

2013 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1363

2013 HOUSE STANDING COMMITTEE MINUTES

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

HB 1363
February 6, 2013
Job 18424
Job 18425, minute 35:20

Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Cost list for pharmaceuticals

Minutes:

Attachments 1-15

Commonly used acronyms within minutes and testimony:

- PBM = pharmacy benefits manager
- MAC = maximum allowable cost, maximum allowable cost pricing
- AWP = average wholesale price

Meeting called to order. Roll taken.

Hearing opened.

Support:

Mike Schwab, executive vice president of the North Dakota Pharmacists Association:
Distributed attachment 1.

1:40 I would like to explain what a pharmacy benefit managers or PBM is and what a PBM does. On one side, you have a health plan. On the other side, you have a prescription benefits plan or a prescription drug plan. When you go to the doctor for your health plan, your copays and out of pocket costs are set, and you know under your health plan. The prescription side of things is done the say way except that on the prescription side, it is typically run by PBM, a pharmacy benefits managing company. Your copays and out of pocket costs are set. Most insurance companies have an agreement and/or ownership in a PBM, such as Blue Cross Blue Shield's for-profit PBM, Prime Therapeutics.

2:45 Chairman Keiser: Any questions from committee members about how a PBM operates?

3:04 **Mike Schwab:** PBMs started as claims processors, processing claims for pharmacies. In today's market, PBMs dictate how much they are going to reimburse pharmacies. They dictate how much they are going to charge employer groups or plan

sponsors. They also help in the makeup or dictate the makeup of drug formularies. This includes which drugs will be covered under the prescription drug plan. PBMs receive large rebate dollars from drug manufacturers to include their drugs on the PBM formulary list. PBMs provide pharmacies with what are often take-it-or-leave-it contracts. Pharmacies have little negotiation power, especially when we're talking about the bill in front of us today. PBMs charge pharmacies for the processing of claims. PBMs conduct pharmacy audits. PBMs own their own mail-order pharmacies most often. PBMs also own a large portion of the fastest growing, most expensive specialty pharmacy market. PBMs hold and control a significant portion of our healthcare dollars. They are technically unregulated from a licensing perspective in terms of having licensure or a governing board.

4:29 I wanted to touch on some of the revenue. Medco and Express Scripts recently merged. To give you an idea of how large the companies are, CVS Caremark in 2011 annual revenues and income were \$108 billion, with a profit of just over \$3.5 billion. Medco, Express Scripts, and Caremark were the three largest PBMs in the country. In 2011, ESI, Express Scripts, and Medco merged under a \$49 billion merger, approved by the FTC. It was the first time in our history that we have over eighty members of congress weigh in to the FTC in opposition to that merger. Numerous state attorney generals and governors weighed in against the merger. According to the NCPA in terms of prescription control, a little over 1.3 or almost 1.5 prescriptions of every 3 that are processed are currently done by Express Scripts. Express Scripts also owns a little over fifty percent of the specialty pharmacy market, as well as about fifty percent of the mail-order market volume.

6:01 Refer to Mike Schwab's written testimony, attachment 1.

8:30 **Representative Kasper:** At the top of the second page of your testimony, you refer to a list that established the maximum allowable cost. Where is the list?

8:43 **Mike Schwab:** If you're referencing this bill in terms of where the list is in terms of a PBM perspective, at this point that is why we have the bill in front of you. They do not have to disclose the list, or they refuse to disclose it even though it could be disclosed in a contractual relationship between that specific pharmacy and the PBM.

9:11 **Representative Kasper:** So you're saying the PBMs have a list but the pharmacies do not have the list and so not know what is on the list.

Mike Schwab: Basically, yes. Supposedly they have a list, but we don't know how they come up with their reimbursement formula, or it is not disclosed.

9:47 **Chairman Keiser:** When you say maximum allowable cost for a generic drug, is that what you pay as a pharmacy, or is that what you charge?

Mike Schwab: That is the ceiling set by the PBM that they will reimburse the pharmacy.

Chairman Keiser: So if you sell the drug and you submit the claim to the PBM, that is what they are going to pay you.

Mike Schwab: In theory, that is what you would assume. That is not always the case.

Chairman Keiser: But in theory, that is what the maximum allowable cost is. So what if you pay more than what they allow you to charge?

Mike Schwab: My understanding is that if the pharmacy pays more than what they are reimbursed they have to eat that cost.

Chairman Keiser: Is that the issue?

Mike Schwab: Correct.

Representative Ruby: Then is there an amount passed on to the customer?

Mike Schwab: That would be a question for one of the pharmacists. My understanding is no, that it is just a relationship between the PBM and the pharmacy. If the MAC rate comes back below the pharmacist's costs, the pharmacist does not have a lot of recourse in terms of trying to get reimbursed for the acquisition costs to buy the drug and dispense it.

11:29 **Representative Kasper:** To clarify, it would be an after-the-fact situation. From what I understand, the pharmacist charges the customer a price based upon the MAC. The customer goes away, and two or three days or a week later the pharmacist finds out that the MAC reimbursement is less than their cost. You cannot go back to the customer and tell them they own you more.

Mike Schwab: That is correct. Typically, you find out at the point of adjudication. At that point, you are obligated to provide patient care.

Representative Ruby: From my standpoint, it seems that when we do buy prescriptions, insurance covers what it will and I get billed for the difference. If the insurance company or PBM covers part of the cost, but I cover the rest of it. So is that not happening in a lot of these cases?

Mike Schwab: If I understand your question, I would see that as being your out-of-pocket expense, based on your prescription drug design from your insurance company.

Representative Ruby: I do have a certain out-of-pocket expense.

Mike Schwab: That is typically the case with your prescription drug benefit design plan.

Representative Ruby: So where then is the loss to the pharmacy?

Mike Schwab: On a brand-named drug, there might not be a loss. On some MAC issues, there might not be a loss. The rationale for this bill is that in many instances lately, we're seeing too many cases where the MAC pricing is below where purchasing power lies.

Representative Ruby: So then why isn't that passed on to the customer like it is to me?

Mike Schwab: I will let a pharmacist answer that from the perspective of adjudicating that claim.

Chairman Keiser: Take a minute to differentiate prescriptions that are not generic versus generic. Is there a difference in MAC?

14:53 **Mike Schwab:** There are two main reimbursement formulas or language in a contract. AWP, the average wholesale price, is typically used for brands, and the pharmacist does have an ability to negotiate. The other price is when it comes to multiple source generic drugs. That is when MAC or maximum allowable cost is applied to the generic drug side of things. Often times with a MAC, it is a multisource generic drug. That is where they are determining the averages. Typically what you'll see in a contract is that basically the PBM will decide the MAC. They do not disclose where they're getting information from, how they are adding drugs to the list or not on that list. They are not very timely in updating those pricing lists because those prices change constantly. It might be two months before they update a pricing list, and that whole time the pharmacist has been getting reimbursed below their cost while dispensing those certain drugs.

16:16 **Representative Becker:** When you have a co-pay or out of pocket, doesn't the co-pay plus what the insurance company covers equal to the maximum allowable cost?

Mike Schwab: Again, you would think that in most cases that would be the case. But there are examples that even if you add in the patient co-pay, it is still below the acquisition cost.

Representative Becker: So if a maximum allowable cost is below acquisition cost, but the insurance company reimburses you plus the co-pay of the patient is still less than your cost?

Mike Schwab: Oftentimes that is the case.

Chairman Keiser: Is it not the case if I agree as a customer to go to a generic, that there is no co-pay? Whereas on a brand name prescription, there is a co-pay?

Mike Schwab: Maybe the pharmacists can give you a better understanding about how it works with a majority of their PBM contracts. My understanding is that with generics, there still is a co-pay.

17:38 **Representative Frantsvog:** If I own a pharmacy and I keep a supply of drugs on hand, on the day I buy those drugs I know that price. When you bring your prescription to my pharmacy, I know how much I paid for those drugs. I do not see where the problem is. If you know what the cost is, you know what you have to sell it for to make a profit.

Mike Schwab: The pharmacists definitely know what their costs are. The problem is they have a contractual obligation to the PBM, and through the contract language the PBM dictates what that reimbursement is going to be to the pharmacy. The pharmacy does not have the ability to designate the price for the day. They have to bill what is usual and customary or they are going to the MACed or have the AWP apply.

19:10 **Representative Kreun:** Isn't there a variable in the co-pay? There is no wiggle room in that situation at all?

Mike Schwab: I guess I am not quite sure what the question is asking.

Representative Kreun: Some have \$20 co-pays; some have \$25 co-pays. Doesn't that affect the profit that you have?

Mike Schwab: Yes, that would be correct.

Representative Kreun: So it is not the same in every case. It depends on your insurance policy. Isn't there an opportunity for you to ask for a price differential from the PBM?

20:03 **Mike Schwab:** Some of the PBMs do allow that. You will hear testimony today of how burdensome and cumbersome that process often times can be compared to other entities with which pharmacies work.

Representative Kreun: So there is variability. We have the ability to ask for a variation. We have some variation in the co-pay.

20:48 **Representative Kasper:** Let me get back to the pricing thing. I think I have an example that would illustrate the situation. A patient comes in with a prescription. The pharmacist and the PBM both know what the co-pay is because the PBM controls the insurance contract. In all of their contractual arrangements the PBM knows the co-pay, so there is no co-pay variable. So let's say it is a \$10 co-pay. Then the MAC reimbursement by the PBM is \$20. So the pharmacist can keep the \$10 co-pay and the \$20 MAC reimbursement. The revenue for the pharmacist is \$20. The problem exists, and this is what the bill addresses, that if the pharmacist's cost for the drug is \$40. That would result in a lost to the pharmacist, and he or she would have no way to recover it. Is that what the problem is?

Mike Schwab: That would be well stated, with the exception that some PBMs to allow an appeals process.

22:13 **Representative Kreun:** On some drugs you will make a profit, and on others you will lose money. Overall, is there profitability?

Mike Schwab: I would like a pharmacist to answer that.

22:40 **Mike Schwab** resumed written testimony (attachment 1) from page 2, starting with the section about the rationale for maximum allowable cost provisions. Used written testimony to walk through the bill by section.

25:25 **Representative Kasper:** Would updating the MAC list every seven days be an onerous task given the level of computerization?

Mike Schwab: They may disagree with that, but we feel it is quite fair. It provides consistency and predictability.

Representative Ruby: Going back to line 16, subsection A, are the market-based sources that they use proprietary?

Mike Schwab: The original intent behind MAC prices was that was why they have nationally recognized data sources in order to come up with price averages. In my testimony, I will touch on the issue of whether that is proprietary.

Representative Ruby: On the issue of seven days, is that often enough?

Mike Schwab: Seven days is what we're seeing in other model language and in the marketplace with a couple of entities that are currently able to do that.

Chairman Keiser: How does this help the situation? They are going to reimburse you only what their price is. If the combination of the reimbursement and the co-pay is less than your cost, this does not help.

Mike Schwab: Additional provisions in the bill help address that. With that first section regarding the updating of this list, our hope is that it would cut down the time that it takes them to update the pricing list and the time that a pharmacist would potentially be filling at a loss.

Chairman Keiser: So the pharmacist could say that they would not fill a certain script because they would lose money?

Mike Schwab: That would be a good question for a pharmacist. My understanding is that through the contract language, the pharmacist is obligated to provide that prescription regardless.

Chairman Keiser: So this does not help; it only gives more transparency to the process?

Mike Schwab: That is correct.

28:12 **Mike Schwab** resumed written testimony on page 3 beginning with the information about Section 1, number 2, letter B.

29:04 **Chairman Keiser:** Are you saying that in some cases the PBM looks at pricing in external sources, decides not to go with those prices, and then decides to set the MAC lower?

Mike Schwab: In a roundabout way, yes. When it comes to the pricing list, the pharmacies do not know where they are getting their information from. If we knew they were using national data sources, we would have the ability to gauge where those pricing averages would fall.

29:47 **Chairman Keiser:** Here you are implying that they may have access to the national databases but still come in at a lower rate than what is recommended in the databases.

Mike Schwab: Correct.

30:10 **Mike Schwab** resumed written testimony, page 3, to explain page 2 line 5 of the bill.

30:50 **Mike Schwab** elaborated on written testimony with an example of contract language regarding timing in the appeals process.

31:37 **Mike Schwab** resumed written testimony from page 3, beginning with the section about page 2 line 15 of bill.

33:45 **Chairman Keiser:** I see what you put down here but I do not understand it. There is a new drug and you cannot buy it yet, and they come out with a MAC rate. If you cannot buy it, you cannot sell it, so you cannot lose any money you cannot buy or sell. But you made the comment that they still have stock on the shelves and are being reimbursed. That has nothing to do with the new drug; that has everything to do with old drugs and the reimbursement rate?

Mike Schwab: That would be correct. That is a great question for a pharmacists.

34:30 **Representative Ruby:** With this subsection number 3, if an insurance company has an agreement with a PBM and they operate in several states, is this going to make us an island as far as some of the requirements? Would that not possibly raise the costs overall?

Mike Schwab: I will touch on the cost perspective and the assumption that premiums will increase and that overall healthcare will increase. There is no question that we would be setting a precedent in North Dakota by passing this bill.

Representative Kasper: To clarify, the insurance company has delegated their authority and responsibility to the PBM to find the drugs. The PBMs are national entities and have availability for the drugs throughout the United States. So the insurance company really is not involved in that decision; they've given it to the PBM. Correct?

Mike Schwab: In most cases, that would be correct.

36:02 **Mike Schwab** resumed written testimony from page 4, with Section 1--Number 4.

37:53 **Representative Becker:** Is there any way you can circumvent the PBMs?

Mike Schwab: At this point in time, I am going to guess that 92% to 94% of the business a pharmacy does is through contractual relationships with PBMs. Could a pharmacist potentially avoid doing business with a PBM? At this point in time, no because the market is not anywhere close to that being able to take place. Could employer groups cut the PBM out of the picture and work directly with a pharmacy in a competitive bid process? Definitely.

Representative Becker: If you want to work with a specific insurance company and they have a PBM, you have to go through their PBM, correct?

Mike Schwab: Yes, that is correct.

Representative Becker: And all major insurance companies have a PBM or have designated a PBM you must work through in order to work with that insurance company?

Mike Schwab: That is correct.

Representative Becker: Is this some sort of incarnation of government policy? How did we get to this point? This is not even the natural course of the market.

Mike Schwab: I do not know how we ended up getting to this point. PBMs originally started out as claims processors and have morphed into having their hands in numerous things. Gave examples. They have quite the middleman job.

40:42 **Representative Kasper:** When you are talking about the fact that if you want to do business with Blue Cross, you have to use Prime Therapeutics. Theoretically that is true. But if an employer were self-funded, whether they were with Blue Cross or any other company, the employer under a self-funded plan could choose to do business with any PBM by going to market. Is that your understanding?

Mike Schwab: That is correct.

41:27 **Mike Schwab:** Read proposed amendment, attachment 2. To provide reason behind the amendment, drew attention to the end of his testimony which shows the appeal process. Read through the appeals process and noted that the dispensing fee is included when determining if the total paid to the pharmacist is less than the acquisition cost.

42:28 I will let a pharmacist talk about how that impacts them. In certain instances, it takes away the ability to appeal a MAC decision. The other case is that the dispensing fee is a separate issue. The intent of the dispensing fee has nothing to do with MAC pricing. That is for the service the pharmacist is providing in dispensing the drug.

43:03 **Mike Schwab** resumed written testimony from page 4.

44:20 **Mike Schwab** drew attention to hypothetical situation provided on page 5 of written testimony. Walked through the hypothetical example.

47:20 **Mike Schwab** continued with written testimony from the bottom of page 5 through page 7.

50:00 **Representative Beadle:** You mentioned that a number of states have quit using a PBM and have switched to a true transparent. How many states have taken steps to eliminate the problem that we have going on in North Dakota with PBMs?

Mike Schwab: I know of three or four. I could produce you a list of which states have decided to negotiate a lot of their own pharmacy benefit contracts.

Chairman Keiser: Can we get that today?

Mike Schwab: Yes.

50:44 **Chairman Keiser:** If MAC pricing is done properly, does it save consumers money?

Mike Schwab: I would assume that yes, it does. I'd like to introduce John Olson to provide a few pieces of testimony which he will highlight and review.

Chairman Keiser:

John Olson, Pharmacy Services Corporation: Distributed two letters, attachments 3 and 4. PBMs which are national enterprises, so it is important that you have a perspective from a national point of view what this industry looks like and what the problems are. My limited role is just to present this to you.

52:35 **John Olson** introduced attachment 3, letter from Anthony Sartoris from Community Pharmacy Prescription Network. That is a collection of independent pharmacies which came together to participate in a competitive bid process for employers for providing these services. John Olson read the letter into the record.

54:46 **John Olson** introduced attachment 4, a letter from David Balto, an attorney with experience as an antitrust practitioner. John Olson read the letter into the record.

1:03:50 **Randy Habeck, pharmacist and owner of Hillsboro Drug:** Refer to written testimony, attachment 5.

1:07:35 **Representative Kasper:** Are you allowed by the PBM contracts you have to fill 90-day prescriptions for your customers, or they mostly being required to go through mail order?

Randy Habeck: Generally I do not have a 90-day contract. When we get contracting from a third party, there usually is 90-day contract with it. There is a 30-day contract and a 90-day contract. The reimbursement on a 90-day contract is much less. Oftentimes a pharmacist will choose not to sign it because we would be losing money by signing it. To be honest, I do not believe that PBMs are giving us a good faith contract. They do not want us to sign the contract because they want the patient to use the mail order company.

Representative Beadle: What percent of scripts are filled at a loss going through PBM reimbursements?

Randy Habeck: I fill about two hundred prescriptions a day, and about five to seven show up in red when I enter them into my system. So about 3%. That does not give the whole picture, though. When we get the MAC pricing issue, we get paid MAC--let's say ten cents per tablet--plus a dispensing fee. The dispensing fee is supposed to cover our operating

costs. Typically a dispensing fee is about \$2, even though that does not get near to covering my costs in dispensing. My cost is in the neighborhood of \$10. So they are paying \$2 dispensing fee to cover my costs and then they are trying to put a MAC on the drug that is exactly at my cost. So they basically want to pay me \$2. But there are 15 to 20 prescriptions per day for which I am paid less than \$2. Their MAC is below my cost and is then eating into my dispensing fee.

1:09:40 **Representative Beadle:** How many PBMs do you work with?

Randy Habeck: I'd say we have contracts with twenty or twenty-five different PBMs.

Representative Beadle: Do any of them provide weekly price lists and adjustments? Are there only one or two PBMs who are the problem, or is it across the board?

Randy Habeck: Some of the MACs are fine. Some companies are more abusive than others. North Dakota Medicaid does publish its MAC list, and their MACs are very fair. I think US Scripts with Workers' Comp of North Dakota is working on something and will have a published MAC. Currently, those are the only two I know of. I've never seen a MAC list.

Chairman Keiser: Those two MACs are not your MACs, right? The MAC for Workers' Comp is pricing for them, but you cannot access that pricing, correct?

Randy Habeck: That is somewhat correct. North Dakota Medicaid is setting the MAC for a Medicaid patient, and that is what they are going to reimburse me. I have no say in what that MAC is. For a patient not on Medicaid, the MAC would be set by the PBM. So there would potentially be thirty different MAC lists that we would have because each PBM would have a different MAC on their drug.

Chairman Keiser: So you lose money based on MAC on maybe two or three percent. On what percent of the rest of them do MACs retard your pricing to the point that when you factor in your operating costs, you would not make money?

Randy Habeck: I can research that and get you a better number. On generics, it varies greatly by PBM. I would estimate that it is 15% to 20% on which I am losing money.

1:12:05 **Representative Kreun:** On the opposite side, how much do you make on the ones on which you are making money?

Randy Habeck: The way the generic industry works is that when a generic drug comes out, there is initially one company which will make the medication. They will get six months during which they are the only company making that medication. After six months there will be multiple players, probably up to five. At that point, the price will drop. Gave example of price changes from brand to generic to multiple generics. The PBMs will respond to that the day it does down regarding the lower MAC. If the MAC price is increased, it will take them months to respond.

1:13:06 **Representative N. Johnson:** That might get to the issue mentioned earlier that you might have purchased a stock supply of that drug back when the price was high, but when the price drops due to the multiple generics, you still have your stock of expensive medication for which you will receive a low reimbursement. Is that the case?

Randy Habeck: That is part of the issue, but it's a small part of the issue. My problem is when there are ongoing problems of them reimbursing us below our costs. To me, if I am stuck with an extra bottle and I am lose \$100 on one bottle one time, that does not concern me. If I am going to lose \$10 for the next year every time I fill a prescription for patient, that creates a conflict of interest between me and the patient. I will still give them the prescription, but at what point does that have to stop? You cannot continue to dispense something at a loss and expect to keep your doors open.

1:14:02 **Representative Ruby:** You cannot charge more to the customer on that?

Randy Habeck: That is correct. My agreement with the third party has a negotiated rate, and wherever the co-pay comes out, I cannot make an adjustment to the co-pay. If I lost \$12 due to a MAC change, I cannot mark their co-pay up from \$5 to \$17. I do not think any pharmacist would do that. We develop relationships with our customers, and we would not feel right changing their co-pay up. I would never do it. However, what I might do is call the doctor and get the drug switched to something on which I could make money. The question was asked earlier if this would increase costs. I believe it will not. Currently, if we are getting paid fairly on generics, we have an incentive to switch our patients from brand to generics. If we're not getting paid fairly, we make more money dispensing brands. Why should we switch to a generic? Brand drugs are ten times as expensive as generics. They should incentivize the pharmacist to fill a generic, and overall healthcare costs would go down.

Chairman Keiser: Help us understand the appeals process.

1:15:36 **Randy Habeck:** To be honest with you, I have not made an appeal in three or four years because of the lack of results I get. The appeals process normally is that you phone the PBM, they may send you a form or ask you to e-mail an example to them, and then they have a committee that meets. You heard the language in there, how vague that is. Then they may or may not adjust the MAC. If you're the only store and you just happen to be purchasing too high, that's kind of on you. If it's a nationwide problem where everyone is getting underpaid, then that is a problem with the PBM and too low of a MAC.

Chairman Keiser: If you're purchasing too high compared to everyone else, that is just bad business.

Randy Habeck: Correct. But this is not just an issue in North Dakota. Thrifty White is a chain, and they're having the same issue as the independents.

Chairman Keiser: You had wanted to respond to some of the questions which had been asked earlier?

1:16:49 **Randy Habeck:** The only thing I'd like to address is whether seven days is fair to the PBMs. I believe it is. They can respond quickly, perhaps in a day, when the MAC price drops. When the MAC price goes up, they do not respond.

Representative Ruby: My question was the other way around. Shouldn't we be asking them to adjust it sooner than seven days?

Randy Habeck: I think seven days would be appropriate.

1:18:00 **Frank Kline, pharmacy contracting corporate manager for Thrifty White Pharmacies:** Refer to written testimony, attachment 6.

1:23:35 **Chairman Keiser:** Regarding the appeals process, the bill actually has in it language to provide a reasonable appeals procedure, and we do not define that. Is seven calendar days reasonable to require them to respond to an appeal?

Frank Kline: I think it is reasonable if we can get the retroactive ____ (audio unclear). So if they make an adjustment or not, we will know within seven days what we have to do as a drug store chain or as a pharmacy. We can look for a place where we can buy the drug cheaper, or if there is not, then we have to make a business decision. If they do the retroactive, then we are not having to deal with such a length of time between payment.

Chairman Keiser: There are times of the year when calendar days become very difficult. If we do leave in days, we will want to change to business days and give a reasonable number of days.

1:25:23 **Representative N. Johnson:** Can you give me an idea of the percentage of prescriptions that go through PBMs as opposed to cash?

Frank Kline: I think our numbers are 90 to 95% going through some sort of prescription benefit plan, and 5% of our business is cash.

1:26:00 **Steven Boehning, pharmacist in Fargo:** From a business owner, the point of this bill is my right to know what I will be paid. How can I make a business decision if I do not know what I am going to be paid? Why should that information be secret or proprietary from me as the person signing the contract? This is not an issue exclusive to North Dakota or pertaining to the ownership law. This impacts independent, retail, chain, hospital, long term care. This pricing and this bill affect across the spectrum. I am not trying to obtain massive increases to drive up the cost of healthcare. What I want to know is that on the claims for which I am not getting paid my acquisition cost, why? Am I paying too much? Is the PBM not reflecting the current market condition? The only way for me to now that is to know what MAC is. I do not know why I do not have a right to know that. In response to Representative Kreun's question, I am not arguing just because of all the claims for which I am getting paid negative. There may be claims for which I am paying too much to my wholesaler. But I need some sort of data or current market condition information to go back to my purchaser so I can negotiate. I cannot go to my wholesaler and ask them to adjust their costs if I do not have a source to prove to them why I am negative margin. Their only source is going to be the MAC rate. There are some drugs for which I am making money at

MAC rate, but there are some for which I am not. But why do I not have a right to know and to be able to audit back what those payment rights are.

1:29:21 Provided examples and prices regarding claims below his acquisition cost. In 2012, I had 464 prescriptions for generics dispensed below margin, totaling a little over \$11,000. These are claims below my acquisition cost. This does not include my cost of dispensing or my dispensing fees. Why don't I have the right to have a source to look at and an appeals process to go through. If the appeals process comes back with a finding that that is what the market rate is, then I can go back to my wholesaler with that argument and try to purchase cheaper. I do not have that recourse at this time. I cannot sell prescriptions for cash below my acquisition cost; that would be a violation of law. Why can the PBM force me sell a drug below acquisition cost? I don't understand why this information proprietary for the PBM when the contract is with me. A number of these claims are market condition issues. I have a drug that has increased 300% and they refuse to update their MAC list for 60 to 90 days. There is not a pharmacist here who has 60 to 90 days inventory sitting on hand.

1:31:12 This bill will force them to adjust the MAC list on a regular basis or give me a defined appeals process to go through to find out why I am getting paid what I am getting paid. It is about auditability, about my being able to track where my payment sources are coming from. If a contract is shoved in front of me with a mysterious number they are going to pay me, how do I know if that is a contract which will keep me above water?

1:31:50 Another issue is multiple MAC rates. I can file a prescription, the exact same prescription, five or six times and fill it to the same PBM five or six times, but I get paid four different rates. Some are above cost; some are below. This is because they are using multiple MAC rates. Don't I have a right to know why those prescriptions paid at different amounts when it is for the exact same drug, to the exact same PBM, under the exact same contract?

1:32:36 Shedding light on how we got here. Right now at my pharmacy, and I think across the country, generic dispensing rates are at about 83%. Five years ago, it was probably 70%. We are seeing a bigger move to generics. From 2013 to 2018, 290 billion in brand name sales will go off patent. In 2013, it is estimated 29 billion drugs go off patent. Those sales are rebate dollars in the PBM's hands. The PBM only negotiates rebates on brands. They are losing a lot of rebate money as drugs shift to generic. Ironically, in this same time frame as generic dispensing rates climb, our MAC issues climb. We are getting to this place that instead of rebate dollars being a driving source of revenue for the PBMs, the potential for spread pricing and MAC issues is replacing some of that lost rebate revenue.

1:33:51 On the appeals process, I have been filing appeals. Some are a faxed form. North Dakota Medicaid has a great system. I fax in a form, and within a certain amount of time I get a fax back to let me know whether I can re-adjudicate or if that is the market condition. US Scripts has the same thing for North Dakota Workman's Comp. If those two entities can do it, why can't the others? I just need an identifiable system in the contract that is easy to follow--a website or a faxed form--and I need a response back. I have sent in hundreds of MAC request forms; never hear back. I've called the PBMs, their helpdesk

center. Their helpdesk lady will confirm that the claim has been sent to the committee for further review and that I will hear back. When I call back two weeks later, she says it is still in committee. Never hear back. I need an identifiable process, and I need a response back. Even if the response is that the amount is market condition, I need a way to know that.

1:35:17 Representative Ruby: It sounds like the contract has at least two major parts for your reimbursement: the MAC price for the drugs, and your dispensing fee. The way I heard testimony, the dispensing fee could be \$1.50 to \$2 when the cost could be \$8 to \$10. So if you're losing money on the cost of the prescription and on your cost to fill, how do you stay in business?

Steven Boehning: Right now, my average dispensing cost is around \$9 to \$10 to get the drug out the door. I'm not saying that there are not some medications for which we are being reimbursed above that. No one in this room is going to deny that there are prescriptions that are profitable. We're talking about mainly generics which cost 25% of what the brand name drug cost. We are talking about drugs which should be inexpensive for the patient and for the pharmacy to dispense. We have a contract in front of us that says we should be paid MAC or a market-source condition plus a dispensing fee, but we have no idea what that market-source condition is. We have no way of seeing what it is, knowing how often they have updated it, and no way to audit why that changed. If I fill that same prescription for five different people to the same PBM for which I have the same contract, why?

1:37:16 Representative Becker: When you're dealing with the PBMs, is your contract with the PBM or with the insurance company?

Steven Boehning: My contract is with the PBM when I file a claim, not with the insurance company.

Representative Becker: So you know the conditions, which may not be great. Why do you choose to then not enter into this contract?

Steven Boehning: I don't necessarily know the conditions because I don't have the MAC rate.

Representative Becker: The very fact that you don't know what the conditions are are poor conditions. So why do you choose to enter into that contract?

Steven Boehning: That is really the only way I am going to be able to compete in the marketplace. About 93.5% of my prescriptions go through a PBM right now.

