Mandated Benefits Review by the Pennsylvania Health Care Cost Containment Council

Senate Bill 260
Mail Order Prescription Drugs

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EXECUTIVE SUMMARY

The Pennsylvania Health Care Cost Containment Council is required to review current or proposed mandated health benefits on request of the executive or legislative branches of government [Section 9 of Act 14 of July 17, 2003 (P. L. 31, No. 14) (Act 14)].

The Council's role in conducting reviews of this nature is primarily to determine if sufficient evidence is available to proceed to a more formal Mandated Benefits Review Panel as outlined in Act 14, which includes contracting with a panel of outside experts to review the scientific validity of the studies submitted. Documentation would be deemed sufficient if it met the necessary requirements for the Panel to fulfill their duties and responsibilities which include: (1) review of the documentation submitted by opponents and proponents, (2) report to the Council on whether the documentation is complete with regard to the eight information categories described in Act 14, whether the research cited meets professional standards, whether all relevant research has been cited in the documentation, and whether the conclusions and interpretation in the document are consistent with the data submitted.

This document presents the results of the Council's review of Senate Bill 260, which would amend the Unfair Insurance Practices Act to deem it unfair for any insurer or health plan to require covered members to obtain drugs from a mail-order pharmacy as a condition of payment, or to provide any differential incentive or other condition for members utilizing mail-order prescription drug services, or to deny or impair the right of members to determine from which venue drugs can be dispensed.

In the case of Senate Bill 260, there was not sufficient information submitted to the Council to continue with a more formal review process.

We note the following points, which may be of interest to the General Assembly:

- The documentation submitted to the Council lacked information that fully addresses the costs and financial benefits that might be associated with this bill. In particular, requisite scientific studies and cost figures were not submitted that could be used to determine (1) the impact that the provisions of Senate Bill 260 would have on overall health care costs, and (2) the expected number of people who might benefit, either in terms of reduced economic cost or increased consumer welfare, from potential changes in laws governing pharmaceutical benefit plan design.

- The Council considers other states' experiences when conducting mandated benefit reviews. In the case of SB 260, there was insufficient and conflicting information regarding other states' experiences with similar legislation. Moreover, much of the data from other states was prospective in nature, and not based on retrospective analyses that detailed the actual impact of similar provisions on insurer, health plan sponsor and plan member costs.

- Respondents supplied conflicting research on the costs of prescription drug benefits provided through mail-service pharmacies to plan sponsors and members. The documentation provided was not sufficient to allow the Council to evaluate the comparative value of the research.

- Finally, some respondents raised concerns about the cumulative effect of all mandates in Pennsylvania on health care costs. They noted that even though one individual mandate may have minimal cost implications, taken together with other mandates, the impact can be substantial.

REVIEW OF SENATE BILL 260

Overview of Bill

Senate Bill 260 would amend the Unfair Insurance Practices Act to deem it unfair for individual and group health insurance policies to require a plan member to obtain drugs from a mail-order pharmacy as a condition of obtaining payment, or to impose upon a member who is not utilizing a mail-order pharmacy a copayment fee or other condition not imposed upon those utilizing a mail-order pharmacy, or to deny or impair the right of an insured to determine the venue from which drugs are dispensed.

Mandated Benefits Review Process

PHC4's enabling legislation, Act 89 of 1986 (as re-authorized by Act 34 of 1993 and Act 14 of 2003), provides that PHC4 review current law or proposed legislation regarding mandated health benefits when requested by the executive or legislative branches of government. Senator Donald White, Chair of the Senate Banking and Insurance Committee, requested that PHC4 review the provisions of Senate Bill 260, PN 298. Senator James J. Rhoades is the bill's prime sponsor.

Notification was published in the *Pennsylvania Bulletin* on August 4, 2007, requesting that interested parties submit documentation and information pertaining to Senate Bill 260 to PHC4. Letters also were sent to individuals and organizations identified as having a potential interest, informing them of the pending review and inviting them to submit information pursuant to the notice. Following the initial comment period, an opportunity was provided for interested individuals and organizations to examine the responses received and submit additional comments. Final submissions were due to PHC4 on November 19, 2007. The Pennsylvania Department of Health and the Insurance Department were notified of the review and received a copy of the submissions.

A list of the submissions received and a copy of the bill are attached.

Act 14 provides for a preliminary PHC4 review to determine if the documentation submitted is sufficient to proceed with the formal Mandated Benefits Review process outlined in the Act. This formal process involves contracting with five experts in specified fields to review the documentation submitted by proponents and opponents.

This report presents the results of PHC4's preliminary review and conclusions regarding whether the material is sufficient to proceed with the formal review process.

Analysis of Documentation Submitted by Opponents and Proponents in Response to the Eight Categories Required by Act 14, Section 9

I. The extent to which the proposed benefit and the services it would provide are needed by, available to and utilized by the population of the Commonwealth.

Respondents agreed that pharmaceutical therapies are important and should be broadly available across all demographic groups of the Commonwealth. Advances in pharmaceutical technology have become a front line defense against chronic disease, have increased longevity and provided curative, palliative and preventive benefits generally for the population.

