Lowering Out-of-pocket Medication Costs for Patients

The overwhelming majority of the prices paid at the pharmacy counter are based on price points established by pharmacy benefit managers (PBMs).

- In a study of 1,130 Nevada adults, over half (55%) reported that they are somewhat worried or very worried about prescription drug costs. Nearly 1 in 3 respondents (30%) did not fill a prescription, cut pills in half, or skipped a dose of medicine in the last year due to cost.[1]
- In 2020, 30% of neighborhoods in Nevada were in pharmacy shortage areas affecting 33% of the total population.[2] According to the Nevada Board of Pharmacy website, since November of 2020, Nevada has a net loss of twelve outpatient pharmacies.[3]
- Recently, the State of Nevada reached an 11.3-million-dollar settlement against one of the major PBMs, Centene, for overbilling Nevada Medicaid.[4]
- Throughout the nation, states are passing laws that protect patient costs and access to prescription medications. Unfortunately, very little has been done in our state to create transparency around the costs of medications set by PBMs.

Nevada must pass comprehensive PBM laws to make sure out-of-pocket costs are lowered for patients and make sure that they are able to access them.

What has been done in Nevada?

- NRS 683A.178 requires a PBM to have an obligation of good faith and fair dealing toward a third party or pharmacy and requires conflict of interests to be disclosed.
- NRS 683A.179prohibits a PBM from penalizing a pharmacy or pharmacist for providing information to a patient if there is a less expensive alternative or generic drug available.
- NRS 679B.133requires PBMs to register with the Nevada Division of Insurance.
- AB434, 2023 prohibits PBM from discriminating against pharmacies that participate in a federal program to facilitate the discounted purchase of prescription drugs. (340B pharmacies)

Why do we need more regulation and transparency of PBMs in Nevada?

PBMs control the pricing of medications (insurance-based claims including Medicaid, Medicare, and private plans) throughout the whole drug supply chain including transactions between:

- Manufacturers and insurance companies
- Pharmacies and insurance companies
- Pharmacies and patient copays

This gives PBMs the power to manipulate the system to direct profits to themselves or other parts of their company.

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What ways can PBMs manipulate the system to increase the costs in the drug supply chain?

- **Spread pricing:** charging the insurance company one price and reimbursing the pharmacy at a lower price. The PBM then keeps the difference.[5]
- **Retaining rebates:** rebates are meant to support patient's access to medications. Currently, PBMs are allowed to retain rebates in Nevada instead of passing the saving on to patients.[6]
- **Overriding physicians' decisions on patient care:** PBMs choose what medications should be on the formularies. This may not be based on clinical guidelines and may be based on financial gain.[7]
- **Placing higher costs medications on formularies:** PBMs are allowed to charge a fee based on the cost of the medication. This can incentivize the PBM to put higher costs medications on their formulary so that they make more money.[7]
- **Steering/specialty pharmacy:** Forcing patients to fill medications that have the largest profit margins at a PBM-owned pharmacy.[8]
- **Charging transaction fees to insurance companies that are based on inflated prices:** PBMs can set their fees based off average wholesale price (AWP). This is an inflated price of medications and PBMs can charge higher fees based off it and trick people into thinking they are saving the health system more money.[8]
- **Vertical integration:** The three biggest PBMs (Cigna, CVS Health, and United Health Group) control 80% of all prescription claims.[9] They also have their own insurance arm, pharmacies, and medical clinics. This creates an unfair advantage for companies that are not vertically integrated and can direct profits to other areas of PBM owned corporations.

Vertical Business Relationships Among Insurers, PBMs, Specialty Pharmacies, and Providers, 2023

