APhA
American Pharmacists Association

August 19, 2022

[Submitted electronically via: PBM@dfs.ny.gov]

Adrienne A. Harris
Superintendent
New York State Department of Financial Services
1 State Street
New York, NY 10004-1511

Re: PBM2022-04 - Request for Public Comments on the Practice of Patient-Steering by Pharmacy Benefit Managers in New York State

Dear Superintendent Harris:

The American Pharmacists Association (APhA) would like to express our sincere gratitude on behalf of our pharmacist members and their patients for the leadership of Governor Hochul in signing into law comprehensive legislation earlier this year to increase transparency and regulation of the pharmacy benefit manager (PBM) industry focused on registration, reporting requirements, and prohibited actions by PBMs. APhA recognizes that appropriate implementation of this legislation is vital to ensure patients continue to have access to services provided by their pharmacist and to affordable, lifesaving medications at their local community pharmacy. APhA appreciates the opportunity to provide additional feedback to that which we provided to your first and second request for comment, and now on the department's fourth request for comment.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health. In New York, APhA represents pharmacists and students that practice in numerous settings and provide care to many of your constituents. As the voice of pharmacy, APhA leads the profession and equips members for their role as the medication expert in team-based, patient-centered care. APhA inspires, innovates, and creates opportunities for members and pharmacists worldwide to optimize medication use and health for all.

As a result of the predatory practices of pharmacy benefit managers (PBMs), patients' access to medications from their local pharmacist across the country has declined[1], taxpayer dollars have been funneled into

[1] Rose J, Krishnamoorth R. Why your neighborhood community pharmacy may close. *The Hill*. Available at https://thehill.com/blogs/congress-blog/healthcare/530477-why-your-neighborhood-community-pharmacy-may-close

corporate profits[2], and generationally owned mom and pop pharmacies have been driven out of business.[3] Appropriate government intervention is necessary to address the misaligned incentives in the PBM industry that prioritize profits over patients. We would encourage your department to consider the following comments related to the Pharmacy Benefit Bureau's rulemaking process:

Rules concerning mandatory specified pharmacy use, including mail order, specialty, and retail pharmacies (commonly referred to as "preferred pharmacies")

The Pharmacy Benefit Bureau should promulgate rules allowing patients to have the autonomy to choose where to receive their health care and should not be forced or coerced into receiving care at a specific location by a PBM.

Throughout their health care journey, patients form a personal relationship with their pharmacist. However, that relationship can be jeopardized when a patient receives notification from their PBM that they must use a certain mail order, specialty, or retail pharmacy, that is often vertically integrated with the PBM.

Additionally, PBMs may attempt to coerce a patient to break their long-standing relationship with their local pharmacist and begin filling medications at another certain mail order, specialty, or retail pharmacy by making it more inconvenient for the patient to access their medications.[4] Numerous studies[5,6,7] have shown that adherence to medications increase when patients are able to fill a 90-day supply. In fact, the State of New York Department of Health[8] has a fact sheet encouraging patients to fill 90-day supplies of their medications. However, despite a prescriber's intention to write a prescription for a 90-day supply and a pharmacist's intention to fill for a 90-day supply, PBMs may only cover a percentage of the days' supply. For example, a PBM may only cover a 30-day supply at a local community pharmacy but would cover a 90-day supply if the patient filled at another mail order, specialty, or retail pharmacy. Not only does this attempt to coerce a patient to severe their relationship with their pharmacist, but if the patient decides to continue filling their medications at their local community pharmacy can decrease their adherence to their medications leading to potential worse health outcomes for the patient.