Representative Becker: I am not asking you to identify them, but is there a PBM that is more egregious than the others?

Steven Boehning: Yes.

Representative Becker: You are a well-organized group. Why don't you decide together not to work with that PBM?

Steven Boehning: I have to contract with that PBM on my own, so I cannot talk to any association or other interest on that contract. I have to negotiate on good faith effort on my own. I have sent hundreds of counteroffers stating that this is not an equitable contract and asking to negotiate. I never get a response back. From my standpoint, what I am looking for is a disclosure as to the reasoning behind the MAC decision.

1:39:31 **Representative Kasper:** Is there an antitrust problem you have that prohibits you from talking to other pharmacists about the contracts they enter into with PBMs and that is the reason you cannot talk to other pharmacists?

Steven Boehning: That is correct.

Representative Kasper: In a contract negotiation, you're supposed to have two sides and an open discussion. From what I understand about the PBM contracts, they are sort of a take-it-or-leave-it approach, and because you have to be reimbursed through the PBM system, you have to take it and have no choice. Correct?

Steven Boehning: Yes, that is correct. One of the big issues today is that the big PBMs own their own pharmacies. They don't want to negotiate with me, and they don't give me that option.

Representative Kasper: With the limited negotiation power you have, are you able to get into the contracts the opportunity to fill 90-day scripts at retail, or is it almost all going to mail order?

Steven Boehning: I do have some 90-day contracts, but they are limited and small. The general answer is that I have a hard time getting into those contracts. That is multifold. The reimbursement rate is so low, and they won't give me the option.

1:41:55 **Dan Churchill, pharmacist in Bismarck and an independent community pharmacy owner:** Refer to written testimony, attachment 7.

1:44:24 **Chairman Keiser:** Looking at the bill, page 2, on lines 17-19, it talks about a rating in the "Orange Book." Can you explain what that is?

Dan Churchill: The FDA produces the Orange Book which lists therapeutically-equivalent drugs, saying that this generic drug is equivalent to that brand name drug, and it is also produced by five other companies. . Basically, the MAC lists are supposed to have multi-source, "A" rated generic drugs. That would mean that the drug is available from many different companies . That way the market is competitive for a low-cost drug. Often times, a lot of the generic companies are dropping out of making certain drugs on which they are not making any money. What used to be a cheap drug is now made by only one or two companies, and the price goes really high, and the drug becomes scarce. Part of the problem with the MAC list is that they are not increasing the MAC when that happens.

Chairman Keiser: You heard in Mike Schwab's testimony that there might be pushback on the subsection immediately above that which says that the drug has at least three nationally available, therapeutically equivalent, multiple source generic drugs. In the Orange Book, how many drugs have at least three therapeutically equivalent drugs?

Dan Churchill: I don't know an exact number. Most generic drugs have at least three manufacturers available.

1:46:12 **Representative Kreun:** I am assuming that pharmacies are competitive with each other. Are the PBMs competitive with each other?

Dan Churchill: Yes, PBMs are competitive with each other. Unfortunately, within the PBM market there has been consolidation to the point where there are so few PBMs left. It is almost becoming monopolistic. In North Dakota, the primary PBM we deal with is Prime Therapeutics. The others, Medco and Caremark, are growing in the North Dakota marketplace, but it has become very limited. We are offered contracts that are non-negotiable, so it is take-it-or-leave-it.

1:47:11 **Representative Kreun:** So if you continue to sign contracts, you can only utilize one contract with one insurance company, though. Is that correct all the way through or just with Blue Cross Blue Shield?

Dan Churchill: That is correct. Every PBM has its own contracts and their own MAC list. If a patient comes in that has Blue Cross Blue Shield of North Dakota, their PBM is Prime Therapeutics, so we will bill that prescription to Prime Therapeutics and Prime will determine the reimbursement.

Representative Kreun: Isn't there a competitive nature within PBMs to have you sign a contract?

Dan Churchill: Yes, that is a competitive process. The PBMs are selling their products to the insurance plans and the employers who purchase insurance. They are essentially purchasing product from us and selling to the insurance plans.

Representative Kreun: If there is competition and another PBM came in, couldn't they underbid Prime for the same health insurance?

Dan Churchill: Yes, another PBM could come in and potentially try to undercut Prime or Caremark with whatever insurance they're contracting with.

1:49:02 **Representative Kasper:** There really is no competition between PBMs with you because the PBMs are part of the insurance company contract, so you're getting a contract from a PBM that has customers through an insurance company's plan. They don't compete when your customers have Blue Cross as an insurance plan. You have to use Prime because that is part of the insurance plan you're reimbursing.

1:49:55 **Dan Churchill:** That is accurate.

1:20:01 Representative Frantsvog: In your testimony you say that every day, you fill prescriptions at MAC and under the wholesale cost. When do find that out?

Dan Churchill: We adjudicate in real time in our pharmacy software system, so when we submit that prescription to the PBM, we know immediately whether that will be at a loss.

Representative Frantsvog: So they reconsider each of these for you, or you do it yourself?

Dan Churchill: As soon as we send that prescription through in the computer, we receive that information back. When we receive payment, which may be two to four weeks down the road, we can then reconcile that payment with what we learned on the day we filled the prescription.

1:51:53 **Joel Kurzman, regional director, State Government Affairs at the National Association of Chain Drug Stores, speaking on behalf of NACDS member Thrifty White Stores:** Refer to written testimony, attachment 8. Distributed attachment 9.

1:55:27 **Representative Beadle:** You mentioned that you are here on behalf of a number of Thrift White stores. How many other businesses or chains are a part of NACDS that you are not here on behalf of?

Joel Kurzman: In North Dakota, there is a unique landscape for chain pharmacies. There are one large number and several, about three, associate members who would not be represented by this testimony. Explained attachment 9, an issued brief from the national organization. I would add that it is unique to North Dakota that it would be in representation of a single member. I have regional responsibilities, and I have eight other states. But again, representing one pharmacy is due to the unique circumstances in North Dakota.

Representative Beadle: What is being done in the other eight states to address PBMs, or is it as big a problem there?

Joel Kurzman: There has been a lot of activity on PBM issues. It has to this point been specific to audit practices. North Dakota was early in addressing those concerns. I worked in conjunction with members on a bill in Minnesota. There are bills in a number of my other states, including South Dakota where the bill was passed out of committee last week. There is a bill being heard this morning in Nebraska. The audit issue has been increasingly common. I would put a number of twelve to fifteen bills on audits nationwide at this time. As to other aspects to PBM concerns expressed by large segments of NACDS members, the MAC pricing issue as Mike Schwab alluded to. There are handful of states that are engaged in that this session. In my region, I anticipate efforts in Michigan. There is groundswell in sentiment in Minnesota, but it is not clear whether that will come to fruition this legislative session.

1:58:08 **Representative Ruby:** You mentioned you're representing chain stores. Is it only the chain stores that do not also own a PBM because CVS is probably on the other side.

Joel Kurzman: That is correct. We wanted to be very specific as to who we are representing in this testimony. In other states, a very large proportion of our members would be supportive of our position on this issue. But again, in North Dakota is very unique.

1:58:44 **Representative Kasper:** Does this bill benefit the majority of your members across the states?

Joel Kurzman: We have a large membership, more diverse than what people would think. With that, we have not just the really large chains but also regional chains and grocery stores. It would be hard to put a percentage on it, but I would be happy to do so as follow up for the committee. I do believe a very large portion of our membership would benefit from this legislation were it in other states' situations.

2:00:04 **Bob Treitline, pharmacy owner in Dickinson and Williston:** Distributed attachment 10. I am in a unique position in that I am a member of an independent buying group. Our wholesaler has an arm that does a lot of the negotiating for us, both contractual negotiations and for resolving these issues for us regarding the MAC list. We have the same problem that all the other people have identified, except that I have a front person to do this for us. They just sent out a memo, dated February 1, which shows the overall effect on our industry in the US. This group is called Access Health, and they have over four thousand members.

2:01:04 Read section of memo, attachment 10, about increased reimbursement due to revisions. So you can see the revenue that we're talking about at the retail end our spectrum that we have no control over. It does not matter if you're associated with a group of four thousand or if you are an independent in a small town. Those people are at a disadvantage because they are not associated with a group like this to help them negotiate this stuff. Without them, we'd have no resolve whatsoever.

2:02:11 When we talk about MAC lists, there are several MAC lists for each PBM. Here is an example. I went through of claims that were processed for a specific antibiotic. In this particular PBM, this is the same quantity, the same drug, same NDC, the same PBM, the same everything. I was paid \$7.91, \$15.26, \$7.00, \$4.55, \$7.91, \$15.00, and \$7.11. There is not any consistence. We did not have any negative numbers on this particular item, but we could have. Why don't I know what I am going to get paid from a PBM and from a plan? We are running our business with a hood over us. We in North Dakota are leaders in our transparency bill, in our PBM audit bill, and we need to lead on this one, too.

2:04:07 **Representative Beadle:** You mentioned this organization you're part of which helps you negotiate. What did it take for you to be involved with that, and what would prevent other pharmacies from being part of that?

2:04:29 **Bob Treitline:** I buy from a particular wholesaler, McKesson Drug, and AccessHealth is an arm of McKesson Drug and that's a service. We pay a fee for that service. From my business plan and my approach to the business, it has value for that, so I have subscribed to that service. In North Dakota, I think we have under thirty independent pharmacies that use our particular wholesaler. But it has been very successful for us. We

still have the same issues, such as the negative numbers at the time of adjudication. At this point, they pick them up at the switch company, so we just watch and they do all the negotiating for us and the attempt to recover.

2:05:33 Representative N. Johnson: The comment was made that a pharmacy does not have to sign the contract. Let's say that for example that 80% of North Dakota are covered by Blue Cross Blue Shield. I don't know the exact numbers, but I think it's in that range. So in that example, 80% of the customers coming into your pharmacy would be with Prime Therapeutics. So if you said that you were not going to accept the contract that that PBM offers you, in essence you're saying to 80% of your customers that you cannot do their pharmaceuticals?

Bob Treitline: That is true to a certain point. We can opt not to take the contract, and if those patients determine that we are providing a service that they're willing to pay extra for at a cash basis and then manually bill Blue Cross, they have that option. Usually the reimbursement costs the patient more at that point because we would be a non-network pharmacy. So we actually have that example in our town with Irsfeld Pharmacy. The take-it-or-leave-it approach did have an impact on Mr. Irsfeld when he made the decision. We were confronted with that same decision. We are in the healthcare business, and I take care of people. There will be a point if you're reimbursed too little that you cannot take care of people, but we've been able to manage that at this point. But it is really real. If the reimbursements continue to go down, if the MAC issues continue to be unresolved, I think access in North Dakota will be affected. We're going to see less opportunities in our small towns

2:08:11 Representative M. Nelson: With your buying club, you said that your buying association was actually a part one of the distributors? Do they buy from all the wholesalers or just through the one? How does that work?

Bob Treitline: We buy about 98% of our product through one wholesaler, and that is an arm of that wholesaler, and we pay an additional fee for that service. The fee is for them to do the negotiations for me. The fee is to be a member of that arm of the wholesaler, called AccessHealth.

Representative M. Nelson: The arm of the wholesaler is negotiating with the wholesaler for you?

Bob Treitline: No, they are negotiating with the PBM.

2:09:51 Harvey Hanel, pharmacy director at WSI: Refer to written testimony, attachment 11. Contains proposed amendment for page 2, line 15.

2:11:31 Representative Becker: Your proposed amendment asks to go from three to two multiple source generic drugs. Is that because there are many circumstances in which there are not three available?

Harvey Hanel: That is correct. Three used to be the standard used. Several years back, there was some market manipulation by one of the generic manufacturers. Because of

that, the industry shifted from using three to two. Now for the majority of drugs included on the MAC list, they use at least two equivalents available for that generic.

2:12:35 Representative Becker: So if there are six nationally available equivalent options, which two do you choose?

Harvey Hanel: I am not privy to what the PBM does. My guess would be that they would choose the two with the lowest prices, with the expectation that pharmacies should have access to one of those two generics through their wholesaler.

2:13:15 Representative Kasper: I'd like to clarify on your statement that the response you received from your PBM was generally favorable. Which means that you PBM at least has no problem with the transparency requirements and the other issues of the bill, other than the three going to two? Everything else is fine with them? Are you able to get MAC prices from them so you're already receiving this type of information?

Harvey Hanel: When they reviewed this particular legislation, they did not have any issues other than using two sources rather than three. What US Script indicated to me was that they are currently working on a web portal so that any contracted pharmacy would be able to access that web portal and access the MAC pricing. It is not in place at the present time, but they are actively engaged in making that available. As to the other aspects of the legislation, the timely appeals process, they indicated that they do not have an issue with that.

2:14:35 Representative M. Nelson: I'm curious about the relationship between WSI and the PBM. They need a margin to run. How are they getting paid? Are you paying a fee for service? Is it two different MAC lists and they're using the differential? Are you paying a percentage off the MAC list that they'd be using with the pharmacist?

2:14:57 Harvey Hanel: Our contract with US Script is that they will adjudicate our state-mandated fee schedule. How they make their money is that we pay a per-transaction fee to US Script so every time the pharmacy hits the button, it costs seventy-five cents. If they're reverse, it costs another seventy-five cents. That was a decision by WSI because we do have a state-mandated fee schedule; we need to ensure that our PBM reimburses according to the state fee schedule. They also do make a little bit of money if there are drugs on our formulary for which they can obtain rebate dollars. They pass some of those rebate dollars along to us. That is a very small percentage because we do not have a very restrictive formulary.

2:16:07 Representative M. Nelson: What you're telling me is that if I'm a pharmacist and I want to find out what price the MAC list has and I run through a transaction to see and then reverse it, you're going to get charged for that?

Harvey Hanel: Yes. I get charged twice.

2:16:45 Mark Hardy, assistant executive director of the North Dakota Board of Pharmacy: Refer to written testimony, attachment 12.

2:19:07 **Jerad Binstock, pharmacy student at NDSU:** Refer to written testimony, attachment 13.

2:22:41 **Jerad Binstock** shared his experience in Ft. Collins, CO, when Walgreens decided not to contract with Express Scripts. Other pharmacies in town marketed the fact that they did accept Express Scripts. It would take a stance by the whole industry not to accept a contract, which is why hopefully this legislation will make everything more transparent. Hopefully, the plan sponsors are putting more pressure on the PBMs, and the plan sponsors who are purchasing the PBMs have more say and can see better what is going on in the industry.

Opposition:

2:25:21 **Robert Harms, lobbyist for CVS CareMark, a retail pharmacy here in North Dakota and also a pharmacy benefits management company:** I will provide context and then focus on page 2, line 29. Nationally, healthcare spending is a huge issue. The spending on drugs is a major part of the healthcare spending by American consumers each year. How did this PBM industry occur? It came through the private market with their goal to lower the cost of the drug spend nationally. They contract with their clients, with insurance companies. The issue at hand is where that dollar goes. Should it go to the retail pharmacist? Or does it come out of the pocket of the North Dakota citizens. On page 2, line 29, the bill exempts the Medicaid program in North Dakota. We believe it does that because if the Medicaid program was included in the bill, we'd have a huge fiscal note, and we'd be hearing insightful comments from Dr. Joyce.

2:28:35 **Representative Kasper:** I believe there is another reason for the exemption of Medicaid, so I'd ask Chairman Keiser to ask Maggie to come down at some point so that we can ask her about the Medicaid exemption.

Chairman Keiser: We will make that request.

2:29:14 **Jonah Houts, vice president of government affairs for Express Scripts:** Distributed written testimony, attachment 14. Express Scripts is a large pharmacy benefit manager. We manage the drug benefits for about 30% of the American people. That is much smaller than half the market for specialty pharmacy. We have built our business model for plan sponsors, whether they are public payers or private payers or others. We only make money when the save money. That is how we built our entire model, both at mail and at retail. I think some of the characterizations that we do not want to work with other pharmacies are not true.

2:30:13 I am here to talk to you about Express Scripts being a pharmacy ourselves. We are a specialty pharmacy, and we are a mail-order pharmacy. In those capacities, we are subject to MAC pricing every day from multiple payers, not just Express Scripts. We are not asking for HB 1363 for some of the reasons I will mention.

2:30:35 Looking back to why we have MAC and why MAC exists. It was developed by state and Medicaid agencies who were overpaying for generic drugs. Unlike brand drugs where there is one manufacturer and one rate, you can clearly stipulate in a contract a

specific percentage discount off of average wholesale price. I have multiple manufacturers, so the percentage off of average wholesale price varies by manufacturers. That variation is not suitable for a contract. What metric would you put in? Of course generic drug prices change frequently and for a variety of reasons. Those things need to be considered that are not done in contracts but are done by forty-six state and Medicaid agencies, federal healthcare programs, the vast majority of the private sector as we manage healthcare benefits.

2:31:47 MAC pricing, by considering all things, keeps the incentives in the right place. The providers of the prescription drugs, the pharmacies are going to look for the best deal for their patients. Without a MAC, there would be no difference between going to a wholesaler that sells a product at 25% off average wholesale price when there is someone out there selling it for 70% off average wholesale price. We are generally in agreement that we spend enough on healthcare in the United States and that we should be looking for more opportunities to incentivize good decision making and good procurement.

2:32:27 Critics of MAC often do not acknowledge that MAC prices go up and go down. Within the last ten days, some of the large fluctuations in our MAC list were because of a significant market price decrease from the national databases, and that caused MAC to go down. On a blood pressure medication, the manufacturers increased their prices and MAC had to go up; it was due to market availability. There was a pain reliever where the MAC was increased because of an appeal by a pharmacy.

2:33:34 I want to leave the committee with three important takeaways. MAC pricing is really necessary in the generic drug market, and there is no other benchmark that can fill this role. We have not heard any alternative methods to do this. There is a potential interactive effect as the federal government attempts to define essential health benefits inside health reform where HHS has not issued a final rule but has thrown down the gauntlet to states on mandates for coverage. Prescription drugs are one of the essential health benefits. Until Health and Human Services issues a final rule, policy adoptions like this that would increase prescription drug costs in the state could then be turned around by HHS and billed back to the state. Mandates like this adopted after January 1, 2012, will not be subsidized or covered by HHS as a results of the Affordable Care Act. Lastly, I would urge the committee to resist temptation to cherry-pick examples of when a pharmacy had to sell something below their acquisition cost. It is sort of a universal of commerce that sometimes you win, and sometimes you do not. You have to look at the entire market basket of all of your transactions. I do not believe the pharmacy landscape in North Dakota is suffering. Last year we had seven new pharmacies apply to join our network, just here in North Dakota. When looking at the entire market basket, risks of harm to pharmacy owners would be evident empirically.

2:36:10 **Representative Becker:** Does your mail order pharmacy work with the MAC as well?

Jonah Houts: Yes. Our mail order pharmacy is subject to a MAC that is developed by a completely different team of people inside the company.

Representative Becker: So it's a different MAC than what the brick-and-mortar retail pharmacies have?

Jonah Houts: No, it is not. Where we see different MACs are at our specialty pharmacies where frequently the payer is not Express Scripts, so we'd be dealing with a different PBM. In those instances, we are charged different MACs because of variation by payers.

Representative Becker: This is something on which I want to be really clear. Can you repeat what you just said?

Jonah Houts: At our mail-order pharmacies, we are charged the same MAC as Express Scripts. At our specialty pharmacies where there are different PBMs adjudicating the transaction, there are multiple MACs to which we are subject.

Representative Becker: Your PBM charges the same MAC for every drug to all pharmacies as they do to your mail order and your specialty pharmacies? Not other PBMs, but your PBM.

Jonah Houts: Some of our largest clients want to build and manage their own MAC lists. An example is the United State Department of Defense. So when that is the case, the MAC list will be different, but different by a matter of cents and not wide swings or variations.

2:38:17 **Representative Becker:** So to do a 90-day fill order for a brick-and-mortar retail pharmacy, your PBM has the same MAC reimbursement for a 90-day in your mail order as a 90-day in all the other pharmacies?

Jonah Houts: If I understand the question correctly, you are asking if there is a solitary MAC that is applied to 90-day prescriptions at mail order and at retail.

Representative Becker: Is there a spread between your mail order and the other pharmacies? If I understand correctly, it was alluded to in the testimony in favor of the bill that you have the capability and in fact would likely be instituting a spread whereby the much lower reimbursement for 90-day makes it not a viable situation for the pharmacies, so therefore they have to turn down the 90-day prescriptions, which then directs the customer to have to go to the mail order, which then you can sort of compensate, have a spread, take that business, because you made it too onerous for the retail pharmacy to do 90-days.

2:39:44 **Jonah Houts:** That is certainly not the case. The comment made earlier, if I recall correctly, was about how 90-day retail would be MACed but not at mail. That is not true. Mail orders are also subject to a MAC. The reason there are such pricing discrepancies between a 90-day fill at a mail-order pharmacy and a 90-day fill at a retail pharmacy is that mail-order pharmacies that Express Scripts run are vastly more efficient in that we use pharmacists for cognitive services with patients and use robotics to dispense the prescriptions. As a result, our cost to fill is dramatically smaller than that of a retail pharmacy. Because of the volume we fill, we are also able to procure the product at the pharmacy at a much lower cost from wholesalers and drug manufacturers. As a result, the

economics of mail-order versus retail in 90-day are held equal because they are both subject to MAC. But there is a pricing delta, and it has to do with scale, not MAC.

2:40:58 Representative Ruby: If I head the previous testimony correctly, it is not so much that they didn't recognize or understand the fluctuation in the pricing. It was more that they did not know what the pricing was. Is it too much to ask to have that known ahead of time?

Jonah Houts: I do not think there is any issue with having that being known ahead of time, with one qualification. What I mean is to say is that if a pharmacy calls Express Scripts and asks for a MAC list, we will provide it to them at any time. My understanding is that that is an industry standard. It there is a bad actor in this space, there are means short of HB 1363 to get someone to provide a MAC list. What I don't want a MAC pricelist used for is to impact the decision of a pharmacist as to whether or not to fill a customer's prescription. It's a degree of discrimination we should not stand for in healthcare. I don't think it should be used between pharmacies with a different payer mix to compare so that they could collude on price in anti-competitive ways that would harm patients and payers. So those would be my qualifications as to how a MAC pricelist is shared with anyone in our network.

2:42:35 Representative Ruby: From what I heard, it was not necessarily that but that they could then negotiate with their supplier. I think that is perfectly legitimate. But we have heard over and over that they have not seen a MAC list and will not know their cost until they run it through their system and bill it. By then it is too late to negotiate with their supplier or the manufacturer.

Jonah Houts: I agree with you that for the purposes of negotiating with the buyer, it would be an excellent tool. I do not understand how a network provider or pharmacist would never have seen a MAC list or if there was a payer in the mix who was asked to provide one and failed to do so. I am not aware of and do not work for a company that would do that.

2:43:43 Representative Kasper: 2:43:44 If I understand you correctly, you're saying that any pharmacist in North Dakota upon a request for a MAC list from your company would get it?

Jonah Houts: So long as they are a contracted provider in our network, that is true.

Representative Kasper: To your recollection, have you ever up to this point in time provided a MAC list to any pharmacist in North Dakota upon their request?

Jonah Houts: I do not know specific to North Dakota, but I do know that it is something we do provide to our network.

Representative Kasper: Obviously we are talking about North Dakota, and all my questions pertain to North Dakota. I do not care actually what you do in other parts of the country. I'm concerned about what is happening in our state. So I would like to ask you, based on your statement that any pharmacist could have a MAC list based upon their request, that within the next thirty days, you would provide any pharmacist in our state a MAC list if they request one from you so that you will follow up on what you say you will do.

Jonah Houts: We will respond to the inquiry from any network provider at any time, ad infinitum, who is seeking a MAC list.

2:45:03 **Representative Kasper:** How do PBMs make money?

Jonah Houts: Our main revenue streams come from a couple different parts. It comes largely from our service to health plans, employers, managed care plans. They price their contracts with us in two different ways. In large, the industry norm is through an administrative fee on each claim to cover the fixed costs on doing business with us. As a result, we provide formulary and benefit consultation, the systematic programming through all the NCPDP systems, the claims reconciliation, network pharmacy audit. There are two main ways which they pay for these services: through an admin fee, or through a spread or delta on what we bill them and what we pay retail provider. Our other main revenue streams are operating our home delivery pharmacies, both mail order and the traditional maintenance medications, and operating specialty pharmacies.

Representative Kasper: On the administrative fees, who do you negotiate those fees with?

Jonah Houts: The simple answer would be our client, the ultimate payer whether it's an employer or a large insurer. There is a cottage industry of benefit-advising consultants who are working with these groups. I point that out because I don't want to answer you incorrectly. We are indeed negotiating with both of those entities.

2:46:39 **Representative Kasper:** I would assume that when you are negotiating your fee, you are going to look at your overhead costs and put a bit of profit in there, and your negotiation will end up with your costs and a little bit of profit to equal the fee. Is that fair assumption? You're not going to have a fee that would give you a loss.

Jonah Houts: There are myriad pricing variables that are looked at when you bid or don't bid a contract. I don't know that I could answer your question that the only inputs for us are the price plus a margin for us. In a business like ours where scale affords you better purchasing, I know for a fact there are clients of ours who actually produce no margin for us. We are a very small margin business with a gross margin less than 3%. Grocers do better than we do in terms of a landscape there. So, no, I don't believe it as simple as adding up the inputs, which can only be predictive, and adding a spread or profit and then coming up with a total price.

2:47:50 **Representative Kasper:** Are there any other sources of revenue which PBMs have?

Jonah Houts: So I have simplified where our revenue streams come from, but they come from the two lines of business: retail network pharmacy, and the mail-order pharmacies that we run. We own a number of different subsidiaries. Provided examples of activities.

Representative Kasper: I'm sort of focusing on the PBM side of things.

Jonah Houts: On the PBM side, revenue streams specific to PBMs are going to come from our managed care clients, the outputs being the pharmacies; manufacture rebates, but those are a revenue stream only about 10% of the time because 90% of the time they are shared directly with the client as a reduction in the net purchase price; mail order; and specialty.

2:49:03 **Representative Kasper:** Would you explain what a rebate is and how you as a company obtain a rebate or negotiate for a rebate?

Jonah Houts: Express Script does it differently than other people. We look at what we call competitive product categories, where you have multiple manufacturers of brand drugs that are comparable--not the same, not generic, not substitutable for one another. Gave example. So you have all these manufacturers who want preferred formulary placement. Not first tier because first tier is reserved for generic drugs, lowest cost. They are competing for a second tier formulary placement. As a result, they prepare blind bids to Express Scripts on their products at best unit price. Because we are not purchasing the drugs and sending them to pharmacies, and the brand manufacturers are not doing that either because they're working through wholesalers, the only way to administer that is through a net purchase price discount that is shared as a rebate. Whoever the lowest net cost provider or manufacture is, they would have preferred formulary placement. Less preferred in the third tier, then you have non-formulary products. That is how that is bid. It is all blind; it is all secret. No manufacturer knows how different they were than their competitors. It is the classic free market race to the bottom in terms of price concessions. Historically, PBMs have received a lot of attention about what they are doing with rebates and who they are sharing them with. I know for a fact that 90% of these rebates are given directly back to clients, and in the instances where they are not, it is because our clients have directed us to retain the rebates in exchange for another pricing concession in the contracts. Our clients are always aware of that revenue stream and where it is coming from.

2:51:35 **Representative Kasper:** Would you be able to provide documentation of that last statement that 90% of your rebates are provided to your clients?

Jonah Houts: I do not know the degree of information you would be looking for. I do know that it was part of testimony my CEO offered just last year. I will look for documentation that does not violate any sort of disclosure issue. I will certainly follow up with you on that.

Representative Kasper: Let's talk about spread pricing. Are you aware of any circumstance that your company does spread pricing ever?

Jonah Houts: Yes, my company does do spread pricing but only at the direction of the payer or client.

Representative Kasper: Could you give me an example of how that would benefit your client on a spread pricing, how the dollars would flow?

2:52:37 **Jonah Houts:** Our clients choose from two different models to manage their drug costs. Some may say they will give us a \$3 administrative fee per claim that affords all of

your services for formulary management. So in the case of a \$100 drug, they are paying a \$3 administrative fee; total cost to them \$103. On a spread example, that drug costs maybe \$100 to the pharmacy but we may actually be able to negotiate a discount with the pharmacy where the pharmacy is paid \$97 and then the net cost to the plan is \$100. If the net plan cost was \$103 but we could negotiate a discount with the pharmacy to pay them \$100, they are \$3 there being paid in that delta. The reason the clients who choose spread pricing choose spread pricing is that there will be an admin fee collected in either scenario, depending on which side of the equation you get it from. In the case of spread pricing, the incentive is always on the PBM to be seeking discounts from the network. In a flat admin fee formula, a PBM would really sort of be agnostic to what a pharmacy charges; the \$3 is fixed. But in a situation where you are negotiating down from a spread, you are always getting to that lower drug cost. Some of our clients choose that formula of alignment.

2:54:22 **Representative Kasper:** I don't understand spread pricing the way you just summarized it. Let me explain my understanding of it, and you can tell me where I am wrong. You pay the pharmacist \$90 for a prescription drug; that is your reimbursement rate to the pharmacist. You charge the plan owner, the employer, \$110 for that same drug. There is a spread of \$20. The PBM keeps the \$20. That's how I understand what a spread price is. So the employer is being charged for the drug at a higher rate than that which you are reimbursing the pharmacist, so you create a spread and it goes into your pocket.