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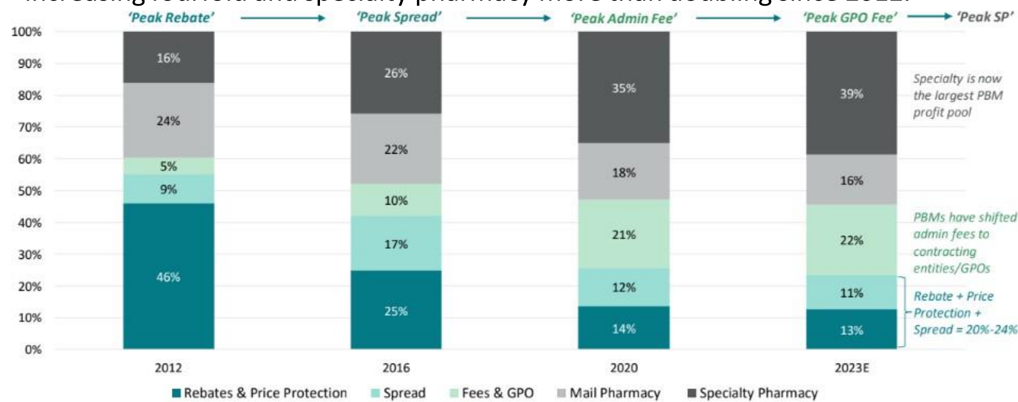
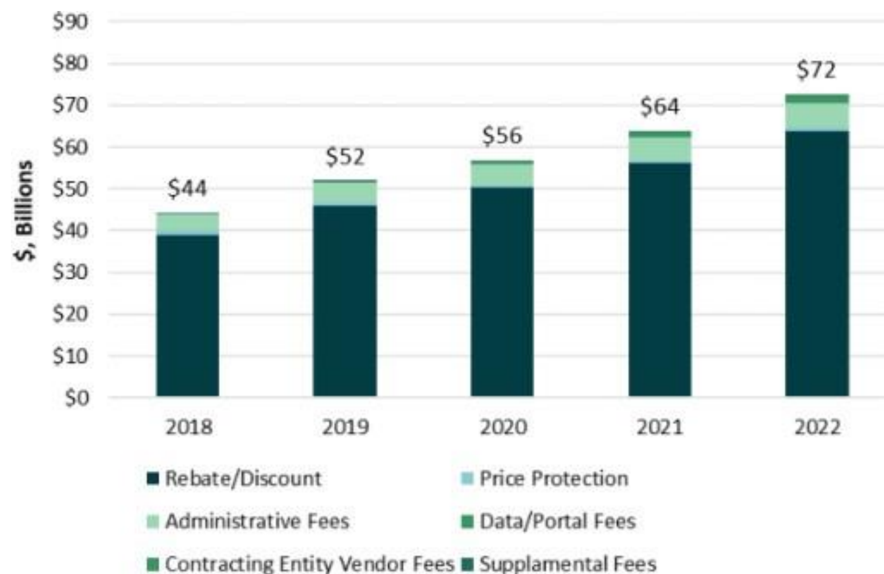
Everyone needs to make a profit. Are PBMs retaining more than they should?

As discussed earlier, PBMs control their data so only limited information is available. Nephron Research conducts studies of PBM profitability based on the data that they can get from manufacturers and PBM contracting entities for pharmacies, group purchasing organizations (GPOs). PBMs keep finding ways to increase their profits. While the value of rebates paid to PBMs continues to grow, fees and specialty pharmacy now drive a greater share of PBM profits, with estimated PBM profits derived from fees increasing fourfold and specialty pharmacy more than doubling since 2012.[10]



Extrapolation leads them to project that total manufacturer compensation to PBMs for commercial **BRAND** sales grew 65% over this period, from $44 billion in 2018 to $72 billion in 2022.[10] **Ask yourself, when will PBMs be held accountable for increasing the costs in the medication supply chain?**



Why haven't laws been passed in Nevada to regulate PBMs?

Drug pricing is a complicated system with PBMs controlling their data. They can choose what information that they want to share and direct the narrative. They can tell patients, insurance companies, and lawmakers that the cost of medications will rise if laws are passed to regulate them. Until recently, many people believed them. **Ask yourself, If PBMs are saving the health system money, why aren't they promoting transparency?**

What is being done federally and in other states?

- Over twenty-five bills have been introduced in Congress. A few examples of bills introduced this session:
  - S. 2973/H.R. 5378, the Modernizing and Ensuring PBM Accountability (MEPA) Act
    - Bans spread pricing in Medicaid managed care by requiring fair and transparent reimbursement to pharmacies and saves over $1 billion.
  - S. 3430, Better Mental Health Care, Lower-Cost Drugs, and Extenders Act
    - Includes the No PBMs Act which requires CMS to define reasonable and relevant contract terms in Medicare.
  - S. 127, the Pharmacy Benefit Manager Transparency Act
    - Prohibits PBMs from arbitrarily, unfairly, or deceptively clawing back reimbursement payments or increasing fees or lowering reimbursements to pharmacies to offset changes to federally funded health plans.
- Other states:
  - Comprehensive reform has been passed throughout the United States but not in Nevada.
- Federal Trade Commission (FTC):
  - FTC Launches Inquiry into Prescription Drug Middlemen Industry on June 7, 2022 (ongoing)

Suggested policy solutions in Nevada:

1. Introduce a bill that would require PBM operating in Nevada to obtain a license and follow specific policies designed to lower out-of-pocket costs and maintain access to prescription medications for patients.
2. Introduce a bill that would require Nevada Medicaid Fee-For-Service (FFS) and Managed Care Organizations (MCOs) to use a single PBM to serve as the state's third-party administrator.

We cannot wait for federal regulations to be passed or the FTC to act.

Lawmakers in Nevada must act!

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Suggested Bill Draft Request for Prescription Benefit Manger Transparency

Recommendation: Introduce a bill that would require Pharmacy Benefit Managers (PBMs) operating in Nevada to obtain a license and follow specific policies designed to lower out-of-pocket costs and maintain access to prescription medications for patients.

