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Testimony of the Department of Commerce and Consumer Affairs

Before the
Senate Committee on Judiciary
Thursday, February 21, 2019
9:00 a.m.
State Capitol, Conference Room 016

On the following measure:
S.B. 1521, S.D. 1, RELATING TO PHARMACY BENEFIT MANAGERS

Chair Rhoads and Members of the Committee:

My name is Colin Hayashida, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purpose of this bill is to establish requirements for pharmacy benefit managers (PBMs) and maximum allowable cost within the purview of the Department, rather than the Department of Health.

By repealing Hawaii Revised Statutes (HRS) section 328-106 and amending HRS chapter 431-R, this bill shifts jurisdiction over the regulation of maximum allowable cost basis reimbursement from the Department of Health to the Insurance Commissioner and amends those regulations.

Page 6, lines 13 to 18 of the bill requires three days' notice "prior to initiating any changes to the maximum allowable cost[.]" Requiring PBMs to provide three days' notice may prompt an increase in appeals, due to discrepancies between wholesale

prices and prices on the maximum allowable cost list. For example, an appeal may arise if wholesale prices increase, and a PBM must wait three days to effect an increase in maximum allowable cost.

Page 8, lines 16 to 20 of the bill provides that if a maximum allowable cost is not upheld on appeal, a contracting pharmacy may "reverse and rebill claims for the appealed drug, until the maximum allowable cost list is updated pursuant to subsection (e), to be reimbursed at the maximum allowable cost established by the appeal." However, the bill does not clearly define the maximum allowable cost established by the appeal.

If the Committee chooses to pass this measure, the Department respectfully requests that its budget ceiling be adjusted to cover the fiscal impact of this bill.

Thank you for the opportunity to testify on this bill.

WRITTEN TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
THIRTIETH LEGISLATURE, 2019

LATE

ON THE FOLLOWING MEASURE:
S.B. NO. 1521, S.D. 1, RELATING TO PHARMACY BENEFIT MANAGERS.

BEFORE THE:
SENATE COMMITTEE ON JUDICIARY

DATE: Thursday, February 21, 2019 **TIME:** 9:00 a.m.

LOCATION: State Capitol, Room 016

TESTIFIER(S): **WRITTEN TESTIMONY ONLY.**
(For more information, contact Daniel K. Jacob,
Deputy Attorney General, at 808-586-1190)

Chair Rhoads and Members of the Committee:

The Department of the Attorney General makes the following comments about the bill.

The purposes of this bill are to: (1) establish requirements for pharmacy benefit managers (PBMs) and maximum allowable cost, including the ability of pharmacies to receive comprehensive maximum allowable cost; (2) bring complaints regarding PBMs and maximum allowable cost within the purview of the department of commerce and consumer affairs rather than the department of health; (3) require PBMs to disclose where an equivalent drug can be obtained at or below the maximum allowable cost, when a maximum allowable cost is upheld on appeal, and to allow contracting pharmacies to reverse and rebill claims if the PBM establishes a maximum allowable cost that is denied on appeal and to pay the difference to the contracting pharmacies; and (4) clarify the available penalties for violations of maximum allowable cost requirements.

This bill may be subject to an Employee Retirement Income Security Act (ERISA) preemption challenge. ERISA is a comprehensive federal legislative scheme that "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C.A. § 1144(a).[1] A state law relates to an ERISA plan

[1] 29 U.S.C.A. § 1144(a), in full, provides as follows:

and is preempted if it has a prohibited connection with or reference to an ERISA plan. We believe this bill may be preempted because of (a) an impermissible connection with an ERISA plan or (b) an impermissible reference to an ERISA plan.

A state law has an impermissible connection with ERISA plans when it governs a central matter of plan administration or interferes with nationally uniform plan administration. *Pharmaceutical Care Management Assocation v. Gerhart*, 852 F.3d 722, 730 (8th Cir. 2017). The concern here arises from the fact the bill would compel PBMs to include specific information in contracts with contracting pharmacies, require PBMs to provide quarterly comprehensive reports, restrict the class of drugs to which PBMs may establish maximum reimbursement amounts and limit the sources from which they may obtain pricing information, require PBMs to notify contracting pharmacies in the event of an increase in the acquisition cost, and require PBMs to establish a clearly defined process for contracting pharmacies to appeal maximum allowable costs. All of these mandates may be found to implicate areas central to plan administration.

