that Nevada passed a drug pricing transparency law that focuses on diabetes medicines given the prevalence of diabetes in the country and associated health costs. Colorado, among other states, has introduced similar legislation.

Additionally, Mr. Silverman stated that a growing number of states are also introducing legislation that creates a mechanism for state residents to purchase medicines that are imported from Canada. Mr. Silverman noted that Utah has introduced such a bill that has Republican support, which is illustrative of the fact that these issues are not just associated with "blue" states such as Vermont and California. Furthermore, in May 2017, Maryland became the first State to prohibit drug manufacturers from "price gouging" in the sale of essential off-patent or generic drugs. Mr. Silverman noted that an extremely large percentage of prescriptions today are written for generic drugs. Mr. Silverman stated that many of the drug pricing transparency laws do not have a lot of "teeth" with regard to their penalty and enforcement provisions. Mr. Silverman noted that from what he has heard regarding VT S.216, the law is not moving the needle.

Emily Donaldson, Senior Director of Policy and Research at PhRMA, stated that drug pricing transparency measures have generally focused on the WAC which is generally not illustrative of the actual cost for a drug that is paid by PBMs and insurers since those entities receive substantial discounts and rebates from brand manufacturers. A recent study found that for certain medicines used to treat chronic conditions such as asthma, high cholesterol, or diabetes, rebates reduced the list price by 30% to 70%. We know that prevention and better management of chronic conditions can save states more money than what is spent on the medicines used to treat them, but PhRMA understands the pressures facing state budgets and state lawmakers and is committed to providing solutions to those challenges.

With regard to VT S.216, Ms. Donaldson stated that PhRMA appreciates why people want to know why the cost of a drug might increase, however, it is unclear that the law will have any impact on patients. We do know what does have an impact on patients: a recent report found that the number of plans with a deductible for medicines doubled between 2012 and 2015. And oftentimes, insurers are receiving rebates for those medicines while the patient is paying full price; and after meeting a deductible, some patients still have to pay coinsurance, which is based on the list price. The number of employees with no deductible for pharmacy or medical benefits continues to decrease: 49% in 2016; 44% in 2017. One-third of employers are considering more cost-sharing measures in the future, which means higher deductibles and additional formulary tiers.

Ms. Donaldson pointed out that these types of policy changes are occurring despite the fact that drug spending growth is slowing. Express Scripts, the nation's largest PBM, and CMS, announced that 2017 growth in Rx spending was between 1.3% and 1.5%, but overall health spending increased more than 4%. In addition, almost half of all commercial plans saw a decrease in their per-enrollee drug spending last year. Ms. Donaldson stated that those statistics indicate that the focus needs to be broadened:

measures that hit one industry or another are not going to make it easier for people to afford their medicines. It is imperative that anything a state does to address these issues must not result in negative unintended consequences.

With regard to CA SB 17, Ms. Donaldson stated that the law's advance price notification requirements can have severe consequences because it has happened before. Notifications based on costs and future price increases can incentivize speculative purchasing and problematic stockpiling that both the industry and the Federal government have sought to eliminate. In the past, speculative purchasing was a practice used by distributors to profit from fluctuations in medicine prices. Congress looked into that issue after drug shortages came to its attention and it found that grey-market companies were charging exorbitant prices for shortage drugs and that fake pharmacies were acquiring prescription drugs and selling them into the grey-market.

As a result, in 2012, Congress passed the Grey Market Drug Reform and Transparency Act: manufacturers and primary distributors - the wholesalers who purchase medicines directly from manufacturers – enter into agreements that manage the volume of medicines that a distributor can hold. These arrangements discourage stockpiling of inventory in amounts that exceed patient need. Advance price notification creates a new incentive for some distributors, especially those without contracts with manufacturers, to profit from purchasing medicines at an old price and selling them at a new price. Such a policy will not help patients afford their medicines.

