



**Pharmacy Benefit Management Reporting Task Force Meeting
July 31, 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
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:

Pritika Dutt, Deputy Director, Office of Financial Review
Deborah Haddad, Acting Deputy Director, Health Policy and Stakeholder Relations
Sarah Ream, Acting General Counsel
Shelley Rouillard, Director
Wayne Thomas, Chief Life Actuary, Office of Financial Review

Facilitator:

Yolanda Richardson, CEO, Teloiv Consulting

1. Welcome and Introductions – [Agenda](#)

Yolanda Richardson opened the meeting by welcoming the Task Force members and members of the public. She asked the Task Force members to introduce themselves. Ms. Richardson then introduced Shelley Rouillard, Director of the Department of Managed Health Care (DMHC).

2. Opening Remarks

Ms. Rouillard welcomed the Task Force members and audience and thanked them for their participation. She briefly explained the role of the Task Force, which is to share their knowledge and expertise and recommend what additional information related to pharmacy costs, besides that required by SB 17, health plans or their contracted Pharmacy Benefit Managers (PBM) should report to the DMHC.

Ms. Rouillard then introduced Assembly Member Jim Wood, the author of AB 315, which created the Task Force.

Assembly Member Wood described his legislative focus on access to care and finding ways to stabilize the cost of health care and explained why he authored AB 315. The impetus for AB 315 came from legislative informational hearings on prescription drug costs and the role PBMs play. Assembly Member Wood is interested in learning

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whether PBMs are delivering the services they're supposed to deliver to their clients in good faith and with transparency and whether the consumer is getting the best possible price for their prescription drug.

Ms. Rouillard then introduced Richard Figueroa, Deputy Cabinet Secretary in the Office of Governor Gavin Newsom.

Mr. Figueroa noted that the Governor is very focused on health care and prescription drug costs, both as a payor (through CalPERS and Covered California) and as a purchaser (through Medi-Cal, Corrections, Veterans Affairs and Public Health). The Administration seeks more transparency in the costs of health care and pharmacy is one of the larger drivers of increased costs.

3. Bagley-Keene Open Meetings Act

Sarah Ream, DMHC Acting General Counsel, explained the rules of the [Bagley-Keene Open Meetings Act](#) and told the Task Force members they should not discuss issues related to the Task Force outside of the public meetings.

4. California Landscape: Pharmacy Reporting

Pritika Dutt, DMHC Deputy Director in the Office of Financial Review, described the DMHC's [Prescription Drug Cost Transparency Report](#) for Measurement Year 2017 which is required under SB 17 (Chapter 603, Statutes of 2017). Ms. Dutt summarized the key findings from the report.

Patrick Robinson asked if the DMHC looked at preferred versus non-preferred drugs (e.g., Tier 2 or tier 3 drugs). He noted rebates are generated off Tier 2. Ms. Dutt replied the analysis was limited to generic, brand and specialty drugs only and did not consider which drugs were in which tier.

Sherri Cherman asked how specialty drugs are defined. Ms. Dutt replied the DMHC used the CMS definition for Medicare specialty drugs which is any drug that costs \$670 or more.

Several Task Force members discussed their interest in comparing the Wholesale Acquisition Cost (WAC) and National Average Drug Acquisition Cost (NADAC) to the drug costs health plans report.

Mr. Robinson suggested considering adding reporting requirements on the Maximum Allowable Cost (MAC) of prescription drugs, acknowledging that terms need to be defined.

Ms. Rouillard asked who determines the MAC. Shane Desselle responded that the PBMs use a formula to calculate the cost, but the formula is not transparent. He stated PBMs may calculate the MAC differently. Clint Hopkins added that pharmacies get paid MAC pricing on drugs that have only one source.

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Mr. Robinson noted there is a federal MAC and a State Medicaid MAC each of which have an upper limit.

Michael Valle, Chief Strategy Officer at the Office of Statewide Health Planning and Development (OSHPD), described OSHPD's mission to advance safe, quality health care environments through innovative and responsive services. Under SB 17, prescription drug manufacturers must provide advance notice to purchasers on specified prescription drug WAC increases. Drug manufacturers must submit information on specific prescription drugs to OSHPD which includes a WAC history. OSHPD maintains a list of registered purchasers and collects and publishes information on specified new prescription drugs introduced to the market and WAC increases. OSHPD recently issued the new drug report which is available on [OSHPD's website](#).

Task Force members expressed appreciation for receiving the notices on WAC increases in advance.

Public Comments:

Danny Martinez, California Pharmacists Association (CPhA) commented that the Direct and Indirect Remuneration (DIR) Fee is charged to pharmacists for standards the pharmacists find to be unachievable. He also stated that pharmacists use Pharmacy Services Administrative Organizations (PSAO) to negotiate contracts with PBMs. He commented that Generic Effective Rates (GER) are effectively the new MAC which PBMs are ignoring. Mr. Martinez mentioned his organization is suspicious "buy outs" of pharmacies by PBMs or pharmacies owned by PBMs and he would like the Task Force to examine this.

Bill Head, Pharmaceutical Care Management Association (PCMA) which represents the PBM industry, encouraged the Task Force to seek out "actionable transparency" meaning transparency for what, to whom and for what objective. He offered to provide background and information as the Task Force seeks to define terms. He stated PBMs are transparent to the client (e.g., CalPERS). He said how the rebates work is an important question and one that should be examined. He stated rebates are only for multiple source drugs and currently 95 percent of rebate dollars are passed through to the client.

Task Force members questioned what data is available to support the claim that of the 95 percent pass through to the health plan and how much of the rebate goes to the PBM.

Mr. Head replied that rebates have an impact on lowering premiums, and this is reflected in both the DMHC and CDI reports on SB 17.