Rules concerning correspondence from PBMs to consumers/insured individuals/patients to encourage mail order or other specified pharmacy use

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[2] 3 Axis Advisors. Analysis of PBM Spread Pricing in New York Medicaid Managed Care. Available at http://www.ncpa.co/pdf/state-advoc/new-york-report.pdf

[3] Callahan C. Mom-and-pop pharmacies struggle to hang on. *Times Union*. Available at https://www.timesunion.com/hudsonvalley/news/article/Mom-and-pop-pharmacies-struggle-to-hang-on-16187714.php

[4] PBM ABUSES. National Community Pharmacists Association. Available at https://ncpa.org/sites/default/files/2020-12/pbm-business-practices-one-pagers.pdf

[5] Rymer JA, et al. Difference in Medication Adherence Between Patients Prescribed a 30-Day Versus 90-Day Supply After Acute Myocardial Infarction. Journal of the American Heart Association. Available at https://www.ahajournals.org/doi/10.1161/JAHA.119.016215

[6] Batal, et al. Impact of Prescription Size on Statin Adherence and Cholesterol. BMC Health Services Research. 2007; 7:175.

[7] Steiner, et al. The effect of prescription size on acquisition of maintenance medications. J Gen Intern Med.1993; 8(6):3063-10

[8] Increasing Adherence by Prescribing 90-Day Supplies of Medication. New York Department of Health. Available at https://www1.nyc.gov/assets/doh/downloads/pdf/csi/csi-map-med-fact-sheet.pdf

As discussed above, attempts by a PBM to force or coerce a patient into using a certain mail order, specialty, or retail pharmacy can harm long-standing patient-pharmacist relationships and lead to the potential for worse patient outcomes.

The Pharmacy Benefit Bureau should promulgate rules allowing patients to have the autonomy to choose where to receive their health care and should not be forced or coerced into receiving care at a specific location by a PBM.

Rules concerning restrictions on services (such as delivery or packaging services) provided by network pharmacies

The Pharmacy Benefit Bureau should promulgate rules to prevent PBM manipulation of patient care through mandatory mail order and increase competition by establishing an "any willing provider provision" in all PBM mail service contracts.

PBMs own automated dispensing facilities that fill and ship prescriptions requiring 90-day supplies, often referred to as "mail order pharmacies." However, these closed environment, robotics-driven assembly lines don't deliver the patient benefits of a traditional pharmacy. Similarly, PBMs that prohibit home delivery hurts patients with restricted mobility and deprives them of their ability to receive their medications from their local, trusted community pharmacist.

While home delivery comes with convenience, it can also raise patient concerns and sever the pharmacist-patient relationship. For example, take an HIV patient with a trusted relationship with their pharmacist. When patients see their pharmacists, the pharmacist can gauge patient's appearance on how healthy the look, check on patient adherence with medications and how they are reacting to current treatment regimens to adjust medications, provide patient care services or make appropriate referrals. Even a few missed doses of HIV meds can lead to resistance. The pharmacist is a critical health provider for HIV patients and other chronic care and immunocompromised patients. This is not covered when delivery is mandated.

In addition, mandatory mail order results in delays in receiving medications, temperature-sensitive drugs being left outside or on delivery trucks, drugs lost in transit, medication switching and even the wrong drugs being shipped that can lead to patient harm and millions in wasted medications.

For another example, take a patient diagnosed with advanced melanoma with brain metastases. The PBM mandated the patient purchase his medications from one of their own mail-order specialty pharmacies. "The most common and devastating issue that cancer patients face with PBMs is the fact that they must wait, for weeks or even months, to obtain medication that they could have received within 24 hours, had they been permitted to get it at the point of care from their oncologist. Beyond the stress and aggravation incurred, delays in receiving medication often translate into delayed treatment and worsening of the patient's condition, and in the most tragic of cases, possibly contributing to the patient's death."[9]

[9] Oncology Community Alliance. Delay, Waste, and Cancer Treatment Obstacles: The Real-Life Patient Impact of Pharmacy Benefit Managers. April 2017. Available at: https://communityoncology.org/wp-content/uploads/2018/08/PBM-HorrorStories-Volume1-final.pdf

Rules concerning restrictions on access to certain in-network pharmacies, and processes for approval of use of a patient's pharmacy of choice

The Pharmacy Benefit Bureau should oversee the process for "any willing pharmacy," to join a PBM/plan network, to discourage incentives to restrict pharmacies in the network to those vertically integrated with the PBM.