The benefit proposed by Senate Bill 260 is not a mandated coverage of a particular treatment or therapy; rather, insurance policies and health plans would be required to offer members access to pharmaceutical benefits under relatively equal terms and conditions between mail order and retail dispensing.

Affected population. Respondents submitted no specific information on the number of individuals in the Commonwealth who might be covered by the provisions of Senate Bill 260. U.S. Census survey data[1], tabulated by PHC4, estimated the number of people in the Commonwealth who have private health insurance policies and who potentially could be covered by the mandate. In 2006, 9.28 million Pennsylvanians were covered by private health insurance. Approximately one-half of this group are estimated to be in fully insured plans subject to the mandate (4.64 million people), while the remainder are expected to be in self-insured plans exempt from state regulations. However, no specific information was submitted regarding what percentage of these individuals might be in plans with pharmaceutical benefits.

Availability and Utilization. Respondents assumed that pharmaceutical benefits are widely available under most health plans and that members have access to both retail and mail-order prescription drug-dispensing, depending on each health plan's particular pharmaceutical benefit design. Proponents noted that many plans require their members to obtain some medications from a particular mail-order pharmacy or provide a significant financial incentive for members to obtain medications from a mail-order pharmacy. See also Section II.

A January 2005 report[2] supplied by proponents of SB 260 stated that approximately 60 percent of middle-aged adults and over 80 percent of older adults have taken at least one prescription drug in the last month. A 2003 study[3] supplied by proponents stated that 22.3 percent of prescriptions nationally go through mail order dispensing.

Mail order pharmacy use in Pennsylvania is consistent with national rates; Highmark cited a report[4] that estimated overall prescription drug spending in the Commonwealth was $11 billion in 2006, with $2.3 billion of the spending on mail-order prescription drugs. (p. 5) Medco, a pharmaceutical benefits manager, stated that it manages prescription drug benefits for more than 32 percent of the Commonwealth's population. It noted: "In 2006, we processed over 38.5 million prescriptions that were filled at retail pharmacies located in Pennsylvania … we dispensed about 5.5 million mail service prescriptions to patients located within the state …" Additionally, Medco pointed out, based on its own data, that "there is a difference in the ratio between days supply of therapy at retail and mail (roughly 2:1) and the ratio of prescriptions dispensed at retail and mail (roughly 7:1). These numbers demonstrate two points: first, that retail pharmacies still manage the majority of all prescriptions dispensed in the state of

Pennsylvania; and second, that mail service prescriptions filled for Pennsylvania patients tend to be for a longer days supply (due in large part to the incentives that plans offer to encourage the use of mail for maintenance medications)." (p. 2) Another pharmaceutical benefits manager for health plans, CVS Caremark, processed 12,228,763 retail claims and filled 2,879,152 mail pharmacy prescriptions for its client-plan sponsors' Pennsylvania members in 2006.

II. The extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the Commonwealth.

Existing coverage. According to U.S. Census survey data, 63.9 percent of Pennsylvanians had private health insurance through their employers in 2006.[5]

Highmark cited a survey by the Kaiser Family Foundation, "Employer Health Benefits Annual Survey, 2007," which found that 98 percent of those covered by an employer health plan have a prescription drug benefit. Highmark also noted that its 4.1 million members have prescription drug coverage that provides access to a network of 59,000 pharmacies, including 21,000 independent pharmacies.

Blue Cross of Northeastern Pennsylvania (BCNEPA) stated that less than 6 percent of its members (approximately 20,000 members) are enrolled in plans which require the use of mail-order services.

Independence Blue Cross stated that it provides health insurance coverage for 2.7 million Pennsylvanians in the southeastern part of the state and that its "[C]ustomers may choose coverage that does not include prescription benefits or provides prescription benefits that does not require or encourage the use of a mail order pharmacy. Essentially, it is the customer, not IBC, that determines that extent and type of prescription drug coverage they wish to purchase." (p. 1)

Capital Blue Cross (CBC) stated that it does not generally require its members to obtain drugs from a mail order pharmacy nor impose a fee on members who choose to use a local pharmacy; deductibles and copayments apply to drugs obtained from both local and mail order channels and members may choose to use a mail order pharmacy due to a significantly lower cost based on volume (e.g., 90 day supply). Additionally, CBC pointed out that its pharmacy network is comprised of more than 50,000 chain and independent pharmacies nationwide and the vast majority of its subscribers continue to fill prescriptions at their local pharmacies. Moreover, CBC stated that it offers its members a price check feature on its Web site that allows them to compare the cost of oral medications at a retail pharmacy to the cost at its mail order pharmacy. (p. 1)

None of the respondents either in favor of or against SB 260 made any specific statements alleging inadequate care.

Financial hardship. Opponents argued that seniors and others currently on maintenance medications that they obtain from mail-service pharmacies would face increased out-of-pocket costs if SB 260 were enacted since members' cost-sharing payments for the mail option are often significantly lower in many plan designs. Respondents did not provide data (e.g., number of persons, per capita costs), however, that could be used to estimate aggregate or average financial hardship in the Commonwealth.

III. The demand for the proposed benefit from the public and the source and extent of the opposition to mandating the benefit.

Support for Senate Bill 260. In support of the mandate, PHC4 received submissions from the Pennsylvania Pharmacists Association, the National Community Pharmacists Association, Philadelphia Association of Retail Druggists, and Value Drug Company, a wholesale purchasing cooperative located in Altoona that represents more than 1,200 independent community pharmacists.