Jonah Houts: I think the example you used, while factually correct and is a scenario that could be imagined, it represents a delta in pricing that would be...

Representative Kasper: What is a delta?

Jonah Houts: A \$20 markup on a \$90 drug, between what is paid to the pharmacy and what is billed to the plan, is exceptionally high.

Representative Kasper: So let's say \$10. Let's say \$90 and \$100. Where do we get to the point where you say it is reasonable and the spread is ours?

Jonah Houts: That situation is reasonable, and it certainly does occur. It is when our clients choose that that's how they want their prescription drug benefits billed.

2:55:50 **Representative Kasper:** I don't understand that last statement. Why would a client choose to pay you more money? In other words, if the insurance plan is responsible for the cost of the prescription drugs and they could have paid only \$100, why would they agree to pay \$110?

2:56:15 **Jonah Houts:** I will respond two ways. Our clients choose to do that because we are the most efficient way to build a pharmacy network, to build out benefits, and to maintain benefits. There will be fees paid for the bona fide services that are performed. They will be in either a spread pricing arrangement or an admin fee arrangement. In the last five years, in a vast majority of proposals to which we have responded, we've responded with two pricing formulas so that our clients could choose. It is a purchasing decision.

2:57:11 **Chairman Keiser:** On the bill itself, page 1, subsection 2A, the bill would provide to the pharmacy at the beginning of each calendar year, the market-based sources used to determine the MAC pricing. If there are adjustments, provide those within seven days. Going back to Representative Becker's line of questioning, Again there was testimony, and I can't recall, there were two national groups that could be referred to in order to obtain MAC pricing. However, you are not obligated to use those. Is there any conflict of interest, potentially, in your company in that, as you testified, that you have a mail order business and are extremely efficient? Prescriptions are filled robotically. You testified that the MAC pricing for your mail order is exactly the same as your MAC pricing for the pharmacists. So you can be very efficient in terms of cost, and you can also purchase from the manufacturers at an extremely low rate. Then you set the MAC pricing based on your costs, but the pharmacist can't possibly meet that. You can issue 90-day scripts; they're at 30. Do you see that as a potential problem? You make the argument that you're using the same MAC, but that's like saying we're giving Wal-Mart the same MAC as that little drug store. Would this require you to disclose that that is what you are doing?

2:59:31 **Jonah Houts:** Yes, this language would require us to disclose that if that is what we were doing. I stand before you today to say that that is not we are doing. We are not basing it on a pharmacy that is purchasing a very small fraction of the volume of product that we are moving. We are rather relying on these independent, market-based analytics that are not just national but also regional. That is why you will have multiple MACS, based on third-party sources that are looking at those things and not on our procurement history. Indeed those decisions are firewalled and managed by separate people.

Chairman Keiser: If this bill were to pass, is the seven days appropriate for you to provide that information?

Jonah Houts: I am hopeful that the committee would consider not passing this legislation...

Chairman Keiser: But if it does pass?

Jonah Houts: If it does pass, reporting a MAC list in seven days is the least of my organization's concerns. In fact, because there multiple pricing adjustments necessary on a daily basis, if we had to wait seven days before we could change that in the market place, we could be doing very harmful things to our network pharmacies or a pretty significant transfer of wealth.

Chairman Keiser: I appreciate that. But you heard testimony that when the prices go one direction, that MAC price information becomes available relatively quickly. When the price goes the other direction, that information does not come as quickly. Is that true or not?

Jonah Houts: I looked at MAC price adjustments just from the date of January 30 and had an equivalent number of drugs for which the price increased as decreased. I can tell you that based on my research, it is not true that there would be greater delay when MAC prices increase.

3:02:07 **Representative Gruchalla:** How many states have you had to defend your practice in, and do you anticipate that if this bill passes, many more?

Jonah Houts: This is the third state that has had a conversation like this. To date, none of them have enacted it largely because of the financial impact to the states. I do expect to see this in more states but not because we're talking about anything that resembles sound policy. This is part of a national campaign by the National Association of Chain Drugstores. To be fair, I belong to trade associations, too, and trade associations are in the business of demonstrating to their membership why they should have a trade association and continue to pay dues. This is the chain of independent drugstores getting together with an idea. From what I understand, they are going to run it in twenty or twenty-five states this year.

3:03:12 **Representative Becker:** To clarify a concept for the committee, I believe that when Mr. Houts refers to a delta, he is referring to the Greek letter which in mathematical nomenclature means a change in two variables. It was testified that this is really about whether the dollar goes into the pharmacist's pocket or the consumer's pocket. In what way does the bill in front of us redirect monies away from the consumer?

Jonah Houts: In many cases for generic drugs, we're at a very low cost. It would actually be lower than the patient's co-payment. So the patient will be responsible for 100% of the drug cost. Were HB 1363 become enacted, there would be a broad swath of the market of products where there was currently a MAC where there would no longer be a MAC, and usual and customary prices would prevail. For those patients who were paying 100% of the cost of the drug for the generic which was below their co-pay, it would immediately increase their drug costs. Longer term, the more money spent on prescription drugs ultimately goes back into premium for the insurers or drug cost for the payer, and they may make decisions about their benefits and whether they can afford them, and as a result co-payments go up, co-insurance is adopted, deductible increase. Those are ways it serves to increase the cost for the consumer.

3:05:38 **Representative Becker:** If PBMs were operating solely and in and of themselves, and the pharmacists came to me and were complaining, I'd tell them to work with a different PBM. But in fact, the PBMs are involved or part of or have agreements with insurance companies who provide the customer base for the pharmacies. In addition, they are involved in or own all or part of mail order and specialty pharmacies, which are fierce competition. Is there a way that you can allay my concern that although PBMs are a good idea, the framework in which they are involved with insurance companies and mail order pharmacies make it a fairly untenable situation when we talk about fairness?

3:06:48 **Jonah Houts:** I do not share the same concerns about fairness. I do want to understand that by insurance company, you may be referring to an ownership interest in a PBM by an insurance company, or by virtue of them being a client of the PBM. That said, it is the client, the insurance company, who is making all these decisions. They are choosing the formulary. They are setting co-payments. There is no conflict of interest with a PBM-owned entity because we do not have the ability legally, through contracts, nor would we seek in the marketplace, the right or ability to control the plan. We do not have control over plans or plan assets. We are simply a vendor to them to assist them in managing this drug benefit. On the subject of mail order and specialty pharmacy, those serve unique and

different parts of the prescription drug market. For more than half of the drug market, they would never be appropriate for a mail-order pharmacy because these are prescriptions for stat drugs. There is a section of the mail-order pharmacy, that maintenance medication, where we compete with retail pharmacy. The fact of the matter is that we just do not compete that well. The mail-order pharmacy market share for more than the last decade has been stuck between 10% and 15%. Where there is growth in the prescription drug marketplace, it is not happening in mail-order pharmacy. On the specialty pharmacy space, our largest competitors are the hospitals and in-patient settings where doctors are administering the product themselves. These are products not appropriate for over the counter or retail pharmacy transactions.

3:09:00 **Representative Kreun:** As we were looking at the discrepancy forms and the time frame, is it accurate?

Jonah Houts: Earlier today during this hearing, I sent a note to our head of appeals. Our response times are nowhere near that and are within two weeks. I believe the legislation proposes within seven days. Again, if this bill were to pass, that goes on the list of things which would concern me less than allowing violations of anti-trust law.

3:09:58 **Dan Ulmer, Blue Cross:** Introduced Tom Christianson.

3:10:13 **Tom Christianson, pharmacy manager at Blue Cross Blue Shield of North Dakota:** The mission of Blue Cross Blue Shield is to maintain a sustainable and affordable healthcare system for all North Dakotans. Prime Therapeutics is our pharmacy benefits manager partner in achieving this goal. Generic drug pricing is a complex process. There are multiple competing manufacturers, multiple competing wholesalers, many pharmacies, competing PBMs, and health plans. We rely on Prime to monitor this complex market and to determine fair but competitive generic pricing. This pricing improves our competitive position in the marketplace and provides lower costs to our members. We share with Prime concern that certain disclosure requirements and restrictions on MAC placement of generic drugs may hinder Prime's ability to achieve competitive generic pricing for our North Dakota members. Our perception is that Prime has been a fair player in the North Dakota market. This is just anecdotal evidence and not something I'd deal with on a day-to-day basis, but when I get involved with appeals, it is because of an escalation of an issue or when a frustrated pharmacist calls me directly for me to light a fire. But that happens fewer than a dozen times a year. Prime processes over two million generic prescription claims for us each year. Prime Therapeutics does have hands-on responsibilities for MAC pricing appeals.

3:13:01 **Representative Ruby:** Do you provide your MAC list to pharmacists who have contracted with you when requested?

Tom Christianson: That request would go to Prime. I do not believe they supply the entire list, but a pharmacist can register on their website and can track individual MAC prices.

3:13:44 **Representative Kasper:** If I hear you right about fielding calls from frustrated pharmacists, they now have an open door to call you if they are frustrated.

Tom Christianson: I know I was inviting that, but frankly they know me. I think many or most probably know my desk number. I will take their calls.

Representative M. Nelson: When pharmacists have gotten frustrated with Prime and have called you with concerns, what were their reasons for calling?

Tom Christianson: It usually has been when a particular manufacturer's product has dropped out of the market for whatever reason. All of a sudden, instead of two generics out on the market, there is only one, and the remaining manufacturer knows that and takes advantaging of that by cranking up their prices. The adjustments are not happening quickly enough, and in a situation like that, we would like to see that corrected quickly. Frankly, the resolutions to those situations have always been positive.

Representative M. Nelson: Have those resolutions been retroactive or from that day moving forward?

Tom Christianson: That I do not know. I believe Prime's policy is to not do retroactive pricing.

2:15:57 **Chairman Keiser:** Are the pharmacists who have spoken about problems misrepresenting the facts?

Tom Christianson: It is a difficult question for me to answer. We are not the only PBM in the state.

Chairman Keiser: Blue Cross Blue Shield has 83% of the small or individual market, so you should know.

Tom Christianson: We have 83% of the market, but probably to the pharmacists out here, we are probably about 25% of their business or somewhere in that range. You've heard testimony today, and it is partly true. Nearly every health plan will partner or contract with a PBM to administer their drug benefits. They are doing things like monitoring this widespread and complex marketplace. They set their MACs. We have done things as a plan on our own because of our own concerns and reasons. At different times, we've had the MACs add a multiplier for North Dakota pharmacies. We've taken other steps where we have protected margins. As we move to the exchange, we as a health plan have to compete, too. There have been questions about self-funded groups and carving business out. It's in our best interest to deal with only one PBM, simply from an administrative point of view. We like to see Prime Therapeutics retain that business. We have to support their efforts to help us provide the most competitive benefits.

3:19:02 **Chairman Keiser:** Does any part of the Blue Cross Blue Shield of North Dakota or any part of the Blue Cross Blue Shield organization own any part of Prime Therapeutics?

Tom Christianson: We do. Prime Therapeutics was formed out of a merger of Blue Cross Blue Shield of Nebraska subsidiary and a Cross Blue Shield of Minnesota subsidiary. We happened to be customers of both those subsidiary plans. When they merged to form

Prime Therapeutics, they went to their other Blues customers, and to help them get this enterprise going, they asked us to make a capital contribution, which we did. It is a small percentage. In the overall Blue Cross system, Cross Blue Shield of North Dakota is tiny. It is to our advantage to align ourselves with other Blue Cross plans to try to remain independent. The Prime Therapeutics business model to us is to try to keep administrative costs low, as well as other aspects we hope will help us maintain competitiveness.

3:31:00 Representative Kasper: It my understanding that Blue Cross has a substantial amount of self-funded business in North Dakota. (Christianson confirms.) If a North Dakota employer who is self-funded with Blue Cross would ask you to be able to negotiate and have their own PBM other than Prime Therapeutics, would you allow that?

Tom Christianson: We do. In the business we call that a carve out. We have had clients carve the PBM out.

3:21:40 Representative M. Nelson: Going back to the complains that come to you. When you contact Prime, what do they tell you is the reason why they couldn't respond to the pharmacist fast enough that he ended up going to you?

Tom Christianson: I generally do not hear that answer. When I call them, I expect to get taken care of. That has been my experience.

Representative M. Nelson: They don't really give you any reason why this is happening?

Tom Christianson: Prime Therapeutics has an appeals process. I believe they will testify as to what their process is. Essentially, how they set MAC prices and those things. It would have to be something in their criteria. Sometimes it is in the timeliness of things or when there has been a substantial price increase in the market.

3:24:20 Chairman Keiser: Maggie Anderson has joined us. We are going to request that she come up and answer a question. Representative Kasper requested the chair to ask her to join us.

3:24:46 Maggie Anderson, Department of Human Services: I understand there was a question about line 29 on page 2.

3:25:00 Representative Kasper: During the testimony, there was an implication that the line 29 carve out for Medicaid was due to costs increasing substantially to North Dakota Medicaid recipients. I'd like you to clarify why the carve out is in there.

Maggie Anderson: The reason why line 29 is in there is that we currently have a MAC list for the Medicaid program, but our MAC list encompasses more than only generic drugs. It also includes other specialty drugs. If we were not carved out of this legislation and we were to follow the definition on page 1, starting on line 10, it would actually increase our costs because our MAC list is broader than what is defined in this bill.

Representative Kasper: Do you make your MAC list available to various pharmacists if they ask to see it?

Maggie Anderson: It is posted on the web.

Chairman Keiser: We are going to take a break and will resume at 2:30 to continue this hearing.

3:26:50 **Meeting reconvened.**

3:27:12 **David Root, representing Prime Therapeutics:** Will defer my time to David Lassen, our chief clinical officer.

3:27:45 **David Lassen, oversight of the clinical services department at Prime Therapeutics:** Prime Therapeutics, an equity-owned pharmacy benefit management company, for profit but not publicly held, is owned by Blue Cross Blue Shield plans across the United States. North Dakota is one of our owners. Our purpose is simply to help people get the medicine they need to stay healthy and live well. One of the ways we do this is to provide affordable healthcare to consumers.

3:28:57 This bill as written may increase some reimbursement levels for generic drugs for North Dakota pharmacies, but it will be at the expense of the North Dakota consumer. Clearly our focus is to wrestle with that conceptually in terms of the opportunity of managing generic pricing but doing that in a way from which the consumer benefits. Three things come to mind. The overall bill would seem to make more sense if it solved a legitimate problem that was clearly comprehensive in nature. You heard a lot of testimony against PBMs. Some of that was quite concerning to me, having been a clinical pharmacist and having practiced in a retail setting. I know that these are differences of opinion. But I'd like to point out five things from the perspective as to why this bill is not needed. Prime does maintain one MAC list across our entire business. We have the same level of financial accountability for our retail partners as we hold ourselves to and apply from a methodology standpoint against our own mail-order system. Prime does not perform spread pricing. From our perspective, that is not a practice that we are part of in any way, shape, or form. We are routinely subject to internal and external audits around our claims and our pricing activities. They review on a routine basis, including MAC lists.

3:31:31 We provide a robust appeals process. The bill asks for a reasonable appeals process and asks for seven calendar days. Our current standard operating procedure is to respond to pharmacies within five business days. We want to be responsive, and there is an avenue for addressing those concerns as they come up. Pharmacies do receive from us access to an online provider portal. That access allows them to look up at any time any drug to see if it is on the MAC list and the pricing for that.

3:32:43 This bill would make more sense if North Dakota pharmacies were experiencing undo financial hardships relative to other neighboring or regional states. From our initial analysis, North Dakota pharmacies receive \$3.6 million more per year in incremental value passed back to them in terms of higher reimbursement rates compared to surrounding states like Kansas, Nebraska, Wyoming, Montana, and Minnesota. North Dakota pharmacists enjoy higher levels of reimbursement and less competition than all the neighboring states. North Dakota as a Blue Cross payer, the largest payer in the state, has

been very consistent around our approach in working with us and toeing the line from a mail-order perspective. Mail order as a percent of claims across the Blue Cross Blue Shield of North Dakota business sector is less than 0.3%. I would estimate that it is closer to 20% or 30% or north of 40% in scenarios where you are mandating mail. That is not a practice for Prime Therapeutics.

3:34:29 This bill would increase costs for North Dakota consumers. North Dakota BCBS has across many of its benefits a co-insurance. That co-insurance is different for consumers because it is not a flat co-payment. What that means is that consumers with co-insurance ride the wave of whatever the drug costs because they are paying a percent or portion of that. There is a direct impact on the pricing of generics in a co-insurance scenario when members are paying roughly 20% for their generics. Benefit designs differ, but as a general rule, that is something to consider.

3:35:15 This bill would make more sense if some of the language in it were a little more clear. As we reviewed the bill, we felt that some is reasonable, and some of this are things we are already doing today, and in some cases doing even better. In Section 2c and 3c the term "without limitations" is subjective terminology. In 2a, "reasonable process" and in 3a, "significant cost difference." Those would be terms you would want to tighten and have at least some clarity around that. We felt the terms were very subjective, and from the perspective evaluating or looking at this language, we really didn't even know how to think through that. As you can see from our perspective, we do have concerns and are in opposition. We believe our practices represent in the best fair interest the strong relationships that we have with North Dakota pharmacies and will continue to have as an equity owner of Blue Cross Blue Shield of North Dakota.

3:37:24 **Representative Frantsvog:** I think I heard you say that costs for consumers will go up. Is that correct?

David Lassen: That is correct.

Representative Frantsvog: Can you explain how or why?

David Lassen: From our initial assessment, we think the majority of the driver behind increased cost to consumer will be driven by generic medications that were once on the MAC list which would no longer be on the MAC list. One of the drivers is reference to a requirement of three unique manufacturers. Relative to what you've heard in the industry already presented today as a common practice of two. That difference alone could pose increased costs and could result in few drugs on the MAC list, which then directly impacts the consumer.

Representative Frantsvog: I have never seen an ad for mail-order prescriptions. How do you get your customers?

David Lassen: We are not actively selling mail order as a service for BCBS of North Dakota members. Likewise, there is a benefit designed that does not design mail order use. So in large part, there would not be widespread knowledge of that as an option within North Dakota.

3:39:21 **Representative Becker:** The way that the cost goes up is that a large number of drugs would fall off the MAC list if three manufactures are required. What percentage of drugs would fall off the MAC list if three are required, and by what percent increase have you seen other drugs go up on average once they are taken off the list?

David Lassen: I do not have those numbers with me today. From the perspective of what percent of the drugs on the list would be impacted with three versus two, that is something we could provide as a follow up.

3:40:33 **Representative Kreun:** We have small communities with small pharmacies. They do not have the same buying power or connections. How would this bill affect them, or how would you see it working to enhance that small, vital business?

David Lassen: I'm not convinced how this bill would specifically help them achieve better buying power. I think they have today the access to MAC information so that they can to their best ability manage that.

Representative Kreun: If we leave everything as it is, will that help or hurt them?

David Lassen: If you leave it as it is, you're going to inevitably hurt the consumer from a financial perspective.

3:42:08 **Chairman Keiser:** If we amend it to two, will that take away that feature of the negative impact on North Dakota consumers? Outside of that change, is there any other area that will cost consumers?

David Lassen: We do support of two versus three. We do think there would be a material impact. The other primary concern we would have would be specific to the retrospective nature of the appeals process. As has been discussed, in an appeals process when we would make a decision and respond to the pharmacy, we would do so in writing and then move forward from there with the price change. We do not convey full retrospective. Because pharmacy is a real-time adjudication process, when you adjudicate that claim, anytime subsequent to that would require you to go back in time and reverse that claim and re-adjudicate that. In some instances, that would involve going back to the consumer and asking for more money. We would have concerns administratively with the retrospective process.

3:43:58 **Representative Kasper:** I think part of the problem I'm hearing regarding the adjudication of the claim and the retrospective process is that it takes a long time for a new MAC pricing. The retrospective would essentially go away if you have to respond in your MAC price changing within seven days, correct?

David Lassen: We respond to an appeal within five business days for any request around an appeal specific to a pricing concern. That does not mean we change the specific drug price within those five days. Today we evaluate on an ongoing fashion the drug market sources that we're using. For a large part, those are wholesaler sources. As we do that, those drug prices are changing constantly. We put those in our system on the 1st and the

15th of the month even though we continually evaluate throughout the month. From a timing perspective, if we receive an appeal today and make a decision on the 17th of the month, the first time we would put that revision into our claim adjudication system if we made the decision to adjust the price would be the 1st of the next month. That really comes down to a level of efficiency within our system. That is our current process.

Representative Kasper: On the bill, page 1 line 22, b, the bill is asking to disclose the market-based sources utilized to set MAC prices. What problem would you have with doing that, being we're trying to find out where you're getting your data?

David Lassen: That would not be an ideal situation for us to disclose that information. We want to work with the pharmacies to disclose the drug list and the MAC pricing questions they would have. From the perspective of our sources, we would consider that information proprietary at this point without further legal review.

3:46:48 **Representative Kasper:** What is so proprietary and confidential about market-based sources?

David Lassen: I would ask the same question of you when the intent of this particular question in terms of market-based source. From our perspective, we utilize wholesale information coming to us as part of our methodology for establishing our MAC pricing. It is not MediSpan or First Data Bank as you heard today that establishes AWP or actual wholesale pricing. MAC pricing is looking at the wholesaler's acquisition cost. That is what we refer to as changing on a regular basis.

Representative Kasper: If the manufacturer changes the price they charge for the drug, is that a market-based source?

David Lassen: My understanding of a market-based source is the actual wholesale acquisition costs that we have access to with our wholesaler agreements.

Representative Kasper: So you have access to the wholesale pricing, but you're not buying the drug? What you're getting access to is the wholesaler telling you what they'll sell it for at a wholesale level. Theoretically, the pharmacist should be able to buy at that wholesale price or near it?

David Lassen: We don't know what the pharmacists are purchasing it for. We would not have an understanding of that. It is many times a timing issue which causes the frustration in terms of what they bought it at and how that changes over time.

Representative Kasper: We're getting to the crux of it, where the pricing goes up greatly and there is no relief from the PBM because it was a period of time before the MAC pricing level was changed. They are having to eat the difference.

David Lassen: I do not disagree with that as a concern. I think that as you look at this bill, the current language which suggests retroactive to the date of the invoice, and as a recommendation, if you put some sort of timeframe around from the date of determination

to the date of getting that into the claim adjudication system in the future would be better compromise than how it is written now.

3:50:31 **Representative Sukut:** Pharmacists say that they do not know the costs or MAC. You're saying that those costs are readily available. There is a huge discrepancy between where you are and where the pharmacies are. Where is the solution to that? I see that a lot of the problems are in that area.

3:51:46 **David Lassen:** That is the right question to ask. I am curious to that answer as well. From our perspective, we believe that information is available. There might be opportunities to improve the efficiency of how that information is made available. But today there should not be anyone who is unable to get an answer to a particular pricing question from us.

3:52:45 **Representative Sukut:** You do realize there is a problem there and is an issue which needs to be addressed. The answer is probably somewhere between the two parties, and somewhere there needs to be some resolution.

David Lassen: We would want to be a part of the solution to that problem.

3:52:13 **Representative Vigesaa:** I heard this morning from one of the pharmacist that they did five prescriptions on the same day for the same drug and have five different MAC prices. Could you explain how that could happen?

David Lassen: I don't know the context of that individual's comment. If they meant that it was the same pharmacy benefit manager and five different drug prices.... (clarification from audience member) If it was different vendors, then that would be understandable. If it was within the same pharmacy benefit management company, I cannot say that that would be an accurate representation.

Chairman Keiser: Let's get clarification.

Audience member acknowledged by Chairman Keiser: It was the same PBM but five different plans administered by the PBM.

Chairman Keiser: That's what I thought. The same PBM. How did that happen?

3:54:26 **David Lassen:** More than likely, those are multiple MAC lists being managed by the same PBM. For Prime Therapeutics, that is not a practice that we would condone.

3:54:53 **Chairman Keiser:** If I am a pharmacist who is losing money on a prescription and I cannot get the MAC changed and I cannot buy it for less, wouldn't I look for something else? Try to get the physician to prescribe something else? If you were a business owner with a bad transaction and you were losing money every day, how long would it take you to reverse it?

David Lassen: I would think a significant amount of time.

Chairman Keiser: It would take you a day. You'd see the problem in the finances and take action.

David Lassen: Your first question, specific to what you would do as a pharmacist...

Chairman Keiser: Could they conceivably move them to something else on which they would not lose money?

3:56:28 **David Lassen:** On behalf of the contingent in favor of this bill, I recognize that it would cost them something to call a physician and seek to get a change to a different drug. That is really what we'd more than likely be talking about.

3:56:51 **Representative Kreun:** Going back to buying and selling. There are always products we sell below cost, but we make it up on other items. Is that the same scenario here? We are only hearing about the ones that are negative cost. How much do they make on the upside?

David Lassen: Obviously we do not know how much they make on the upside. But we do have a sense the fact that they are making more, relatively speaking, than surrounding states. They have a higher level of reimbursement, partially due to the very intentional and strong relationship we have with the pharmacies in the state. I would offer to you that from our internal appeals records, our current understanding of what the downside total aggregate amount may be upwards of 5% to 10% but that is anecdotal.

3:58:56 **Pat Ward, representing Express Scripts:** In the last four or five years, I sold stocks or real estate at a loss...more examples. You should keep in mind that the plans are not in here complaining. The customers of the PBMs are the health plans. I've drawn a diagram of how the whole thing works. The big player here is the pharmaceutical companies. They charge a lot of money for these drugs. Beneath that you have the PBMs working for the health plans to try to keep those costs down. The PBMs create networks with pharmacies and try to determine what are the best drugs to have in the health plan, what are the cheapest drugs, and what has the best availability. When we were here a few years ago, they were telling you that we did not want them to use generics. Now they're telling you that 83% of the drugs they are selling are generics. The MAC prices relate to the generics. The margins are much lower on these generics because they are cheaper to begin with. They buy their drugs from wholesalers who buy their drugs from the manufacturers. The wholesalers have a markup. They may not buy directly from wholesalers; they may buy from a PSAO, which is buying group that buys from wholesalers. When these MAC list is put together, those prices are determined by getting prices from various PSAOs and wholesalers to determine what is an average, fair price for a generic. The PBMs are trying to make the drugs as affordable as they can. When you see your copay go down, it's when the drug goes generic. There has been a lot of collateral talk about PBMs. The federal trade commission has investigated PBMs and has said that PBMs have brought down the overall increase in drug spending. The PBMs are a good thing for this business because they can stand up to the large pharmaceutical companies. In fact, in 2002 drug spend went up 17% annually. That is now at 2% annually. A lot has to do with generics. No other state has passed a MAC pricing bill, and the federal government has not either. Why is this bill here in North Dakota? It is a

national agenda item of their pharmacy association. They are bringing it here because pharmacists in North Dakota have a good relationship with the legislature and have been able to get other things done, including protecting themselves against the big box competitors. There was some talk about lawsuits. Lawsuits do not work. There have been lawsuits against PBMs. There have been some settlements. The bottom line is that there is a lot of competition in this industry. There has been a lot of change. There has to be reasonableness in all this. This bill is not necessarily the right approach. I would urge you not to pass this bill.

4:05:00 Robert Harms on behalf of CVS Caremark: Distributed written testimony from Erik Woehrmann, director of state government affairs, CVS Caremark Corporation, attachment 15. I wanted to be sure the committee understands CVS Caremark's position. I told you earlier that I thought this was all about healthcare spend and how to manage it. The concerns you've heard here are legitimate. I would suggest you that the better resolve is not legislation, but let the market work. I just listened to the ___ (audio unclear) and I identified four areas where the free market is working. Gave examples. The market is working to resolve some of these issues.

Neutral:

Hearing closed.

During committee action time on the afternoon of February 6, 2013, Chairman Keiser **appointed a subcommittee**. This was recorded on Recording Job 18425 at minute 35:20 to end.

Representative N. Johnson, chair of subcommittee
Representative Kasper
Representative Gruchalla

2013 HOUSE STANDING COMMITTEE MINUTES

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

HB 1363 Subcommittee
February 11, 2013
Job 18744

Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Maximum costs for pharmaceuticals

Minutes:

You may make reference to "attached testimony."

