Pharmacy Benefit Management Reporting Task Force Meeting
October 14, 2019
Meeting Notes

Task Force Members Present:
Sherri Cherman, PharmD, President and CEO, Elements Pharmacy
Shane Desselle, RPH, PhD, FAPhA, President, Applied Pharmacy Solutions
Lisa Ghotbi, PharmD, Director of Pharmacy Services, San Francisco Health Plan
Clint Hopkins, PharmD, Owner and CEO, Pucci's Pharmacy
Patrick Robinson, RPh, MBA, Pharmacy Manager, Sutter Health Plus
Neeraj Sood, PhD, Professor and Vice Dean for Research at the USC Price School of Public Policy
John Stenerson, Deputy Executive Officer, Self-Insured Schools of California
Nicole Thibeau, PharmD, AAHIVP, Director, Pharmacy Services, Los Angeles LGBT Center

Department of Managed Health Care Staff Present:
Shelley Rouillard, Director
Pritika Dutt, Deputy Director, Office of Financial Review

Facilitator:
Yolanda Richardson, CEO, Teloiv Consulting

1. Welcome and Introductions - Agenda

Yolanda Richardson welcomed the Task Force members and informed them that Rochelle Pleskow is no longer participating in the Task Force. Ms. Richardson then asked Shelley Rouillard, Director of the Department of Managed Health Care (DMHC), for her opening remarks.

2. Opening Remarks

Ms. Rouillard provided a recap of the September 12, 2019 meeting. Ms. Rouillard also mentioned the Office of Statewide Health Planning and Development's (OSHPD) release of the Prescription Drug Wholesale Acquisition Cost (WAC) Increases data report which showed prescription drug costs are increasing, but many manufacturers did not give specific reasons for pricing increases. This demonstrates that the provisions of Senate Bill (SB) 17 (Chapter 603, Statutes of 2017) are working in that there is increased transparency, but if price increases continue more transparency is needed.

Ms. Rouillard also noted that over the weekend, Governor Gavin Newsom signed Assembly Bill (AB) 824 (Chapter 531, Statutes of 2019), introduced by Assemblymember Jim Wood and sponsored by the California Attorney General (AG). AB 824 provides the AG with additional tools to scrutinize and penalize settlement

agreements that collusively limit competition between generic and biosimilar drugs. The bill prohibits “pay for delay” agreements in which the patent holder of a drug pays a generic manufacturer to stop challenging the validity of the patent and to delay marketing a generic version of the drug. These are also known as “reverse settlements” which allow both parties to benefit from monopoly pricing. These agreements hurt consumers by delaying competition for the brand name drug and by reducing the number of competing drugs that ultimately enter the market, resulting in higher prices for generic drugs. The bill makes reverse settlements presumptively anticompetitive but allows the parties to demonstrate any procompetitive impacts of the settlements. It also allows the AG to pursue civil penalties for violation of the statute.

Ms. Rouillard stated that Governor Newsom also signed Senate Bill (SB) 159 (Chapter 532, Statutes of 2019) to allow individuals to get pre-exposure and post-exposure prophylaxis without prior authorization, an important consumer protection.

Ms. Richardson reminded the Task Force members that the Task Force’s charge is to determine what additional data elements the DMHC should require health care service plans or their contracted Pharmacy Benefit Managers (PBM) to report, in addition to the current data reporting requirements.

Ms. Richardson then provided an overview of the agenda and introduced Task Force member Neeraj Sood to present information on PBM Economics.

3. Wholesale Costs and Rebates

Dr. Sood presented a broad overview of the pharmaceutical supply chain. Dr. Sood also discussed potential policy solutions for increasing transparency. He noted the policy solutions represent his own views and were in response to the discussions at the previous PBM Task Force meetings.