Proponents stated that retail pharmacies currently face significant competitive disadvantages as a result of many plans' benefit designs, and believe that Senate Bill 260 would remedy this situation. Statements by the National Community Pharmacists Association (NCPA) and the Pennsylvania Pharmacists Association are representative of key arguments made by proponents.

National Community Pharmacists Association:

> [M]andatory mail [order dispensing] serves as a disincentive for patients to continue their relationship with their pharmacist, a state licensed health care professional. NCPA believes that mail order drug programs represent a serious threat to public health. It is not possible for mail order drug vendors, which lack face-to-face contact with patients, to comprehensively monitor their patients' health status, gather information on the full spectrum of their prescription and nonprescription drug use patterns, or adequately assess their understanding and compliance with drug therapy.
>
> NCPA questions the integrity of a drug distribution system that relies exclusively on the mails and in which drugs are dispensed in excessive volume, over long distances, often exposed to extreme temperatures or humidity, delayed, and otherwise compromised.
>
> … NCPA is concerned with the 'self-dealing' aspect of allowing a pharmacy benefit manager (PBM), an unregulated entity in Pennsylvania, to refer to its own wholly owned mail order pharmacy. While some states have enacted laws to regulate PBMs, Pennsylvania does not currently regulate them… [a lawsuit against one PBM raises] concerns about switching of medication by the PBM without approval of the prescriber …
>
> … NCPA supports Senate Bill 260 because mandatory mail order requirements and/or coercive copayments which force patients to use mail order by making it more costly to maintain their relationship with their local community pharmacist are not cost effective for the patient… (p. 1-2)

Pennsylvania Pharmacists Association:

> [M]any insurers and their prescription drug plans, which are managed through a PBM, are requiring patients to utilize mail order. In most cases, they are requiring the use of their self-owned mail order pharmacy. Unfortunately, the hidden costs of directing patients to mandatory mail order are driving up the costs of health care. These hidden costs include the aspect of spread pricing (the differential between what is billed the employer or plan and what is really paid for the prescription) and also the significant

amount of waste through the large supply of mailed quantities often not used. Many PBMs also data mine the prescription drug information and sell it for additional profits.

Pharmacy benefit pricing is a complicated model and one that many do not want to spend the time carefully researching so the easy sell to employers is that mail-order is 'cheaper' has worked well. Unfortunately, without looking below the service at all the facts, it is easy to fall into this trap. Employers and policy makers truly interested in reducing health care costs need to be prepared to explore further into the systems and consider the whole picture … mail order is not the proclaimed 'bargain.' Even when it comes to the individual co-payments, both number and amount, this is under the control of the PBM and could be equal for both mail order and community pharmacy, if the PBM wanted it to be. Of course, typically they do not because they own the mail order pharmacy. (p. 2)

Opposition to Senate Bill 260. PHC4 received submissions from nine organizations (Capital Blue Cross, Independence Blue Cross, Blue Cross of Northeastern Pennsylvania, Highmark, the Insurance Federation of Pennsylvania, the Pennsylvania Chamber of Business and Industry, Express Scripts, Medco, and CVS Caremark) that oppose the mandate.

Opponents argue that the provisions of SB 260 do not mandate the coverage of a benefit but restrict the way in which a health insurer could administer and manage an existing benefit. The Insurance Federation of Pennsylvania noted that the bill's provisions "will not result in any supply of goods or contractual terms not now available." (p. 2)

BCNEPA stated: "What the bill does is mandate that insurers cannot use the tools necessary to manage costly prescription drug benefits, including provider networks, negotiated rates, mail order services and incentives … there is clearly a narrow, provider-driven strategy by independent and chain pharmacies that oppose the use of mail order services and networks for obvious economic reasons—the loss of business to competitive mail-order pharmacies." (p. 3) Additionally, it stated: "The [proposed] statute would, however, regulate only insurers and not Pharmaceutical Benefit Managers (PBMs) who sell carve out benefit programs directly to self-funded clients. This would place Pennsylvania's insurers at a competitive disadvantage in selling prescription benefits." (p. 6)

Opponents provided studies and reports concluding that mail-order pharmacies offer several advantages as a cost-containment and quality control tool for health plans. (See also Sections VII and VIII.A.) Advantages cited include: (1) mail order dispensers have economies of scale as a result of automated prescription order and recordkeeping systems, (2) they also can obtain discounts from drug manufacturers due to their volume and predictability of business, (3) charging low or no dispensing fees, and (4) safety advantages, such as a significantly lower dispensing-error rate than retail pharmacies.