Subcommittee meeting location: Peace Garden Room

Meeting called to order at 2:47 pm

Subcommittee members present:

Representative N. Johnson, chair; Representative Kasper; Representative Gruchalla

Others present: Registration sheet attached

Topics discussed:

1. How the changes in the bill would impact Essential Health Benefits
2. Perceived mandates within bill, subsection 2, letter c
3. PPACA
4. Pricing disclosure by PBMs to HHS, to the exchanges, and to the plans
5. MAC lists for pharmacy and for the insurance company
6. Example of when health plan or employer group controls the costs
7. Pass through arrangement versus spread arrangement
8. Disclosure of margins or gross spread prices by PBM
9. Bidding by multiple PBMs for both arrangements provided for clients for comparison
10. Number of appeal requests per year
11. Attachment 1: Proposed amendments presented by Amy Bricker; explained reasoning behind each proposed amendment
 - a. Generic and brand drugs
 - b. Removal of words *market-based* because that is not a defined term
 - c. Every two weeks is more in line with their operating procedure
 - d. *Under contract* includes the network; would provide to specific pharmacy provider
 - e. Removal of lines regarding the setting of MAC lower than market-based sources
 - f. Calendar days becomes business days
 - g. Update to MAC for appealed drug based on the review period (date appeal filed)

- i. Time allowed for PBM to respond to an appeal
 - ii. Clarification of similarly situated
 - h. Change from three to one nationally available therapeutically equivalent multisource drug
 - i. Some drugs on MAC list are older drugs and are not "A" rated
 - j. Unable to know if a drug is not available to every pharmacy
 - k. Would not support disclosing difference in amounts
 - l. Would include Medicaid program
 - m. Fine instead of misdemeanor
- 12. Proposed fine versus Class B misdemeanor
- 13. Organizational chart presented by Pat Ward
- 14. Bidding by a self-funded employer for a PBM
- 15. Special sanctions for organizations
- 16. Comments by Mike Schwab on amendments presented by Amy Bricker
 - a. Concerns regarding retroactive billing. Willing to remove request for retroactivity if language changes from *respond* to *determination*.
 - b. Suggested wording captured on recording at approximately minute 59:20
 - c. Suggestion that in 3b, keep reference to "A" rated but add in "B" and "Z" rated
 - d. Would like to look more closely at "similarly situated"
 - e. Comment on whether section 1, number 4, is really an issue
 - f. Comment on whether this bill requires the sharing of proprietary information
- 17. Comments by Shane Wendell
 - a. Reference to e-mail he sent to members of IBL committee regarding prescription for which price changed 45 days ago but for which MAC has not been adjusted
 - b. Comment on not receiving replies for appeals that are not granted
 - c. Comment on utilization of generics
 - d. Comment on PBM paying pharmacist under cost
 - e. Comment on disclosure of price at which drugs can be purchased
 - f. Comment on reason to leave in term *market-based* source
 - g. Suggestion of carving out for those few drugs which have only one source
 - h. Request that if an appeal gets addressed, the adjustment would be extrapolated to other pharmacists
 - i. Comment on showing his invoice when making an appeal; double-standard because PBM won't show their pricing source
- 18. Question regarding increase in pricing of pharmaceuticals
- 19. Question regarding PBMs that own their own mail-order pharmacies; direct solicitation of pharmacist's clients by PMB for mail-order pharmaceuticals
- 20. Need for definition of market-based source
- 21. Ramification of changing requirement to one generic source rather than three or two
- 22. Collusion; sharing of pricing information with wholesalers
- 23. Comments by Robert Harms
 - a. CVS Caremark has not approved the amendments presented today
 - b. This issue needs much review. The truth is in the middle between the two viewpoints.
 - c. Was left with impression that there are two MAC lists: one for insurance plan and one for pharmacists. That is not true.
 - d. Use of consultants by large employers
- 24. Question regarding pricing of drugs common across multiple MAC lists

25. Question regarding multiple MAC lists within a healthcare plan

- a. Prime Therapeutics has one MAC list
- b. Express Scripts could have ten different prices on ten different lists, depending on the contracts

26. Medicaid exemption

- a. Process for making, maintaining MAC list
- b. Process when a pharmacy reports a pricing discrepancy
- c. Communication to pharmacies when those maintaining MAC list when a better price is found
- d. Bases effective date of price change on date of pharmacy's invoice
- e. Medicaid includes items on MAC list which would typically not be on a PBM's MAC list

Subcommittee will reconvene tomorrow, February 12, at the conclusion of committee action time

Meeting adjourned at 4:30 pm

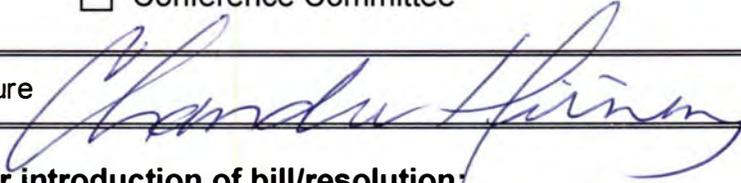
2013 HOUSE STANDING COMMITTEE MINUTES

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

HB 1363 Subcommittee
February 12, 2013
Job 18837

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Maximum costs for pharmaceuticals

Minutes:

Attachments 1-2

Subcommittee meeting location: Peace Garden Room

Meeting called to order at 3:03 pm

Subcommittee members present:

Representative N. Johnson, chair; Representative Kasper; Representative Gruchalla

Others present: Registration sheet attached

Topics discussed:

1. Pat Ward provided update on adjustments to the amendments (attachment 1)
2. Reference to existing law, 26.1-27.1-05, attachment 2
3. Clarification on *contracted payor* and *covered entity* and *plan sponsor*. TPA = third party administrator
4. Clarification on proposed removal of term *market-based*
5. Concern that pharmacies are left out of information shared between contracted payor and pharmacy benefits manager
6. Request for additional definitions throughout
7. Question whether 26.1-27.1-05, subsection 2, addresses the concern about parties and contracts when reference is made to covered entity
8. Question on placement within code
9. Question on contracts between Blue Cross and Prime Therapeutics
10. Response from Mike Schwab to amendments offered today by Pat Ward
11. Clarification on the definition of *market-based source*

Meeting adjourned at 4:01 pm

Subcommittee will meet again on February 13, 2013, at 11:00 am

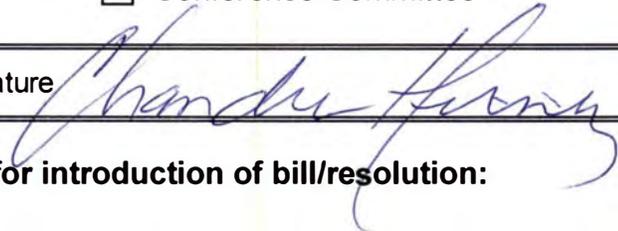
2013 HOUSE STANDING COMMITTEE MINUTES

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

HB 1363 Subcommittee
February 13, 2013
Job 18876

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Maximum costs for pharmaceuticals

Minutes:

Subcommittee meeting location: Peace Garden Room

Meeting called to order at 11:01 am

Subcommittee members present:

Representative N. Johnson, chair; Representative Kasper; Representative Gruchalla

Others present: Registration sheet attached

Topics discussed:

1. Request to come back on Monday because the parties are close to a resolution.

Meeting adjourned at 11:03 am

Subcommittee will meet again on Monday, February 18, 2013, at 11:00 am.

2013 HOUSE STANDING COMMITTEE MINUTES

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

HB 1363 Subcommittee
February 19, 2013
Job 19215

Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Maximum costs for pharmaceuticals

Minutes:

Attachment 1 and 2

Subcommittee meeting location: Peace Garden Room

Meeting called to order at 3:29 pm

Subcommittee members present:

Representative N. Johnson, chair; Representative Kasper; Representative Gruchalla

Topics discussed:

1. Mike Schwab walked through Attachment 2 to present amendments agreed upon by NDPhA and the PBM involved in the discussions.
2. Pat Ward spoke of need to list a MAC rate for Z-rated drugs. Suggested that Z-rated drugs be included after Section 1, Number 3, Letter B or after the mention of Orange book in that Z-rated drugs are not included in the Orange Book.
3. Brendan Joyce clarified definition of Z-rated drugs.
4. Mike Schwab concurred with request given by Pat Ward. Proposed wording adjustment after mention of Orange Book.
5. Jack McDonald voiced support of proposed amendments, including addition of wording regarding Z-rated drugs.
6. Robert Harms requested on behalf of CVS Caremark the addition of "upon request" in Section 1, Number 2, Letter B.
7. Representative Kasper motions to adopt amendment suggested for page 2, 3B, to add "or Z-rated". Representative Gruchalla seconds the motion. Voice vote, and motion carries unanimously.
8. Representative Kasper admonished parties that the committee members are considering their proposed amendments to represent their overall wishes.
9. Representative Kasper motions to adopt amendments as presented in attachment. Representative Gruchalla seconds the motion. Voice vote, and motion carries unanimously.

Meeting adjourned at 3:59 pm

2013 HOUSE STANDING COMMITTEE MINUTES

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

HB 1363
February 20, 2013
Job 19250

Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Maximum costs lists for pharmaceuticals

Minutes:

Attachment 1, amendment and marked up version

Representative N. Johnson: Distributed **Amendment 13.0669.02002, including marked up version** provided by Legislative Council. The parties involved in this bill worked to establish these proposed amended. Walked through amendment.

11:41 **Chairman Keiser:** Looking at the markup provided by the parties during the subcommittee, it said *final determination*. On the version from the Legislative Council, page 2, section e, lines 16-20, and counsel has not used the word *final*. I wonder if *final determination* has a different meaning than *determination*.

Representative N. Johnson: If you look on page 1, 1a, line 10, it defines *determination*. I think the definition might have been changed, but it has to be resolved.

Chairman Keiser: I think it's okay then.

13:00 **Representative M. Nelson:** Looking on the bottom of page 2, 3a, lines 27-29. I understand an older generic drug where there is just one manufacturer. The way that it written, wouldn't it allow them to MAC a generic drug once it is available from one manufacturer?

Representative N. Johnson: That would be correct. They have two have two sources, unless there is only one source of that generic. That sometimes happens. If there is only one source, it can be on the MAC list with just one source. But otherwise, it has to have two.

Representative M. Nelson: Isn't everything always either one or two or more?

Representative Kasper: When a drug comes off brand and goes to generic, there is generally a six-month window when the company that had the brand gets to offer the generic by itself. After that, it is opened up to the rest of the manufacturers. This addresses that six-month period.

Chairman Keiser: It was the intent of this section to say that if there are two or more sources, you have to do that. But if there are not two or more and there is only one source, you can use the one.

Motion to adopt Amendment 13.0669.02002. Motion made by Representative N. Johnson and seconded by Representative Kasper.

Voice vote on adoption of amendment. **Motion carries.**

Motion for a Do Pass as Amended. Motion made by Representative Frantsvog and seconded by Representative Gruchalla.

Roll call vote on a Do Pass as Amended.

Yes = 15

No = 0

Absent = 0

Carrier: Representative Kasper

VR
2/20/13
19 2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1363

Page 1, line 10, after "a." insert ""Determination" means a decision that settles and ends a controversy or the resolution of a question through appeal."

b."

Page 1, line 12, remove "generic"

Page 1, line 13, replace "b." with "c. "Multiple source drug" means a therapeutically equivalent drug that is available from at least two manufacturers."

d."

Page 1, line 16, replace "calendar year" with "contract and contract renewal"

Page 1, line 17, remove "market-based"

Page 1, line 18, replace ", update that pricing information" with "."

b. Update any maximum allowable cost price list"

Page 1, line 19, replace "calendar" with "business"

Page 1, line 19, replace "establish a reasonable process for the" with "provide"

Page 1, line 20, replace "updates" with "changes"

Page 1, line 21, replace "b." with "c."

Page 1, line 21, remove "market-based"

Page 1, line 23, replace "network or pharmacy provider to which each" with "maximum allowable cost price"

Page 1, line 23, after "list" insert "that"

Page 1, line 23, after "applies" insert "to the contracted pharmacy"

Page 2, line 3, replace "c." with "d."

Page 2, line 3, remove "market-based"

Page 2, line 4, replace "available for purchase without limitations by pharmacy providers" with "utilized by the pharmacy benefits manager"

Page 2, line 5, replace "d." with "e."

Page 2, line 7, replace "respond" with "provide a determination"

Page 2, line 8, remove "through the procedure"

Page 2, line 8, replace "calendar" with "business"

Page 2, line 9, after "rate" insert "for an appealed drug"

Page 2, line 10, remove "retroactive"

Page 2, line 11, replace "pharmacy provider's invoice" with "determination"

Page 2, line 11, after "all" insert "similarly situated"

Page 2, line 12, after "in" insert "this state within"

Page 2, after line 12, insert:

"f. Ensure dispensing fees are not included in the calculation of maximum allowable cost price reimbursement to pharmacy providers."

Page 2, line 15, replace "three" with "two"

Page 2, line 16, remove "generic"

Page 2, line 16, replace "with a significant cost difference" with "or a generic drug is available only from one manufacturer"

Page 2, line 18, after "A" insert "or B"

Page 2, line 19, after "Book" insert "or the drug is Z rated"

Page 2, line 20, after "is" insert "generally"

Page 2, line 20, remove "without limitations"

Page 2, line 20, remove "all"

Page 2, line 21, remove "or temporarily"

Page 2, line 22, remove "unavailable"

Page 2, line 23, remove "A pharmacy benefits manager shall disclose to a plan sponsor whether the pharmacy"

Page 2, remove lines 24 through 28

Page 2, line 29, remove "5."

Page 2, line 30, replace "6." with "5."

Renumber accordingly

Date: 2-19-2013

Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1363

subcommittee

House Industry, Business, and Labor Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment

Rerefer to Appropriations Reconsider Consent Calendar

Motion Made By Kasper Seconded By Gruchalla

Representatives	Yes	No	Representatives	Yes	No
Chairman George Keiser			Rep. Bill Amerman		
Vice Chairman Gary Sukut			Rep. Joshua Boschee		
Rep. Thomas Beadle			Rep. Edmund Gruchalla		
Rep. Rick Becker			Rep. Marvin Nelson		
Rep. Robert Frantsvog					
Rep. Nancy Johnson					
Rep. Jim Kasper					
Rep. Curtiss Kreun					
Rep. Scott Louser					
Rep. Dan Ruby					
Rep. Don Vigasaa					

Total Yes _____ No _____

Absent _____

Floor Assignment _____

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

page 2, 3b, add ^{or} 2-rated

Date: 2-19-2013

Roll Call Vote #: 2

Subcommittee

**2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1363**

House Industry, Business, and Labor Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider Consent Calendar

Motion Made By Kasper Seconded By Gruchalla

Representatives	Yes	No	Representatives	Yes	No
Chairman George Keiser			Rep. Bill Amerman		
Vice Chairman Gary Sukut			Rep. Joshua Boschee		
Rep. Thomas Beadle			Rep. Edmund Gruchalla		
Rep. Rick Becker			Rep. Marvin Nelson		
Rep. Robert Frantsvog					
Rep. Nancy Johnson					
Rep. Jim Kasper					
Rep. Curtiss Kreun					
Rep. Scott Louser					
Rep. Dan Ruby					
Rep. Don Vigasaa					

Vote

Total Yes _____ No _____

Absent _____

Floor Assignment _____

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

*amendments presented
on Attachments 1-2*

Date: 2-20-12

Roll Call Vote #: 1

**2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1343**

House Industry, Business, and Labor Committee

Legislative Council Amendment Number 13.0669.02002

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider Consent Calendar

Motion Made By Johnson Seconded By Kasper

Representatives	Yes	No	Representatives	Yes	No
Chairman George Keiser			Rep. Bill Amerman		
Vice Chairman Gary Sukut			Rep. Joshua Boschee		
Rep. Thomas Beadle			Rep. Edmund Gruchalla		
Rep. Rick Becker			Rep. Marvin Nelson		
Rep. Robert Frantsvog					
Rep. Nancy Johnson					
Rep. Jim Kasper					
Rep. Curtiss Kreun					
Rep. Scott Louser					
Rep. Dan Ruby					
Rep. Don Vigesaa					

Total Yes _____ No _____
Absent _____

Floor Assignment _____

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

Date: 2-20-13

Roll Call Vote #: 2

**2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1303**

House Industry, Business, and Labor Committee

Legislative Council Amendment Number 13.06609.02002

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider Consent Calendar

Motion Made By Frantsvog Seconded By Gruchalla

Representatives	Yes	No	Representatives	Yes	No
Chairman George Keiser	✓		Rep. Bill Amerman	✓	
Vice Chairman Gary Sukut	✓		Rep. Joshua Boschee	✓	
Rep. Thomas Beadle	✓		Rep. Edmund Gruchalla	✓	
Rep. Rick Becker	✓		Rep. Marvin Nelson	✓	
Rep. Robert Frantsvog	✓				
Rep. Nancy Johnson	✓				
Rep. Jim Kasper	✓				
Rep. Curtiss Kreun	✓				
Rep. Scott Louser	✓				
Rep. Dan Ruby	✓				
Rep. Don Vigesaa	✓				

Total Yes 15 No 0

Absent 0

Floor Assignment Kasper

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

REPORT OF STANDING COMMITTEE

HB 1363: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (15 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1363 was placed on the Sixth order on the calendar.

Page 1, line 10, after "a." insert """Determination" means a decision that settles and ends a controversy or the resolution of a question through appeal."

b."

Page 1, line 12, remove "generic"

Page 1, line 13, replace "b." with "c. "Multiple source drug" means a therapeutically equivalent drug that is available from at least two manufacturers."

d."

Page 1, line 16, replace "calendar year" with "contract and contract renewal"

Page 1, line 17, remove "market-based"

Page 1, line 18, replace ". update that pricing information" with "."

b. Update any maximum allowable cost price list"

Page 1, line 19, replace "calendar" with "business"

Page 1, line 19, replace "establish a reasonable process for the" with "provide"

Page 1, line 20, replace "updates" with "changes"

Page 1, line 21, replace "b." with "c."

Page 1, line 21, remove "market-based"

Page 1, line 23, replace "network or pharmacy provider to which each" with "maximum allowable cost price"

Page 1, line 23, after "list" insert "that"

Page 1, line 23, after "applies" insert "to the contracted pharmacy"

Page 2, line 3, replace "c." with "d."

Page 2, line 3, remove "market-based"

Page 2, line 4, replace "available for purchase without limitations by pharmacy providers" with "utilized by the pharmacy benefits manager"

Page 2, line 5, replace "d." with "e."

Page 2, line 7, replace "respond" with "provide a determination"

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Page 2, line 10, remove "retroactive"

Page 2, line 11, replace "pharmacy provider's invoice" with "determination"

Page 2, line 11, after "all" insert "similarly situated"

Page 2, line 12, after "in" insert "this state within"

Page 2, after line 12, insert:

"f. Ensure dispensing fees are not included in the calculation of maximum allowable cost price reimbursement to pharmacy providers."

Page 2, line 15, replace "three" with "two"

Page 2, line 16, remove "generic"

Page 2, line 16, replace "with a significant cost difference" with "or a generic drug is available only from one manufacturer"

Page 2, line 18, after "A" insert "or B"

Page 2, line 19, after "Book" insert "or the drug is Z rated"

Page 2, line 20, after "is" insert "generally"

Page 2, line 20, remove "without limitations"

Page 2, line 20, remove "all"

Page 2, line 21, remove "or temporarily"

Page 2, line 22, remove "unavailable"

Page 2, line 23, remove "A pharmacy benefits manager shall disclose to a plan sponsor whether the pharmacy"

Page 2, remove lines 24 through 28

Page 2, line 29, remove "5."

Page 2, line 30, replace "6." with "5."

Re-number accordingly

2013 SENATE HUMAN SERVICES

HB 1363

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1363
3/26/13
20489

Conference Committee

Committee Clerk Signature 

Explanation or reason for introduction of bill/resolution:

Relating to maximum allowable cost lists for pharmaceuticals; and to provide a penalty

Minutes:

"attached testimony."

Chairwoman J. lee opens the public hearing on HB 1363

Rep. Kasper introduces the HB 1363 to the committee.

Mike Schwab Executive Vice President of the North Dakota Pharmacists Association. Testifies in favor of HB 1363. **See attached testimony #1 Senator Anderson**, discusses the price of generics and updating drug price lists. **Senator Dever** ask for clarification on PBM and their role.

John Olson Pharmacies Association. Testifies in favor of HB 1363 **See attached testimony. #2 Chairwoman J Lee.** Asks about profits of PBMs **Senator Dever** if the bill adequate in addressing the concerns.

Steve Boehning, pharmacist from Fargo, ND. Testifies in favor of HB 1363. **See attached testimony #3.** 3534 **Senator Larsen:** asks clarification on the 60 and 90 day lag time, and when they update sheet. **Senator Dever** what PBM and pharmacists have done to work together iron issues?

Mark J. Hardy PharmD, Assistant Executive Director of the North Dakota State Board of Pharmacy. **See attachment #4 Senator Anderson** would the board would be the enforcers. **Senator Anderson** would complaints come to the board.

Mark A. Aurit , pharmacist with the Gateway Heathmart pharmacy in Bismarck , ND. **See attachment #5.** 4825 . **Chairwoman J. Lee** discusses a prescription reimbursement **Senator Larsen** Why the difference in price changes?

Jeff Lindoo from Thrifty pharmacist and am Vice President of Governmental and Regulatory Affairs for Thrifty White Pharmacy, **See attached testimony #6.**

Patrick Ward, represents Express Scripts, testifies in favor HB 1363. Mr. Ward disagrees with testimony given by John Olson. Mr. Ward explains how PBMS work. **Senator Larsen** asks about time of reporting of pricing lists.

Robert Harms the lobbyist for CVS Caremark , Oppose HB 1363. . **See attached testimony #7 Senator Anderson** discussions about access to MAC lists. **Senator Dever** questioned the proposed amendments and if business days are the same as calendar days.

Jack McDonald represents Prime Therapeutics and is neutral. Mr. McDonalds explains why the different contracts with different companies. **Senator Larsen** is the price in one pharmacy going to be same in another pharmacy for the same drug.

Mike Schwab Executive Vice President of the North Dakota Pharmacists Association is asked about the proposed amendment by CVS Caremark. **Chairwoman J. Lee** asks about the web site access.

There is no other testimony

Chairwoman J. Lee closes the hearing for HB 1363

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1363
3-26-13
20509

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to maximum allowable cost lists for pharmaceuticals; and to provide a penalty

Minutes:

You may make reference to "attached testimony."

Chairwoman J. Lee opens the discussion

Chairwoman J. Lee recognizes Dr. Dave Larson with CMS.

Dr. Dave Larson introduces himself to the committee and explains what he does. (Ends 6:35)

Senator Anderson motions for a Do Pass on HB 1363

Senator Dever Seconds

DO PASS 5-0-0

Senator Anderson will carry.

Date: 3-26-13
Roll Call Vote #: 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1363

Senate Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Anderson Seconded By Dever

Senators	Yes	No	Senator	Yes	No
Chariman Judy Lee	✓		Senator Tyler Axness	✓	
Vice Chairman Oley Larsen	✓				
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.	✓				

Total (Yes) 3 No 7

Absent _____

Floor Assignment Anderson

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

REPORT OF STANDING COMMITTEE

HB 1363, as engrossed: Human Services Committee (Sen. J. Lee, Chairman)
recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING).
Engrossed HB 1363 was placed on the Fourteenth order on the calendar.

2013 TESTIMONY

HB 1363



① HB 1363
2-6-2013

1641 Capitol Way
Bismarck ND 58501-2195
Tel 701-258-4968
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E-mail ndpha@nodakpharmacy.net

House Industry, Business and Labor Committee
Representative George Keiser – Chairman
HB 1363 – February 6th, 9:00

Chairman and members of the committee, for the record, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1363. Passage of HB 1363 is needed to bring fairness, reasonableness and standardization to an area of the PBM industry which is long overdue. Maximum Allowable Cost (MAC) regulation is needed to standardize a currently unregulated business practice.

This is not only an independent pharmacy issue, but an issue for chain pharmacies, LTC pharmacies and even hospital outpatient community pharmacies. Currently, there is federal model legislation being advocated for by the National Community Pharmacy Association (NCPA) as well as the National Association of Chain Drug Stores (NACDS). There are also a number of states currently working on MAC related legislation in their respective state (Oklahoma, Hawaii, Michigan, and Alabama). A number of other states continue to discuss introducing such legislation. In an effort to further explain the bill in front of you, I have provided information related to Maximum Allowable Cost (MAC) and have added additional information related to provisions in HB 1363.

History of Maximum Allowable Cost (MAC) pricing

Where did the term Maximum Allowable Cost (MAC) come from?

Maximum allowable cost price lists were created by the Center for Medicare and Medicaid Services (CMS) to smooth generic drug cost variations and give pharmacies an incentive to purchase lowest cost products. This methodology was created as an industry standard for price management of multiple generics to the original brand name drug. Nationally recognized data sources and pricing terms are produced by two main entities (First Data Bank and MediSpan). They both are a nationally recognized data source for pricing averages related to prescription drug costs.

What is Maximum Allowable Cost (MAC) pricing?

Maximum allowable cost or MAC refers to a pricing program or list that establishes the maximum allowed cost for generic drugs. It does not matter whose version of a drug the pharmacy buys, the pharmacy should get reimbursed equal to the pharmacies acquisition cost to cover the cost of purchasing the generic drug from a wholesaler.

Rationale for Maximum Allowable Cost (MAC) Provisions included in HB 1363

As is to be expected, the Pharmacy Benefit Management (PBM) business model centers largely on pricing mechanisms. While PBMs once operated primarily on a fee basis, in recent years we have seen a shift to a more complex and more profitable business model. MAC pricing is one of those complex but highly profitable pricing mechanisms PBMs currently use. There is no standardization in the industry as to the criteria for the inclusion of multiple source generic drugs on MAC lists. There is no standardization related to how the PBMs determine the maximum allowable cost price, or how the MAC lists are changed or updated. The PBMs have free reign in developing the ultimate price paid to pharmacies and charged to employers. The pharmacies are left entirely in the dark and have to agree to contract terms not knowing what they will be reimbursed for generic drugs until the time of adjudication. I would like to take the time to explain certain provisions of HB 1363 to give all committee members a better understanding of HB 1363.

Section 1 – Number 2 – Letter a (page 1 line 16):

This section of provisions requires the PBM to disclose what market-based sources are utilized to determine the maximum allowable cost pricing structure. It requires the PBM to disclose to the pharmacies where the PBM is gathering their pricing information. Are they using a nationally recognized data resource such as First Data Bank? Are they using Medispan? If neither, who are they using or do they get free reign to make up their own prices? It is not unreasonable for a pharmacy to know what they are going to be paid for generic drugs, especially when over 80% of all drugs dispensed at a pharmacy are generic drugs. This section, further states the PBM must update the MAC pricing lists at least every 7 days. Drug prices change constantly and there needs to be some kind of standardization to the process. Currently, if MAC prices decrease in price or payment to the pharmacy, the PBM changes the price right away. However, if the price moves higher and the pharmacy should

be reimbursed more for a certain generic drug, the PBMs take forever to update the MAC list (6-8 weeks in a lot of cases). During this period the pharmacy is filling the prescriptions at a loss or below their acquisition cost.

Section 1 – Number 2 – Letter B (Page 1 Line 21):

This section directs PBMs to disclose which market based sources are utilized for each MAC list if multiple MAC lists are being used by the PBM. The PBM must identify which MAC price lists apply to each network or pharmacy provider. The PBMs further have to make the MAC price lists readily accessible and usable to contracted pharmacies. This can be easily accomplished via password protected email or website link, so pharmacies are able to easily predict what they are going to be paid for generic drugs.

Section 1 – Number 2 – Letter C (Page 2 Line 3):

This section simply states if PBMs are going to use MAC pricing lists, the prices for reimbursement should not be set below market based sources utilized and available for purchase by pharmacies.

Section 1 – Number 2 – Letter D (Page 2 Line 5):

Currently, some PBMs do not even allow for an appeals process if a pharmacy provider wants to challenge his/her reimbursement from a PBM. Some of the pharmacists here today, will be able to testify to this fact and also explain the PBMs that allow for an appeals process take literally weeks to respond or update their MAC list(s). This section further requires a PBM to allow a pharmacy to retroactively bill if a price change is warranted. The ability to retroactively bill is necessary, especially given how long it takes for a PBM to respond. Again, while the pharmacy is challenging the reimbursement, they are filling at a loss and need to be reimbursed appropriately for those drugs dispensed in good faith on behalf of the PBM. Using a pharmacy's invoice for proof of purchase is a common practice in the industry or common request from a PBM.

Section 1 – Number 3 – Letter A (Page 2 Line 15):

This section provides standardization for how products are selected for inclusion on a MAC price list. I assume this section is where most of the push back from the PBMs will come from. We understand and are going to address this provision. The rationale for using the number “three” as a benchmark is because the PBMs currently get free reign to decide which drugs they want to apply a MAC rate on. There is no standard or benchmark for choosing which drugs should be included on a PBM MAC list. The federal government uses a benchmark of “three” as well when figuring out the Federal Upper Limits (FUL's), which is comparable to the MAC process. The intent of MAC is to apply an average or maximum allowable cost on “multiple source generics”.

If we don't set a benchmark or standard, PBMs can MAC a single source generic even though there are no comparable generics on the market or other averages to compare.

Section 1 – Number 3 – Letter C (Page 2 Line 20):

Sometimes a PBM will place a MAC price on a generic drug before the competing generic drug even enters the market and a pharmacy is supposed to accept the new MAC rate even though they cannot buy the new generic yet. In the meantime, they still have stock on the shelves and they are being reimbursed below cost.

Chairman and members of the committee, I can tell you one thing, not having some kind of standard or benchmark established under lines 13-22 on page 2 allows the PBMs to deviate from the original intention of MAC lists and they once again are the judge and jury.

Section 1 – Number 4 – Page 2 line 23:

This section requires a PBM to disclose to the plan sponsor if the PBM is using multiple MAC lists. If the PBM uses one MAC list to reimburse pharmacies and a different MAC list to charge plan sponsors, they need to disclose such to the plan sponsor. This disclosure would reveal price spreading if it is occurring and it would provide the plan sponsor with additional information regarding how their prescription drug plan operates. I cannot imagine a plan sponsor who wouldn't want to know this information.

I would also like to address the proposed amendment provided to the committee related to HB 1363. This amendment is needed because of a new PBM tactic pharmacies are starting to see in contract language. Please turn to attachment A and I will explain why the amendment was brought forward.