If there are restrictions on patient access to certain pharmacies, the patient and pharmacy must have a simple process to joining the network to ensure that patients can maintain access to their medications and their long-standing relationships with their local community pharmacists. This process should be overseen by an entity independent of the PBM, such as the Pharmacy Benefit Bureau, to discourage incentives to restrict pharmacies in the network to those vertically integrated with the PBM.

Rules concerning differences in quantity limits, days supply limits, or cost sharing for the patient (copay or coinsurance) between different pharmacies within a PBM network

As discussed above, the Pharmacy Benefit Bureau should promulgate rules ensuring patients have the autonomy to choose where to receive their health care and should not be forced or coerced into receiving care at a specific location by a PBM through differences in quantity limits, days' supply limits, or cost sharing for the patient (copay or coinsurance) between different pharmacies.

Regarding days supply limits, see our previous comments regarding "preferred pharmacies," above referring 90-day supply fills.

In addition to ensuring that PBMs do not increase the cost sharing for the patient to coerce a patient to fill their medications at a certain mail order specialty, or retail pharmacy, it is important to understand the incentives PBMs have to artificially inflate the list price of a medication, especially at a PBM-owned pharmacy. As described by The Commonwealth Fund, "PBMs are reimbursed partially on the rebates they obtain, which are calculated as a percentage of a drug's list price…Patients may bear these high prices if their cost-sharing is based on a percentage of the list price or if they are among the 25 percent of Americans who have high-deductible health plans."[10] For example, reports have shown that a PBM set the price of the same drug, strength, and quantity at over $3,800 at a PBM-owned pharmacy but on average less than $200 at a non-PBM owned pharmacy.[11]

It is vital the Bureau consider the full scope of PBMs misaligned incentives when crafting rules to ensure patients are not coerced to fill at a certain pharmacy and PBMs are not able to inflate the price of medications at pharmacies, especially PBM-owned pharmacies which can increase the cost sharing of patients.

[10] Pharmacy Benefit Managers: Practices, Controversies, and What Lies Ahead. The Commonwealth Fund. Available at https://www.commonwealthfund.org/publications/issue-briefs/2019/mar/pharmacy-benefit-managers-practices-controversies-what-lies-ahead

[11] Pharmacy Benefit Management. Purchaser Business Group on Health. November 30, 2021.

Rules concerning restrictions or thresholds on the dispensing of certain medications or NDCs within a network pharmacy.

The Pharmacy Benefit Bureau should promulgate requiring PBMs to fully disclose to Bureau as well as plan sponsors potential conflicts of interest in PBM service contracts.

For example, in 2015, retail pharmacies drove a 82% generic dispensing rate (GDR) while PBM dispensing facilities had GDRs under 58%. At the same time, PBMs receive billions from drug manufacturers each year to increase brand name drug market share. Increasing GDR is one of the most effective methods to drive and guarantee savings for both the patients and plans without mandating or restricting patient access to care through negative incentives and cost-shifting.

Thank you again to Governor Hochul, your department, the Pharmacy Benefit Bureau, and your work to prioritize patients' access to health care services and medications over corporate profits. We are confident that with the appropriate implementation of this law, New York will be seen as a leader of transparency in the drug supply chain to protect patients from the harmful business practices of the PBMs. If you have any questions or require additional information, please don't hesitate to contact E. Michael Murphy, PharmD, MBA, APhA Advisor for State Government Affairs by email at mmurphy@aphanet.org.

Sincerely,

E. Michael Murphy, PharmD, MBA
Advisor for State Government Affairs
American Pharmacists Association

cc: The Honorable Governor Kathy Hochul