A 2006 report[6] cited by several opponents outlined some reasons why mail-service pharmacies can operate at lower cost relative to retail pharmacies:

- Mail-service pharmacies are capable of processing thousands of prescriptions per day, compared to a few hundred prescriptions for the average retail pharmacy.
- Labor also accounts for roughly 40% of the overall cost to fill a prescription in mail-service pharmacies versus over 70% of a retail pharmacy's cost per prescription.
- An integrated mail-service pharmacy [i.e., a PBM-owned mail service] can achieve cost savings of 2 percent to 4 percent over a contracted mail order facility.[7]

Medco stated: “By prohibiting health plans from encouraging the use of lower cost mail service pharmacies, this bill will increase costs for patients and health insurers and make it harder for employers to continue to offer affordable prescription drug benefits to their employees.” (p. 1)

BCNEPA raised concerns that the bill would eliminate its pharmacy network and affect both cost and safety, arguing that health insurers would be required to reimburse members for prescriptions purchased “out of network, out of the country, and via the Internet—essentially, any willing pharmaceutical provider. BCNEPA has no means of assuring the quality or, through network contracts and negotiations, controlling the cost of prescription drugs purchased through pharmacies not in our network.” (p. 4)

Several opponents noted that it is easier for large employers to self-insure and be governed by federal law (ERISA) than for small employers, thus avoiding state mandates such as SB 260. The small employer group which does not self-insure would thus be subject to the bill. Highmark stated: “An estimated 50 percent of the employer group market in Pennsylvania is self-insured, which means the burden of Senate Bill 260 would be most harmful to small and medium-sized businesses offering coverage, organizations that are least able to afford the added expense associated with the coverage.” (p. 7)

Several key arguments regarding mandated health insurance requirements more generally were repeated throughout opponents’ submissions:

- *Mandates, in general, increase total health care costs*

  Opponents stated that mandates increase premium costs, reduce health coverage for some individuals, and force others to become uninsured, rather than ensure better health care. Opponents suggested the mechanism by which mandates increase the total cost of health care:

  - Large employers become self-insured to avoid mandates.
  - Medium-size and small businesses that do not self insure bear the increased insurance premiums, and pass on those costs to their employees.
  - Higher employee contributions toward health care coverage may lower net hourly rates or salaries.
  - Some employees may choose not to contribute higher premiums and become uninsured.
  - Employers may reduce labor costs through lay-offs and increase numbers of the unemployed uninsured.

- *The cumulative effect of mandates is substantial*

Several opponents noted that even though one individual mandate may have minimal cost implications, taken together with other mandates, the impact is substantial. Respondents supplied a number of studies and reports that specifically address many of the cost issues raised in the previous statements of both proponents and opponents. (These will be covered in more detail in Sections VII and VIII.) Two studies cited by opponents that support this conclusion are:

1. The Council for Affordable Health Insurance, in its *Health Insurance Mandates in the States 2007*, found that the collective impact of mandates increased the costs of basic coverage from slightly less than 20% to more than 50%, depending on the state.

2. Mandated Benefits Laws and Employer-Sponsored Health Insurance (Health Insurance Association of America, January 1999)

- As many as one in four people are uninsured because of the cost of state health insurance mandates.

IV. All relevant findings bearing on the social impact of the lack of the proposed benefit.

Proponents of the bill raised concerns about the safety of mail-order dispensing; specifically, spoilage for medications that must be kept at a certain temperature and the lack of face-to-face interaction with pharmacists so that questions about drug administration could be fully addressed. See also Section III. Not enough information was provided in order to determine the exact risk and prevalence of these safety concerns for the Commonwealth's population.

Opponents stated that mail-service pharmacies have safety checks built into their system of fulfillment and perform regular test mailings of medications that require refrigeration or special handling to ensure that they arrive safely and securely. They attested that such prescriptions generally arrive quickly, 48 hours for phone orders and overnight for specialty pharmaceuticals. Opponents also stated that many PBMs offer members 24-hour access to toll-free telephone conversations with licensed pharmacists, who can answer members' specific questions concerning their prescriptions.[8]

V. Where the proposed benefit would mandate coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapies and no therapy.

Senate Bill 260 does not introduce new therapies or cover one particular type of therapy.

VI. Where the proposed benefit would mandate coverage of an additional class of practitioners, the result of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits.

Senate Bill 260 does not mandate coverage for an additional class of practitioners.

VII. The results of any other relevant research.

Respondents provided research studies that addressed cost issues associated with the comparative utilization of mail-service and retail pharmacy dispensing channels.

Opponents argued that plan designs should encourage utilization of mail-service dispensing of prescription drug benefits because of its lower cost to both plan sponsors and members. They cited several studies and reports that generally supported this conclusion.

- A 2003 Government Accountability Office (GAO) report[9] based on a review of Federal Employees Health Benefit Program (FEHBP) plans found that the PBMs in its study achieved significant discounts for prescription drugs purchased both at retail pharmacies and through their mail-order pharmacies. The average price PBMs obtained for drugs from

retail pharmacies was about 18 percent below what the average price cash-paying customers would pay at retail pharmacies for 14 selected brand-name drugs and 47 percent below the "cash price" for 4 selected generic drugs. For the same quantity, the average price paid at mail order for the brand-name and generic drugs was about 27 percent and 53 percent, respectively, below the average cash-paying customer price.[10]

- A 2005 Federal Trade Commission (FTC) report[11] studied the relationship between prescription drug costs for plans and their members and the PBMs who own mail-service pharmacies and provide pharmaceutical benefit administration for them. Using claims data from eight PBMs, the FTC compared total costs, using actual payments, for mail and retail drugs for both plan sponsors and members for all prescriptions dispensed in December 2003. The FTC analysis adjusted for differences in prescription size and therapeutic drug class and for reporting purposes grouped the drugs into Generic (G), Multi-Source Brand Name (MS) and SSB (Single-Source Brand Name) categories. The FTC found that[12]:

    - For 30-unit prescriptions, both members and plans paid lower average prices at mail than at retail for each of the three drug types: the total average not owned by PBM retail price was higher than the owned by PBM mail price by 23.9% for generic, 14.9% for multi-source brand and 13.9% for single source brand.