An impermissible reference to an ERISA plan is also problematic. In *Gerhart*, the United States Court of Appeals for the Eighth Circuit found that an Iowa law had an implicit reference to ERISA and ERISA plans because the Iowa law regulated PBMs that administer benefits for health benefit plans, employers, and other groups that provide health coverage. 852 F.3d at 729-730. PBMs are subject to ERISA regulation, and the Eighth Circuit found that the law affected benefits provided by these ERISA programs and that the law was preempted by ERISA. *Id*. at 732. This bill may be similarly challenged as containing an impermissible reference to ERISA.

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

We note, however, that the United States Court of Appeals for the First Circuit upheld a law regulating PBMs as not preempted by ERISA. *Pharmaceutical Care Management Association v. Rowe*, 429 F.3d 294 (1st Cir. 2005). Therefore, there may be a split between the Circuit Courts of Appeals. Nevertheless, this bill may be subject to a court challenge.

Thank you for the opportunity to comment.

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Karl Rhoads, Chair
The Honorable Glenn Wakai, Vice Chair
Members, Committee on Judiciary

From: Paula Yoshioka, Vice President, Government Relations and External Affairs, The Queen's Health Systems

Date: February 19, 2019

Hrg: Senate Committee on Judiciary Decision Making; Thursday, February 21, 2019 at 9:00 AM in Room 016

Re: Support for S.B. 1521, S.D. 1 Relating to Pharmacy Benefit Managers

The Queen's Health Systems (Queen's) is a not-for-profit corporation that provides expanded health care capabilities to the people of Hawai'i and the Pacific Basin. Since the founding of the first Queen's hospital in 1859 by Queen Emma and King Kamehameha IV, it has been our mission to provide quality health care services in perpetuity for Native Hawaiians and all of the people of Hawai'i. Over the years, the organization has grown to four hospitals, 66 health care centers and labs, and more than 1,600 physicians statewide. As the preeminent health care system in Hawai'i, Queen's strives to provide superior patient care that is constantly advancing through education and research.

Queen's appreciates the opportunity to testify in support of S.B. 1521, S.D. 1 Relating to Pharmacy Benefit Managers. Under the insurance commissioner, this measure would establish requirements for pharmacy benefit managers (PBMs) and maximum allowable cost (MAC). Contracted pharmacies will be able to receive comprehensive MAC lists from PBMs as well as know, upon upheld appeal, where an equivalent drug may be obtained at or below the MAC. The measure also clarifies penalties for violations of MAC requirements.

Queen's contracts with over 15 PBMs, with each PBM having multiple MAC lists. Because PBMs control the formularies for prices like those through MAC lists, they have the ability create pricing uncertainty for pharmacies. In addition to price uncertainty, our pharmacies go through undue burdens when accessing MAC prices for any given drug and we currently do not receive data in a standard and comprehensive list format, and must obtain MAC prices on an individual prescription basis. With no guideline or standard approach when it comes to the disclosure of MAC list, each PBM has been able develop their own burdensome process which puts pharmacies at a disadvantage.

Over the past year, Queen's has been able to work with a major PBM and appreciate their willingness to meet, discuss, and address some of the challenges pharmacies face. However, this measure will ensure that best practices are the standard for doing business across the board for PBMs. Transparency in the data sources that PBMs utilize to derive costs will greatly benefit our pharmacies and patients. Thank you for the opportunity to testify on this measure.