Ms. Donaldson stated that PhRMA understands the need for transparency in healthcare and it agrees that it is crucial for patients to have the ability to know what they will pay for both medical services and medicines. That is why PhRMA is supportive of measures that take a wholistic, meaningful approach to transparency – not transparency for the sake of the word. Specifically, for PBMs, transparency could mean registration requirements so that there is some accountability. Also, to increase understanding and awareness of the different prices paid by supply-chain stakeholders and consumers, PBMs could disclose, in aggregate, the rebates they receive, the rebates that are passed along to health plans and employers, and the fees that they receive. PBMs should also be prohibited from restricting pharmacists from informing consumers of lower cost prescription drug options.

For insurers, according to Ms. Donaldson, states could consider adopting the NAIC's Prescription Drug Benefit Management Model Act, and at a minimum, require that insurers provide: formulary information that is easily accessible and regularly updated, including notice of formulary changes; concise, clear reporting on a per-drug basis on prior-authorization requirements, step therapy, exceptions processes, and cost-sharing; and the rights on denials and appeals. PhRMA believes that reporting requirement for pharmaceutical manufactures should be focused on medicines with a significant impact on the state. Identification of medicines should be done by a state agency with knowledge and expertise on the issue such as the Department of Health of Department of Insurance. Information contained in manufacturing reporting should be consistent with the 10-K filing that manufacturers already file with the SEC which already requires thorough financial disclosures. State reporting requirements should also preempt any county and municipal requirements

Ms. Donaldson stated that PhRMA has been working to improve cost-sharing fairness and affordability for patients. One option is to require that health insurers disclose to

current and prospective enrollees and plan sponsors that the enrollees' cost-sharing amount for prescription medicine could exceed the amount paid by the insurer[1]. One large, major insurer already does this. Another option is to require that health insurers certify in their annual filing documents that a majority of the rebates they received are passed through to consumers at the point of sale. Another option is to require that one of several specific rebate pass-through amounts is passed through to consumers at the point of sale.

Rep. Tom Oliverson (TX) stated that in every industry there are both good and bad actors, and asked Ms. Donaldson what are some of PhRMA's suggestions to reign in some of the bad actors. Ms. Donaldson stated that PhRMA has changed some of its membership rules and that it is important to remember that when talking about a research-based industry, you don't want to stifle innovation by overreaching on some in ways that could negatively affect others. Ms. Donaldson stated that it takes approximately $2.6 billion to take a drug to market and for every success, there are many failures, but those successes can be life changing and life saving. PhRMA is committed to making sure patients can afford their medicines and offered to discuss some state-specific options with Rep. Oliverson.

Rep. George Keiser (ND) stated that North Dakota was one of the first states to pass PBM "gag clause" legislation, and it has also passed specialty drug legislation – both are currently being litigated.

Rep. Deborah Ferguson (AR) stated that everyone involved in the issue of drug pricing affordability deserves some blame, not just PBMs. Some drugs, such as the EpiPen, have nothing to do with research and development (R&D) costs – they have been around for so long. PhRMA spends more money on advertising than on R&D. Ms. Donaldson stated that she believed Rep. Ferguson's R&D vs. advertising costs can be disputed and offered to discuss that issue with her later. Ms. Donaldson also stated that her earlier remarks regarding a "wholistic" approach to drug pricing transparency was meant to include PhRMA. One approach that PhRMA is looking into is value-based contracting which would help to re-align incentives across the supply-chain to lower medicine costs for patients.

Mr. Silverman closed by stating that PhRMA has filed suit in California alleging CA SB 17 is unconstitutional on several grounds; and the generic drug trade group has also filed suit over the Maryland law. Ms. Silverman also noted that Ms. Donaldson's statistic of $2.6 billion for taking a drug to market has been disputed. The drug pricing transparency laws discussed today have value, but more work needs to be done to help lowers costs for consumers.