    - For 90-unit prescriptions, both members and plans paid lower average prices at mail than at retail: the total average not owned by PBM retail price was higher than the owned by PBM mail price by 6.8% for generics, 15.6% for multi-source brand and 11.3% for single source brand.

    - Using a subset of three of the eight PBMs' claims data, the FTC compared prices where the plan sponsors required that PBMs use mail-service facilities that they did not own. Total prices at the PBM-owned mail pharmacies were 3 percent lower than the total prices at other mail-order pharmacies for both 30-unit and 90-unit prescriptions. For 30-unit, average member prices were 13% lower and plan sponsor prices were 2% higher; for 90-unit, average member prices were 5% lower and plan sponsor prices 2% lower, leading to 3% lower overall in each case.

    - The FTC reviewed 26 PBM-plan sponsor contracts as part of their analysis and found that plan sponsors negotiated different prices for the same drugs dispensed through mail-order and retail pharmacies, which may have contributed to the price differences.[13] Moreover, the FTC stated that it was unable to track any pharmaceutical payments made to plan sponsors, which could have reduced the average prices paid by plans for mail products even further compared to retail.[14]

Proponents argued that (1) mail-service dispensing is not more cost-efficient to plan sponsors when measuring cost appropriately, and that (2) pricing differences in dispensing options are primarily determined by the PBM, which encourages mail-service utilization by plan members because the PBM has an inherent conflict of interest when it owns the mail-service pharmacy. They cited in support of their arguments:

- Research in 2000 by University of Arkansas researchers analyzed the 87,528 claims of 6,673 plan members from seven plans with varying prescription drug-benefit designs.

The study found that plans that encourage mail-order utilization had lower costs (of 27 percent) over other plans on a per-day basis (due to economies of scale); however, when calculated on the basis of cost per utilizing member (CPUM = total approved costs/total utilizing members), retail pharmacy-oriented plans averaged significantly lower CPUM. The researchers argued that CPUM is a more valid metric for plan sponsors to base cost decisions, rather than per member per month (PMPM) or per member per year (PMPY) because it measures aggregate pharmaceutical costs more specifically. Moreover, while PMPM and PMPY measures are useful for plan pricing decisions, they are not, the authors noted, as useful for tracking pharmaceutical costs since the denominator reflects both utilizing and non-utilizing members.[15]

- A 2005 report studied the comparative costs of mail order and retail based on the prices offered by a large PBM to a health plan using a "market basket" of the top ten brand-name and generic maintenance drugs, as measured by dollar volume nationally. After totaling drug costs for 30-day and 90-day supplies, applying national utilization rates to the plan's membership base, the study found that "mail order actually costs the plan sponsor more than using neighborhood pharmacies."[16]

- A 2006 review of the literature on mail-order pharmacy utilization and cost by Michael Johnsrud, a University of Texas Center for Pharmacoeconomic Studies researcher, "did not identify a single well-controlled, peer-viewed article that measured plan net prescription costs related to a mandatory mail order plan compared to a traditional network of community pharmacies."[17] Studies reviewed lacked controls for plan design and product mix differences between the two dispensing channels. The author criticized the FTC report cited above for not adjusting the generic-to-brand-name product mix across therapeutic categories in order to determine the net economic impact to plan sponsors and enrollees. Johnsrud argued that studies should compare unit prices paid by each plan through mail order to the plan's network pharmacies. Moreover, cost comparisons should include both net costs to the plan as well as net costs to the enrollee.[18]

  Additionally, Johnsrud cautioned against the "reliance on expected savings [by plan contracting administrators] merely due to differences in discounted AWP [average wholesale price] reimbursement calculations between mail order and community pharmacy [which] ignore additional factors affecting total net costs. Such factors might include … lower generic dispensing rates routinely found within mail order claims …"[19] Johnsrud added: "[I]t is common for plans to include financial incentives for consumers [i.e., plan members] to use [the] mail [option,] such as reduced cost sharing. The patient saves money, but savings may not carry over to the plan sponsor."[20] In terms of cost methodology, he recommended that "the appropriate comparison of costs should find a common denominator to measure between the two outlets … either cost per enrollee month, or cost per therapy day … calculations based on a 'per claim' basis would not be appropriate."[21]

- A March 2007 follow-up study[22] by Johnsrud and other researchers at the University of Texas adopted these metrics to compare net plan and member costs for two large publicly financed plans in Texas that utilized both mail-order and retail dispensing channels. Plan A had 460,000 members and 5.1 million claims, and Plan B had 177,000 members and 3.6 million claims. For Fiscal Year 2004, the study found that total payments per day were lower across therapeutic classes in the mail-order channel, controlling for differences in product mix and establishing 30 comparative therapeutic

categories between the two delivery channels. However, pharmacy plan members enjoyed nearly all the benefit of this discount in pricing, with little or no cost savings for the plan sponsors.