Chairman and members of the committee, the reason we are before this committee is because the PBMs are unwilling to work with the pharmacy providers in a good faith effort to change contract language to reflect needed market changes and address reasonable requests. Pharmacies typically contract with at least 2 dozen PBMs and with each PBM making up their own rules, the market has become unmanageable and further regulation is needed. MAC pricing is one example of where regulation is needed to address the problems and inconsistencies that exist in the PBM industry. According to a report issued by the Pharmacy Benefits Management Institute, 82% of the respondent's, stated their PBMs do not use a MAC pricing list for their own mail order pharmacies.

Instead they use a different pricing formula called the average wholesale price (AWP). Why do PBMs do this? This allows the mail order pharmacy, which the PBMs typically own, an opportunity to create a spread larger than when using a MAC list. *Below I have listed an example of how a PBM may apply this theory on MAC pricing to retail pharmacies but not to their own PBM mail order pharmacies. Experts have testified in Congress regarding this kind of an example. For the record, I am not one of those experts, but testimony from one of those experts will be shared with all of you later.*

Contract Language Example (hypothetically speaking):

Retail Pharmacy Contract Language: AWP – 22% plus \$1.40 dispensing fee or MAC plus \$1.40 dispensing fee

Mail Order contract language: AWP – 30% plus \$0 dispensing fee or MAC plus \$0 dispensing fee In addition, the patient copays are often times waived to incentivize patients to use the PBM owned mail order pharmacies. PBM mail order pharmacies promote themselves as providing an 8% discount compared to the retail contract, plus no dispensing fee to plan sponsors making it seem like they are giving them a discount compared to the retail pharmacy.

Retail cost to fill if the PBM applies MAC to the pharmacy:

Metformin 1000mg #180 at MAC + \$1.40 dispensing fee = \$31.24 (patient pays \$8 copay and PBM pays the pharmacy \$23.24.

Fluoxetine 20mg #90 at MAC + \$1.40 dispensing fee = \$14.49 (patient pays \$8 copay and PBM pays the pharmacy \$6.49

Mail Order cost (using AWP language above) to plan sponsor:

Metformin 1000mg #180 at AWP = \$181.44 (patient pays \$0 copay). PBM bills the plan sponsor \$181.44.

Fluoxetine 20mg #90 paid at AWP = \$164.73 (patient pays \$0 copay). PBM bills the plan sponsor \$164.73.

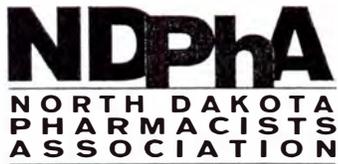
Total costs for both identical drugs:

Retail = \$45.73 (patient pays \$16, PBM pays the pharmacy \$29.73)

Mail Order = \$346.17 (\$0 patient copay and PBM bills \$346.17)

Difference of over \$300

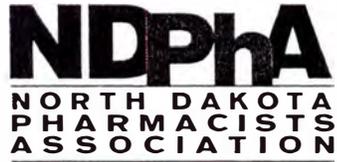
I also want to address some of the comments you might hear from the opposition today. The PBMs might state this bill will cause them to disclose proprietary information and it will cause an



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expense to the overall health care system. Our response is HB 1363 does not require any disclosure be shared with market competitors and any contract is bound by confidentiality. This is a standard practice. The PBMs would simply be required to disclose needed information related to a specific contract! This requirement allows the interested party in the contract to know information related to how they will be reimbursed and how such reimbursement is calculated. I assume as business owners, all of you would like to know how much you are going to be reimbursed and how the reimbursement is calculated. This would also allow a pharmacy the ability to audit their reimbursement. I am sure you will hear more about that subject in a minute. PBMs also might state, premiums are going to increase. If premiums are going to increase, it is because the PBMs haven't been operating their MAC lists in a good faith effort. It is funny how reimbursements to pharmacies continue to decrease at a consistent rate and expenses to plan sponsors continue to increase, all during a time when generic drugs make up on average 80% of the prescriptions dispensed. The only ones making money or saving money are the PBMs themselves. There have been a number of states who have quit using a PBM or have switched to a true transparent PBM and have saved millions. The U.S. Military's healthcare provider, TRICARE estimated saving over \$1.6 billion in 2010 by negotiating its own pharmacy benefit instead of using a PBM for its over nine million beneficiaries.

In conclusion, from the National Association of Chain Drug Stores, to the National Community Pharmacists Association, to the National Association of Insurance Commissioners, to the National Legislative Association on Prescription Drugs, to numerous states and consumer advocacy groups, everyone is saying the same thing, PBM transparency is needed and HB 1363 helps address some of the transparency being advocated for. As you know, even the National Association of Boards of



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Pharmacy recently issued model language calling on state boards of pharmacy to start requiring licensure of PBMs as they are currently not licensed by any governing body. HB 1363 is reasonable and fair legislation. Again, we are asking for your support of HB 1363.

Thank you for your time and attention regarding this important matter. I would be happy to try and answer any questions you may have.

Respectfully Submitted,

A handwritten signature in black ink that reads "Mike Schwab". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Mike Schwab

NDPhA EVP

PBM ↓

Catamaran Legacy CATALYST RX MAC Pricing Appeal Process

If your pharmacy holds an Independent contract with legacy CATALYST RX, you may appeal directly to CATALYST RX. If you are part of a chain, franchise, third party network or PSAO, please direct your appeals to your corporate office or third party network.

Criteria for MAC Appeal:

- 1. Claim was paid based on MAC pricing
- * 2. Total paid (Payment plus Patient Co-pay plus Dispensing Fee) must be less than the acquisition cost (Verified via First Data Bank wholesale pricing or YOUR invoice)

Documentation required for MAC Appeal:

1. Claim Information: Rx Number, NCPDP Number & Pharmacy Name, Rx Date, Drug Name, Drug NDC
2. Contact Name & Contact information for individual appealing
3. Copy of invoice for specific NDC you are appealing

If MAC appeals are being sent by Chains, Third party networks, or PSAO's, it is expected that they will be screened PRIOR to being forwarded to CATALYST RX. Claims reimbursed at contracted rates based on AWP discounts, Usual and Customary or Ingredient Costs as submitted by the pharmacies do NOT qualify for review or appeals unless it is suspected that our claims adjudication system processed incorrectly.

MAC appeals can be sent to crx-pbm-mac@catalystrx.com. In the subject, please put MAC APPEAL or they may also be faxed to 855-390-2641 using the attached form for your convenience.

If you have an open issue with our call center, please reference that issue # on your appeal.

Thank you.

(2) HB 1363
2-6-2013

13.0669.02001
Title.

Prepared by the Legislative Council staff for
Representative Kasper
January 28, 2013

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1363

Page 2, after line 12, insert:

"e. Ensure patient copayment and dispensing fees are not included in the calculation of maximum allowable cost price."

Renumber accordingly



④ ③
HB 1363
2-6-2013

January 31, 2013

Mr. Mike Schwab
Executive Vice President
North Dakota Pharmacists Association
1641 Capitol Way
Bismarck, ND 58501

Dear Mike,

I caught wind of your pending MAC legislation, HB 1363, and on behalf of Community Pharmacy Prescription Network and all of our members I wanted to let you and your members know that what you are doing for pharmacies throughout the U.S. is greatly appreciated.

It is about time that the unfair practices of the PBM industry, specifically the arbitrary and fictitious Maximum Allowable Cost (MAC) levels that are set by PBM's, are addressed head on as you are doing.

Community Pharmacy Prescription Network (CPRxN) is a group of independent pharmacies that came together originally to participate through a direct to employer competitive bid process as a member of the preferred Caterpillar network which originally included only Walgreens and Wal-Mart. As of January 1, 2013, CPRxN pharmacies are further participating in the General Dynamics and Johnson Controls preferred networks.

This direct to employer bid process (pharmacy to employer, bypassing the PBM) is a true cost plus model where generic prices are bid based on their landed cost plus a fee to dispense the prescription. There is no MAC pricing and yet Caterpillar has saved millions over their former PBM run model and pharmacies in the network, who purchase their prescription drugs from a variety of large and small wholesalers, have no trouble finding generics at a suitable price in order to fill those prescriptions at a savings to the payor and consumer, while retaining a fee for their services. To reiterate, Caterpillar was able to achieve a greater savings through a direct to pharmacy competitive bid process rather than through the traditional PBM model which included the MAC pricing.

Good luck in passing this very important piece of legislation.

Best regards,

Anthony Sartoris
Chief Operating Officer
Community Pharmacy Prescription Network

DAVID A. BALTO
ATTORNEY AT LAW
1350 I STREET, NW
SUITE 850
WASHINGTON, DC 20005

(3) (4)

HB 1363
2-6-2013

PHONE: (202) 789-5425
Email: david.balto@yahoo.com

February 4, 2013

Michael Schwab
Executive Vice President
North Dakota Pharmacists Association
1641 Capitol Way
Bismarck, ND 58501

Re: House Bill No. 1363

Dear Mr. Schwab,

I write in support of House Bill No. 1363 (“H.B. 1363”), which provides guidelines for the transparency of the maximum allowable cost (“MAC”) of generic pharmaceuticals paid to retail pharmacies by Pharmacy Benefit Managers (“PBMs”). The importance of this legislation cannot be understated. PBMs use arbitrary and opaque MAC pricing to derive record profits at the expense of independent pharmacies, plan sponsors and consumers. In addition to the lack of transparency surrounding MAC pricing, the PBM market is fraught with other deceptive and fraudulent conduct that has led to independent pharmacies being driven from the market and harm to consumers. This legislation is a prudent response to this significant market imbalance PBMs hold and its enactment will benefit the consumers of North Dakota.

I write to you based on my experience of over a quarter century as an antitrust practitioner, the majority of which was spent as a trial attorney in the Antitrust Division of the Department of Justice, and in several senior management positions, including Policy Director at the Federal Trade Commission’s (“FTC”) Bureau of Competition and attorney advisor to Chairman Robert Pitofsky. I helped bring some of the first antitrust cases against PBMs and have testified before Congress, regulators, and state legislatures over ten times on PBM competition. I have testified before Congress four times and before ten state legislatures on PBM reform issues and have served as an expert witness for the State of Maine on PBM regulation.¹

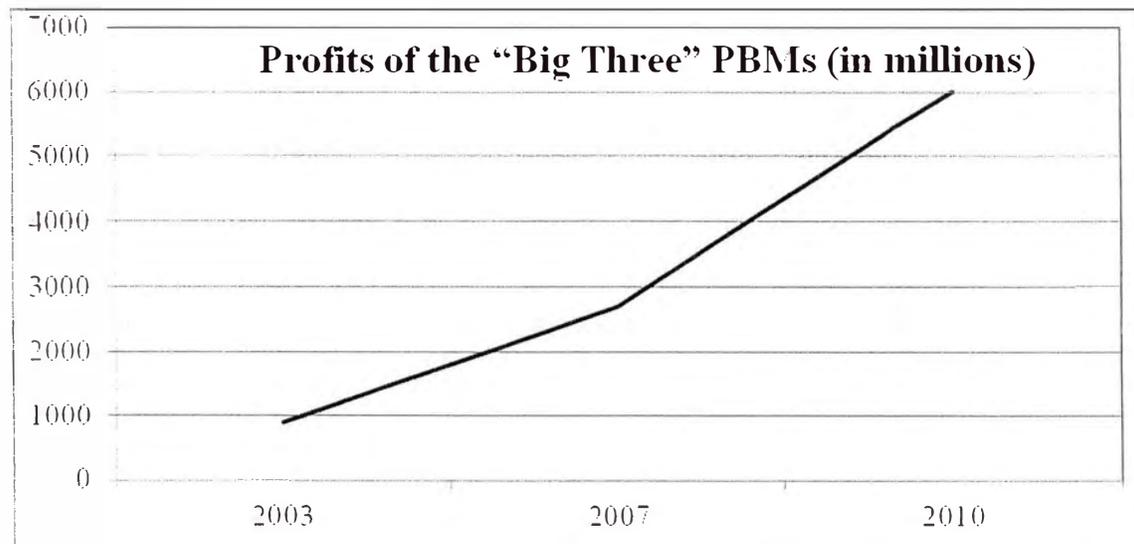
BACKGROUND

Pharmacy Benefit Managers are one of the most problematic, least regulated and least understood aspects of the healthcare delivery system. Over 80% of pharmaceuticals in the United States are purchased through PBM networks. PBMs serve as intermediaries between

¹ See David Balto, Advocacy and Testimony, available at <http://www.dcantitrustlaw.com/index.php?id=9>.

health plans, pharmaceutical manufacturers and pharmacies, and PBMs establish networks for consumers to receive reimbursement for drugs. Although the primary function of a PBM initially was simply to create networks and process pharmaceutical claims, these entities have exploited the lack of transparency and created conflicts of interest which have significantly distorted competition, reduced choices for consumers and ultimately increased the cost of drugs.

The PBM market is dominated by two PBMs, ESI/Medco and CVS Caremark who together control over 80% of the market for large health plans. Because the two largest PBMs' operations are clouded in secrecy and are replete with significant conflicts of interest, PBMs have effectively increased the cost of drugs over the past several years and have seen their profits skyrocket from \$900 million a year to over \$7 billion a year at the expense of payors and consumers.



MAC PRICING IS A SIGNIFICANT SOURCE OF PBM REVENUE AT THE EXPENSE OF CONSUMERS AND RETAIL PHARMACY

Like many health care businesses PBMs must establish reimbursement rates for services and the dispensing of drugs. This system works best, for consumers, plans, and pharmacies when there is a transparent and consistent system for determining these reimbursement rates. When there is a transparent and consistent system all of the market participants can effectively plan, purchase goods and provide services. Where transparency and consistency are absent there is a significant opportunity for providers and ultimately consumers to be harmed by deceptive and unfair conduct.

Unfortunately, currently the reimbursement system for generic drugs often lacks these critical elements. Generic reimbursement is based on a MAC list, which sets the maximum allowable cost. MAC lists are PBM-generated list of products that includes the upper limit or maximum amount that a PBM will pay for generic drugs and brand name drugs that have generic

versions available. There is no standard methodology for derivation of MAC lists or how the maximum prices are determined. Neither plan sponsors nor retail pharmacies are informed how products are added or removed from a MAC list or the methodology that determines how reimbursement is calculated. Moreover, PBMs often utilize multiple MAC lists to create a spread between what they charge a plan versus the amount they reimburse a pharmacy. This lack of transparency and prevalence of nonstandard MAC list and pricing derivation allows PBMs to utilize an aggressively low MAC price list to reimburse their contracted pharmacies and a different, higher list of prices when they sell to their clients, plan sponsors. Essentially, the PBMs reimburse low and charge high with their MAC price lists, pocketing the significant spread between the two prices. Most plans are unaware even that multiple MAC lists are being used and have no real concept of how much revenue the PBM retains.²

This can be additionally problematic from a plan sponsor perspective. The lack of transparency surrounding MAC list derivation causes plans worry that they are paying more than they should for some multisource products. Without the knowledge of whether certain generics are included or excluded on MAC lists, a plan does not know whether a member's copay may increase due to drugs not being available on MAC lists. A member may complain that they cannot get access to a generic that should be available through their benefit and the plan is forced to pay a higher price to the PBM.

H.B. 1363 will address these problems by, *inter alia*, requiring PBMs to disclose the specific market-based sources they use to determine and set MAC prices; ensuring that MAC prices are not set below costs (market-based sources available); setting specific requirements of drugs to be included on MAC lists; and requiring PBMs to disclose to plan sponsors whether the PBM is using an identical MAC list with respect to billing the plan sponsor and the network retail pharmacy. If a PBM is using multiple MAC lists the PBM must disclose to the plan sponsor any differences between the amount paid to any pharmacy and the amount charged to the plan sponsor. Where transparency and consistency are absent there is a significant opportunity for providers and ultimately consumers to be harmed by deceptive and unfair conduct. By requiring disclosure of MAC pricing, H.B. 1363 will help ensure North Dakota consumers, plans and pharmacies do not pay more for generic drugs than they should.

WEAK TRANSPARENCY STANDARDS ALLOW PBMS TO ENGAGE IN DECEPTIVE CONDUCT

In addition to MAC list and pricing, facing weak transparency standards, the major 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 in exchange for exclusivity arrangements that may keep lower priced drugs off the market. PBMs may switch patients from prescribed drugs to an often more expensive drug to take advantage of rebates that the PBM receives from drug manufacturers. In addition, PBMs derive enormous

² See Mark Meador, *Squeezing the Middleman: Ending Underhanded Dealing In the Pharmacy Benefit Management Industry Through Regulation*, 20 *Annals of Health L.* 77, 80-81 (2011).

profits from the ability to “play the spread” between pharmaceutical manufacturers, pharmacies, and health care plans.

Ultimately, the US Department of Justice and 30 state attorneys general brought cases against each of the major PBMs for some of these actions, including allegations of fraud, misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. These cases have resulted in over \$377 million in damages to states, plans, and patients, including the Federal Trade Commission’s recent finding of Medicare fraud by CVS Caremark resulting in a multi-million dollar fine.³

Because the PBM system is unregulated, the lack of transparency can inflict significant harm. The dominant PBMs are not required to and therefore refuse to disclose the amount of rebates they receive, or other relationships they have, with drug manufacturers and their arrangements with pharmacies. This lack of transparency leaves payors having to rely on the pricing dictated by the PBMs, diminishing their ability to control costs. Because of the lack of transparency, PBMs are free to “play the spread” between manufacturers, pharmacists, and plans because of a lack of disclosure.⁴ Unclear and inadequate disclosure of MAC pricing undermines the ability of plan sponsors to compare competing proposals, and effectively increases the costs for pharmaceuticals for plans and their beneficiaries.

Transparency and a lack of conflicts of interest are vitally important for payors and their beneficiaries. H.B. 1363 is essential to provide transparency for consumers, which will help 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 payors to make sure they are getting the benefits they deserve. We urge the Legislative Assembly to enact H.B. 1363.

Sincerely,



David A. Balto

³ *In the Matter of CVS Caremark* (Federal Trade Commission 2012) (\$5.5 million fine); *United States v. Merck & Co., Inc., et al.* (E.D. Pa. 2006) (\$184.1 million fine); *United States of America, et al. v. AdvancePCS, Inc.* (E.D. Pa. 2005) (\$137.5 million fine); *States Attorneys General v. Caremark, Inc.* (2008) (\$41 million fine); *State Attorneys General v. Express Scripts* (2008) (\$9.5 million fine).

⁴ See David Balto, Testimony Before S. Jud. Comm, Subcomm. on Antitrust, Competition Policy and Consumer Rights (Dec. 6, 2011), available at <http://www.dcantitrustlaw.com/assets/content/documents/testimony/SenateJudiciary.ESIMedci.Balto.pdf>.

House Bill No. 1363

5 HB 1363
2-6-2013

House Industry, Business and Labor Committee

9AM February 6th, 2013

Chairman Kaiser and members of the IBL committee, my name is Randy Habeck and I am here in support of House Bill No. 1363. I'm an owner and pharmacist at Hillsboro Drug. I graduated from NDSU in May of 2002 and have practiced in Hillsboro since the fall of 2003. Hillsboro Drug is the only pharmacy in Hillsboro. I am testifying today because I feel MAC legislation is very important for the long term success of my store. Hillsboro Drug serves Hillsboro a community of about 1,700 people. We also fill for many surrounding communities, all of whom don't have a pharmacy in their town. I feel if there is not MAC reform it will limit my ability to provide care for my customers in the manner that I would like.

Currently there are no guidelines or regulations on PBM's and their MAC pricing. Remember, House Bill Number 1363 wouldn't set the pricing for generic drugs. However, it would give fair guidelines to PBM's and even the playing field for retail pharmacy. The current process for a disputed MAC price is cumbersome and normally doesn't result in a change in the MAC. The process is so futile that I no longer even file appeals due to the time it takes and the poor results I have received. PBM's have made the process a burden. I would much rather be spending my time with patients rather than disputing claims with the PBM.

Currently at Hillsboro Drug about 86% of the prescriptions I fill are for generic drugs and 14% are brand medications. On the 14 % of brand prescriptions I know what I will get paid. Actually, it is more profitable for me to fill a brand name drug. However, on the 86 % of generic drugs I am signing contracts blind and have no idea what the MAC pricing will be. So in essence, when I sign a contract with a PBM I am not sure what I will be paid on 86% of claims. We try very hard to fill as many generics as we can. This is cheaper for the customer and the PBM and brings overall healthcare expenses down. However, it is very difficult to switch a patient to a generic when I know I will lose money on the prescription.

Over the last 9 years I have been a pharmacist at Hillsboro Drug, I have noticed that PBM's respond very quickly to adjust the MAC on a generic drug if the price has gone down. However, when drug prices go up due to drug shortages and increased pricing from the manufacturer PBM's are very slow to respond. This bill would require that price increases are treated the same way that the price decreases are by the PBM's. I feel that House Bill No. 1363 allows for a fair process for pharmacists to address MAC issues.

In closing, I will leave you with 2 examples of MAC issues that came up on Monday of this week.

- 1.) In August 2012 there was a 20 % increase in the price of doxycycline 20mg tabs. Many PBM's still haven't adjusted the price. I have lost \$12.61 on a prescription filled on 12/21/2012 and 02/04/2013. Another PBM has paid me at a loss of \$8.03 on 2 prescriptions for doxycycline on

10/18/12 and 02/05/2013. Note that the price increase occurred in August and we still haven't seen an increase in the MAC.

- 2.) Diltiazem ER 240mg price increase in November. With one PBM I have lost \$2.25 on prescriptions filled on 12/13/12, 01/07/2013, and 02/04/2013. Note the increase was in November and the price still has not been adjusted.

These are just 2 examples from a long list of losses that I have incurred due to inappropriate MAC pricing. I hope that you will consider passing House Bill NO. 1363. Thank you for your time. Please feel free to ask any questions.



⑥ HB 1363
2-6-2013

Testimony North Dakota House Committee on HB 1363

My name is Frank Kline, Pharmacy Contracting Corporate Manager for Thrifty White Pharmacies. We are an employee-owned company, operating 90 pharmacies in the upper Midwest, with 29 locations in North Dakota. In my position with Thrifty White, I receive, evaluate and negotiate contracts with pharmacy benefit managers or PBMs. I would like to thank you for the opportunity to speak to you about this very important legislation.

Today, approximately 75% of the prescriptions filled in our pharmacies are generics. In the next two years, we anticipate this percentage to grow to 80-85%. The contracts that I receive from PBMs indicate that our reimbursement for these generics will be MAC, or maximum allowable cost, plus a dispensing fee. Nothing in the contract indicates how MAC will be calculated or how MAC will relate to AWP or any other benchmark, which makes it impossible for me to evaluate the proposed reimbursement on any individual contract or to compare reimbursement between contracts. Even if I am able to evaluate MAC reimbursement for the previous year of a contract, nothing in the contract assures me that MAC prices will remain consistent from the previous year or even remain consistent through the term of the contract. Some PBMs will provide me with a list of their MAC prices, others indicate that their MAC prices are proprietary and the only way to find out a MAC price is to process a claim for that drug. It is important to understand that once I sign a contract, we are obligated to fill any prescription a customer brings to us, regardless of the reimbursement. Some PBM will ask for documentation from us to justify making a change to the MAC price of a drug. When we do send in the information the PBM's request in order for them to review the MAC pricing issue many do not retro-activate the new price. If they do make a change, the MAC pricing change is just going forward, some PBM's start the new MAC the day they make the decision to make a change and other only make the changes twice a month. I have had many times when I have been able to show the PBM that we are losing money on this particular MAC and are told they are not going to be raising the MAC and do not provide any documentation as to why they feel the MAC price is justified.

HB 1363 establishes reasonable and flexible guidelines to provide me with basic information that any business would expect to have in a contract relationship. It will require I am provided with market-based sources used to determine MAC prices in a contract, so I can better evaluate the contract prior to signing. If the PBM uses more than one MAC list, they will be required to identify which MAC list or lists apply to the contract. They will be required to make a copy of the MAC lists that apply to the contract available to me, will be required to notify me when a MAC price changes and to provide a reasonable process for me to appeal a MAC price. They will be required to retroactively adjust MAC pricing and allow us to reprocess claims. All of this information is essential so that we can evaluate contracts prior to signing and to plan our business going forward. The requirements are broad and allow considerable leeway in how PBMs meet these requirements. I urge you to support HB 1363.

Thank you.

House Industry, Business, and Labor Committee

Chairman – Rep. George Keiser

HB 1363 Hearing

02/06/2013

⑦
HB 1363
2-6-2013

Chairman Keiser and members of the committee, my name is Dan Churchill. I am a pharmacist from Bismarck and an independent community pharmacy owner. I request that you issue a Do Pass recommendation on House Bill 1363.

This bill will bring common sense, fairness, and transparency to the way Pharmacy Benefits Managers (PBM) determine reimbursement for drugs on their Maximum Allowable Cost (MAC) lists. Every day in my pharmacy filling prescriptions that are on PBM MAC lists results in being paid under our wholesale cost. It's a money losing proposition. Most PBM's don't publish their MAC lists. So pharmacies really have no idea what they will be paid for prescriptions when they sign a PBM contract. Most PBM's don't have an appeals process when a MAC is unfair. If the PBM has a MAC appeals process, they usually don't even respond to the appeal. In one scenario I had a patient that filled a prescription that appeared on the PBM's MAC list and every month our reimbursement was \$100 less than our wholesale cost. I appealed to the PBM following their process. Every month for 6 months I filled out forms, made copies of our wholesale invoices for the drugs, and faxed them in to the PBM. Not once did I hear anything back from the PBM, nor was their MAC ever adjusted. In this particular case the drug was a generic, but not a multi-source generic, meaning that only one manufacturer is producing it. This type of drug should never be on a MAC list. The one manufacturer of this drug could change the price at any time.

Another major problem with MAC lists at the current time is dealing with drug shortages. The drug shortages the pharmaceutical market is faced with leads to wild price fluctuations that payers need to be responsive to. If a drug's cost spikes by 30-fold overnight, like recently happened with a widely used oral antibiotic, PBM's need to respond with reimbursement to match that price increase. The job of the PBM is to adjudicate claims for plans and employers so that the insured beneficiary receives health care services. If the PBM is not willing to pay for those services then the insured beneficiary is the ultimate sufferer.

As a pharmacist, my ultimate responsibility is the health and well being of the patient. I need to be able to provide medications and services that promote that health and well being . In order to do that I need fair business partnerships with PBMs that financially reimburse the pharmacy in a realistic manner.

I urge you to issue a do pass recommendation on House Bill 1363 so that North Dakota pharmacists, health care practitioners, and citizens are treated with fairness and transparency in business transactions with Pharmacy Benefits Managers.

Thank you,

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



In Support of HB 1363 Addressing Transparency in PBM MAC Pricing

I am Joel Kurzman, Regional Director, State Government Affairs at the National Association of Chain Drug Stores (NACDS). I am here today on behalf of NACDS member Thrifty White Stores, who operate 26 pharmacies in the state of North Dakota, to testify in support of House Bill 1363. The viewpoints expressed in this testimony represent the position of only this member, and not the NACDS state membership in its entirety.

This important legislation requires pharmacy benefit managers (PBMs), who administer pharmacy benefits on behalf of a variety of health plans, including large organizations such as employers, unions, insurance plans and the government, to establish fair and transparent reimbursement methodologies with the pharmacies that provide pharmacy services through their networks. PBMs reimburse pharmacies for most generic drugs based on maximum allowable cost (MAC) lists. This legislation establishes reasonable requirements for how PBMs set MAC prices; when it is appropriate to establish a MAC price; and generally injects greater transparency into the process for establishing MAC prices.

Often, pharmacies are unaware of the methodology used in the development of the MAC list or the determinations and calculations that go into updating the MAC list. It is even unclear as to the frequency at which MAC lists will be updated. This lack of transparency makes it hard for pharmacies to predict how much they may be reimbursed for a particular drug at any given time. House Bill 1363 addresses this issue by establishing requirements for PBMs to inform pharmacies via the contract of the market-based sources used by the PBM to establish MAC list prices. This information allows

pharmacies to evaluate whether the reimbursement under the plan is adequate *before* they enter into a contract with the PBM.

PBMs use their market power and leverage to impose contract terms to pharmacies; pharmacies have little, if any, ability to negotiate contract terms for this reason. As a result, these contracts often allow PBMs to make unilateral contract modifications, including unpredictable changes to MAC lists, and do not state clearly in their contracts the terms of pharmacy reimbursement. House Bill 1363 remedies this by requiring PBMs to establish a process for prompt notification of pricing updates and to provide such notification in a timely manner. Additionally, this legislation establishes criteria for when it is appropriate to establish a MAC price. Notably, the criteria established by House Bill 1363 is similar to the criteria used by the Centers for Medicare and Medicaid Services to designate a generic drug on the Federal Upper Limit drug price list used as a reimbursement cap for Medicaid prescriptions.

For the reasons discussed, our member Thrifty White Stores supports House Bill 1363, as this measure will establish more transparent and upfront pricing when it comes to generic drugs that is lacking in today's market. We appreciate your consideration of our viewpoints on this topic and urge you to vote in support of House Bill 1363.



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2-6-2013

The Importance of Honest and Transparent Pricing

Introduction

Pharmacy benefit managers (PBMs) are middlemen that design, negotiate and manage prescription drug benefits for a variety of health plans, including large organizations such as employers, unions, insurance plans and the government. Collectively, PBMs have the ability to determine the details of prescription drug benefits available to patients through their plans. PBMs develop formularies (i.e., lists of covered and preferred drug products), negotiate discounts and rebates with pharmaceutical manufacturers and establish plan networks that mandate how, when and where patients fill their prescriptions.