Asm. Cahill closed by asking any interested parties to submit comments on CA SB 17, VT S.216, and other drug pricing transparency laws to NCOIL staff since the Committee will continue to look at this issue going forward.

DISCUSSION ON THE REGULATION OF PHARMACY BENEFIT MANAGERS (PBMs)

[1] While the witness used the word "insurer" here, it is likely that "PBM" would better reflect this scenario for instances where the PBM pays the drug manufacturer a price for a drug and collects an amount greater than that price from its member. It is not usual for a health insurer to buy & sell medications, while it is for PBMs. .

Sen. Jason Rapert (AR), NCOIL President, began by referring to an article written by David Smith, an owner of a community pharmacy in Arkansas, about PBMs titled: "The Monster in the Closet." PBMs act as intermediaries on every drug prescription transaction. They were originally intended only to process claims from the pharmacy to the insurance company for payment but over the past 20 years they have grown into something entirely different. They still connect pharmacies with insurance companies, but they now have control over which medications consumers have, how many doses consumers can take each day, how many times consumers can get them filled during the course of a year, and how much consumers have to pay as a co-pay when getting them filled.

Sen. Rapert stated that there is a tremendous amount of information about PBMs that we simply do not know and that while every other industry involved in prescription drug transactions is subject to regulation, there is no "referee" for PBMs. Pharmacy owners are required to sign contracts with PBMs in order to process prescriptions through the PBM for payment which is where, as Dr. Smith states, the monster peeks out of the closet. The contracts are non-negotiable in which the pharmacy literally has no bargaining power, and pharmacies are not allowed to band together locally in a geographic area to try to negotiate a better deal – that would be considered price fixing and they would go to jail.

Sen. Rapert stated that he has heard stories in Arkansas of where Tamiflu costs the pharmacy $80 to purchase but it gets reimbursed $34 from the PBM and the PBM gets paid $100 for that transaction. As the practice of PBMs have begun to be seriously analyzed in Arkansas, pharmacists have been receiving faxes from PBMs stating that they are not permitted to discuss their contracts with any government official without prior approval from the PBM. The Arkansas Attorney General is also now investigating certain PBMs for anti-trust violations.

Sen. Rapert stated that he believes what is needed is not something that is favorable to pharmacists or PBMs, but rather favorable to the consumers and taxpayers. A referee is needed. In Arkansas, a bill was recently introduced that would require PBMs to be licensed by the Insurance Department and would give said Department the authority to enforce the State's maximum allowable cost (MAC) law which currently is enforced by the Attorney General through deceptive trade practices. Sen. Rapert stated that the Arkansas bill provides necessary but reasonable regulation over PBMs to review pharmacy reimbursement programs for the purpose of ensuring there are an adequate number of pharmacies and pharmacy networks for consumers who are insured.

The AR bill provides reasonable licensing and financial solvency standards on PBMs and it officially brings into one state agency, the Insurance Department, the pharmacy pricing laws that are currently in place. The bill does not govern ERISA or self-funded health plans. The bill also provides for the protection of PBMs' proprietary information. Sen. Rapert closed by stating that this issue is what NCOIL was built for: to hear from all interested parties on a certain issue; debate the issue; and come up with reasonable policy that can be considered across the country and tailored to states' specific needs. Also, Sen. Rapert noted that a special legislation session on PBMs has been scheduled in Arkansas for later in the month.

Lauren Rowley, Vice President of State Affairs at the Pharmaceutical Care Management Association (PCMA) stated that PBMs exist to hold down the costs of prescription drugs

and they are hired by highly sophisticated purchases of healthcare, including the federal government with Medicare Part D, and unions, not individual businesses. Typically, those entities will submit an RFP and the bidding process is highly competitive. PBMs hold down the costs of prescription drugs by making everyone in the prescription drug delivery system accountable. To the extent there are different drugs in a therapeutic class, PBMs negotiate rebates because rebates hold down the cost of prescription drugs. There is no correlation between rebates and list price – there are studies that show that. Ms. Rowley noted that independent pharmacies do ban together under what's called a Pharmacy Services Administrative Organization (PASO) and it negotiates with PBMs on behalf of the individual pharmacies in addition to providing the drugs to the pharmacies. The only time an independent pharmacy will directly contract with a PBM is in rural settings due to network adequacy standards.