SB-1521-SD-1
Submitted on: 2/19/2019 10:43:52 PM
Testimony for JDC on 2/21/2019 9:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Melodie Aduja	Testifying for O`ahu County Committee on Legislative Priorities of the Democratic Party of Hawai`i	Support	No

Comments:

An Independent Licensee of the Blue Cross and Blue Shield Association

February 19, 2019

The Honorable Karl Rhoads, Chair
The Honorable Glenn Wakai, Vice Chair
Senate Committee on Judiciary

Re: SB 1521 SD1 – Relating to Pharmacy Benefit Managers

Dear Chair Rhoads, Vice Chair Wakai, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 1521, SD1, which establishes requirements for pharmacy benefit managers (PBMs) and maximum allowable cost (MAC), including the ability of pharmacies to receive comprehensive MAC lists and bring complaints within the purview of the department of commerce and consumer affairs, rather than the department of health. It requires PBMs to disclose where an equivalent drug can be obtained at or below the MAC when a MAC is upheld on appeal and allow contracting pharmacies to reverse and rebill claims if the PBM establishes a MAC that is denied on appeal and pay the difference to the contracting pharmacies. It also clarifies the available penalties for violations of MAC requirements.

HMSA would like to express concerns and offer comments on this measure. PBMs play an important role in addressing the rising cost of pharmaceutical drugs. Health insurance companies contract with PBMs to manage pharmaceutical drug plans providing both expertise and scale to negotiate better rates for prescription drugs; these savings are in turn passed along to our members. A similar measure considered last legislative session estimated an increase of annual prescription drug claims by over $5 million; this would be in addition to the normal increase in the cost of prescription drugs.

We have been working with community pharmacies since last year to address some of the concerns highlighted in this bill. While we appreciate the intent of this measure, we believe this bill will create additional regulations and pose administrative challenges that could increase costs for our members.

Should this bill move forward, we respectfully submit for your consideration the following amendment to Section 3 of the bill, adding a definition for contracting pharmacy which focuses this measure on increasing access to truly rural, non-national chain pharmacies:

> "Contracting pharmacy" means an independent pharmacy that is not part of a regional or national chain, or part of a pharmacy services administration organization (PSAO), and there is no other pharmacy within a ten mile radius.

Thank you for the opportunity to provide testimony on this measure.

Sincerely,

Pono Chong
Vice President, Government Relations

1275 Pennsylvania Avenue, NW
Suite 700
Washington, DC 20004

February 21, 2019

LATE

Senator Karl Rhoads, Chair
Senator Glenn Wakai, Vice Chair
Committee on Judiciary
415 South Beretania Street
Honolulu, Hawaii 96813

RE: SB 1521 S.D.1 Relating to Pharmacy Benefit Managers
February 21, 2019, 9:00 a.m., conference room 016

Aloha Chair Rhoads, Vice Chair Wakai and members of the committee:

CVS Health is writing to share with you our concerns and some suggested amendments regarding Senate Bill 1521 S.D. 1 ("SB 1521 S.D. 1"), relating to pharmacy benefit managers (PBMs). CVS Health is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,800 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 93 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 39 million people through traditional, voluntary and consumer-directed health insurance products and related services, including a rapidly expanding Medicare Advantage offering. This innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

SB 1521 S.D. 1 seeks to amend the existing law relating to "maximum allowable cost" (MAC). MAC is one of the most common methodologies used in paying pharmacies for dispensing generic drugs. A MAC list is a common cost management tool that is developed from a survey of various sources, including wholesale prices existing in the marketplace, taking into account market share, existing inventory, expected inventories, reasonable profits margins and other factors. Each PBM develops and maintains its own confidential MAC list derived from its specific proprietary methodologies. The MAC list helps to ensure that the PBM, on behalf of their clients (employers and health plans), are paying a fair price for widely available generic drugs.

The existing law was carefully negotiated and agreed to by all stakeholders in 2015. CVS Health believes that any proposed changes to the existing law should stay within the spirit of the negotiations. We are requesting the following amendments:

Section 2(b)(2)(c) (Page 4, lines 19-21, Page 5, lines 1-12):

> "(c) The pharmacy benefit manager shall make available to a contracting pharmacy, upon request, a comprehensive report for the requested plan for all drugs on the maximum allowable cost list, which contains the most-up-to-date maximum allowable cost price or prices used by the pharmacy benefit manager for patients served by the pharmacy, in a readily accessible~~,~~ and secure~~,~~ electronic ~~and searchable format~~, or usable web-based ~~or other comparable~~ format ~~that can be downloaded~~. The comprehensive report shall also include the following:
>
> (1) The name of the drug;
>
> (2) Pharmacy benefit manager's maximum allowable cost price;
>
> (3) National drug code;

~~(4) Generic code number; and~~

~~(5) Generic product identifier.~~

CVS Health currently already makes available to all Hawaii contracted pharmacies an easily accessible, electronic method of looking up specific drugs subject to MAC reimbursement rates. This provides pharmacies with the most up-to-date, real-time pricing information applicable to a given drug on a MAC list. Currently, upon a pharmacy's request, CVS Health also provides a comprehensive MAC list by plan sponsor. CVS Health believes that our website portal is the most useful tool for a contracted pharmacy to use to search by individual drug as opposed to working through lists.