Overall, on a cost-per-day basis, mail-order claims were 0.5% lower for Plan A and 0.4% lower for Plan B than similar claims processed through retail pharmacies; plan members A and B saved 28.6% and 37.0%, respectively, from obtaining prescriptions through mail-service processing.[23] Furthermore, the study compared the generic dispensing ratios for the two channels and found that community pharmacies dispensed a significantly higher ($p<.001$) proportion of generic drugs than mail-order pharmacies. (38.1% to 28.0% for Plan A and 32.7% to 24.1% for Plan B).[24] The authors concluded overall that savings from lower unit pricing through the mail-order channel primarily benefited the plan member but did not translate into significant cost savings for the plan sponsor.

- Researchers at Creighton University School of Pharmacy and Health Professions[25] in January 2007 compared mean retail and mail-order prices for the top-50 (as of 2002) national prescription volume brand-name and generic drugs using data from a survey of drug pricing formulas used by large employers and PBMs (*The Prescription Drug Benefit Cost and Plan Design Survey Report*). They found that "savings can be achieved by using mail rather than retail for brand-name prescriptions. Conversely, for generics, the data suggest that savings are available by using retail rather than mail. The positive [cost] result for generics dispensed via retail is enough to counter the savings generated from using mail delivery for brand-name prescriptions. Moreover, there is no statistical difference between mail order and retail when the costs of brand-name and generic prescriptions are combined."[26] Additionally, they commented that "the mail facility does not save the plan sponsor nearly as much money as [the] retail pharmacy on generic drug pricing because of the larger markup by mail pharmacies on generic drugs."[27]

VIII. Evidence of the financial impact of the proposed legislation.

A. The extent to which the proposed benefit would increase or decrease cost for treatment or service.

Respondents submitted conflicting information on how prescription drug costs would be affected by Senate Bill 260.

Opponents argued that because mail-order pharmacies are more cost efficient for plans, eliminating incentives for plan members to utilize them would necessarily result in higher plan and member costs. A study[28] cited by opponents stated that plan designs with financial incentives for mail order dispensing have significantly higher utilization of this option than plans without such incentives.

Highmark cited the July 2005 *Employee Benefit Plan Review*[29], which reported that employees, on average, can save up to $400 per year in out-of-pocket expenses using mail-service pharmacies, especially for 90-day supplies of medication. It argued that SB 260 would likely increase plan members' out-of-pocket expenses by equalizing copayment fees across all dispensing options.

BCNEPA stated that the bill would eliminate the cost containment efficacy of its pharmacy networks: "Senate Bill 260 would restrict BCNEPA's ability to direct members to use participating providers with whom BCNEPA contracts. The cost of filling a prescription at a pharmacy that is not in our network—a prescription paid at cash and carry charge—is on average $15 more expensive than a prescription filled in-network. Furthermore, the administrative cost to process a member-submitted, paper, out of network claim is at least $1.50 versus approximately $0.25 for an electronic network claim. BCNEPA processes approximately 3.5 million prescription drug claims for about 300,000 members a year. If all claims were cash and carry, the result would be an estimated $52.5 million in additional drug costs and about $4.4 million in additional administrative cost."(p. 4)

The Insurance Federation of Pennsylvania argued that the provisions of SB 260 would "exert an upward effect on prescription drug costs because pharmacy benefits managers would lose their bargaining power in negotiating contracted retail rates" and that benefits managers would be "prohibited from passing on the savings in ingredient and dispensing costs to the purchasers of benefits packages." (p. 2)

Medco cited the *Wall Street Journal* from February 15, 2005, which reported General Motors' use of mail-service pharmacy dispensing had saved $80 million overall across total annual drug benefit costs of $1.3 billion, even though the company acknowledged that certain individual claims may be more expensive using mail service. In addition, Medco argued that "the employer or health plan who is purchasing the benefit … is in the best position to determine which pharmacy offers the lowest price for their benefit. They can look at each claim and evaluate their overall costs." (p. 4)

As detailed in Section VII, proponents argued that plan sponsors are not sufficiently informed of the PBM business model nor of the comparative costs of various dispensing options. The complexity of the cost variables involved may lead to reliance on information provided by PBMs, who may have a conflict of interest in reporting potential pricing options to plan sponsors. When net costs to both the plan and its members are taken into account, they argue, retail pharmacies provide a better value for health plans.

B. The extent to which similar mandated benefits in other states affected charges, costs and payments for services.

Respondents submitted several references to other states' experiences with similar laws. However, other states' laws may differ in scope from Senate Bill 260. Moreover, many of these analyses provided are prospective and were undertaken to predict the impact of proposed legislation in various states, rather than evaluating the actual experience of other states.

BCNEPA provided a list of 28 states (as of January 2007) that have enacted some type of mail-order pharmacy restriction. (p. 5)

- States that prohibit insurers from requiring the use of mail-order pharmacy: AZ, AR, DE, GA, ID, LA, MS, NE, NJ, NC, IL, KS, MD, OK, RI, WV

- States that restrict an insurer's ability to offer incentives for mail-order pharmacy use: AL, AR, DE, GA, ID, LA, MS, NE, NJ, NC, WI

- States that have a limited prohibition on an insurer's requiring the use of mail-order pharmacies: KY, TN, UT, WI

Highmark also submitted a list of states and provisions, which was nearly identical to the BCNEPA list.