PBMs reimburse pharmacies for generic drugs based on maximum allowable cost (MAC) lists. The MAC list establishes the amount the pharmacy will be reimbursed for a particular generic. Often, pharmacies are unaware of the methodology used in the development of the MAC list or the determinations and calculations that go into updating the MAC list. It is even unclear as to the frequency at which MAC lists will be updated. This lack of transparency makes it hard for pharmacies to predict how much they may be reimbursed for a particular drug at any given time.

Honest and Transparent Pricing

Many PBMs use their incredible market power and leverage to dictate contract terms to pharmacies. PBMs require pharmacies to sign one-sided, take-it-or-leave-it contracts to participate in PBMs' networks. Often, these contracts allow PBMs to make unilateral contract modifications, including unpredictable changes to MAC lists. Pharmacies have no choice but to dispense drugs at a financial loss or lose access to many longtime patients. In most cases, PBMs do not state clearly in their contracts the terms of pharmacy reimbursement.

NACDS supports legislation and regulation that would increase MAC list transparency by requiring PBMs include contract pricing terms which are clear, objective, predictable and consistent with both marketing and pricing practices. Including:

- How PBMs determine the methodology and parameters for pharmacy reimbursement, including the methodology for how PBMs calculate maximum allowable costs (MACs)
- The frequency and notification of price updates to the MAC list
- A commitment to deliver a predictable, particular average reimbursement rate for generics
- Requiring transparency in MAC pricing also allows pharmacies to contest MAC pricing decisions with which they disagree.

Conclusion

NACDS supports reining in questionable PBM activities through legislation requiring more transparent and upfront pricing when it comes to generic drugs. PBM manipulation of MAC list pricing is just one of the many objectionable PBM activities.

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February 1, 2013

AccessHealth 2013 Off to a Fast Start

10 HB 1363
2-6-2013

As January ends, AccessHealth is sending this reminder recapping a few of the recent Initiatives we hope you're employing to add value to your business. As part of over 4,000 Independent pharmacies in the AccessHealth Network, you receive the benefits of scale and the efficiency needed to effectively compete in today's marketplace.

- **Increased accesses to covered lives-** contracts are in place with 56 Medicare Part D **preferred** networks and 23 commercial **restricted** networks. Our contracts help you compete for market share.
- **Increased Reimbursement-** In January, the MAC Success Manager resulted in favorable reimbursement revisions for 122 products. For all of 2012, there were over 1,200 favorable revisions made covering hundreds of thousands of claims. Month in and month out, the MAC Success manager continues to bring awareness and get action on potential wide-spread issues impacting many pharmacies, and emphasize common pricing errors.
- **Timely Education-** recent articles have highlighted Fraud, Waste and Abuse, Short Cycle Billing, Direct and Indirect Remuneration, and Medication Therapy Management (MTM). We will continue to keep you up to date with timely and actionable information.
- **Security** – Your receivables and information are handled with the expertise of a Fortune 14 organization. We have obtained ISO 27001 certification which ensures confidentiality, integrity, and availability of your information assets and minimizes information security risks.
- **Superior Customer Service-** expanded service to 11 hours/day availability, email service (Service.AccessHealth@McKesson.com), and Spanish & Korean speaking representatives.

You can continue to expect the highest levels of service and expertise. We look forward to serving you in 2013.

Thank you for your membership.

Contact AccessHealth's customer care team at 800.824.1763 (Monday through Friday from 8:00 AM – 7:00 PM, EST)

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(11) HB 1363
2-6-2013

2013 House Bill No. 1363
Testimony before the House Industry, Business and Labor Committee
Presented by: Harvey Hanel, Pharmacy Director
Workforce Safety & Insurance
February 6, 2013

Mr. Chairman, Members of the Committee:

My name is Harvey Hanel, Pharmacy Director at WSI.

WSI is generally supportive of HB 1363 with the exception to the requirement to use at least three nationally available, therapeutically equivalent multiple source generic drugs for the pricing standard as stated on page 2, line 15 of the bill. To that effect we are offering an amendment asking to reduce the pricing standard to two nationally available, therapeutically equivalent multiple source generic drugs.

WSI does use a pharmacy benefit management company to administer the pharmacy portion of medical coverage for our injured workers. WSI's PBM reviewed the language of the bill and we received their feedback on how the bill would affect our provision of pharmacy benefits and, ultimately, how it would affect our contractual agreement with the PBM.

The response that we received from our PBM was generally favorable, with the exception of the before mentioned requirement to use three generically equivalent drugs when establishing MAC pricing for generics. They indicated that the industry standard is to use two generically equivalent multiple source generic in establishing the MAC price for that generic product.

In conclusion, WSI offers the attached amendment to HB 1363. It simply replaces the word "three" on Page 2, line 15 with the word "two".

Thank you for your consideration and I would be happy to answer any questions that the committee might have.

PROPOSED AMENDMENTS TO HB 1363

Page 2, line 15, replace "three" with "two"

Renumber accordingly



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HB1363
2-6-2013

BOARD OF PHARMACY
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Jack Dalrymple, Governor

Mark J. Hardy, PharmD, R.Ph.
Assistant Executive Director
Howard C. Anderson, Jr, R.Ph.
Executive Director

HB 1363 – Pharmacy Benefits Managers
House Industry, Business and Labor Committee
9:00 AM – Wednesday – February 6th, 2013 – Peace Garden Room

Chairman Keiser, members of the House Industry, Business and Labor Committee, for the record I am Mark J. Hardy, PharmD, Assistant Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today about House Bill 1363.

The Board of Pharmacy members have discussed **P**harmacy **B**enefit **M**anagers [PBM] and some of the problems that they encounter in their practices. Often discussed are stories of pharmacists having to choose between losing money on a prescription due to the maximum allowable cost set by the PBM being too low to cover the actual 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 patient and dispense the item and take the loss with the hope that they will be able to recover or rebill a claim once the MAC is adjusted to the actual cost. These situations appear to be happening with an increasing frequency, especially in the recent trend of 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, but does not get in the way of patient care decisions either.

Pharmacy Benefit Managers have long been a source of conflict between pharmacists and 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 effect patient care.

The Board of Pharmacy believes the provisions set in House Bill 1363 will standardize a currently unregulated process to ensure that it will be fair for all parties concerned, the pharmacy, the PBM and most importantly the patient.

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

House Bill 1363 – MAC Legislation
House Industry, Business, and Labor Committee
Chairman – Representative George Keiser
February 6, 2013 – 9:00 a.m.

13 HB1363
2-6-2013

Chairman and members of the committee, my name is Jerad Binstock and I am a pharmacy student at North Dakota State University. I appreciate the opportunity to speak with you today about my support for House Bill 1363.

I will start by telling you a little bit about myself. I grew up in Dickinson and have attended NDSU since 2007 pursuing a Doctor of Pharmacy degree. I have worked at the Prescription Shop in West Fargo for the last five years as an intern and I have seen first-hand what goes into running a pharmacy. I am now finishing up my last year before graduating in May. As part of my final year I must complete 8 different internships. I am currently completing a Healthcare Policy internship. I believe healthcare policy is extremely important to future pharmacists and the future of the pharmacy profession. I am very lucky that my last year coincided with a ND Legislative Session and that I have the opportunity to speak with you today.

The bill that is before you is one that greatly impacts how pharmacies are operated in North Dakota. As I have gained more experience working in retail pharmacy, I have seen the way prescription insurance dictates the profession. Specifically, many of the issues surrounding how Pharmacy Benefit Managers (PBMs) conduct their business within the healthcare arena. One day I hope to own and operate my own pharmacy, but that will not be right after I graduate. I do not see myself negotiating contracts with PBMs and drug wholesalers, and completely understanding the whole process within the next year. I know it will take years of experience to fully understand the processes. As you can probably imagine, understanding the pharmacotherapy behind medications is a pretty daunting task, but trying to understand prescription insurance and reimbursement is just as difficult. That is why this bill would be

very helpful to any new pharmacy owner because it makes reimbursement rates and PBMs in general more transparent.

After researching the Maximum Allowable Cost (MAC) topic for the last three weeks, I understand that when MAC pricing is used appropriately it is very important to managing the costs of prescriptions. However, MAC pricing can also be used to create a profit, overcharge plan sponsors, and short-change pharmacies. Especially if multiple MAC lists are used. House Bill 1363 does not eliminate MAC pricing but it does help regulate the transparency of MAC pricing. This is very important to pharmacies as their reimbursement for generic medications is usually dictated by MAC price lists. It is only fair that pharmacies should be able to see how the MAC list is generated so they can adjust how they obtain their medications from wholesalers if necessary. For instance if the PBM knows of a cheap manufacturer that has product available and that is what they base their reimbursement on, it is only fair that the pharmacy should know where they can purchase this cheaper drug from so they do not lose money by dispensing it. This bill also requires the PBMs to update their MAC lists in a timely fashion. This is important because sometimes in the generic market there are drug recalls that deplete supplies and increase the costs of the drugs that are available. This law would require PBMs to stay on top of their MAC price lists so that when the pharmacy dispenses a medication that has recently increased in cost, they are reimbursed the correct amount and not the cheaper amount from the month before.

Thank you for your time and consideration of the bill before you. I urge you to vote YES on HB 1363, not just for me, but for all current and future pharmacy owners. I would be happy to try and answer any questions you may have.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Jerad Binstock". The signature is fluid and cursive, with a long horizontal stroke at the end.

Jerad Binstock
PharmD Candidate 2013

Testimony
House Bill 1363
House Industry, Business and Labor Committee
Representative Keiser, Chairman
Wednesday, February 6, 2013

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HB 1363

2-6-2013

Good morning, Chairman Keiser and members of the House Industry, Business and Labor Committee. My name is Jonah Houts, Vice President of Government Affairs for Express Scripts. I am here to provide testimony in opposition to HB 1363.

Express Scripts administers prescription drug benefits on behalf of our clients – employers, health plans, unions and government health programs — for approximately 109 million Americans. Headquartered in St. Louis, we provide integrated pharmacy benefit management services including pharmacy claims processing, home delivery, specialty benefit management, benefit-design consultation, drug-utilization review, formulary management, medical and drug data analysis services, as well as extensive cost-management and patient-care services. In North Dakota, we provide some or all of these services for many of the state’s residents.

As a pharmacy benefit manager, we use maximum allowable cost benchmarks to ensure a fair reimbursement to pharmacies for generic drugs. MAC pricing was originally developed by state Medicaid programs as they realized that were overpaying for generic medications. Today, 46 Medicaid programs, multiple federal programs, and most private payers use a MAC benchmark.

There is no single publisher of a MAC price. All of the other pricing benchmarks that exist are useful for brand drugs, but none are flexible or broadly applicable enough for the generic drug market. As the marketplace changes, because manufacturers discontinue production of a product, there is a shortage, the FDA imposes a sanction on a manufacturer or any other reason, MAC prices will fluctuate.

One of the ways that my company serves patients in North Dakota is as a mail order and specialty pharmacy. At each of these businesses, we recognize the importance of maximum allowable cost pricing to ensure that the pharmacy industry doesn’t include members that try to overcharge patients for generic medicines. It keeps us constantly working to make sure we’re purchasing products at the lowest possible cost for our plans and patients. As a pharmacy who is subject to MAC prices every day, we are not asking for HB 1363. We do not support this legislation. Different manufacturers will charge different amounts for equally interchangeable generic drugs. If a pharmacy buys the higher-priced product, it will not make as large a spread or could lose money, but if it buys the cheapest generic drug it will make more. MAC pricing keeps the economic incentives in the right place.

Critics of MAC pricing often do not acknowledge that maximum allowable cost prices increase frequently. This year, the MAC prices for certain drugs that treat high blood pressure, arthritis, pain and infections all increased for various reasons. In several cases, the wholesalers raised their price. In others, there were issues with nationwide availability for the product. In another, the MAC price increased because of a pharmacy complaint.

It is important for the Committee to understand that many pharmacies in North Dakota do not directly contract with pharmacy benefit managers. Rather, they use group purchasing organizations called pharmacy services administrative organizations (PSAOs) who collectively contract with PBMs. Simultaneously, the PSAOs are serving as the wholesaler to the pharmacies and selling them the drugs for their pharmacies. Simply put, the PSAO sells the pharmacy the inventory AND administers the contract for reimbursement at the pharmacy. If there is an egregious difference between the amounts a pharmacy pays to procure and drug and the amount they are reimbursed in return, we cannot have a complete dialogue without having the PSAO present to address their dual role in the supply chain.

Pharmacies are doing well in North Dakota and we regularly have new pharmacies apply to join the Express Scripts network to serve our patients. In 2012, seven new independent pharmacies joined our network. But this growth in the North Dakota pharmacies is due to competition in the market, and not the kind of policies in HB 1363. If MAC information is publicized, it would have an anti-competitive effect on insurers and employers, as well as PBMs. Competing plans, wholesalers, pharmacies and others would have access to others' pricing information. According to the FTC, this would drive up drug prices for employers and consumers. In a letter to the Mississippi House of Representatives in 2011 about a similar type of disclosure, the FTC warned that "pharmacies and manufacturers will be less likely to offer "deals" when they know that everyone they do business with can see the terms of the deal and will likely demand the same terms."

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



15 HB 1363
2-6-2013

Written Testimony in Opposition to HB 1363

Submitted by:

Erik Woehrmann

Director, State Government Affairs

CVS Caremark Corporation

To:

The House Industry, Business and Labor Committee

February 6, 2013

Chairman Keiser, Vice Chairman Sukut and members of the Committee on Industry, Business and Labor, CVS Caremark is submitting this testimony in opposition to HB 1363, a bill creating and enacting a new section of the Century Code, relating to maximum allowable cost lists for pharmaceuticals. HB 1363 is being promoted as an effort to promote transparency in Maximum Allowable Cost (MAC) lists but it, in fact, serves to weaken the ability of Pharmacy Benefit Managers (PBMs) to drive down health care costs for clients and consumers. It also interferes with private contracts in an unprecedented way. We respectfully ask for you to reject HB 1363.

CVS Caremark is the leading pharmacy health care provider in the United States. Through our integrated offerings across the entire spectrum of pharmacy care, we are uniquely positioned to provide greater access to care, engage plan members in behaviors that improve their health, and lower overall health care costs for health plans and their members. CVS Caremark provides multiple points of care to patients through our retail, mail and specialty pharmacies and MinuteClinics. As one of the country's top Pharmacy Benefit Managers (PBM), we also provide access to a network of more than 65,000 pharmacies, including more than 7,400 stores across the United States. We serve over 2,200 clients who provide health coverage through large employers, unions, health plans and state and federal plans. We touch more than 60 million American lives and are one of the largest providers of Medicare Part D coverage.

In North Dakota, CVS Caremark employs more than 170 employees, including 23 pharmacists and operates 6 neighborhood CVS pharmacy stores. IN 2012, CVS Caremark dispensed nearly 1.5 million prescriptions in the state. We are a trusted and reliable source of health care in North Dakota. We do not take this lightly and, in fact, take great pride in our employees and the services that they provide to the citizens of your state

Introduction to PBMs

Pharmacy Benefit Managers (PBMs) provide pharmacy benefit management services to health plan clients, employers, unions and federal, state and local government bodies. We help design prescription drug benefit options to fit the sponsor's beneficiary population and needs and then administer the benefit on the sponsor's behalf. PBMs make prescription drugs more affordable for clients with such tools as:

- **Plan Design:** PBMs advise their clients on ways to structure their drug benefit in an innovative and cost-effective manner to ensure appropriate use of resources. A PBM's role is advisory only; the decision to select the features of the benefit rests with the client.
- **Network Management:** PBMs negotiate with thousands of pharmacies to create provider networks for beneficiaries to obtain prescription drugs, monitor safety issues across the network and ensure appropriate spending through audits and other efforts that promote network integrity.
- **Formulary Management:** PBMs use panels of independent physicians, pharmacists and other experts to develop lists of drugs approved for reimbursement by the client, and administer cost-sharing and utilization management (e.g., step therapy) as directed by the client.
- **Mail-Service Pharmacy:** PBMs provide highly efficient mail-service pharmacies that offer safe, cost-effective and convenient home delivery of medications.
- **Manufacturer Rebates and Discounts:** PBMs negotiate substantial discounts from drug manufacturers to lower benefit costs for sponsors and beneficiaries.

There are, essentially, three different types of Pharmacy Benefit Managers. ExpressScripts, is the best example of what can be termed as a "traditional PBM model". The second model is the health-plan carve-in, in which medical and pharmacy plans are offered as an integrated package. A good example of this model is United Healthcare and its in-house management OptumRx business unit. The third is the integrated PBM model. CVS Caremark is the lone player in this category, as is more fully described above. What's truly special about this model is that it preserves the economic benefit of mail order while providing more flexible access to medications through either mail or retail. It also provides members with more ways to access clinical support – they can speak with a pharmacist at their local CVS Pharmacy or on the phone.

Introduction to MAC

MAC (Maximum Allowable Cost) is a common cost management tool specifying the reimbursement limit for a particular strength and dosage of a generic drug that is available from multiple manufacturers, but sold at different prices. It is calculated based on aggregate data that shows what pharmacies on average pay for generic drugs in the marketplace. MACs are used to ensure pharmacies are not overpaid or underpaid and that Payers and their members get the best deal. Likewise all pharmacies, may dispute the accuracy of any MAC claim and be compensated accordingly. For instance, in 2012, there were

approximately 170 CVS Caremark MAC claim inquiries in North Dakota of which 30 had price adjustments made.

It is important to note that there are currently 46 state Medicaid programs that now use MAC lists, including North Dakota Medicaid. States adopted MAC lists after Government audits showed that Medicaid reimbursements for generic drugs far exceeded pharmacy's acquisition costs. HB 1363 exempts North Dakota Medicaid from the requirements of the bill. The fact is that MAC lists are used in both the public and private sectors to help control costs. If this legislation were beneficial and necessary – then why is the state Medicaid program excluded from this bill, and why is it the only publicly funded program that is excluded? If this legislation is truly in the best interest of the citizens of North Dakota, then Medicaid should be included too.

The clients of Pharmacy Benefit Managers are sophisticated purchasers of health care that rely on PBMs to manage their drug benefit. Pharmacy benefit managers consider many factors when establishing MAC lists, including: First Databank/Medispan data, the federal upper limits of CMS, wholesaler information, pharmacy incentive to dispense the generic over the brand, pharmacy feedback, non-MAC discounts and client performance guarantees, to name a few. Contract pricing, including MAC lists, are proprietary information and should not be publicly disclosed or available to other PBMs. Disclosure of proprietary pricing information has been deemed by the Federal Trade Association as anti-competitive and would only serve to drive up costs in the marketplace. If MAC information is publicized, competing PBMs could have access to others' pricing information and competing pharmacies would have access to others' reimbursement calculations. There is no provision in this bill for maintaining the confidentiality of this information.

Why CVS Caremark Opposes HB 1363

There is no set MAC list or price. The lists and prices change at any given time and it would be impossible for a pharmacist to review all of the changes in lists and prices even if we were able to make all of them available. According to the Generic Pharmaceutical Association, "10,072 of the 12,751 drugs listed in the FDA's Orange Book have generic counterparts." In other words, this bill would require us to notify every retail pharmacy in our network in North Dakota anytime there is a change in pricing for any one of these 10,000 generic drugs. There are multiple lists because along with our clients and employers, CVS Caremark creates them to keep budgets in check and manage prices. Our clients keep their healthcare costs down by using MAC lists as one of several cost control techniques available to them. Employers and their employees lose if this bill becomes law as it is money out of their pockets and they will be forced to react accordingly. I have included examples of changes in pricing for your review and the necessity of MAC list flexibility.

HB 1363 mandates by statute a one-size-fits-all approach to the key contract term of MAC pricing without any consideration as to its necessity or consequence. State-mandated terms of private PBM agreements could impede plans' ability to seek favorable terms during contract negotiations. A PBM may offer its client multiple variations of plan options based on a client's Request for Proposals ("RFP"),

culminating into a contract after aggressive negotiations where members' access to prescription drugs, economic efficiency and quality are key considerations on both sides. Clients choose pricing arrangements that consider impact on their overall costs and cash flow as well as the level of risk they wish to assume. This flexibility affords plans the ability to choose from the most efficient PBM plan options that meet the needs of their members, which ultimately fosters competition among PBMs and allows both sides to preserve incentives that reduce overall health care costs. By dictating the key terms of a contract between health plans and PBMs and by interfering in these contracts, HB 1363 handcuffs PBMs and plans from engaging in aggressive negotiations that would otherwise reduce costs while increasing health care quality.

Interference in private PBM contracting as proposed by HB 1363 is, again, contrary to sound public policy. A March 2007 report from the tax, audit and advisory firm PricewaterhouseCoopers ("PwC") concluded that restricting PBM activities would result in increased costs for prescription drugs, higher insurance premiums and an increase in the number of uninsured individuals. PwC determined that PBMs save consumers and plan sponsors, on average, 29 percent on the cost of prescription drugs compared to retail purchases with no pharmacy benefit management support.ⁱ The terms of PBM contracts with drug manufacturers, clients and pharmacies are valuable, confidential property protected by federal and state law.

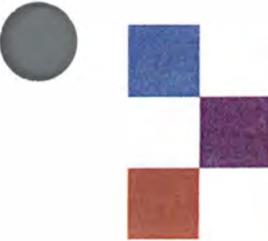
Conclusion

CVS Caremark appreciates the opportunity to provide comments in opposition to HB 1363. In addition to these comments, it is necessary to highlight the unique nature of this legislation. The legislature, by passing this bill, would be inserting itself, by mandate, into the pricing contracts that are agreed to between businesses in a competitive and private marketplace. Setting minimum reimbursement rates, that will likely be higher than the current minimums and drive up costs, will only hurt competition and, ultimately, the patients who depend on life saving medications. Furthermore, this legislation takes the severe and unusual step of calling for misdemeanor punitive actions to enforce unfair standard operating procedures and business practices on PBM's. CVS Caremark respectfully asks you to reject HB 1363.

¹ PricewaterhouseCoopers, *Pharmacy Benefit Management Savings in Medicare and the Commercial Marketplace & the Cost of Proposed PBM Legislation, 2008-2017* (March, 2007).

ii (PCMA, July 2004)

Addendum



Generic Lipitor Cost Comparison

- Atorvastatin 20mg Tab pricing at launch

- Average Estimated Acq Cost discount = AWP – 23%
- (\$4.23/tablet)

- Atorvastatin 20mg Tab pricing after exclusivity

- Average Estimated Acq Cost discount = AWP – 86%
- (\$0.78/tablet)



Generic Lipitor Cost Comparison

- Atorvastatin 20mg Tab pricing at launch

- Average Estimated Acq Cost discount = AWP – 23%
- (\$4.23/tablet)

- Atorvastatin 20mg Tab pricing after exclusivity

- Average Estimated Acq Cost discount = AWP – 86%
- (\$0.78/tablet)



Generic Price Range

<u>Drug</u>	<u>Estimated Acquisition Cost Range</u>
Amlodipine 10mg Tab (indication: high blood pressure)	\$0.05/tab – \$0.32/tab
Fluoxetine 20mg Cap (indication: depression)	\$0.05/cap – \$0.23/cap
Simvastatin 40mg Tab (indication: high cholesterol)	\$0.05/tab – \$0.37/tab



Example of why MAC is needed with only 1 vendor

Drug: Anagrelide Cap 0.5mg
Number of generic vendors: 1
Estimated acquisition cost: \$0.20/capsule (translates to AWP-97%)

Approximate current reimbursement (MAC): ~\$50/rx

Non-MAC AWP discounts vary : AWP-25% is typical (FEP)

Approximate reimbursement (AWP): ~\$680/rx (AWP=7.50 /capsule)

Other Companies that use a MAC with one generic vendor like FEP:
IBM, Wells Fargo, Siemens

① HB 1363
Subcommittee
2-11-2013

Sixty-third
Legislative Assembly of North Dakota
HOUSE BILL NO. 1363

Introduced by Representatives Keiser, N. Johnson, Kasper, Pollert, Weisz, Mock, M. Nelson Senators
Klein, J. Lee, Heckaman

A BILL for an Act to create and enact a new section to chapter 19-02.1 of the North Dakota Century Code, relating to maximum allowable cost lists for pharmaceuticals; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 19-02.1 of the North Dakota Century Code is created and enacted as follows:

Maximum allowable cost lists for pharmaceuticals - Pharmacy benefits managers - Penalty.

1. For the purposes of this section:

a. "Maximum allowable cost price" means a maximum reimbursement amount for a group of therapeutically equivalent and pharmaceutically equivalent multiple source generic drugs.

b. "Pharmacy benefits manager" has the same meaning as in section 19-03.6-01.

2. With respect to each contract between a pharmacy benefits manager and a pharmacy, each pharmacy benefits manager shall:

a. Provide to the pharmacy, at the beginning of each calendar year, the market-based sources utilized to determine the maximum allowable cost pricing of the pharmacy benefits manager, update that pricing information at least every seven calendar days every two weeks, and establish a reasonable process for the prompt notification of the pricing updates to network pharmacies.

b. Disclose the market-based sources utilized for setting maximum allowable cost price rates on associated with each maximum allowable cost price list included under the contract and identify each network or pharmacy provider to which each list applies. A pharmacy benefits manager shall make the list of the maximum allowable costs available to a contracted pharmacy in a format that is readily accessible and usable to the contracted pharmacy.

c. Ensure maximum allowable cost prices are not set below market-based sources available for purchase without limitations by pharmacy providers.

d. Provide a reasonable administrative appeals procedure to allow a dispensing pharmacy provider to contest a listed maximum allowable price rate. The pharmacy benefits manager shall respond to a provider that has contested a maximum allowable price rate through the procedure within seven calendar business days. If an update to the maximum allowable price rate for an appealed drug is warranted, the

~~pharmacy benefits manager shall make the change retroactive based on the date of the review period pharmacy provider's invoice and make the adjustment effective for all similarly situated North Dakota pharmacy providers in the network.~~

~~3. A pharmacy benefits manager may not place a prescription drug on a maximum allowable price list unless:~~

~~a. The drug has at least three nationally available, therapeutically equivalent, multiple-source generic drugs with a significant cost difference. The drug has at least one nationally available, therapeutically equivalent multisource drug.~~

~~b. The drug is listed as therapeutically equivalent and pharmaceutically equivalent or meets bioequivalence ratings in "A" rated in the United States food and drug administration's most recent version of the "Orange Book"; and:~~

~~c. The drug is available for purchase without limitations by all pharmacies in the state from national or regional wholesalers and not obsolete or temporarily unavailable.~~

~~4. A pharmacy benefits manager shall disclose to a plan sponsor contracted payor whether the pharmacy benefits manager is using the identical maximum allowable price list with respect to billing the plan sponsor contracted payor as the pharmacy benefits manager uses when reimbursing all North Dakota network pharmacies. If multiple maximum allowable price lists are used, the pharmacy benefits manager shall disclose to the plan sponsor contracted payor any differences between the amount paid to any pharmacy and the amount charged to the plan sponsor contracted payor.~~

~~5. This section does not apply to state medicaid programs.~~

~~65. A pharmacy benefits manager that violates this section is guilty of a class B misdemeanor shall be subject to a fine of up to \$1,000 per pharmacy.~~

Proposed Subcommittee Amendments to HB 1363

February 11, 2013

From Pat Ward for PBM's

Prepared for Nancy Johnson, Jim Kasper, Ed Gruchalla

p. 1, L12, Remove "generic"

p. 1, L17, Remove "market-based"

p. 1, L 18, Remove "every"

p. 1, L 19, Replace "seven calendar days" with "every two weeks"

p. 1, L 22, Replace "on" with "associated with"

p. 1, L 23, Remove "and identify each network or pharmacy provider to which each list applies"

p. 2, LL 3-4, Remove lines 3-4

p. 2, L 5, Replace "d" with "c"

p. 2, L 8, Replace "calendar" with "business"

p. 2, L 9, After "rate" insert "for an appealed drug"

p. 2, L 10, Remove "retroactive" and after "date of the" insert "review period."

p. 2, L 11, Delete "pharmacy provider's invoice"

p. 2, L 11, After "all" insert "similarly situated North Dakota"

p. 2, Remove lines 15 and 16 and replace with "The drug has at least one therapeutically equivalent multisource drug"

p. 2, Remove lines 17 through 29

p. 2, L 30, Remove "is guilty of a Class B"

p. 2, L 31, Replace "misdemeanor" with "shall be subject to a fine of up to \$1,000 per pharmacy."

Renumber Accordingly

① HB1363
2-12-2013
Subcommittee

Sixty-third
Legislative Assembly of North Dakota
HOUSE BILL NO. 1363

Introduced by Representatives Keiser, N. Johnson, Kasper, Pollert, Weisz, Mock, M. Nelson Senators
Klein, J. Lee, Heckaman

1 A BILL for an Act to create and enact a new section to chapter 19-02.1 of the North Dakota
2 Century Code, relating to maximum allowable cost lists for pharmaceuticals; and to provide a
3 penalty.

4 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

5 **SECTION 1.** A new section to chapter 19-02.1 of the North Dakota Century Code is created
6 and enacted as follows:

7 **Maximum allowable cost lists for pharmaceuticals - Pharmacy benefits managers -**

8 **Penalty.**

9 1. For the purposes of this section:

10 a. "Maximum allowable cost price" means a maximum reimbursement amount for a
11 group of therapeutically equivalent and pharmaceutically equivalent multiple
12 source brand and generic drugs.

13 b. "Pharmacy benefits manager" has the same meaning as in section 19-03.6-01.

