HINMAN STRAUB PC
ATTORNEYS AT LAW

121 State Street
Albany, New York 12207-1693
Tel: 518-436-0751
Fax: 518-436-4751

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RE: AN ACT to amend the public health law, in relation to prohibited activities by pharmacy benefit managers

A.8781 (Rosenthal)
S.6940 (Hannon)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shields Plans oppose enactment of this bill, which would prohibit pharmacy benefit managers (PBMs), which serve as third party administrators of prescription drug programs for commercial and employer-sponsored health plans, from collecting a copayment that exceeds the amount the dispensing pharmacy is paid by the PBM for the prescription medication and allow a pharmacy to pocket these funds. While promoted as a necessary measure to reduce prescription drug costs incurred by consumers, the long-term impact of this bill will only result in higher expenses for PBMs and insurers to manage their prescription drug benefit, ultimately increasing costs to consumers through higher premiums.

Insurers and PBMs engage in value-based health care contracts with pharmacies and use post-adjudication reconciliation to make payment adjustments once performance data is available. Many insurers and PBMs include quantitative performance metrics in arrangements with pharmacies, which are imposed on the insurer by New York and CMS as a way of ensuring payment incentives for the pharmacy are aligned with the insurer and PBM. As reconciliation requires a review of actual pharmacy performance, any recoupments (or lack thereof) must be determined retroactively, after the performance period has taken place. Thus, depending on a pharmacy's performance on certain measures, a pharmacy may be required under the terms of its contract to remit a certain percentage or amount of "adjudicated costs" as part of legitimate value-based contractual design, which may be precluded by this Bill. These arrangements are driven by legitimate public policy reasons and this Bill would limit the ability of insurers and PBMs to better control drug costs, keep premiums affordable, and promote value-based health care purchasing.

More importantly, while this Bill claims to be designed to ensure that consumers are not overpaying for prescription drugs, it actually only results in a transfer of the excess portion of the copayment to pharmacies, rather than the consumer. When patients pay their set copayment amount when their prescription drug is purchased, this amount is collected by the pharmacy in full.

Weeks or months later, the PBM determines the reimbursement amount to the pharmacy and collects the remaining portion of the copayment (amount in excess of what the pharmacy is owed, if any remains). Supporters of this Bill inaccurately claim that this amount goes to the bottom line of the PBM with no additional benefit to the patient's healthcare. Rather, the copayment amounts collected by the PBM, administering the pharmacy drug benefit for the insurer, function to maintain premiums as low as possible as these proceeds are returned to the health insurer and contribute to the insurer covering the cost of care for all enrollees. In fact, this Bill provides that the pharmacy is to keep this excess cost, which in reality, provides no absolutely no direct benefit to patients or to overall health care costs, but only increases the bottom line for the pharmacy.

This Bill also fails to consider the role of copayments in health insurance coverage and in relation to the increased spending on healthcare. When developing health insurance policies, health insurers assign prescription drugs categories known as copayment tiers, based on drug usage, cost and clinical effectiveness. Tiered copayment formularies are designed to provide financial incentives for enrollees to use generic or preferred brand named drugs, curtail the use of drugs with little therapeutic value, and limit unnecessary health cost strain on premiums. Copayments represent a fixed amount that an enrollee has agreed to pay for a prescription drug, based on the insurer's formulary offering when they enroll in a health insurance policy. As opposed to coinsurance, copayments are not reflective of the actual costs of the medical service, but rather serve to share the cost of medical services with policyholders, which are often a fraction of the actual cost of the service provided.

While this Bill equates the copayment with the level of pharmacy reimbursement, assuming that is the true cost of the medical service, this policy would disrupt an important cost-sharing mechanism that health insurers rely on to set premiums at the lowest possible level. In capping copayments to the pharmacy reimbursement amount, insurers would be required to increase premiums in order to account for the reality that the lower copayment will likely result in increased utilization, which in turn results in higher medical costs incurred by each enrollee. In most instances, the copayment amount that consumers pay represent a fraction of the actual cost of a prescription drug.

For the foregoing reasons, the Blue Cross and Blue Shield Plans urge that this bill not be enacted.

Respectfully submitted,

HINMAN STRAUB ADVISORS, LLC.
Legislative Counsel for the Blue Cross and Blue Shield Plans of New York