Additionally, respondents provided more specific information about the following states:

- Michigan

Opponents provided a 2003 study by Milliman USA actuaries[30] estimating that proposed legislation (Michigan House Bill 4987) would increase the prescription drug benefit coverage costs of employers covered by the mandate 7.9 percent. The Michigan bill would have (1) allowed enrollees to get maintenance prescriptions filled at any pharmacy located in the state and to bypass PBM-established network pharmacies, (2) prohibited differential reimbursement between mail-order and retail distribution channels for ingredient and dispensing components of the prescription, and (3) prohibited differential copayments and pricing between mail-order and retail based on the quantity of drugs dispensed (days supply). The report assumed that the provisions would (a) make employers less inclined to include a mail-order option in their plan design if they had to pay the same cost per unit regardless of the distribution channel, and (b) weaken the negotiating position of PBMs and plans when setting contracted retail pharmacy reimbursement levels.

Proponents supplied a 2004 study[31] that estimated retail pharmacies in Michigan would lose $268 million in revenue and 167 pharmacy professional jobs, and that business activity would be reduced by $336 million if plans sponsored by the United Auto Workers and the automotive industry would require members to use mail-service pharmacies for certain prescriptions.

- Maryland

Medco cited a 2005 study[32] conducted by the Maryland Health Care Commission, which found that if all 90-day prescriptions dispensed to state residents were filled at mail, consumers would save about $16 million annually and that it would reduce total Maryland consumer spending on prescription drugs by about 2 to 6 percent. (p. 3). Medco did not supply details of the Maryland study.

Additionally, a report[33] supplied by opponents projected the cost impact of various mail-service pharmacy restrictions on all states, including Pennsylvania. However, it is not clear whether the provisions analyzed can be compared to SB 260; moreover, its estimates included a significantly broader insured base (e.g., including self-insured plan members and Medicare enrollees) than might be covered by SB 260.

C. The extent to which the proposed benefit would increase the appropriate use of treatment or service.

Proponents argued that Senate Bill 260 would encourage greater utilization of retail pharmacies and face-to-face interaction with local pharmacists. (See Sections III and IV).

D. The impact of the benefit on administrative expenses of health care insurers.

Highmark stated that administrative expenses for prescription drug benefits are charged to customers by contract per month, different from administrative expenses for medical and surgical benefits. It was not clear from the information provided how the bill would affect administrative expenses.

BCNEPA argued that because the bill would require insurers to reimburse any drug-dispensing venue chosen by its members and that the administrative expense of handling out-of-network claims is significantly higher ($1.50 compared to $0.25 for in-network claims). The total cost of handling the increase in out-of-network transactions for its membership base would be $4.4 million annually.

E. The impact of the proposed benefits on benefits costs of purchasers.

BCNEPA stated that prescription drug costs represented approximately 16 percent of premium costs for 2006 and 2007 for its insured base of approximately 600,000 members. It estimated that prohibiting mandatory mail order services would have cost at least $323,000 in 2006; and prohibiting the use of co-pay incentives to encourage the use of mail order pharmacies would have cost $1.5 million.

BCNEPA stated that if every member on a maintenance drug used mail order pharmacy services, the potential savings for BCNEPA customers would be approximately $4.9 million annually. It was not clear whether these estimates represented cost savings to both plan sponsors and members or just plan sponsors.

Highmark stated that its actuaries projected a cost increase exceeding $36.2 million annually if SB 260 were enacted. Costs of reducing mail-order discounts, which are higher than those on retail pharmacy drugs, would be $25.9 million; while dispensing fees, currently not imposed on mail-order prescriptions, would apply under SB 260 and cost $10.3 million.

BCNEPA supplied a letter from November 21, 2005 from Steven Crawford, Secretary for Legislative Affairs, to the chairs of the House Insurance Committee, expressing the Office of the Governor's opposition to House Bill 814 (Session 2005 – 2006). According to the letter, HB 814 would have prohibited insurers and health plans from "requiring an insured to obtain drugs from a mail-order pharmacy as a condition of obtaining the payment for the prescription drugs, imposing a co-payment upon an insured who is not utilizing a mail-order pharmacy, or denying or impairing the right of an insured to determine from where drugs are dispensed." The letter continued: "The Pennsylvania Employee Benefit Trust Fund (PEBTF) has reviewed this provision of the bill and has indicated that the elimination of their ability to require the insured to purchase their drugs via mail order will cost the trust fund $47.4 million in the first year of implementation … [therefore] the Administration must oppose such a measure." (Attachment to BCNEPA submission)

F. The impact of the proposed benefits on the total cost of health care within the Commonwealth.

None of the submissions provided specific estimates for the overall impact of Senate Bill 260 on health care costs within the Commonwealth. Additionally, it is not clear how the provisions of Senate Bill 260 would impact the total cost of prescription drug benefits in the Commonwealth based on the documentation supplied by respondents.

Submissions for Senate Bill 260

1. Blue Cross of Northeastern Pennsylvania
   - Letter in opposition to Senate Bill 260.
   - Statement addressing Section 9 requirements.
   - November 2005 letter from Governor's Office to Senate Insurance Committee expressing opposition to prior legislation (Senate Bill 814).