CVS Health is requesting to delete the requirement that the report contain the generic code number and generic product identifier. We do not own the rights to those identifiers and therefore cannot provide them. The national drug code number is a sufficient identifier and should be the only identifier required to be included in the report.

Section 2(e) (Page 6, lines 9-12):

> "(e) The pharmacy benefit manager shall review and make necessary adjustments to the maximum allowable cost of each drug on a maximum allowable cost list at least once every seven days using the most recent date sources available…~~provided that the pharmacy benefit manager shall reimburse a contracting pharmacy for a drug based on the maximum allowable cost of that drug on the day the drug is dispensed.~~"

We are unclear as to the intent of the new language included at the end of this section ("provided that the…dispensed"). The MAC reimbursement for the pharmacy would be the rate on the day the drug was dispensed. This language is unnecessary and are therefore requesting that it be deleted.

Section 2(f) (Page 6, lines 13-21):

> "~~(f) The pharmacy benefit manager shall notify all contracting pharmacies of a ten percent or greater increase in drug acquisition cost for any drug on the maximum allowable cost list from sixty percent or more regional pharmaceutical wholesalers at least three days prior to initiating any changes to the maximum allowable cost for that drug. The notification required under this subsection may be provided electronically and shall contain the national drug code of the drug whose acquisition cost is increasing."~~

We are requesting this amendment because the section assumes that a PBM has access to such wholesaler pricing data at a granular level and specific to a particular pharmacy's acquisition costs. PBMs are not privy to the private contracts between pharmacies and wholesalers and do not have access to such information. As such, compliance with this section would be impossible. Additionally, the requirement of a three day notification for changes to MAC reimbursements prior to initiating the change completely conflicts with the law and would likely be harmful to consumers, payers, and the pharmacies themselves. The law already requires the MAC list to be updated at least once every seven days and for the PBM to immediately implement those changes. If a PBM has to immediately implement the changes, a PBM would be unable to then provide three days' notice. It would also be operationally impossible for a PBM to adjust a MAC price upon a successful MAC appeal by a pharmacy within one calendar day of the date of the decision as is required by law if the PBM must give three days' notice first. Ultimately, if PBMs were to comply with the section, PBMs would be violating other sections of the existing law and prescription drug costs for Hawaiian consumers and employers could increase. Therefore, we request that this section be stricken.

Section 2(g)(4) (Page 8, lines 1-10):

> "(4) If the maximum allowable cost is upheld on appeal, the pharmacy benefit manager shall provide to the contracting pharmacy the reason therefor and the national drug code of an equivalent drug that may be purchased by a similarly situated pharmacy ~~from a source where it may be purchased from a licensed wholesaler by a retail pharmacy~~ at a price that is equal to or less than the maximum

allowable cost of the drug that is the subject of the appeal, ~~with the name of the source, including but not limited to the wholesaler or distributer, where the drug may be purchased;~~"

We are requesting this amendment as the new language proposed in this section goes well beyond the intent of the law regarding what should occur if the MAC is upheld on appeal. The provision would require the PBM to provide the specific source where a drug may be purchased. Pharmacy acquisition prices are on an individual basis, and vary by pharmacy and by wholesaler. PBMs do not have access to individual pharmacy acquisition cost information as those arrangements are ultimately negotiated between the wholesaler and the pharmacy based on specific negotiated business terms. Therefore, we request that the above provisions be deleted.

