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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2022

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A N A C T

RELATING TO INSURANCE -- CONTROL OF HIGH PRESCRIPTION COSTS -- REGULATION OF PHARMACY BENEFIT MANAGERS

Introduced By: Senators Calkin, Bell, Anderson, Mendes, and Mack

Date Introduced: March 10, 2022

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 20.12

CONTROL OF HIGH PRESCRIPTION COSTS -- REGULATION OF PHARMACY BENEFIT MANAGERS

27-20.12-1. Legislative findings.

Legislative findings.

(1) About forty percent (40%) of Americans struggle to afford their regular prescription medicines, with one-third (1/3) saying they have skipped filling a prescription one or more times, because of the cost.

(2) COVID-19 has exacerbated this problem by causing job and health insurance loss and delaying routine care.

(3) Pharmacy benefit managers (PBMs) are for-profit companies that manage prescription drug benefits for more than two hundred sixty-six million (266,000,000) Americans on behalf of private insurers, Medicare Part D drug plans, government employee plans, large employers, and Medicaid managed care organizations (MCOs).

(4) PBMs began in the 1970s as small independent middlemen between insurers and pharmacies, taking a set fee for processing claims.

(5) Today, three (3) PBMs control eighty percent (80%) of the market and are part of large vertically integrated conglomerates that include health insurance companies and pharmacies:

(i) CVS Caremark – thirty-two percent (32%) market share – parent company: CVS (Aetna)

(ii) Express Scripts – twenty-four percent (24%) market share – parent company: Cigna

(iii) OptumRx – twenty-one percent (21%) market share – parent company: UnitedHealth

(6) Revenues of top PBM conglomerates exceed those of top pharmaceutical manufacturers and PBM conglomerates such as CVS, United Health Group and Cigna are ranked fourth, fifth and thirteenth, respectively, on the Fortune 500 list ranking largest corporations by revenue.

(7) PBMs drive revenues for their parent companies, e.g., CVS Health's Pharmacy Services (PBM) segment will make forty-six percent (46%) of three hundred twenty-four billion dollars ($324,000,000,000) in 2021 revenues for the company and remains key to its revenue growth.

(8) PBMs harm consumers and taxpayers because:

(i) PBMs have a conflict of interest and put drugs on formularies to get higher legal kickbacks ("rebates") from drug manufacturers rather than choose the most effective or affordable drugs for consumers.

(ii) Drug manufacturers cover PBM rebates by raising list prices for drugs and rebates – adding an estimated thirty cents ($0.30) per dollar to the price consumers pay for prescriptions.

(iii) Maximum allowable cost ("MAC") prices are the upper limits that a PBM will pay a pharmacy for generic drugs and brand name drugs that have generic versions available (multi-source brands). PBMs use arbitrary and opaque MAC pricing to charge insurers (including state Medicaid) more than what they reimburse pharmacies and are allowed to pocket the difference ("the spread").

(9) PBM conglomerates own retail, mail order and specialty pharmacies and work against consumer interests by:

(i) Setting low reimbursements for their competitors, causing local independent pharmacies to disappear.

(ii) "Steering" customers to their affiliated mail order and specialty pharmacies, e.g., by requiring a higher copay if the patient obtains the drug from a non-affiliated pharmacy.

(iii) Not allowing pharmacists to discuss cheaper options ("gag orders").

(10) PBMs can make government oversight impossible by hiding profits in multiple ways, e.g., by:

(i) Keeping their negotiated discounts and rebates as well as maximum allowable cost (MAC) lists confidential.

(ii) Disguising profits, e.g., as "rebate management fees" and "savings."

(iii) Controlling their own audits, e.g., by having the right to veto auditors, determine frequency of audits, require auditors to sign "confidentiality agreements".

(11) PBMs use "utilization management" that adversely affects clinical outcomes by making providers spend excessive time on administrative tasks, delaying and discouraging patient care, such as:

(i) "Prior authorization," which requires patients to get third-party approval prior to getting the medicine prescribed by their health care provider.

(ii) "Step therapy," also known as "fail-first," "sequencing," and "tiering," which requires patients to start with lower-priced medications before being approved for originally prescribed medications.

(iii) "Non-medical drug switching" which forces patients off their current therapies for no reason other than to save insurers money, including by increasing out-of-pocket costs, moving treatments to higher cost tiers, or terminating coverage of a particular drug.

(12) PBMs can profit from a federal program ("Section 340B") meant to help low-income patients by engaging in "discriminatory reimbursement," e.g., offering 340B entities lower reimbursement rates than those offered to non-340B entities.

(13) Multiple states besides Rhode Island are aggressively regulating PBMs, e.g., Ohio, Kentucky, New York, Pennsylvania, and Virginia.

(i) Other states have taken actions including:

(A) Imposing transparency reporting requirements;

(B) Investigating PBMs;

(C) Carving out PBMs from managing Medicaid pharmacy benefits;

(D) Prohibiting spread pricing;

(E) Restricting PBM rebates;

(F) Prohibiting PBM "claw backs";

(G) Restricting Section 340B reimbursements; and

(H) Limiting "utilization management."

(14) A recent Supreme Court case, Rutledge v. PCMA, supports states taking more actions to regulate PBMs.

(15) Rhode Island policymakers have essentially ignored PBMs and their effects on the cost of prescription drugs, see, e.g., office of health insurance commissioner and Rhode Island cost trends project health care cost analyses.