Dr. Sood explained that the flow of prescription drugs starts with the manufacturer that sells the drug to a distributor/wholesaler that in turn sells the drug to a pharmacy that sells the drug directly to the consumer. PBMs do not play a role in the actual physical distribution of prescription drugs; instead, they play a different role in the market, including:

- Helping health plans manage their drug benefits through negotiating or contracting with manufacturers on behalf of the health plan.
- Negotiating or contracting with pharmacies on behalf of health plans.

In both instances, the negotiations involve rebates which place drugs in a lower cost sharing tier, allowing more drugs to be sold.

Lisa Ghotbi asked if Dr. Sood could describe the process for generic drugs, which are 90% of prescriptions that are filled today. Dr. Sood explained there are no or minimal

rebates for generic drugs. Dr. Sood's own research, as well as other industry research on the same topic, found that, pharmacy distributors and PBMs have much higher margins for generic drugs compared to brand name drugs. Because generic drugs have multiple manufacturers making the exact same drug, there is competition and the manufacturer does not have market power. For brand name drugs, there is only one manufacturer who has a patent, which gives them the market power. For the PBM market, the manufacturer does not have the market power but a distributor that awards a contract to one manufacturer can influence sales across the entire market. Therefore it is the distributors, pharmacies, and PBMs that have more market power or higher margins.

Dr. Sood described the following ways PBMs make money:

- Retained Rebate: Difference between rebate received from the manufacturer and amount passed through to plans.
- Spread Pricing: Difference between negotiated payment from health plan and what is paid to pharmacies.
- Administrative Fees: Money PBMs receive for managing a drug benefit.

Dr. Sood explained that, with the current information available, the following questions cannot be answered:

- What are the major sources of profits for PBMs?
- Who is benefiting from the rise in drug prices?
- Is the PBM market competitive?
- Are vertically integrated PBMs limiting competition by helping their own pharmacies?
- Are PBMs good agents of health plans and consumers?

Dr. Sood recommended gathering the following data to increase PBM transparency:

- PBM revenue sources:
    - Revenues by line of business: PBM, specialty pharmacy, mail order pharmacy, retail pharmacy, and other.
    - PBM line of business: Revenues from manufacturers, health plans, pharmacies, and others.
- PBM expenditure sources:
    - Expensed by line of business: PBM, specialty pharmacy, mail order pharmacy, retail pharmacy, and other.
    - PBM line of business: Payments to pharmacies, claims processing expenses, rebate pass through to health plans, expenses on special programs, administrative expenses, and others.

- Revenues at the drug level:
  - For the top 25 drugs in terms of PBM revenues and/or list price inflation:
    - Total rebates per unit, retained rebates per unit, spread pricing per unit, and other revenues per unit.
- Dealings with own pharmacies:
  - For the top 25 drugs in terms of expenditures:
    - Reimbursement to own pharmacy, competing chain pharmacy, and independents.
  - For the top 25 drugs sold by own pharmacy:
    - Market share of own PBM and other PBMs.
- Formulary decisions:
  - For top 25 drug classes in terms of expenditures:
    - Net cost of drug to health plans (pharmacy reimbursement less rebate pass-through).
    - Net revenue of drug to PBM (retained rebate plus spread pricing).
    - Formulary placement of drug (tier, average cost sharing).
- PBM health plan customers:
  - PBMs should report:
    - The health plans they support and number of members supported, including data from the past 5 years to see the change in customers.
- Information from health plans and PBMs:
  - Health plans: Amount sent to PBM for reimbursing pharmacies and amount of rebate received from PBM.
  - PBMs: Amount reimbursed to pharmacies on behalf of health plans and amount of rebate passed on to health plans.