Ms. Rowley stated that for employers, PBMs develop tiered formularies and the goal is to arrive at lowest-cost drug – generics are preferred. PBMs also implement utilization management techniques that make sure a person is not going to the directly advertised drug but to a lower-cost alternative instead. PBMs also implement drug adherence programs. With regard to "gag clauses," Ms. Rowley stated that it is the policy of PCMA and its companies that pharmacists should be able to talk to consumers about lower-cost drug alternatives. Ms. Rowley closed by saying that nobody is forced to hire a PBM – they are hired because of the important services they provide in holding down prescription drug costs.

Asm. Cahill asked Ms. Rowley what PCMA's position is on proposed laws such as Arkansas' that requires licensing of PBMs. Ms. Rowley stated that 26 states currently require PBMs to register as a TPA. It is important to note that PBMs are not insurers – they do not collect premiums and they are not at risk. Rather, PBMs are administrators of a drug benefit which is designed by the plan sponsor. Accordingly, treating PBMs like insurers does not make sense. PBMs allow their clients to review rebates, but open disclosure of rebates is not a good thing, and the FTC has written many opinions saying such and would lead to tacit collusion among pharmaceutical manufacturers.

Leanne Gassaway, Senior Vice President of State Affairs at America's Health Insurance Plans (AHIP), stated that many health insurers use PBMs to administer their pharmacy benefits for two main reasons: a.) to strive towards evidence-based care; and b.) to lower healthcare costs. Ms. Gassaway stated that when entities use PBMs, they demand certain information. With regard to point-of-sale rebates, if Medicare was to change the way it operates its Part D program, it would cost the Federal government $42 billion over 10 years, to allow the point-of-sale rebate to go down to the counter instead of going back to the Federal government and back to the taxpayers.

Ms. Gassaway continued that on the health plan side, the rebate is shared with the consumer. AHIP's most recent study shows that over 22 cents of every premium dollar goes towards prescription drugs and that number is rising. She stated that the problem starts with the price of the drug, and everything that PBMs and health plans do are in an effort to lower that price. Accordingly, it is important to be cognizant that any reforms being discussed do not have unintended consequences that would raise premiums and harm consumers. Ms. Gassaway stated that it is important to not be distracted from the real issue that s hurting most consumers – the list price of drugs.

Scott Brunner, Senior Vice President of Communications & State Government Affairs at the National Community Pharmacists Association (NCPA), stated that there are 22,000 independent community pharmacies nationwide, mostly based on main streets in small towns who provide civic leadership. 80% are located in areas with populations less than 50,000 and they serve as essential healthcare providers in underserved areas. 91% of prescriptions are covered by insurance, and in those instances, the patient's price is set by the PBM, not the pharmacy. For cash transactions, the pharmacy sets the price. Mr. Brunner stated that what community pharmacies charge patients and are reimbursed is often determined by a competitor because PBMs own or are affiliated with competing retail and/or mail-order and/or specialty pharmacies and PBMs often require or incentivize patients to use the PBM-owned pharmacy. Everyone involved in the prescription drug supply chain is highly regulated except for PBMs. Usually, PBMs have no fiduciary duty to anyone but their shareholders, unless health plans and plan sponsors write it into their contracts. Also, in most states the state Medicaid agency does not write into the contract a fiduciary responsibility.

