PCMA 2019-20 State Budget Testimony and Policy Joint Legislative Hearing on Senate Finance and Assembly Ways & Means Committees

February 5, 2019

Introduction

Good morning Chairwoman Krueger, Chairwoman Weinstein, Health Committee Chairs Rivera and Gottfried, and Committee members. I am Lauren Rowley, the Vice President of State Affairs for the Pharmaceutical Care Management Association (PCMA) of New York. PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through employers, health insurance plans, labor unions, state governments, Medicaid and Medicare.

It is my privilege to testify before you today on the Governor's proposals related to PBMs in the 2019-20 Executive Budget. I am happy to answer any questions you have and hope to continue a dialogue with each of you on these important issues.

PBMs reduce prescription drug costs and improve convenience and safety for consumers. According to new research, PBMs are projected to save employers, unions, government programs like Medicare and Medicaid, and consumers in New York $40 billion over the next decade. The PBM business model requires confidentiality to secure competitive rebate offers from manufacturers and keep prices low for consumers. This has made it easy for some to portray as "opaque middlemen" responsible for soaring drug prices. However, the "secret" to high drug prices is no secret: pharmaceutical prices start and end with the manufacturers. PBMs are instrumental in limiting drug costs.

Our entire business is predicated on providing value to our clients and the consumers we serve, and this is what we do. This fact is not lost on those who oversee health plans, like former Medicaid Director, Jason Helgerson. Two years ago when the Governor's PBM licensure proposal was first introduced, Jason Helgerson made sure it did not apply to Medicaid Managed Care plans because he knew this proposal would affect PBM's ability to secure rebates and operate effectively, and would ultimately increase costs under the Medicaid Cap. And when he was asked by this Committee last year about problematic PBMs,

he refuted that PBMs were problematic, and answered that PBMs are the basis for effective rebates that ensure Medicaid members have access to the drugs they need.

Moreover:

- PBMs keep drug prices in check: Drug spending nationally grew by only 0.4% in 2017, and continues to grow at a much lower rate than other categories like hospital and physician services. After rebates, prescription drug spending is 9.5% of health spending. Without discounts and rebates PBM's secure, it would be closer to 20%.
- PBMs are not making excessive profits at the expense of consumers: Based on an independent analysis of publicly traded corporations, gross profit margins for PBMs were 6%, compared to 20% for pharmacies, and 71% for drug manufacturers. Net profits on drugs are approximately $23 out of every $100 spent, of which wholesalers received .32 cents, PBMs received $2, pharmacies $3, health plans $3, and manufacturers $15.
- PBMs do not engage in unfair practices against pharmacies: Not every PBM owns competing retail pharmacies that operate directly with independent pharmacists. Even still, allegations of unfair or uncompetitive practices are not true. The Ohio Medicaid Spread pricing audit found that PBMs paid independent pharmacists in Ohio more than their own pharmacies, and didn't identify any preferential pricing that would create an anti-competitive advantage.
- PBMs are not –unregulated: PBM services are regulated under Federal and State law. Significant oversight of pharmacy spending already exists through DOH, OMIG and DFS. Specifically, Medicaid contracts require health plans to submit quarterly reports specific to their PBMs, including the amounts paid by the plan to the PBM for pharmaceutical services by category, the amounts for each prescription drug, and the amounts paid for PBM administrative services. This is what enabled DOH's own spread pricing analysis.

As to our testimony with respect to the Governor's Budget Proposals:

- **PCMA urges you to reject Part I of the HMH Bill**, This Section would give DFS sole oversight over PBMs and unlimited discretion to disclose proprietary financial information of PBMs and their clients (including many employers in your districts) at their whim. While our analysis shows this proposal would increase costs, the State hasn't assigned any fiscal to it, which highlights that it's simply not a Budget issue and doesn't need to be dealt with through this process. DFS is using the Budget to force its policy position on the Legislature. We urge you to reject the Governor's proposal and work on this post-budget. In particular, much time and energy has gone into developing model PBM regulation language. This language has been developed with input from

independent pharmacists, drug makers, health plans, and PBMs. While PCMA still has concerns with this model proposal, at least all stakeholders have been afforded an opportunity to comment and offer insight, and it keeps the process within the Legislature. We urge you to reject the Governor's proposal that would instead give unfettered discretion on this issue to the DFS.

- **Spread Pricing**: The Executive's proposal to eliminate spread pricing in Medicaid Managed Care is not nearly as problematic from our perspective as Part I. Spread or lock-in pricing is just one of many contract options payers have, and not every contract in Medicaid Managed care uses spread pricing anyway. Spread pricing locks in prices for payers, allowing them to avoid market risk while placing this risk on PBMs. PCMA's concern is that DOH will establish an administrative fee that does not reasonably compensate PBMs for the services we provide.

  While much has been made of the Ohio audit and the need for spread pricing reform, we wish to highlight that the Ohio analysis found that PBMs still saved Ohio Medicaid $145 million through PBM management compared to what they would have had to spend under FFS. And unlike the analysis prepared by PSSNY you heard about, DOH's own analysis assigned a fiscal savings target of eliminating spread pricing of $43 million, out of a pharmacy program with $5.7 billion in total gross spending. This amounts to less than 1% of all pharmacy spending --a far cry from the excessive profit-making alleged in the PSSNY report. And while the report claims to be a representative statewide analysis, please know that the analysis only examined payments at 11 independent pharmacies out of more than 2700 in the State. It also excludes all data from chain pharmacies. Forty-four percent (44%) of New York's retail community pharmacies are chain pharmacies, making this a critical omission. Thus, what the report terms a "representative sample" is actually a mere convenience sample that has been generalized to be representative of the entire pharmacy population of New York. We hope you'll continue to rely on facts and data as the basis for your policy proposals this Session and going forward.

Thank you again for affording me this opportunity. I am happy to answer any questions.

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