Section 2(g)(5) (Page 8, lines 11-20):

"(5) If the maximum allowable cost is not upheld on appeal, the pharmacy benefit managers shall adjust, the appealing contracting pharmacy, the maximum allowable cost of the drug that is the subject of the appeal, within one calendar day of the date of the decision on the appeal and allow the contracting pharmacy to reverse and rebill the claim~~s~~ that is the subject of the appeal, and for all claims for the appealed drug at the plan level, until the maximum allowable cost list is updated pursuant to subsection (e), to be reimbursed at the maximum allowable cost established by the appeal."

We are requesting this clarifying amendment to this section to reflect current practice that requires a contracted pharmacy to submit a MAC appeal at the plan level.

Section 2(h) (Page 9, lines 1-6):

"~~(h) Any pharmacy benefit manager that refuses a maximum allowable cost reimbursement for a properly documented claim by a contracting pharmacy under this section shall be deemed to have engaged in an unfair or deceptive act or practice in the conduct of trade or commerce, within the meaning of section 480-2.~~"

We believe this section is overly broad and out of the context of the bill. It could open up Hawaii plan sponsors to fraud, waste and abuse. A prescription could be "properly documented" but submitted improperly because of a technical or clerical error that resulted in an overpayment to the pharmacy. Such errors should be permitted to be remedied. Additionally, the penalty proposed is overly punitive and unnecessary. Pharmacies already have the right to appeal a disputed reimbursement per their contracts with the PBM/plan sponsor and existing law. Therefore, we are requesting that this section be deleted.

Section 2(i) (Page 9, Lines 7-17)

(i) A contracting pharmacy shall not disclose to any third part the maximum allowable cost list and any related information it receives…~~except to the insurance commissioner or an elected representative. The maximum allowable cost list and related information disclosed to the insurance commissioner or an elected representative shall be considered proprietary and confidential and not subject to disclosure under chapter 92F.~~

We are requesting this amendment because MAC lists are competitive and proprietary information that is owned by the PBM. A contracting pharmacy should not be permitted to disclose such information without providing proper notification to the PBM first so that the PBM can take steps to properly protect such competitive information. Additionally, we are concerned with the use of the broad term "elected representative" – it could mean many things and if an elected representative happens to be a pharmacy owner, they would then have access to the competitive reimbursement information of other pharmacies. This would be anti-competitive and could lead to increased costs for plan sponsors and consumers.

Section 2(j) (Page 9, Lines 18-21, Page 10, lines 1-6)):

"(i) The insurance commissioner shall adopt rules pursuant to chapter 91 to enforce the provisions of this section. ~~to establish a process to subject complaints of violations of this section to an external review process, which may be binding on a complaining contracting pharmacy and a pharmacy~~

~~benefit manager against whom a complaint is made, except to the extent that the parties have other remedies available under applicable federal or state law, and which may assign the costs associated with the external review process to a complaining contracting pharmacy and a pharmacy benefit manager against whom a complaint is made.~~"

CVS Health had serious concerns regarding Section 2(j), which requires the insurance commissioner to establish a process to subject any complaints regarding a potential violation of the law to an external review process. CVS Health does not believe that the enforcement of the law should be assigned to an outside entity. We are unclear as to why this is necessary, are concerned that this would lead to frivolous complaints, and believe that such a process would drive up the costs of health care for health plans, employers, and ultimately consumers. If there are any contractual issues that arise between a pharmacy and a PBM, those are already handled by contract with appropriate remedies available to the parties under the law. CVS Health does not believe that an external review process is necessary and requests the above amendment.

Section 3 (Page 10, lines 13-15):

"Maximum allowable cost list" means a list of ~~the maximum allowable reimbursement~~ ~~costs~~ of ~~multi-source generic~~ drugs for which a maximum allowable cost has been established by a pharmacy benefit manager,"

We are requesting this amendment because the need for the proposed changes in this section are unclear to us. The existing definition was carefully negotiated within the context of the entire bill and is consistent with many other states that have MAC laws in place. For these reasons, we are requesting that the proposed language be amended back to reflect existing law as it was contemplated.

On behalf of CVS Health, I thank you for allowing us to provide our concerns and amendments for consideration.