Model Language:

- West Virginia (licensing and policies) – https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB4112%20SUB.htm&yr=2022&sesstype=RS&i=4112
- Notes:
    - Some of the policies in West Virginia's language may already be laws here and can be left out. Please see the following:
        - 33-51-9(a) may already be in NRS 683A.179
        - 33-51-9(d)(e) may already be in AB434 passed in the 2023 session.
    - The Nevada Division of Insurance seems to be the best entity to license and regulate PBMs.

Policies in the bill:

- Licensure and regulation of PBMs by the Division of Insurance, including the authority to audit claims for discrepancies.
- Allow patients to choose which provider/pharmacy best meets their needs, preventing patient steering or the requirement of mail order.
- PBMs must be transparent about fees charged to patients, pharmacies, and plans.
- Rebates must be passed on to health plans and not retained by PBMs.
- Protect pharmacies from unfair business practices, including:
    - Not taking money away from the pharmacy after the prescription is sold.
    - Not reimbursing the pharmacy less than the cost of the medication.
    - Not reimbursing PBM-owned pharmacies more than non-PBM-owned pharmacies.

Nevada Revised Statutes (NRS) Revisions: The current chapters that have policies regarding PBMs are NRS 422.273, NRS 422.4053, NRS 679B.133, and NRS 683A.178X. These policies would need to be added into NRS.

Background: The overwhelming majority of the prices paid at the pharmacy counter are based on price points established by PBMs. To protect patients' out-of-pocket medication costs and access to care, transparency must be established through statute.

- PBM Transparency background in Nevada
- List of states that have already passed PBM licensure requirements.

Suggested Bill Draft Request for Pharmacy Benefit Manger Transparency

Recommendation: Introduce a bill that would require Nevada Medicaid Fee-For-Service (FFS) and Managed Care Organizations (MCOs) to use a single Pharmacy Benefit Manager (PBM) to serve as the state's third-party administrator.

Model Language:

- Kentucky - https://apps.legislature.ky.gov/recorddocuments/bill/20RS/sb50/bill.pdf
- Add additional language: PBM must transit claims data to the managed care organizations and the state within 48 hours of claims being processed.

Policies in the bill:

- The state will establish an application process for PBMs to apply to become the processor for the state.
- Licensed providers in our state will serve on the pharmacy and therapeutics committee to determine which medications are on the formulary. This prevents PBMs from placing medications on the formulary that create the most profit for themselves but may be more expensive for patients and the state.
- PBMs will be prevented from making unfair profits by charging an insurance plan a higher fee for a medication than what they reimburse the pharmacy for, thus preventing spread pricing.
- Patients will be allowed to choose which provider/pharmacy best meets their needs, preventing patient steering or the requirement of mail order.
- Rules will be established regarding what a PBM can define as a specialty drug, preventing PBMs from requiring that certain medications must be filled at a PBM-owned pharmacy.
- PBMs must submit claims data to the state/MCO within 48 hours.

Nevada Revised Statutes (NRS) Revisions: The current chapters that have policies regarding PBMs are NRS 422.273, NRS 422.4053, NRS 679B.133, and NRS 683A.178X and other chapters as determined by Nevada Legislative Counsel Bureau. These policies would need to be added into NRS.

Background: As the financial burden of healthcare increases, Nevada must pass legislation to protect patients and the state. PBMs processing claims for Nevada FFS and MCOs are unchecked, and their business practices lack transparency. PBMs have mismatched incentives, often prioritizing their internal profit over what is best for the

state, patients, and plans. This bill aims to create transparency. Other states that have passed similar legislation have seen lower prescription healthcare costs since implementation.

A growing number of states have sought to realign FFS and MCO incentives by transitioning to a single PBM for all managed care organization beneficiaries. Examples of states that have passed legislation to require a single PBM include:

- Kentucky: Savings since SB50 took effect in 2021 amount to about $283 million through 2022, $56.6 million of that in state money, officials told the committee.
- Ohio single PBM: The single PBM brings much needed accountability and price transparency for Ohio taxpayers and Ohio pharmacies, providing assurance that Ohio's tax dollars are spent appropriately. In addition, the single PBM significantly reduces costs by eliminating duplicative MCO administrative expenses and risk margin across multiple MCOs resulting in savings of $128M in 2022 and savings of $184.4M in 2023.

Benefits:

- Administrative ease for providers, patients, and pharmacies.
- The ability for licensed providers in our state to serve on the pharmacy and therapeutics committee to determine which medications are on the formulary.
- Cost savings for the state and federal government.
- Fewer disruptions for patients who may switch between managed care plans.
- Rebate maximization by selecting drugs with the lowest cost or maximum rebate potential.
- Rebate transparency for more accurate cost management.
- Better care through continuity of therapy and consistent interpretation of clinical criteria, including the elimination of multiple prior authorization processes.