Tennessee Pharmacists Association

VOTE YES on HB2661/SB2458

Addressing Enforcement of PBM Reform

WHAT ARE PBMS?

- Pharmacy Benefit Managers, or PBMs, are third party administrators contracted by health plans, employers, and government entities to manage prescription drug programs on behalf of health plan beneficiaries.
- PBMs determine which pharmacies will be included in a prescription drug plan's network and how much those pharmacies will be paid for their services.
- PBMs also determine which medications will be covered by the plan or plan formulary, and drug manufacturers often pay "rebates" to PBMs to get their drugs onto those formularies.
- Today, three large companies – Express Scripts, CVS Health, and OptumRx – cover more than 238 million lives, or roughly 89 percent of the national market. Their annual revenues nationally were a staggering $100.5 billion, $177.5 billion, and $60.4 billion in 2016, respectively.

HOW WILL HB 2661/SB 2458 HELP REIN IN PBMS?

TPA has been working closely with legislative leadership to ensure that Tennessee Public Chapter 569 (passed in 2021) can be properly enforced by the Tennessee Department of Commerce & Insurance (TDCI). Tennessee Public Chapter 569 was intended to ensure *patient choice* and address *non-transparent pricing*. To date, TDCI has seen PBMs use several reasons to not comply with the law, including:

- The PBM is not based in Tennessee and therefore not bound by Tennessee law, and
- The plan is a self-funded or ERISA plan, not within the jurisdiction of the state.

ENSURE PATIENT CHOICE

Currently, patients may be required to use a pharmacy determined by a PBM, not of their choosing, and pharmacy reimbursement is often determined by a competitor.

- PBMs own or are affiliated with competing retail and/or mail-order and/or specialty pharmacies.
- PBMs often require/incent patients to use PBM-owned pharmacies rather than allow patients to choose.

ADDRESS NON-TRANSPARENT PRICING

Currently, there is no standardization on the upper limit of what a plan will pay for medications, nor which ones are included.

A "maximum allowable cost" or "MAC" list generally refers to a payer or PBM-generated list of products that includes the upper limit that a plan will pay for generic drugs and brand name drugs that have generic versions available. However, there is no standardization in the industry as to the criteria for the inclusion of drugs on MAC lists or for the methodology as to how the maximum price is determined, changed or updated.

HB 2661/SB 2458 WILL:

- Prevent PBMs from steering patients to a PBM-owned pharmacy, and allow patients to have a choice in which local pharmacy they use for pharmacy services.
- Provide clarity to plan sponsors and pharmacies with regard to how MAC pricing is determined and updated and establish an appeal process in which a dispensing provider can contest a listed MAC price.
- Provide standardization for how products are selected for inclusion on a MAC list.

U.S. SUPREME COURT DEFENDS STATES' RIGHTS TO REGULATE PBMS

In response to Arkansas Act 900, the Supreme Court of the United States issued a unanimous (8 to 0) decision in Rutledge v. Pharmaceutical Care Management Association (PCMA) on December 10, 2020.

- Confirms the rights of states to enact reasonable regulations in the name of fair competition and public health.
- Similar to Arkansas Act 900, Tennessee Public Chapter 569 requires PBMs to reimburse pharmacies for prescription drugs at a rate equal to or higher than the pharmacy's acquisition cost.