The lack of oversight and regulation on PBMs means that PBMs steer patients to PBM-owned retail, mail order, or specialty pharmacies (with whom the patient has no relationship or which may not be geographically convenient). There are also network access hurdles, particularly in preferred networks, that limit patient access to pharmacies. Mr. Brunner stated that the lack of oversight and regulation of PBMs results in take-it-or-leave-it contacts between PBMs and pharmacies – contracts that would not be permissible in any other industry. There is also a lack of transparency in reimbursement pricing, and underwater reimbursements without recourse, in addition to retaliatory audits and network exclusion for any reason they want. Prior authorization requests are also problematic, and there is not a process for appeals or a remedy for unfair practices. Oftentimes PBMs impose retroactive fees, particularly in the Part D space, that lead to a culture of unpredictability.

Mr. Brunner stated that PBMs make money through: administrative fees paid by plan sponsors and pharmacies; rebates (discounts the manufacturers gives to PBMs for formulary placement); and spread-pricing (profit-taking that results from the difference between what the PBM reimburses the pharmacy for a medication and what it bills the health plan for that medication cost). The main point is that PBMs make money from almost every player in the prescription supply chain, including the patient, yet they never touch a medication. They have tremendous market power – the three largest PBMs cover 89% the market. Insurance Commissioners are the logical referee best suited to oversee PBM practices.

Scott Pace, Executive Vice President & CEO of the Arkansas Pharmacists Association, stated that starting in January of this year, they saw that the largest insurer operating in the Arkansas exchange moved from a transparent relationship with its PBM, to a spread-pricing relationship, which means instead of the pharmacy being paid what the insurance plan was charged by the PBM, that became hidden behind a curtain of secrecy. As a result, reimbursements to pharmacies plummeted, charges to the plans stayed at a very high level, and patient access began to diminish because the spread in the middle became greater than the total payment to the pharmacies for buying the drug and providing the service. Mr. Pace said that pharmacists were able to see this data from patient's EOBs and it was discovered that during the first three weeks of this year, the spread was more than the total amount paid to the pharmacies. That was consistent with a December 2017 report to the Virginia General Assembly that showed an average

spread of $22.72 per prescription for a total spread of almost $14 million in just one quarter. And in Kentucky, it was found that last year, $1.68 billion was paid out for pharmacy benefits last year in the Medicaid program, but only $1 billion went to pharmacies.

Mr. Pace stated that the spread statistics matter because they affect the medical loss ratio (MLR) numbers that are being reported by plans to CMS to determine if premium increases are justified and if certain rebate amounts are due back to the consumers. Additionally, there are anticompetitive practices which PBMs operate under such as termination without cause and gag clause provisions in contracts. Additionally, data shows that major PBMs paid themselves $63.51 per prescription more than locally owned pharmacies. This is a case of the fox guarding the henhouse. Mr. Pace closed by stating that he disagreed with Ms. Gassaway's assertion that the list price should be the focus – it is the rebates that are driving the list price so the pharmaceutical industry can maintain their margins. Insurance commissioner oversight of PBMs would solve many of these problems.

On behalf of the NAIC, Russ Galbraith, Chief Deputy Commissioner at the Arkansas Department of Insurance, stated that the NAIC Health Carrier Prescription Drug Benefit Model Act was adopted in 2003 and sets out standards for the establishment, maintenance and management of prescription drug formularies and other PBM procedures. The Model also establishes a medical exceptions process to permit consumers to request a non-formulary prescription drug or to request an exception to a PBM procedure requirement. During the drafting process, the NAIC held a public hearing concerning the role of PBMs in the development and management of prescription drug formularies. At the hearing, testimony was given stating that PBMs were already regulated as TPA's or utilization review organizations depending on what activity they were performing. After reviewing the testimony, the NAIC decided to develop a Model that would provide standards for the development and maintenance of formularies and not develop a Model that would directly regulate PBMs. Consistent with other NAIC Models, the NAIC decided to regulate the health carrier who contracts with an entity, such as a PBM. During recent discussions concerning whether to revise the Model to include provisions that would regulate PBMs, the NAIC decided to leave it the state's discretion.