2. Capital Blue Cross
   - Letter and comments in opposition to Senate Bill 260

3. CVS Caremark Corporation
   - Letter and comments in opposition to Senate Bill 260.
   - Research studies and government analyses about mail-order pharmacy and pharmacy benefit managers (PBMs).

4. Express Scripts
   - Letter and comments in opposition to Senate Bill 260.
   - Statement addressing Section 9 requirements.
   - Study on mail-order pharmacy benefits.

5. Highmark
   - Statement addressing Section 9 requirements.
   - Research studies, government analyses, fact sheets and news stories about prescription drug costs and mail-order pharmacy.

6. Independence Blue Cross
   - Letter and comments in opposition to Senate Bill 260.

7. Insurance Federation of Pennsylvania
   - Letter and comments in opposition to Senate Bill 260.
   - Testimony on prior legislation (Senate Bill 1470 - introduced May 2003) and Michigan study on prescription drug costs.

8. Medco
   - Letter and comments in opposition to Senate Bill 260.

9. National Community Pharmacists Association
   - Letter in support of Senate Bill 260.
   - Research studies on mail-order pharmacies and pharmacy benefit managers.

10. Pennsylvania Chamber of Business and Industry
    - Letter and comments in opposition to Senate Bill 260.

11. Pennsylvania Pharmacists Association
    - Research studies and press information about mail-order pharmacy and pharmacy benefit managers.

12. Philadelphia Association of Retail Druggists
    - Letter in support of Senate Bill 260.
    - Research studies on mail-order pharmacies and pharmacy benefit managers.

13. Value Drug Company
    - Letter in support of Senate Bill 260.
    - Research studies on mail-order pharmacies and pharmacy benefit managers.

[1] 2007 Annual Social and Economic (ASEC) Supplement (for 2006), U.S. Census Bureau Current Population Survey.
[2] Hewitt and Associates, "Pharmacy Benefits Purchasing: What Every Employer Should Know," (January 2005), commissioned for the Human Resources Policy Association.
[3] Langenfeld, J., and Maness, R., "The Cost of PBM 'Self-Dealing' Under a Medicare Prescription Drug Benefit (2003)", document supplied by retail pharmacy groups.
[4] The Lewin Group, "Mail-Service Pharmacy Savings and the Cost of Proposed Limitations in Medicare and the Commercial Sector," September 2006, commissioned for the Pharmaceutical Care Management Association.
[5] 2007 Annual Social and Economic Supplement, U.S. Census, op cited.
[6] The Lewin Group, "Mail-Service Pharmacy Savings and the Cost of Proposed Limitations in Medicare and the Commercial Sector," September 2006, op cited.
[7] Lewin Group report, op cited, p. 3.
[8] Miller, W., "Prescriptions by Mail Get Employer Stamp of Approval", *Employee Benefit Plan Review*, New York, July 2005, 60, p. 33-37.
[9] GAO report GAO-13-196, "Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies," (January 2003).
[10] Ibid, p. 9.
[11] Federal Trade Commission (FTC), "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," (August 2005).
[12] FTC report, op cited, p. 30-36.
[13] Ibid, p. 37.
[14] Ibid, p. 33, footnote 15.
[15] Halberg, D.L., Smith, E., and Sedlacek, K., (2000) "Effect of Mail-Order Pharmacy Incentives on Prescription Plan Costs," commissioned for the National Community Pharmacists Association.
[16] Winkelman Management Consulting analysis, April 2005.
[17] Johnsrud, M., Will a Mandatory Mail Order Pharmacy Benefit Save Payers Money? Investigating the Evidence," (January 2006), commissioned by the National Association of Chain Drug Stores Foundation, quote from p. 9.
[18] Ibid, p. 12.
[19] Ibid, p. 13-14.
[20] Ibid, p. 14-15.
[21] Ibid, p. 16.
[22] Johnsrud, M., Lawson, K., and Shepherd, M.D., (2007), "Comparison of Mail-Order with Community Pharmacy in Plan Sponsor Cost and Member Cost in Two Large Pharmacy Benefit Plans," *Journal of Managed Care Pharmacy*, 13 (2), 122-134.
[23] Ibid, p. 130.
[24] Ibid.
[25] Garis, R.I. et al. (January 2007), "Evaluating the Costs of Brand-name and Generic Prescriptions Dispensed by Mail Versus Retail," *Drug Benefit Trends*. 19, 15-19.
[26] Ibid, p. 18.
[27] Ibid, p. 19.
[28] Lewin Group report, op cited, p. 4.
[29] Miller, W., "Prescriptions by Mail Get Employer Stamp of Approval", op cited.
[30] "Potential Cost Impact of Michigan House Bill 4987 on Prescription Drug Benefit Costs," Milliman USA, October 2003.
[31] Health Management Associates, "The Financial Impact of Mandatory Mail Order on Community Pharmacies and the Economy of the State of Michigan," (2004).
[32] Maryland Health Care Commission report, *Mail-order Purchase of Maintenance Drugs: Impact on Consumers, Payers and Retail Pharmacies* (12/23/2005)
[33] Lewin Group report, op cited.