May 15, 2019

The Honorable Bob D. Hackett, Chair
The Honorable Stephen A. Huffman, Vice-Chair
The Honorable Cecil Thomas, Ranking Member
Honorable Members
Finance Subcommittee on Health and Human Services
Ohio State Senate
1 Capitol Square
Columbus OH 43215

RE: Ohio State Budget

Dear Chair, Vice-Chair, and Honorable Members:

Chairman Hackett, Vice-Chair Huffman, Ranking Member Thomas, and Members of the Senate Finance Subcommittee on Health and Human Services, on behalf of the Pharmaceutical Care Management Association (PCMA), I am writing to share PCMA's concerns on the state budget proposals that were passed by the House of Representatives last week. PBMs administer prescription drug plans for more than 266 million Americans with health coverage provided through large and small employers, health plans, labor unions, state and federal employee-benefit plans, and government programs.

PCMA appreciates the Ohio State Legislature's desire to manage its Medicaid program with integrity, and to ensure that Medicaid beneficiaries are receiving high-quality of care and that taxpayer funds are being used efficiently. As administrators of the pharmacy benefit in Medicaid, PBMs are a key part of the solution to rising drug prices. While drug manufacturers alone set and raise prices of the drugs they sell, PBMs are working to put downward pressure on aggressive rising cost trends. PBMs do this by working on behalf of Medicaid MCOs to obtain (and pass through 100%) of drug manufacturer price concessions, which lower the net cost of drugs; managing cost-effective pharmacy networks; and ensuring that patients have high-quality, convenient and affordable access to the full suite of pharmacy services to which they are entitled under the Medicaid benefit. In all Ohio health care programs, including Medicare and Medicaid, PBMs will help save over $24 billion over a ten year period.[1] At the end of the day, PBMs are the only entities in the drug supply chain focused on reducing cost.

We believe that the Ohio Legislature wants to focus on efficiency and quality in the Medicaid benefit, but we are concerned that some of the House budget proposals may result in unintended consequences including raised administration costs and reduced quality. Also, the proposals raise many questions about how the administration of the Medicaid pharmacy benefit will work under a new structure. First, there are many questions about how the single PBM would interact with MCOs, how data and information would be shared among the parties, which responsibilities for management of the beneficiary's pharmacy benefit would be managed by the MCO vs. a state-

[1] Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers, Visante, (February 2016), available at https://www.pcmanet.org/pbms-generating-savings-for-plan-sponsors-and-consumers/.

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managed PBM, and how continuity of care for beneficiaries would work as the state would move to a single formulary.

Additionally, PCMA has concerns that a fiduciary requirement on the single PBM does not make sense given the nature of the relationship between PBMs and the state and courts' interpretations of fiduciary requirements in the administration of health benefits. A "fiduciary" relationship is a legal term of art that indicates a transferring of "discretionary control" over the assets of the plan (in this case, the state money that funds the Medicaid pharmacy benefit). However, PBMs typically serve an administrative function, the responsibilities and compensation terms for which are outlined in a contract between the parties. Like any party to a contract, PBMs have an obligation to perform that contract according to the terms and there are remedies on both sides if there is a breach of contract. Under a contract that outlines roles, responsibilities, and compensation for PBMs, the purchaser of PBM services (whether it be an MCO or the state) has the flexibility to design a program that best suits the needs of its beneficiaries, contracting providers, and the taxpayers who fund the program. Setting a fiduciary requirement in statute unnecessarily restricts the state itself in the administration of the benefit. If the state seeks transparency, ensuring full pass-through of price concessions, an obligation that a PBM perform a contract in good faith, prevent self-dealing and conflicts, etc., it has the ability to address all of these issues (and already had addressed many) through contract, without having to transfer control over the assets to the PBM and require a fiduciary duty.

On the specialty pharmacy issues in the budget, by restricting through statute the ability to refer patients to select specialty pharmacies, the state may forgo the most efficient way to get the highest quality of care for patients. There are times that a PBM-affiliated specialty pharmacy is the best suited to provide access to the full range of services needed for a patient with a particular health condition, which may include convenient access to a specialty or high-cost drug, assistance with administration of a drug that is difficult to administer, live support available 24/7 from a medical practitioner with a specialization in the patient's disease state, and tracking and assisting with managing side effects, among other support services. Not every pharmacy is equipped to provide these services—Medicaid MCOs need to be able to direct beneficiaries to appropriate pharmacies in every circumstance.

The House proposal also prohibits so-called gag clauses and clawbacks in PBM-pharmacy contracts. As we indicated in our statement of support of these provisions in HB 63 (Lipps, West), PCMA and its member companies believe that a patient should always pay the lowest price available at the pharmacy counter for their prescribed drug and believe pharmacists and patients should be allowed and encouraged to discuss pharmaceutical options and costs. In all Medicare Part D plans, patients pay the lesser of their plan's cost-sharing amount or the cash price of the drug at the pharmacy counter, and as an industry, PCMA member companies support this policy in the commercial market. PCMA supported both federal bills that ban gag clauses ("Know the Lowest Price Act of 2018"—S. 2553 and the "Patients' Right to Know Drug Prices Act"—S. 2554), enacted in October 2018. PCMA has also supported state legislation across the country that outlaws gag clauses and "clawback" contract provisions that would cause a patient to pay more than necessary for his or her drug. We would support changes to this budget language that ensures the language does not prohibit the use of value-based contracts. Overall, PCMA supports the policy contained in HB 63 and in the House proposed budget that ensures that pharmacists

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would have no hesitation to know that they could communicate with their patients about the cost of their prescription, with or without insurance.

Thank you for your consideration of our comments. I am happy to answer any questions from the committee.

Sincerely,

April C. Alexander
Assistant Vice President, State Affairs