Rep. Botzow requested that this topic continue to be on the agenda and that he supports Sen. Rapert's goal of developing an NCOIL Model law to regulate PBMs.

Rep. Darlene Taylor (GA) stated that she is a TPA and has watched over the last 25 years the costs of prescription drugs continually to rise to currently about 25/30% of a healthcare plan. That is not sustainable, and, in some cases, she has seen clients drop their PBMs and their costs went down. The process surrounding rebates is deceptive, and they often are not returned until several months later, making auditing extremely difficult. Rep. Taylor stated that something needs to be done, and that the states will need to be the ones to be proactive.

Rep. Oliverson asked why there can't be more transparency on MAC. As a physician, he knows his contracted rates when he signs the contracts, and that he understands that formulary prices change but in the internet age, it is shocking that a pharmacist finds himself in a situation where they are not sure what they will be reimbursed until they process the claim. Further, Rep. Oliverson asked Ms. Gassaway if future business

models include independent pharmacists because it seems that there are strategies in place to run them out of business. As to Rep. Oliverson's first question, Ms. Rowley stated that "MAC" began in Medicaid and has been used by the industry for many years because there are sometimes thousands of generic drugs in the marketplace and each manufacturer sells them at a different price. PBMs, and Medicaid, find what the median price is for those drugs and sets a reimbursement rate. If the PSAO, as purchasers of the prescription drug, does a good job then the pharmacy will make extra money on a specific drug. However, if PSAO's don't purchase at a good price, the pharmacy won't make as much money, but you have to look at the basket of drugs and it evens out. Ms. Rowley stated that marketplace solutions work and that it is in the best interest of PBMs to keep as many pharmacies in its network as it can. In many states, including Arkansas, there are "any willing provider" laws which basically means if you agree to certain conditions you can participate in any PBM's pharmacy network. MAC works despite there being some outlier situations of the pharmacy being underwater.

Rep. Oliverson asked why we can't know what the MAC is at the point of service with certainty – why is there secrecy over what the price actually is. Ms. Rowley stated that it is not secret – the list price can change week to week. PBMs update their MAC lists according to what's happening the marketplace with those drugs.

As to Rep. Oliverson's second question, Ms. Gassaway stated that business practices are constantly evolving, and she sees community pharmacists embracing technology. She does not agree that community pharmacists are being pushed out of the market and stated that is best for everyone to stop competing and start working together. Community pharmacies have actually increased nationwide in the past 8 years, including in Arkansas.

Rep. Ferguson asked Mr. Brunner what his recommendations are for solving problems associated with mail order prescriptions. Mr. Brunner stated that no patient should be forced to use mail-order; there should be legislation in states to prevent PBMs from steering patients to pharmacies in which they have an ownership interest, at least without full disclosure. Community pharmacies should also be permitted to do 90-day fills. Frequently, when community pharmacies are chosen over mail-order, the patient can only get a 30-day fill. Rep. Ferguson asked if there are cost savings associated with mail-order. Mr. Brunner stated that it depends on what outcome you want as he believes regular interaction with a pharmacist goes a long way in getting the patient better.

Sen. Bob Hackett (OH) asked if there is a formula for determining rebates. Ms. Rowley stated that there is no formula. Some insurers want 100% pass-back to the consumer whereas some want to use some of it to lower their administrative fee. The client of course gets to see that information and can audit the PBM to make sure the rebates are being dealt with as agreed upon. There is good transparency between the contracted parties, but the FTC has opined that public disclosure will raise prices. Sen. Hackett stated that it is important to note that everybody's plans have gotten much weaker. Costs are trying to be controlled and one way is to reduce benefits – the consumer is being harmed. Ms. Gassaway agreed and stated that if you look at the average launch price of a drug today versus what it was 10 years ago, it is baffling.

Sen. Rapert thanked all of the panelists for coming and stated that by November, he hopes that a Model law will be ready for the Committee to consider.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:45 a.m.