Task Force members asked if Mr. Head has a document that consolidates the definitions discussed earlier and, if so, to provide it to the Task Force.

Mr. Desselle wondered about the extent to which rebates help curb costs. He commented that rebates also drive medication utilization and hopes the Task Force can

shed light on cost effectiveness and whether the prescribed drug is the best drug for the patient. He would like to examine whether rebates cause one drug to be prescribed over another drug and whether this results in optimal medication use.

Assembly Member Wood expressed his concerns regarding whether the drug on the formulary is the best drug for the patient or is it the most cost-effective drug for the PBM. He wondered how a more effective, less costly drug makes it onto a health plan formulary.

There was support among Task Force members to discuss DIR fees because these fees have been growing substantially and may be driving up costs and contributing to the opaqueness of drug pricing.

Mr. Head offered to give a presentation on formularies and how they are established.

There was discussion about direct to consumer advertising and how that may impact drug utilization.

Brett Johnson, California Life Sciences Association, stated PBMs are a frustration in his industry. He stated definitions are largely industry controlled and can differ from contract to contract. He agreed that actionable transparency is very important and is thinking about how this information could be used for other transparency efforts such as the Healthcare Payments Database OSHPD is creating. Mr. Johnson also mentioned a report by IQVIA that discusses pharmacy trends, costs and projections and offered to send it to the DMHC.

Assembly Member Wood asked Mr. Johnson if his organization represents generic manufacturers. Assembly Member Wood questioned why there are no generic insulins available.

Mr. Johnson commented that some of the companies his organization represents have branded generics, but insulin is a biosimilar and getting biosimilars to the market has been challenging.

Mr. Desselle suggested that the gap between the increases in the WAC and revenue to drug manufacturers is something to consider.

5. Pharmacy Cost Information the DMHC Should Consider for PBM Reporting

Ms. Richardson asked what presentations or topics the Task Force members would like to explore in future meetings.

Task Force members offered the following suggestions:

Access/Network Issues

- Mail order requirements to narrow the network and the treatment and relationships of vertically integrated pharmacies versus independent pharmacies

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and the impact of differential reimbursement rates which are paid to vertically integrated pharmacies and not to independent pharmacies

- Whether patients are being directed to the pharmacy with which the PBM has a relationship
- Access to pharmacies and how the use of PBMs may limit access- for example, examining the impact that the use of providing alternate rebates for 340B drugs may have on access
- Access issues due to low Medi-Cal reimbursement- some chains have opted out of networks due to low Medi-Cal payments
- How PBMs may have affected pharmacy closures in the state
- How mergers and acquisitions impact the market in California
- Which PBMs are associated with which pharmacy chains
- Requirements that PBMs become specialty providers without a clear definition of what constitutes a specialty provider
- Physician-administered drugs (PAD) and whether they can be managed through a PBM

Rebates/Pricing/Reimbursements

- Gag clauses and claw-backs, which is where a patient might be able to pay less for a generic at a pharmacy but the pharmacist is not allowed to tell the patient the cheaper drug is available (*It was noted that federal and state laws, including California law, already prohibit this*)
- How rebates influence what drugs are preferred and non-preferred
- Brand effective Rate (BER) and post-adjudication remuneration tactics to take money back from a pharmacy after a claim has been paid
- An examination of the various fees, including who benefits and how they influence fair market value (for example, professional, dispensing and PNR fees)
- Inflation protection contracts
- The difference in MAC pricing and PBM pricing versus what pharmacies are paid
- Development of a CalADAC since the cost of living in California is much greater compared to other states (e.g., a NADAC specific to CA)
- Verified Accredited Wholesale Distributors (VAWD) and how they set MAC prices

PBM functions/Delegation

- Management of pharmacy benefits and proper oversight by plans and regulators
- The process that PBMs use to change the prescription after the prior authorization has been initiated (such as PEP instead of PrEP)
- Subcontracting of PBMs with other entities

Generics

- An overview of the generic drug industry
- Generic versus brand name drugs
- WAC and AB generics versus authorized generics and how the FDA sets rules around substitutions

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- The impact of margins or spread pricing with generics, such as a high price on generic drugs at a mail order pharmacy that was not affiliated with a PBM

Pharmacy Services Administrative Organizations

- What is the value of PSAOs?
- The relationship between PSAOs and wholesalers

Ms. Rouillard reminded the Task Force members of the availability of the [DMHC Help Center](#) webpage when their clients or patients are having problems accessing prescription drugs.

Task Force members suggested having presentations from the following entities:

- California Pharmacists Association
- Pharmacy Services Administrative Organization(s)
- Pharmacy Benefit Managers, or the Pharmaceutical Care Management Association, to describe the full scope of what they do including P&T utilization management policies, contract negotiations, appeals, network development, margin pricing, how drugs get on formularies
- Health plans, to describe how they use PBMs in California
- Pharmaceutical Research Manufacturers Association (PhRMA) perspective on cost-effectiveness and medication utilization; how effective drug use could be improved

Ms. Richardson asked the audience for any comment on future presentations.

Mr. Head suggested having CalPERS talk about its relationship with its PBM.

T. Abraham from the Hospital Council suggested a presentation on the relationship between the health plans and the PBMs.

6. Proposed Task Force Timeline

Ms. Richardson noted that the DMHC's report to the Legislature based on Task Force recommendations is due February 1, 2020. She anticipates sharing a draft with the Task Force in mid-January.

The next Task Force meeting is scheduled for September 12, 2019 from 10:00 a.m. to 1:00 p.m.

7. Closing Remarks

Director Rouillard commented she found the discussion to be fascinating and informative. She expressed appreciation to the Task Force members for their engagement and for sharing their experiences. She commented that based on this meeting, the DMHC picked the right people for the Task Force.