Respectfully,

Melissa Schulman
Senior Vice President, Government and Public Affairs
CVS Health

Cynthia M. Laubacher
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LATE

February 21, 2019

To: The Honorable Karl Rhoads, Chair
Members of the Senate Committee on Judiciary

Fr: Cynthia Laubacher, Senior Director, State Affairs

Re: Senate Bill 1521 S.D. 1: February 21, 2019 9:00am

Thank you for the opportunity to provide testimony regarding our concerns with Senate Bill 1521 S.D. 1. Cigna recently completed its purchase of Express Scripts, one of the nation's leading pharmacy benefit managers.

In 2015, Express Scripts worked with plans, PBMs and local pharmacies on legislation ultimately enacted to address the pharmacies concerns with generic reimbursements ("MAC"). Last year we returned to the table to discuss issues that have arisen in the time since that initial agreement. We either reached agreement or were close when the session ended. In January, the discussions began again. We are committed to continuing to work with the local pharmacies with the hope of reaching agreement in 2019.

We appreciate the amendments to the bill taken in the Senate Committee on Health. We do have additional recommended amendments for your consideration.

1. P. 6, line 6, strike "~~that same day~~" and replace with:
   a. <u>The next calendar day</u>

<u>RATIONALE</u>: This issue was discussed at length during the 2015 negotiations and again last year. There is no way to update the list on "the same day." Price changes happen at all hours and updates take time to implement. PBMs need at least one calendar day to update. This also makes it consistent with subsection (f)(5) which requires updates within one calendar day when an appeal is upheld.

2. P. 6, line 9, strike "~~provided that the pharmacy benefit~~…" through line 12.

<u>RATIONALE</u>: This language is confusing and unnecessary. The language of the bill already requires that reimbursements be based on updated MAC pricing.

3. P. 6, Strike lines 13-21.

RATIONALE: First, this section conflicts with Section 2(e) on page 6. Second, this requirement is **impossible** for a PBM to comply with as PBMS do not have control of or visibility into wholesalers' pricing. Prescription drugs that are subject to MAC fluctuate, often daily. A MAC list would never be current under the provisions of this section.

4. P. 6, Line 8, strike, "w~~ith the name of the source, including but not limited to the wholesaler or distributor, where the drug may be purchased."~~

RATIONALE: Pharmacy acquisition prices vary by pharmacy and wholesaler, and are based on the negotiated arrangements agreed upon by the parties, which often include a PSAO – which is essentially a buying group that contracts with pharmacies to, among other things, purchase the drugs dispensed by the pharmacy. Those contracts may interfere with the pharmacy's ability to purchase a drug at lower price available to other purchasers.

~~5.~~ P. 9, line 7, Section 2 (i): We request the following language be stricken beginning on line 13: "e~~xcept to the insurance commissioner or an elected representative."~~

RATIONALE: MAC lists contain highly proprietary data that is considered a trade secret that is protected under our contracts with pharmacies in our networks. The purpose for sharing this information outside the bounds of a contract with a pharmacy is unclear and presents numerous concerns. Allowing an "elected official" access to this information could have serious legal implications if, for example, that official is a non-contracted pharmacist or pharmacy owner or employee. They would have access to highly competitive reimbursement information. We request this language be removed.

6. Page 8, lines 1-10: External Appeals Process
(h) The insurance commissioner may adopt rules pursuant to chapter 91 **to enforce the provisions of this section.**

~~establish a process to subject complaints of violations of this section to an external review process, which may be binding on a complaining contracting pharmacy and a pharmacy benefit manager against whom a complaint is made, except to the extent that the parties have other remedies available under applicable federal or state law, and which may assign the costs associated with the external review process to a complaining contracting pharmacy and a pharmacy benefit manager against whom a complaint is made."~~

RATIONALE: Private contracts between the PSAO and PBMs, or pharmacies and PBMs, should utilize the resolution process in their contract. We are concerned that having an external review process through the insurance commissioner would lead to frivolous complaints, and would drive up the costs of health care for health plans, employers, and ultimately consumers. If

there are any contractual issues that arise between a PSAO and a PBM or a pharmacy and a PBM, they are handled by contract with appropriate remedies available to the parties under the law making an external review process unnecessary.

Thank you for your consideration of our concerns and proposed changes.