14 2. With respect to each contract between a pharmacy benefits manager and a pharmacy,
15 each pharmacy benefits manager shall:

16 a. Provide to the pharmacy, at the beginning of each calendar year, the
17 market-based sources utilized to determine the maximum allowable cost pricing
18 of the pharmacy benefits manager, update that pricing information at least every
19 seven calendar days every two weeks, and establish a reasonable process for the prompt
20 notification of the pricing updates to network pharmacies.

21 b. Disclose the market-based sources utilized for setting maximum allowable cost
22 price rates on associated with each maximum allowable cost price list included under the
23 contract

24 and identify each network or pharmacy provider to which each list applies. A
pharmacy benefits manager shall make the list of the maximum allowable costs

1 available to a contracted pharmacy in a format that is readily accessible and
2 usable to the contracted pharmacy.

3 ~~c. Ensure maximum allowable cost prices are not set below market-based sources~~
4 ~~available for purchase without limitations by pharmacy providers.~~

5 d. Provide a reasonable administrative appeals procedure to allow a dispensing
6 pharmacy provider to contest a listed maximum allowable price rate. The
7 pharmacy benefits manager shall render final resolution respond to a provider that has
8 contested a
9 maximum allowable price rate through the procedure within seven calendar-business days.
10 If an update to the maximum allowable price rate for an appealed drug is warranted, the
11 pharmacy
12 benefits manager shall make the change retroactive based on the date of the review period
13 pharmacy provider's invoice and make the adjustment effective for all similarly situated North
14 Dakota pharmacy
15 providers in the network.

16 3. A pharmacy benefits manager may not place a prescription or drug on a maximum
17 allowable price list unless:

18 a. The drug has at least three nationally available, therapeutically equivalent,
19 multiple source generic drugs with a significant cost difference The drug has at least two
20 nationally available therapeutically equivalent drugs or where a generic drug product is
21 available from only one manufacturer.

22 b. The drug is listed as therapeutically equivalent and pharmaceutically equivalent
or "A" "B" or "Z" rated in the United States food and drug administration's most recent
version of the "Orange Book"; and.

c. The drug is available for purchase without limitations by all pharmacies in the
state from national or regional wholesalers and not obsolete or temporarily
unavailable.

23 4. A pharmacy benefits manager shall, as directed under the terms of the contract between the
contracted payor and the pharmacy benefits manager, disclose to a ~~plan sponsor~~ *contracted*
payor whether the pharmacy
24 benefits manager is using the identical maximum allowable price list with respect to
25 billing the ~~plan sponsor~~ *contracted payor* as the pharmacy benefits manager uses when
reimbursing all *North Dakota*
26 network pharmacies. If multiple maximum allowable price lists are used, the pharmacy
27 benefits manager shall disclose to the ~~plan sponsor~~ *contracted payor* any differences between
the
28 amount paid to any pharmacy and the amount charged to the ~~plan sponsor~~ *contracted payor*.
29 5. This section does not apply to state medicaid programs.
30 6. A pharmacy benefits manager that violates this section is guilty of a class B
31 misdemeanor.

(Z) HB 1363
Subcom.
2-12-2013

CHAPTER 26.1-27.1

PHARMACY BENEFITS MANAGEMENT

Section		Section	
26.1-27.1-01. Definitions.			management agreement —
26.1-27.1-02. Licensing.			Requirements.
26.1-27.1-03. Disclosure requirements.		26.1-27.1-06.	Examination of insurer-covered
26.1-27.1-04. Prohibited practices.			entity.
26.1-27.1-05. Contents of pharmacy benefits		26.1-27.1-07.	Rulemaking authority.

26.1-27.1-01. Definitions. In this chapter, unless the context otherwise requires:

1. "Covered entity" means a nonprofit hospital or a medical service corporation; a health insurer; a health benefit plan; a health maintenance organization; a health program administered by the state in the capacity of provider of health coverage; or an employer, a labor union, or other entity organized in the state which provides health coverage to covered individuals who are employed or reside in the state. The term does not include a self-funded plan that is exempt from state regulation pursuant to the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.]; a plan issued for coverage for federal employees; or a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long-term care, or other limited-benefit health insurance policy or contract.
2. "Covered individual" means a member, a participant, an enrollee, a contractholder, a policyholder, or a beneficiary of a covered entity who is provided health coverage by the covered entity. The term includes a dependent or other individual provided health coverage through a policy, contract, or plan for a covered individual.
3. "De-identified information" means information from which the name, address, telephone number, and other variables have been removed in accordance with requirements of title 45, Code of Federal Regulations, part 164, section 512, subsections (a) or (b).
4. "Generic drug" means a drug that is chemically equivalent to a brand name drug for which the patent has expired.
5. "Labeler" means a person that has been assigned a labeler code by the federal food and drug administration under title 21, Code of Federal Regulations, part 207, section 20, and that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.
6. "Payment received by the pharmacy benefits manager" means the aggregate amount of the following types of payments:
 - a. A rebate collected by the pharmacy benefits manager which is allocated to a covered entity;

Rebate

Share Filings
Rate Filings

- b. An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;
- c. A pharmacy network fee; and
- d. Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, formulary management program, mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.
7. "Pharmacy benefits management" means the procurement of prescription drugs at a negotiated rate for dispensation within this state to covered individuals; the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals; or the providing of any of the following services with regard to the administration of the following pharmacy benefits:
- a. Claims processing, retail network management, and payment of claims to a pharmacy for prescription drugs dispensed to a covered individual;
- b. Clinical formulary development and management services; or
- c. Rebate contracting and administration.
8. "Pharmacy benefits manager" means a person that performs pharmacy benefits management. The term includes a person acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. The term does not include a public self-funded pool or a private single-employer self-funded plan that provides benefits or services directly to its beneficiaries. The term does not include a health carrier licensed under title 26.1 if the health carrier is providing pharmacy benefits management to its insureds.
9. "Rebate" means a retrospective reimbursement of a monetary amount by a manufacturer under a manufacturer's discount program with a pharmacy benefits manager for drugs dispensed to a covered individual.
10. "Utilization information" means de-identified information regarding the quantity of drug prescriptions dispensed to members of a health plan during a specified time period.

Source: S.L. 2005, ch. 269, § 2.

26.1-27.1-02. Licensing. A person may not perform or act as a pharmacy benefits manager in this state unless that person holds a certificate of registration as an administrator under chapter 26.1-27.

Source: S.L. 2005, ch. 269, § 2.

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26.1-27.1-03. Disclosure requirements.

- 1. A pharmacy benefits manager shall disclose to the commissioner any ownership interest of any kind with:
 - a. Any insurance company responsible for providing benefits directly or through reinsurance to any plan for which the pharmacy benefits manager provides services.
 - b. Any parent company, subsidiary, or other organization that is related to the provision of pharmacy services, the provision of other prescription drug or device services, or a pharmaceutical manufacturer.
- 2. A pharmacy benefits manager shall notify the commissioner in writing within five business days of any material change in the pharmacy benefits manager's ownership.

Source: S.L. 2005, ch. 269, § 2.

26.1-27.1-04. Prohibited practices.

- 1. A pharmacy benefits manager shall comply with chapter 19-02.1 regarding the substitution of one prescription drug for another.
- 2. A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one contract in order to participate in another contract. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in a particular network if the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the pharmacy benefits manager's contract.

Source: S.L. 2005, ch. 269, § 2.

26.1-27.1-05. Contents of pharmacy benefits management agreement — Requirements.

- 1. A pharmacy benefits manager shall offer to a covered entity options for the covered entity to contract for services that must include:
 - a. A transaction fee without a sharing of a payment received by the pharmacy benefits manager;
 - b. A combination of a transaction fee and a sharing of a payment received by the pharmacy benefits manager; or
 - c. A transaction fee based on the covered entity receiving all the benefits of a payment received by the pharmacy benefits manager.
- 2. The agreement between the pharmacy benefits manager and the covered entity must include a provision allowing the covered entity to have audited the pharmacy benefits manager's books, accounts, and records, including de-identified utilization information, as necessary to confirm that the benefit of a payment received by the pharmacy benefits manager is being shared as required by the contract.

Source: S

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Source: S.L. 2005, ch. 269, § 2.

26.1-27.1-06. Examination of insurer-covered entity.

1. During an examination of a covered entity as provided for in chapter 26.1-03, 26.1-17, or 26.1-18.1, the commissioner shall examine any contract between the covered entity and a pharmacy benefits manager and any related record to determine if the payment received by the pharmacy benefits manager which the covered entity received from the pharmacy benefits manager has been applied toward reducing the covered entity's rates or has been distributed to covered individuals.
2. To facilitate the examination, the covered entity shall disclose annually to the commissioner the benefits of the payment received by the pharmacy benefits manager received under any contract with a pharmacy benefits manager and shall describe the manner in which the payment received by the pharmacy benefits manager is applied toward reducing rates or is distributed to covered individuals.
3. Any information disclosed to the commissioner under this section is considered a trade secret under chapter 47-25.1.

Source: S.L. 2005, ch. 269, § 2.

26.1-27.1-07. Rulemaking authority. The commissioner shall adopt rules as necessary before implementation of this chapter.

Source: S.L. 2005, ch. 269, § 2.

CHAPTER 26.1-28

INSURANCE VENDING MACHINES

Section	Section
26.1-28-01. Sale of insurance from vending machines restricted.	26.1-28-04. Suspension, revocation, or refusal of license — Notice and opportunity to be heard.
26.1-28-02. Sale of insurance through vending machines under certain conditions.	26.1-28-05. Penalty.
26.1-28-03. Licensing of vending machine devices — Expiration date.	

26.1-28-01. Sale of insurance from vending machines restricted.

No insurance may be offered for sale, issued, or sold by or from any vending machine or appliance or any other medium, device, or object designed or used for vending purposes, in this chapter referred to as a vending machine, except as provided in this chapter.

Source: S.L. 1985, ch. 316, § 5.

Derivation: N.D.C.C. § 26-33-01.

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Stated

Prepared by: Mike Schwab

① HB 1363
2-19-2013
subcommittee

Sixty-third
Legislative Assembly of North Dakota
HOUSE BILL NO. 1363

Introduced by Representatives Keiser, N. Johnson, Kasper, Pollert, Weisz, Mock, M. Nelson,
Senators Klein, J. Lee, Heckaman

A Bill for an Act to create and enact a new section to chapter 19-02.1 of the North Dakota Century Code, relating to maximum allowable cost lists for pharmaceuticals, and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA

SECTION 1. A new section to chapter 19-02.1 of the North Dakota Century Code is created and enacted as follows:

Maximum allowable cost lists for pharmaceuticals – Pharmacy benefits managers – Penalty.

1. For purposes of this section:
 - a. "Maximum allowable cost price" means a maximum reimbursement amount for a group of therapeutically equivalent and pharmaceutically equivalent multiple source ~~generic~~ drugs.
 - b. "Pharmacy benefits manager" has the same meaning as in section 19-03. 6-01.
 - c. "Determination" means a decision settling and ending a controversy, the resolving of a question through appeal.
 - d. "Multiple source drug" is a therapeutically equivalent drug that is available from at least two different manufacturers.
2. With respect to each contract between a pharmacy benefits manager and a pharmacy, each pharmacy benefits manager shall:
 - a. Provide to a pharmacy, at the beginning of each ~~calendar year~~ contract and contract renewal, the ~~market-based~~ sources utilized to determine the maximum allowable cost pricing of the pharmacy benefits manager.
 - b. Update maximum allowable cost price lists ~~pricing information~~ at least every seven ~~calendar~~ business days and ~~establish a reasonable process for the~~ provide prompt notification of the pricing ~~updates~~ changes to network pharmacies.
 - c. Disclose the ~~market-based~~ sources utilized for setting maximum allowable cost price rates on each maximum allowable cost price list included under the contract and identify each ~~network or pharmacy provider to which each list applies~~ maximum allowable cost price list that applies to the contracted pharmacy. A pharmacy

benefits manager shall make the list of the maximum allowable costs available to a contracted pharmacy in a format that is readily accessible and usable to the contracted pharmacy.

- d. Ensure maximum allowable cost prices are not set below ~~market-based~~ sources available for purchase without limitations by pharmacy providers utilized by the pharmacy benefits manager.
 - e. Provide a reasonable administrative appeals procedure to allow a dispensing pharmacy provider to contest a listed maximum allowable price rate. The pharmacy benefits manager shall ~~respond~~ render final determination to a dispensing pharmacy provider that has contested a maximum allowable price rate ~~through the procedure~~ within seven calendar business days. If an update to the maximum allowable price rate for an appealed drug is warranted, the pharmacy benefits manager shall make the change ~~retroactive~~ based on the date of the final determination ~~pharmacy provider's invoice~~ and make the adjustment effective for all similarly situated North Dakota pharmacy providers in the network.
 - f. Ensure ~~copayments and~~ dispensing fees are not included in the calculation of maximum allowable cost price reimbursement to pharmacy providers.
3. A pharmacy benefits manager may not place a prescription or drug on a maximum allowable price list unless:
- a. The drug has at least ~~three~~ two nationally available, therapeutically equivalent, multiple source ~~generic drugs with a significant cost difference~~ or where a generic drug is only available from one manufacturer; and
 - b. The drug is listed as therapeutically equivalent and pharmaceutically equivalent "A", or "B" ~~or "Z"~~ rated in the United States food and drug administration's most recent version of the "Orange Book"; and
 - c. The drug is generally available for purchase ~~without limitations~~ by all pharmacies in the state from national or regional wholesalers and not obsolete ~~or temporarily unavailable~~.
- ~~4. A pharmacy benefits manager shall disclose to a plan sponsor whether the pharmacy benefits manager is using the identical maximum allowable price list with respect to billing the plan sponsor as the pharmacy benefits manager uses when reimbursing a network pharmacies. If multiple maximum allowable price lists are used, the pharmacy benefits~~

JMS

~~manager shall disclose to the plan sponsor any differences between the amount paid to any pharmacy and the amount charged to the plan sponsor.~~

5. This section does not apply to state Medicaid programs.
6. A pharmacy benefits manager that violates this section is guilty of a class B misdemeanor.

Mike Schwab
2/18/13

Red font = items to be added

Double-strikethrough = items to be removed

Teal highlight = items NDPhA has agreed to at PBMs request

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② HB 1363
2-19-2013
Subcommittee

Sixty-third
Legislative Assembly of North Dakota
HOUSE BILL NO. 1363

Introduced by Representatives Keiser, N. Johnson, Kasper, Pollert, Weisz, Mock, M. Nelson,
Senators Klein, J. Lee, Heckaman

A Bill for an Act to create and enact a new section to chapter 19-02.1 of the North Dakota Century Code, relating to maximum allowable cost lists for pharmaceuticals, and to provide a penalty.

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Maximum allowable cost lists for pharmaceuticals – Pharmacy benefits managers – Penalty.

1. For purposes of this section:

- a. "Maximum allowable cost price" means a maximum reimbursement amount for a group of therapeutically equivalent and pharmaceutically equivalent multiple source ~~generic~~ drugs.
- b. "Pharmacy benefits manager" has the same meaning as in section 19-03. 6-01.
- c. "Determination" means a decision settling and ending a controversy, the resolving of a question through appeal.
- d. "Multiple source drug" is a therapeutically equivalent drug that is available from at least two different manufacturers.

2. With respect to each contract between a pharmacy benefits manager and a pharmacy, each pharmacy benefits manager shall:

- a. Provide to a pharmacy, at the beginning of each ~~calendar year~~ **contract and contract renewal**, the ~~market-based~~ sources utilized to determine the maximum allowable cost pricing of the pharmacy benefits manager.
- b. Update **maximum allowable cost price lists** ~~pricing information~~ at least every seven ~~calendar~~ **business** days and ~~establish a reasonable process for the~~ **provide** prompt notification of the pricing ~~updates~~ **changes** to network pharmacies.
- c. Disclose the ~~market-based~~ sources utilized for setting maximum allowable cost price rates on each maximum allowable cost price list included under the contract and identify each ~~network or pharmacy provider to which each list applies~~ **maximum**

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Red font = items to be added

Double strikethrough = items to be removed

Teal highlight = items NPhA has agreed to at PBM's request

allowable cost price list that applies to the contracted pharmacy. A pharmacy benefits manager shall make the list of the maximum allowable costs available to a contracted pharmacy in a format that is readily accessible and usable to the contracted pharmacy.

- d. Ensure maximum allowable cost prices are not set below market-based sources available for purchase without limitations by pharmacy providers utilized by the pharmacy benefits manager.
- e. Provide a reasonable administrative appeals procedure to allow a dispensing pharmacy provider to contest a listed maximum allowable price rate. The pharmacy benefits manager shall respond render final determination to a dispensing pharmacy provider that has contested a maximum allowable price rate through the procedure within seven calendar business days. If an update to the maximum allowable price rate for an appealed drug is warranted, the pharmacy benefits manager shall make the change retroactive based on the date of the final determination pharmacy provider's invoice and make the adjustment effective for all similarly situated North Dakota pharmacy providers in the network.
- f. Ensure copayment and dispensing fees are not included in the calculation of maximum allowable cost price reimbursement to pharmacy providers.

3. A pharmacy benefits manager may not place a prescription or drug on a maximum allowable price list unless:

- a. The drug has at least three two nationally available, therapeutically equivalent, multiple source generic drugs with a significant cost difference or where a generic drug is only available from one manufacturer; and
- b. The drug is listed as therapeutically equivalent and pharmaceutically equivalent "A", [redacted] -rated in the United States food and drug administration's most recent version of the "Orange Book"; and [redacted] The drug is generally available for purchase without limitations by [redacted] pharmacies in the state from national or regional wholesalers and not obsolete or temporarily unavailable.

4. A pharmacy benefits manager shall disclose to a plan sponsor whether the pharmacy benefits manager is using the identical maximum allowable price list with respect to billing

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Red font = items to be added

~~Double strikethrough~~ = items to be removed

Teal highlight = items NDPhA has agreed to at PBMs request

~~the plan sponsor as the pharmacy benefits manager uses when reimbursing at network pharmacies. If multiple maximum allowable price lists are used, the pharmacy benefits manager shall disclose to the plan sponsor any differences between the amount paid to any pharmacy and the amount charged to the plan sponsor.~~

5. This section does not apply to state Medicaid programs.
6. A pharmacy benefits manager that violates this section is guilty of a class B misdemeanor.

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1363

Page 1, line 10, after "a." insert """Determination" means a decision that settles and ends a controversy or the resolution of a question through appeal."

b."

Page 1, line 12, remove "generic"

Page 1, line 13, replace "b." with "c. "Multiple source drug" means a therapeutically equivalent drug that is available from at least two manufacturers."

d."

Page 1, line 16, replace "calendar year" with "contract and contract renewal"

Page 1, line 17, remove "market-based"

Page 1, line 18, replace ", update that pricing information" with "."

b. Update any maximum allowable cost price list"

Page 1, line 19, replace "calendar" with "business"

Page 1, line 19, replace "establish a reasonable process for the" with "provide"

Page 1, line 20, replace "updates" with "changes"

Page 1, line 21, replace "b." with "c."

Page 1, line 21, remove "market-based"

Page 1, line 23, replace "network or pharmacy provider to which each" with "maximum allowable cost price"

Page 1, line 23, after "list" insert "that"

Page 1, line 23, after "applies" insert "to the contracted pharmacy"

Page 2, line 3, replace "c." with "d."

Page 2, line 3, remove "market-based"

Page 2, line 4, replace "available for purchase without limitations by pharmacy providers" with "utilized by the pharmacy benefits manager"

Page 2, line 5, replace "d." with "e."

Page 2, line 7, replace "respond" with "provide a determination"

Page 2, line 8, remove "through the procedure"

Page 2, line 8, replace "calendar" with "business"

Page 2, line 9, after "rate" insert "for an appealed drug"

Page 2, line 10, remove "retroactive"

Page 2, line 11, replace "pharmacy provider's invoice" with "determination"

Page 2, line 11, after "all" insert "similarly situated"

Page 2, line 12, after "in" insert "this state within"

Page 2, after line 12, insert:

f. Ensure dispensing fees are not included in the calculation of maximum allowable cost price reimbursement to pharmacy providers."

Page 2, line 15, replace "three" with "two"

Page 2, line 16, remove "generic"

Page 2, line 16, replace "with a significant cost difference" with "or a generic drug is available only from one manufacturer"

Page 2, line 18, after "A" insert "or B"

Page 2, line 19, after "Book" insert "or the drug is Z rated"

Page 2, line 20, after "is" insert "generally"

Page 2, line 20, remove "without limitations"

Page 2, line 20, remove "all"

Page 2, line 21, remove "or temporarily"

Page 2, line 22, remove "unavailable"

Page 2, line 23, remove "A pharmacy benefits manager shall disclose to a plan sponsor whether the pharmacy"

Page 2, remove lines 24 through 28

Page 2, line 29, remove "5."

Page 2, line 30, replace "6." with "5."

Renumber accordingly

Introduced by

Representatives Keiser, N. Johnson, Kasper, Pollert, Weisz, Mock, M. Nelson

Senators Klein, J. Lee, Heckaman

1 A BILL for an Act to create and enact a new section to chapter 19-02.1 of the North Dakota
2 Century Code, relating to maximum allowable cost lists for pharmaceuticals; and to provide a
3 penalty.

4 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

5 **SECTION 1.** A new section to chapter 19-02.1 of the North Dakota Century Code is created
6 and enacted as follows:

7 **Maximum allowable cost lists for pharmaceuticals - Pharmacy benefits managers -**
8 **Penalty.**

9 1. For the purposes of this section:

10 a. "Determination" means a decision that settles and ends a controversy or the
11 resolution of a question through appeal.

12 b. "Maximum allowable cost price" means a maximum reimbursement amount for a
13 group of therapeutically equivalent and pharmaceutically equivalent multiple
14 source generic drugs.

15 b-c. "Multiple source drug" means a therapeutically equivalent drug that is available
16 from at least two manufacturers.

17 d. "Pharmacy benefits manager" has the same meaning as in section 19-03.6-01.

18 2. With respect to each contract between a pharmacy benefits manager and a pharmacy,
19 each pharmacy benefits manager shall:

20 a. Provide to the pharmacy, at the beginning of each calendar year contract and
21 contract renewal, the market-based sources utilized to determine the maximum
22 allowable cost pricing of the pharmacy benefits manager - update that pricing
23 information.

- 1 b. Update any maximum allowable cost price list at least every seven
2 calendar business days, and establish a reasonable process for the provide
3 prompt notification of the pricing updates changes to network pharmacies.
- 4 b-c. Disclose the market based sources utilized for setting maximum allowable cost
5 price rates on each maximum allowable cost price list included under the contract
6 and identify each network or pharmacy provider to which each maximum
7 allowable cost price list that applies to the contracted pharmacy. A pharmacy
8 benefits manager shall make the list of the maximum allowable costs available to
9 a contracted pharmacy in a format that is readily accessible and usable to the
10 contracted pharmacy.
- 11 e-d. Ensure maximum allowable cost prices are not set below market based sources
12 available for purchase without limitations by pharmacy providers utilized by the
13 pharmacy benefits manager.
- 14 d-e. Provide a reasonable administrative appeals procedure to allow a dispensing
15 pharmacy provider to contest a listed maximum allowable price rate. The
16 pharmacy benefits manager shall respond provide a determination to a provider
17 that has contested a maximum allowable price rate through the procedure within
18 seven calendar business days. If an update to the maximum allowable price rate
19 for an appealed drug is warranted, the pharmacy benefits manager shall make
20 the change retroactive based on the date of the pharmacy provider's
21 invoiced determination and make the adjustment effective for all similarly situated
22 pharmacy providers in this state within the network.
- 23 f. Ensure dispensing fees are not included in the calculation of maximum allowable
24 cost price reimbursement to pharmacy providers.
- 25 3. A pharmacy benefits manager may not place a prescription drug on a maximum
26 allowable price list unless:
- 27 a. The drug has at least threetwo nationally available, therapeutically equivalent,
28 multiple source generic drugs with a significant cost difference or a generic drug is
29 available only from one manufacturer;

- 1 b. The drug is listed as therapeutically equivalent and pharmaceutically equivalent
2 or "A" or "B" rated in the United States food and drug administration's most
3 recent version of the "Orange Book" or the drug is "Z" rated; and
4 c. The drug is generally available for purchase without limitations by all pharmacies
5 in the state from national or regional wholesalers and not obsolete or temporarily
6 unavailable.
- 7 4. A pharmacy benefits manager shall disclose to a plan sponsor whether the pharmacy
8 benefits manager is using the identical maximum allowable price list with respect to
9 billing the plan sponsor as the pharmacy benefits manager uses when reimbursing all
10 network pharmacies. If multiple maximum allowable price lists are used, the pharmacy
11 benefits manager shall disclose to the plan sponsor any differences between the
12 amount paid to any pharmacy and the amount charged to the plan sponsor.
- 13 5. This section does not apply to state medicaid programs.
- 14 6-5. A pharmacy benefits manager that violates this section is guilty of a class B
15 misdemeanor.

**Senate Human Services Committee
Madam Chair Judy Lee
HB 1363 – March 27, 2013 – 10:30am**

Madam Chair and members of the committee, for the record, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1363. Passage of HB 1363 is needed to bring fairness, reasonableness and standardization to an area of the PBM industry which is overdue. Maximum Allowable Cost (MAC) legislation such as this will provide predictability and consistency regarding reimbursements to pharmacies for generic drugs.

This is not only an independent pharmacy issue, but an issue for chain pharmacies, LTC pharmacies and even hospital outpatient community pharmacies. Currently, there is federal model legislation being advocated for by the National Community Pharmacy Association (NCPA) as well as the National Association of Chain Drug Stores (NACDS). There are also a number of states currently working on MAC related legislation in their respective state (Oregon, Arizona, Oklahoma, Hawaii, Michigan, Alabama). Kentucky recently passed similar MAC legislation and the bill was signed by their Governor on March 22, 2013. A number of other states continue to discuss introducing such legislation.

History of Maximum Allowable Cost (MAC) pricing

Where did the term Maximum Allowable Cost (MAC) come from?

Maximum allowable cost price lists were created by the Center for Medicare and Medicaid Services (CMS) to smooth generic drug cost variations and give pharmacies an incentive to purchase lowest cost products. This methodology was created as an industry standard for price management of multiple generics to the original brand name drug. Nationally recognized data sources and pricing terms are produced by two main entities (First Data Bank and MediSpan). They both are a nationally recognized data source for pricing averages related to prescription drug costs.

What is Maximum Allowable Cost (MAC) pricing?

Maximum allowable cost or MAC refers to a pricing program or list that establishes the maximum allowed cost for generic drugs. It does not matter whose version of a drug the pharmacy buys, the

pharmacy should get reimbursed at least a price equal to the pharmacy's acquisition cost to cover the cost of purchasing the generic drug from a wholesaler.

Rationale for Maximum Allowable Cost (MAC) Provisions included in HB 1363

As expected, the Pharmacy Benefit Management (PBM) business model centers largely on pricing mechanisms. While PBMs once operated primarily on a fee basis, in recent years we have seen a shift to a more complex and more profitable business model. There is no standardization in the industry as to the criteria for the inclusion of multiple source generic drugs on MAC lists. There is no standardization related to how the PBMs determine the maximum allowable cost price, or how the MAC lists are changed or updated. The PBMs have free reign in developing the ultimate price paid to pharmacies and charged to employers. The pharmacies are left entirely in the dark and have to agree to contract terms not knowing what they will be reimbursed for generic drugs until the time of adjudication. Below I have highlighted certain provisions of HB 1363 to give all committee members a better understanding of HB 1363.

Section 1 – Number 2 – Letter A (page 1 line 20):

This section of provisions requires the PBM to disclose what sources are utilized to determine the maximum allowable cost pricing structure. It requires the PBM to disclose to the pharmacies where the PBM is gathering their pricing information. Are they using a nationally recognized data resource such as First Data Bank? Are they using Medispan? If neither, who are they using?

Section 1 – Number 2 – Letter B (Page 2 Line 1)

This section, further states the PBM must update the MAC pricing lists at least every 7 days. Drug prices change constantly and there needs to be some kind of standardization to the process. Currently, if MAC prices decrease in price or payment to the pharmacy, the PBM changes the price right away. However, if the price moves higher and the pharmacy should be reimbursed more for a certain generic drug, the PBMs take forever to update the MAC list (6-8 weeks in a lot of cases). During this period the pharmacy is filling the prescriptions at a loss or below their acquisition cost.

Section 1 – Number 2 – Letter C (Page 2 Line 4):

This section directs PBMs to disclose which sources are utilized for each MAC list if multiple MAC lists are being used by the PBM. The PBM must identify which MAC price lists apply to each contracted pharmacy provider. The PBMs further have to make the MAC price lists readily accessible and usable to contracted pharmacies. This can be easily accomplished via password protected email

or website link, so pharmacies are able to easily predict what they are going to be paid for generic drugs.

Section 1 – Number 2 – Letter D (Page 2 Line 10):

This section simply states if PBMs are going to use MAC pricing lists, the prices for reimbursement should not be set below sources utilized by the PBMs.

Section 1 – Number 2 – Letter E (Page 2 Line 12):

Currently, some PBMs do not even allow for an appeals process if a pharmacy provider wants to challenge his/her reimbursement from a PBM. The PBM needs to provide a determination regarding the appeal (a contested rate) within seven business days.