(16) Five (5) year Rhode Island managed care organization (MCO) contracts with an

estimated cost of one billion seven hundred million dollars ($1,700,000,000) per year are scheduled to expire and be renewed in April 2022, and are missing PBM oversight and restrictions, e.g., they do not require PBMs to identify their spread pricing profits; they do not make all statutory limits on prior authorizations also apply to Medicaid managed care PBMs; etc.

27-20.12-2. Legislative intent.

The intent of this legislation is to:

(1) Ensure PBMs provide sufficient information to the state to allow accurate analyses of PBM costs and benefits for Rhode Island consumers and taxpayers.

(2) Restrict PBM practices that lead to overcharging, including, "spread pricing," "claw backs," "pharmacy steering," discriminatory reimbursements, manufacturer rebates, and Section 340B discriminatory practices.

(3) Restrict PBM and affiliated companies from imposing harmful utilization management practices on patients including, prior authorization, step therapy and non-medical drug switching.

(4) Establish enforcement procedures and penalties to ensure consumer and taxpayer protection and PBM compliance with this chapter.

27-20.12-3. Implementation.

(1) PBMs shall provide state authorities and the general public information on a quarterly or more frequent basis that permits an accurate determination of the costs and benefits of PBMs for Rhode Island taxpayers and consumers.

(2) The executive office of health and human services (EOHHS) shall carve out PBMs from Medicaid Managed Care Organization (MCO) contracts set to renew in April 2022.

(3) PBMs shall cease activities that result in "spread pricing" profits, including creating multiple maximum acquisition cost (MAC) lists that list higher prices for insurer to PBM reimbursements and lower prices for PBM to pharmacy reimbursements for the same drug.

(4) PBMs shall implement administrative-fee only compensation, i.e., a set per-member-per-month (PMPM) fee that is the sole compensation for services performed.

(5) PBMs shall implement pharmacy pass-through pricing. For covered claims paid by PBMs, the payers shall reimburse the PBM an amount equal to the actual amount the PBM pays to the dispensing pharmacy, including any contracted dispensing fee. In no event shall payers owe the PBM more than the amount the PBM paid to the dispensing pharmacy, including any contracted dispensing fee.

(6) PBMs shall implement one hundred percent (100%) pass-through of manufacturer-derived revenues.

(7) PBMs shall pay or credit payers one hundred percent (100%) of all manufacturer-

derived revenue PBMs receive, including rebates and other manufacturer revenues.

(8) PBMs shall not charge payers any management or administrative fees associated with obtaining, collecting, or negotiating any manufacturer-derived revenue.

27-20.12-4. Definitions.

As used in this chapter:

(1) "Other manufacturer revenue(s)" means, without limitation, compensation or remuneration received or recovered, directly or indirectly, from a pharmaceutical manufacturer for administrative, educational, research, clinical program, or other services, product selection switching incentives, charge-back fees, market share incentives, drug pull-through programs, or any payment amounts related to the number of covered lives, formularies, or the PBM's relationship with the payer.

(2) "Rebate(s)" means all price concessions paid by a manufacturer or any other third party to PBMs including rebates, discounts, credits, fees, manufacturer administrative fees, or other payments that are based on actual or estimated utilization of a covered drug or price concessions based on the effectiveness of a covered drug.

27-20.12-5. Requirements for pharmacy benefits managers.

PBMs shall:

(1) Cease taking money that consumers paid pharmacies as co-pays in excess of what pharmacies paid to acquire a drug (i.e., taking "claw backs") and any such funds must be returned to consumers;

(2) Cease reimbursing affiliated pharmacies more than non-affiliated pharmacies for the same drugs;

(3) Cease "pharmacy steering," i.e., steering consumers to affiliated pharmacies (including mail order and specialty pharmacies), e.g., by requiring a higher copay if the patient obtains the drug from a non-affiliated pharmacy;

(4) Prioritize benefits to consumers and not PBM or affiliated company profits in determining placement of drugs on formularies;

(5) Cease profiting from a federal program ("Section 340B") meant to help low-income patients by engaging in "discriminatory reimbursement," e.g., offering 340B entities lower reimbursement rates than those offered to non-340B entities; and

(6) Cease "utilization management" strategies that delay and discourage patient care, and adversely affect clinical outcomes, including, prior authorizations, step therapy and non-medical drug switching.

27-20.12-6. Compliance -- Rules and regulations.

(a) The executive office of health and human services (EOHHS), the department of business regulation (DBR), and the office of health insurance commissioner (OHIC), shall ensure that PBMs comply with the provisions of this chapter by the promulgation of any rules and regulations they deem necessary.

(b) The office of the auditor general shall hire and supervise financial consultants with expertise about PBMs to conduct or oversee audits that determine whether PBM costs to the state are excessive and whether PBMs are in compliance with the provisions set forth in this chapter.

(c) The attorney general is hereby authorized to undertake appropriate civil and criminal investigations of and actions against PBMs and affiliates to enforce the provisions of this chapter.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- CONTROL OF HIGH PRESCRIPTION COSTS -- REGULATION OF PHARMACY BENEFIT MANAGERS

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This act would regulate pharmacy benefit managers' (PBMs) policies and practices relating to accurate costs and pricing reporting, restricting discriminatory practices and establishing consumer protections with enforcement of penalties for violations by the office of the attorney general.

This act would take effect upon passage.

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