Public Comments

Bill Head, Pharmaceutical Care Management Association (PCMA), commented that a 2018 Office of Inspector General (OIG) report illustrated that, despite the increase in rebates, the utilization of brand name drugs decreased from 2011 – 2015. A subsequent U.S. Government Accountability Office (GAO) report found that 99.6% of rebates are passed on to plan sponsors. Ultimately, rebate savings are passed on to consumers. Further, there are 66 PBMs nationally and 3 distributors. The same distributors selling to the pharmacies also represent the pharmacies as Pharmacy Services Administrative Organizations (PSAO) in contracting with the PBMs and this should be considered. Wholesalers are selling to the entities on whose behalf the wholesaler is negotiating as the distributor and as the PSAO. It should be considered how that impacts prices. PBMs don't dictate formulary placement. This is a decision that is made at the health plan. The group should consider how the formulary is developed. A number of the suggestions the Task Force is making are already required pursuant to Assembly Bill (AB) 315 (Chapter 905, Statutes of 2018).

Dr. Ghotbi asked whether the spread of generics was indicated as one of the major revenue opportunities for the PBMs. Mr. Head stated that the OIG report pointed out that, even after rebates are accounted for, rebates aren't the cause of the increase in the list price of the drug. In the broader context, medical costs are still the driving force in the increased cost of health care.

4. Actionable Transparency: Identification of Additional Reporting Requirements

Ms. Richardson asked the Task Force to turn their attention to the Additional Data Elements for Consideration worksheet and consider for each data element where the information would come from, whether it is available, and what the value in collecting the data may be.

Patrick Robinson stated the data element, "health plan member assignment by PBM" should be collected in member months so that Per Member Per Month (PMPM) or trending can be calculated. Dr. Sood commented that the member months are needed to calculate the PBM's market share.

Pritika Dutt confirmed the health plans are already required to report which PBMs they contract with pursuant to SB 17, so DMHC could consider whether to require reporting by member months in the SB 17 data template.

Mr. Robinson recommended data on regional pricing should be collected due to differences in pricing regionally.

Nicole Thibeau recommended that, in order to discern the cost to the pharmacy for brand name drugs and generics relative to the costs that consumers see, data should be collected on member assistance (i.e., co-pay coupons and cost sharing).

Mr. Robinson commented that some pharmacies would have that data and could report it to the PBM. Dr. Ghotbi replied that total spend at the pharmacy is already collected pursuant to SB 17 and what should be added is member share of cost at the National Drug Code (NDC) 11 level. This would get to the WAC.

Ms. Richardson asked the Task Force members to explain the data element "formulary placement by drug." Dr. Sood suggested that this could be rolled up and reported in aggregate.

Ms. Richardson asked the Task Force members to respond to the data element "costs related to specific drugs and how they differ from generic drugs." Dr. Ghotbi commented that OSHPD recommended using the NDC-11 level to break it up by package size.

Sherri Cherman explained the Task Force should recommend collecting what is paid to each pharmacy by NDC, drug ingredient cost per metric unit number and Drug

Enforcement Administration (DEA) number to identify differential reimbursement that PBMs pay to vertically integrated versus non-preferred pharmacies.

Ms. Richardson asked the Task Force to explain the data element “price paid for a drug after claw-backs.” Dr. Cherman explained that this data element should include anything that is given back to the PBM from the pharmacy. Dr. Ghotbi suggested the purchaser could be required to report the aggregated amount of fees imposed on or collected from network pharmacies or other assessments against network pharmacies. Dr. Sood clarified all revenues received from the manufacturer versus what was sent to the health plan should be collected at the NDC level. This should give a line of sight into what revenues were kept by the PBMs. Dr. Cherman stated that this should include the fees that are from the health plan to the PBM as well, which would take into account spread pricing.

Regarding the data element concerning Maximum Allowable Cost (MAC) pricing, the Task Force determined that MAC prices can be changed every 7 days, and this data is not under the purview of the Task Force, and would be too granular to be useful.

5. Closing Remarks

Ms. Richardson asked the Task Force members if they had any additions or deletions to the meeting minutes.

The next meeting is scheduled for December 4, 2019. The location will be the second floor conference room at DMHC.

Ms. Rouillard thanked Dr. Sood for his presentation and the Task Force for their expertise.