Section 1 – Number 3 – Letter A (Page 2 Line 24):

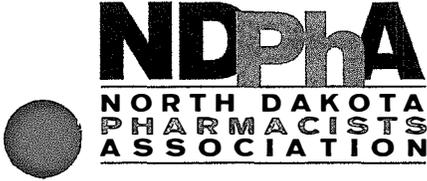
This section provides standardization for how products are selected for inclusion on a MAC price list. There is no standard or benchmark for choosing which drugs should be included on a PBM MAC list.

Section 1 – Number 3 – Letter C (Page 2 Line 29):

Sometimes a PBM will place a MAC price on a generic drug before the competing generic drug even enters the market and a pharmacy is supposed to accept the new MAC rate even though they cannot buy the new generic yet. In the meantime, they still have stock on the shelves and they are being reimbursed below cost.

Madam Chair and members of the committee, the reason we are before this committee is because pharmacies typically contract with at least 2 dozen PBMs and with each PBM making up their own rules, the market has become unmanageable and further regulation is needed. MAC pricing is one example of where regulation is needed to address the problems and inconsistencies that exist in the PBM industry.

In conclusion, from the National Association of Chain Drug Stores, to the National Community Pharmacists Association, to the National Association of Insurance Commissioners, to the National Legislative Association on Prescription Drugs, to numerous states and consumer advocacy groups, everyone is saying the same thing, PBM transparency is needed and HB 1363 helps address some of the transparency being advocated for. As you may know, even the National Association of Boards of Pharmacy recently issued model language calling on state boards of pharmacy to start requiring



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licensure of PBMs as they are currently not licensed by any governing body. HB 1363 is reasonable and fair legislation. Again, we are asking for your support of HB 1363.

Thank you for your time and attention regarding this important matter. I would be happy to try and answer any questions you may have.

Respectfully Submitted,

Mike Schwab

NDPhA EVP

(2)

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March 25, 2013

Senator Judy Lee
Chairman
North Dakota Senate Committee on Human Services
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: House Bill No. 1363

Dear Madam Chair Lee:

I write in support of House Bill No. 1363 (“H.B. 1363”), on which the Senate Committee on Human Services will hold a hearing on Tuesday, March 26, 2013. The bill would provide guidelines for the transparency of the maximum allowable cost (“MAC”) of generic pharmaceuticals paid to retail pharmacies by Pharmacy Benefit Managers (“PBMs”). The importance of this legislation cannot be understated. PBMs use arbitrary and opaque MAC pricing to derive record profits at the expense of independent pharmacies, plan sponsors and consumers. In addition to the lack of transparency surrounding MAC pricing, the PBM market is fraught with other deceptive and fraudulent conduct that has led to independent pharmacies being driven from the market and harm to consumers. This legislation is a prudent response to this significant market imbalance PBMs hold, and its enactment will benefit the consumers of North Dakota.

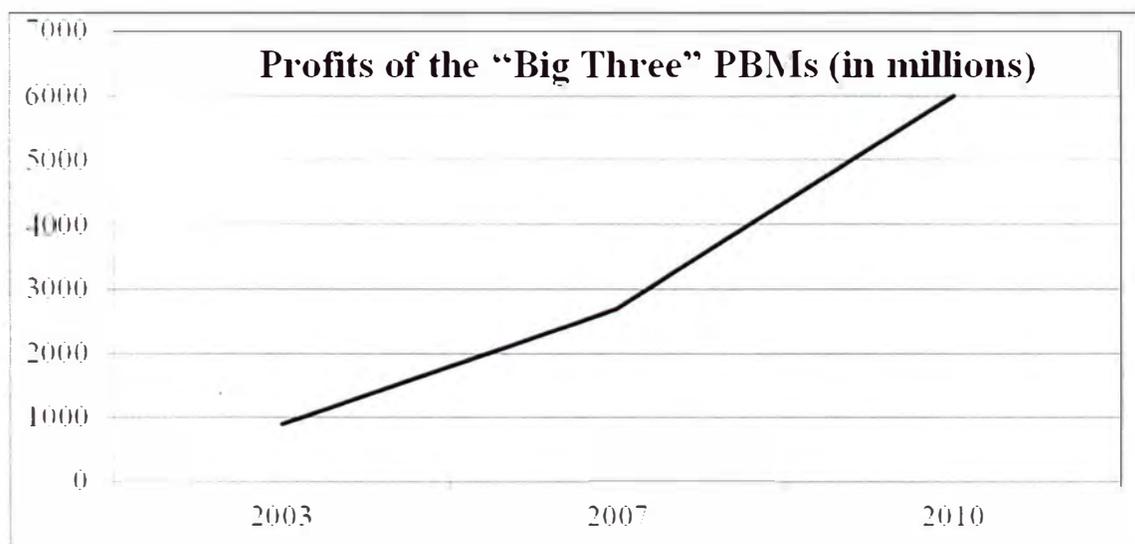
I write to you based on my experience of over a quarter century as an antitrust practitioner, the majority of which was spent as a trial attorney in the Antitrust Division of the United States Department of Justice, and in several senior management positions, including Policy Director at the Federal Trade Commission’s (“FTC”) Bureau of Competition and attorney advisor to Chairman Robert Pitofsky. I helped bring some of the first antitrust cases against PBMs and have testified before Congress, regulators, and state legislatures over ten times on PBM competition. I have testified before Congress four times and before ten state legislatures on PBM reform issues and have served as an expert witness for the State of Maine on PBM regulation.¹

¹ See David Balto, Advocacy and Testimony, available at <http://www.dcantitrustlaw.com/index.php?id=9>

BACKGROUND

Pharmacy Benefit Managers are one of the most problematic, least regulated and least understood aspects of the healthcare delivery system. Over 80% of pharmaceuticals in the United States are purchased through PBM networks. PBMs serve as intermediaries between health plans, pharmaceutical manufacturers and pharmacies, and PBMs establish networks for consumers to receive reimbursement for drugs. Although the primary function of a PBM initially was simply to create networks and process pharmaceutical claims, these entities have exploited the lack of transparency and created conflicts of interest which have significantly distorted competition, reduced choices for consumers and ultimately increased the cost of drugs.

The PBM market is dominated by two PBMs, ESI/Medco and CVS Caremark who together control over 80% of the market for large health plans. Because the two largest PBMs' operations are clouded in secrecy and are replete with significant conflicts of interest, PBMs have effectively increased the cost of drugs over the past several years and have seen their profits skyrocket from \$900 million a year to over \$7 billion a year at the expense of payors and consumers.



MAC PRICING IS A SIGNIFICANT SOURCE OF PBM REVENUE AT THE EXPENSE OF CONSUMERS AND RETAIL PHARMACY

Like many health care businesses PBMs must establish reimbursement rates for services and the dispensing of drugs. This system works best, for consumers, plans, and pharmacies when there is a transparent and consistent system for determining these reimbursement rates. When there is a transparent and consistent system all of the market participants can effectively plan, purchase goods and provide services. Where transparency and consistency are absent there is a significant opportunity for providers and ultimately consumers to be harmed by deceptive and unfair conduct.

Unfortunately, currently the reimbursement system for generic drugs often lacks these critical elements. Generic reimbursement is based on a MAC list, which sets the maximum allowable cost. MAC lists are PBM-generated list of products that includes the upper limit or maximum amount that a PBM will pay for generic drugs and brand name drugs that have generic versions available. There is no standard methodology for derivation of MAC lists or how the maximum prices are determined. Neither plan sponsors nor retail pharmacies are informed how products are added or removed from a MAC list or the methodology that determines how reimbursement is calculated. Moreover, PBMs often utilize multiple MAC lists to create a spread between what they charge a plan versus the amount they reimburse a pharmacy. This lack of transparency and prevalence of nonstandard MAC list and pricing derivation allows PBMs to utilize an aggressively low MAC price list to reimburse their contracted pharmacies and a different, higher list of prices when they sell to their clients, plan sponsors. Essentially, the PBMs reimburse low and charge high with their MAC price lists, pocketing the significant spread between the two prices. Most plans are unaware even that multiple MAC lists are being used and have no real concept of how much revenue the PBM retains.²

This can be additionally problematic from a plan sponsor perspective. The lack of transparency surrounding MAC list derivation causes plans worry that they are paying more than they should for some multisource products. Without the knowledge of whether certain generics are included or excluded on MAC lists, a plan does not know whether a member's copay may increase due to drugs not being available on MAC lists. A member may complain that they cannot get access to a generic that should be available through their benefit and the plan is forced to pay a higher price to the PBM.

H.B. 1363 will address these problems by, *inter alia*, requiring PBMs to disclose the specific market-based sources they use to determine and set MAC prices; ensuring that MAC prices are not set below costs (market-based sources available); setting specific requirements of drugs to be included on MAC lists; and requiring PBMs to disclose to plan sponsors whether the PBM is using an identical MAC list with respect to billing the plan sponsor and the network retail pharmacy. If a PBM is using multiple MAC lists the PBM must disclose to the plan sponsor any differences between the amount paid to any pharmacy and the amount charged to the plan sponsor. Where transparency and consistency are absent there is a significant opportunity for providers and ultimately consumers to be harmed by deceptive and unfair conduct. By requiring disclosure of MAC pricing, H.B. 1363 will help ensure North Dakota consumers, plans and pharmacies do not pay more for generic drugs than they should.

WEAK TRANSPARENCY STANDARDS ALLOW PBMS TO ENGAGE IN DECEPTIVE CONDUCT

In addition to MAC list and pricing, facing weak transparency standards, the major PBMs frequently engage in a wide range of deceptive and anticompetitive conduct that ultimately

² See Mark Meador, *Squeezing the Middleman: Ending Underhanded Dealing In the Pharmacy Benefit Management Industry Through Regulation*, 20 *Annals of Health L.* 77, 80-81 (2011).

harms and denies benefits to consumers. Some PBMs secure rebates and kickbacks in exchange for exclusivity arrangements that may keep lower priced drugs off the market. PBMs may switch patients from prescribed drugs to an often more expensive drug to take advantage of rebates that the PBM receives from drug manufacturers. In addition, PBMs derive enormous profits from the ability to “play the spread” between pharmaceutical manufacturers, pharmacies, and health care plans.

Ultimately, the US Department of Justice and 30 state attorneys general brought cases against each of the major PBMs for some of these actions, including allegations of fraud, misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. These cases have resulted in over \$377 million in damages to states, plans, and patients, including the Federal Trade Commission’s recent finding of Medicare fraud by CVS Caremark resulting in a multi-million dollar fine.³

Because the PBM system is unregulated, the lack of transparency can inflict significant harm. The dominant PBMs are not required to and therefore refuse to disclose the amount of rebates they receive, or other relationships they have, with drug manufacturers and their arrangements with pharmacies. This lack of transparency leaves payors having to rely on the pricing dictated by the PBMs, diminishing their ability to control costs. Because of the lack of transparency, PBMs are free to “play the spread” between manufacturers, pharmacists, and plans because of a lack of disclosure.⁴ Unclear and inadequate disclosure of MAC pricing undermines the ability of plan sponsors to compare competing proposals, and effectively increases the costs for pharmaceuticals for plans and their beneficiaries.

Transparency and a lack of conflicts of interest are vitally important for payors and their beneficiaries. H.B. 1363 is essential to provide transparency for consumers, which will help 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 payors to make sure they are getting the benefits they deserve. We urge the Legislative Assembly to enact H.B. 1363.

Sincerely,



David A. Balto

³ *In the Matter of CVS Caremark* (Federal Trade Commission 2012) (**\$5.5 million fine**); *United States v. Merck & Co., Inc., et. al* (E.D. Pa. 2006) (**\$184.1 million fine**); *United States of America, et al. v. AdvancePCS, Inc.* (E.D. Pa. 2005) (**\$137.5 million fine**); *States Attorneys General v. Caremark, Inc.* (2008) (**\$41 million fine**); *State Attorneys General v. Express Scripts* (2008) (**\$9.5 million fine**).

⁴ See David Balto, Testimony Before S. Jud. Comm, Subcomm. on Antitrust, Competition Policy and Consumer Rights (Dec. 6, 2011), available at <http://www.dcantitrustlaw.com/assets/content/documents/testimony/SenateJudiciary.ESIMedci.Balto.pdf>.



Community Pharmacy
Prescription Network

January 31, 2013

Mr. Mike Schwab
Executive Vice President
North Dakota Pharmacists Association
1641 Capitol Way
Bismarck, ND 58501

Dear Mike,

I caught wind of your pending MAC legislation, HB 1363, and on behalf of Community Pharmacy Prescription Network and all of our members I wanted to let you and your members know that what you are doing for pharmacies throughout the U.S. is greatly appreciated.

It is about time that the unfair practices of the PBM industry, specifically the arbitrary and fictitious Maximum Allowable Cost (MAC) levels that are set by PBM's, are addressed head on as you are doing.

Community Pharmacy Prescription Network (CPRxN) is a group of independent pharmacies that came together originally to participate through a direct to employer competitive bid process as a member of the preferred Caterpillar network which originally included only Walgreens and Wal-Mart. As of January 1, 2013, CPRxN pharmacies are further participating in the General Dynamics and Johnson Controls preferred networks.

This direct to employer bid process (pharmacy to employer, bypassing the PBM) is a true cost plus model where generic prices are bid based on their landed cost plus a fee to dispense the prescription. There is no MAC pricing and yet Caterpillar has saved millions over their former PBM run model and pharmacies in the network, who purchase their prescription drugs from a variety of large and small wholesalers, have no trouble finding generics at a suitable price in order to fill those prescriptions at a savings to the payor and consumer, while retaining a fee for their services. To reiterate, Caterpillar was able to achieve a greater savings through a direct to pharmacy competitive bid process rather than through the traditional PBM model which included the MAC pricing.

Good luck in passing this very important piece of legislation.

Best regards,

Anthony Sartoris
Chief Operating Officer
Community Pharmacy Prescription Network

February 11, 2013



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APRx Wins Again as CVS Fails to Keep RICO Suit Out of Court

Ruling Strengthens Position in Landmark Suit

The 5th U.S. Circuit Court of Appeals has rejected CVS-Caremark's appeal of an earlier federal court ruling that most of American Pharmacies' RICO lawsuit against CVS must be heard in open court.

The ruling today (February 11) by the three-judge panel means the lawsuit can proceed on the merits of the case.

In April 2012, U.S. Judge John Rainey overruled the objections of CVS Caremark to a ruling that keeps most of APRx's Racketeer Influenced & Corrupt Organizations lawsuit out of arbitration and in open court before a jury. **CVS Caremark had asked to**

send the entire case against it and its subsidiaries to arbitration to keep the suit out of the public eye, but Judge Rainey ruled that the plaintiffs' claims against CVS Pharmacy and parent company CVS Caremark should be heard in open court, while claims against Caremark LLC, a subsidiary, should be heard in arbitration.



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John Cooper,
VP of Generics & Vendor
Relations

Last Wednesday (Feb. 6), a panel of three federal judges for the 5th Circuit heard CVS Caremark's appeal of the ruling. Miguel S. Rodriguez, APRx lead attorney on the lawsuit, argued against CVS Caremark's appeal.

"We are pleased that the Court of Appeals affirmed the lower court rulings and we look forward to proving the merits of our claims in an open trial," said Rodriguez, a partner at the Austin law firm of [Taylor Dunham LLP](#).

The class-action suit was filed in September 2010 by six APRx board members on behalf of all non-CVS pharmacies. **The lawsuit alleges that CVS Caremark violates the firewall between the retail pharmacy and the PBM entities as required by the Federal Trade Commission when it approved the CVS-Caremark merger in 2007.** Instead, the suit alleges, the company built an information technology platform that straddles all of CVS Caremark's business segments, capturing in-depth patient data for marketing and other purposes in violation of HIPAA patient privacy laws.

American Pharmacies President Mike Gohlke said there is a lot of hard work behind the ruling and a lot of credit to be distributed for APRx's success so far.

"The courage of our plaintiffs and the outstanding work of our legal team made this great day possible for independent pharmacy," Gohlke said. "We all eagerly await our day in court to argue the merits of our case."

Gohlke also extended thanks to the APRx Board and membership and to other group purchasing organizations for their financial support and constant encouragement.

STAY TUNED FOR MORE UPDATES!!

Support the APRx Legal Defense Fund

APRx is proud to be the **PROVEN LEADER** of legislative, legal and regulatory action to defend independent pharmacy. **But we can't do it alone. Our lawsuits are critical to protect your business model, but they are costly and we need your help.** Please support our efforts by contributing to the [APRx Legal Defense Fund](#).

Questions? Contact our legal team: afields@aprx.org and mrodriguez@taylordunham.com.

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3

SENATE HUMAN SERVICE COMMITTEE

March 26th, 2013 – HB 1363

Madam Chair Lee

Madam Chair and members of the Senate Human Services Committee for the record, my name is Steve Boehning, Pharmacist from Fargo, N.D. I am here in support of HB 1363. This bill is very important to the practice of pharmacy and will provide an auditable means of tracking reimbursement and aid in contract negotiations.

This is not an issue for just N.D. pharmacists or independent pharmacy; this is an issue for the pharmacy profession across the board. MAC legislation is being or has been introduced in a number of other states and is on the forefront of pharmacy issues. This is not just a N.D. issue and has nothing to do with the current ownership law in this state. This is an issue for chain, mass merchant, independent, outpatient hospital and long-term care pharmacies.

This is not about trying to obtain massive increases in reimbursement or trying to drive up the cost of prescription medications. This is not about if MAC should be used. This bill is not trying to eliminate MAC as a source for reimbursement. This is about obtaining a "fair" and transparent MAC rate that is disclosed to the pharmacy and is auditable. I do not understand why I do not have a right to know the basis for what I am to be reimbursed. Who would sign a contract that would not explain how you are going to be paid. How am I supposed to evaluate a contract if I cannot accurately determine what my reimbursement rate is! If my contract states MAC plus \$1.50 per prescription, but MAC is not defined or source of the MAC is not disclosed, how can I evaluate if I can accept this contract? The contract might as well state; I will pay you whatever I feel like today and reserve the right to change it tomorrow and you do not have a right to know what it is.

This bill will also address an appeals process that will require a timely response. Over the past year I have had 464 prescriptions reimbursed at a negative margin totaling \$11,198.19. These are not claims that I am seeking a massive increase on, but that I should be paid at the market rate and should be able to audit what source is being used to determine that rate. I should have a fair and easily identifiable way of appealing these claims and I should receive a response in a reasonable amount of time. On some of these claims maybe the MAC rate is at market value and I am buying at a higher rate. Even if that is the case, I should be able to audit that and take the results to my purchaser for negotiation. Right now I receive nothing more than an electronic note stating; claim paid at MAC.

If I am not allowed to sell prescriptions for cash paying customers below market acquisition cost, why should I be forced to accept a rate from a PBM that is below my acquisition cost? I am also confused as to why MAC should be proprietary for the PBM? Again, why am I not allowed to know what I am going to be paid? I am not asking for information that I should not have a right to know and audit. Every business that I can think of has a way of auditing its reimbursements, why am I not allowed this same information? What I am getting reimbursed should not be a "secret" or "proprietary" from me. Is this

information proprietary so that a PBM can charge one MAC price to the pharmacy and another to the plan sponsor? Why should this information not be auditable?

A number of these claims that are negative margin are due to price increases in the marketplace. The PBM should be able to update the MAC list weekly to reflect market conditions. This is currently being done for name brand medications. There should not be a 30-90 day lag time between when a drug increases in cost and the MAC list is updated. Pharmacies are not sitting on a 60-90 day inventory. If I had a source for the MAC listed in my contract or a published MAC rate, it would give me an auditable way of reviewing if the PBM had updated its price when my claim was submitted. This would also allow me to appeal if the list price was not updated. This bill will allow me to be able to audit why my claim is being paid the way it is. Should I not have the right to do that? Maybe the price being charged to me by my wholesaler is above market conditions. By being able to audit the claim, I can go back to my wholesaler for negotiation. Many times when the wholesaler increases my cost, some PBM claims are paid at an increased MAC rate while others are not. Why is one PBM updating their MAC list while the other is not? Why should I not be able to review this and see where the MAC rate is coming from?

Another issue is multiple MAC rates. I can have a contract with one PBM that offers multiple plans and has a different MAC rate for each plan. I believe I should be able to access what MAC rate is tied to what plan. I will fill the same medication for the same quantity to the same PBM under the same contract and get 5 different payment rates. Again, I should be able to know what I am getting paid and be able to audit the process. What I am getting paid should not be a "secret" or proprietary from me.

This bill also addresses the issue of an appeals process. There needs to be an easily identifiable way to appeal a claim that a pharmacy believes is being paid in error. This process should be identified in the contract, be easy to file, and the pharmacy should receive this in a timely response. I have appealed to numerous PBM's about MAC issues and have sent faxed forms, emails, or made phone calls. Most of the time, I do not get a response back from the PBM. I believe it should be required to give me a timely response back to my appeal. ND Medicaid and Workforce Safety can do this, why can't the other PBM's?

PBM's are losing a large amount of revenue because of the increase in generic dispensing. There has been and will be a very large number of brand name medications going generic over the next few years. Rebates from the brand name manufacturer are a very large revenue stream for the PBM's and the loss of these patents will hurt revenue. Ironically, as this has been happening, MAC issues have become more and more prevalent. I am afraid the PBM's are using the proprietary nature of MAC rates to offset the loss of the brand name rebate revenue by paying the pharmacy at one MAC rate and charging the plan sponsor another higher MAC rate. These rates should be the same no matter how the prescription is filled (retail or mail order). It should not be allowed to have the retail pharmacy paid at one MAC rate, but the mail order pharmacy owned by the PBM, another higher MAC rate.

This bill is very important for the practice of pharmacy. Every business should have the right to know what it is going to be paid and be able to audit those payments. This is a bill to allow the pharmacy that right.



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HB 1363 - Pharmacy Benefits Managers
Senate Human Services Committee
10:30 AM - Tuesday - March 26th, 2013 - Red River Room

Madam Chair Lee, members of the Senate Human Services Committee, for the record I am Mark J. Hardy, PharmD, Assistant Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today about House Bill 1363.

The Board of Pharmacy members have discussed **P**harmacy **B**enefit **M**anagers [PBM] and some of the problems that they encounter in their practices. Often discussed are stories of pharmacists having to choose between losing money on a prescription due to the maximum allowable cost set by the PBM being too low to cover the actual 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 patient and dispense the item and take the loss with the hope that they will be able to recover or rebill a claim once the MAC is adjusted to the actual cost. These situations appear to be happening with an increasing frequency, especially in the recent trend of 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, but does not get in the way of patient care decisions either.

Pharmacy Benefit Managers have long been a source of conflict between pharmacists and 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 effect patient care.

Both sides of the issue worked out a good compromise during a subcommittee meeting in the House Industry, Business and Labor Committee. The Board of Pharmacy believes the provisions set in House Bill 1363 will standardize a currently unregulated process to ensure that it will be fair for all parties concerned, the pharmacy, the PBM and most importantly the patient.

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

Express Scripts / Medco

(5)

MAC Pricing Reimbursements

Jan 1st - Jan 31st, 2013

455	THH	11	- 7	Azithromycin 29 Day 6PK
671		1111	- 4	
734		1	- 1	
930		1	- 1	Gateway HealthMart Pharmacy
991		1	- 1	
1000		111	- 3	3101 N 11th St Bismarck ND 58503
1054	THH		- 4	
1200	111		- 3	
1344	11		- 2	Mark A Aurit RPh
1472	1		- 1	
1500	1111		- 4	
1523	1		- 1	
1548	11		- 2	
1555	1		- 1	

14 Different 35 Rx
MAC prices

February 1, 2013

AccessHealth 2013 Off to a Fast Start

As January ends, AccessHealth is sending this reminder recapping a few of the recent initiatives we hope you're employing to add value to your business. As part of over 4,000 independent pharmacies in the AccessHealth Network, you receive the benefits of scale and the efficiency needed to effectively compete in today's marketplace.

- **Increased accesses to covered lives-** contracts are in place with 56 Medicare Part D preferred networks and 23 commercial restricted networks. Our contracts help you compete for market share.
- **Increased Reimbursement-** In January, the MAC Success Manager resulted in favorable reimbursement revisions for 122 products. For all of 2012, there were over 1,200 favorable revisions made covering hundreds of thousands of claims. Month in and month out, the MAC Success manager continues to bring awareness and get action on potential wide-spread issues impacting many pharmacies, and emphasize common pricing errors.
- **Timely Education-** recent articles have highlighted Fraud, Waste and Abuse, Short Cycle Billing, Direct and Indirect Remuneration, and Medication Therapy Management (MTM). We will continue to keep you up to date with timely and actionable information.
- **Security** - Your receivables and information are handled with the expertise of a Fortune 14 organization. We have obtained ISO 27001 certification which ensures confidentiality, integrity, and availability of your information assets and minimizes information security risks.
- **Superior Customer Service-** expanded service to 11 hours/day availability, email service (Service.AccessHealth@McKesson.com), and Spanish & Korean speaking representatives.

You can continue to expect the highest levels of service and expertise. We look forward to serving you in 2013.

Thank you for your membership.

Contact AccessHealth's customer care team at 800.824.1763 (Monday through Friday from 8:00 AM - 7:00 PM, EST)

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Senate Human Services Committee

March 26, 2013

Madam Chair, members of the committee, my name is Jeff Lindoo. I am a pharmacist and am Vice President of Governmental and Regulatory Affairs for Thrifty White Pharmacy. We are a 100% employee-owned company and operate 29 pharmacies in the State of North Dakota. I want to thank you for hearing HB 1363 today and for accepting my testimony.

I believe any business that enters into a contractual relationship to provide services for another business expects that the contract will lay out how that business will be compensated for their services. Unfortunately, this has not been the case with respect to generic prescriptions, for pharmacies contracting with pharmacy benefit managers. In the past, generics made up a minority of our business and the situation has been tolerable. Today, however, about 75% of the prescriptions we fill are generics and that percent is expected to rise to over 85% in the next year or two. The lack of transparency and predictability on how we will be compensated for 75 to 85% of the service we provide is making it difficult to impossible for pharmacies to evaluate PBM contracts or to plan and manage our business. I can tell you that not a single day goes by that our company does not have an issue arise around MAC, or generic pricing with a prescription plan.

We realize that the way generic drugs are priced in the marketplace and a lack of uniform benchmarks on generics make the calculation of pharmacy reimbursement on generics difficult for PBMs. That is precisely the reason for the need for transparency in the process. HB 1363 does not hamper the ability for PBMs to control medication costs for their sponsors. It is not intended to increase profits for pharmacies. HB 1363:

- Provides predictability and consistency in making sure that generic reimbursement rates are up-to-date and reflect current market conditions.
- Requires PBMs to ensure they are not setting their reimbursement rates below the market-based sources they utilize.
- Provides standardization on how products are selected for inclusion on PBM drug price lists.
- Because the calculation of generic reimbursement rates is not an exact science, it provides a process for pharmacies to appeal when reimbursement is set below the price at which a pharmacy can purchase the drug.

HB 1363 was debated extensively in the North Dakota House. Many changes in language were made to correct situations where the bill unintentionally hindered legitimate cost-saving strategies of the PBMs. The bill before you today is the result of much debate and compromise. We strongly believe it is fair and equitable to pharmacies, PBMs and payers and plan sponsors. I urge you to pass HB 1363 in its current form.

Thank you. I would be glad to answer any questions.

THE HARMIS GROUP

ND Senate
Senate IBL Committee

March 26, 2013

OPPOSE HB 1363 (Unless amended)

My name is Robert Harms. I am the lobbyist for CVS Caremark in North Dakota. We must OPPOSE HB 1363, but request you consider a few amendments that would further improve the bill.

CVS Caremark Corporation is one of the nation's largest independent providers of health improvement services, touching the lives of millions of health plan participants. CVS is the largest employer of licensed pharmacists in the United States, with over 25,000 pharmacists nationwide. In North Dakota we currently operate 6 CVS Pharmacies employing over 150 people in North Dakota.

Our pharmacy benefit manager (PBM), Caremark, offers our health plan customers a wide range of health improvement products and services designed to lower the cost and improve the quality of pharmaceutical care delivered to health plan participants. Because of the cost containment and formulary management tools Caremark clients utilize, they are able to offer a high-quality, cost effective outpatient drug benefit for their enrollees. Caremark clients include a broad range of highly sophisticated private and public health plan sponsors, including Blue Cross Blue Shield plans, health insurance plans, employers, governments, third-party administrators and Taft-Hartley plans.

HB 1363, as it stands needs a couple of modest amendments we could not reach agreement on in the House before it came out of Committee.

Those amendments are:

Page 2, line 1 replace "seven" with "fourteen".

(In our view this is a more reasonable time frame within which to update MAC lists, and will not overwhelm the PBMs or the pharmacies with more information than is useful).

Page 2, line 2, insert "upon request" after and. (This amendment addresses even the greater need to manage the level of data the bill currently requires, which would include literally thousands of data points on each day from a company such as CVS Caremark. The bill is designed to afford the pharmacist information with

regard to a prescription he is to fill. Inundating the pharmacist with hundreds of MAC lists, containing thousands of drugs will make the data so voluminous as to defeat its purpose).

We have OPPOSED the bill in the House believing that it interferes with our business practice in controlling health care costs for our customers and will increase the amount spent on drugs in North Dakota. We have worked with other stakeholders to shape the bill to its current form so that we could SUPPORT it—reluctantly, but as a matter of compromise. But, we believe these last two amendments are necessary to make the bill workable for all concerned. Unless so amended, we must OPPOSE HB 1363.

Thank you.

Robert W. Harms, JD
The Harms Group
On behalf of CVS Caremark