Mystery Middlemen Managing Your Prescription Drugs: Pharmacy Benefit Managers (PBMs)

SUMMARY:

About 40% of Americans struggle to afford their regular prescription medicines - with 1/3 saying they have skipped filling a prescription one or more times, because of the cost.[1] COVID-19 has exacerbated the problem by causing job and health insurance loss and delaying routine care.

Rhode Island policymakers know skyrocketing prescription drug prices must be better controlled.

Unfortunately, they have ignored a key cost driver: Pharmacy Benefit Managers (PBMs).

PBMs such as CVS Caremark, Express Scripts and OptumRx "manage" prescription drug benefits on behalf of insurers and siphon off enormous revenues in the complex non-transparent system that gets drugs from manufacturers to patients.

Other states are doing a much better job monitoring and controlling PBMs and have saved consumers and tax payers hundreds of millions of dollars.

Rhode Island should follow their lead.

To urge RI policymakers to take action, please sign this petition.

What are PBMS?

In between most patients and healthcare providers are middlemen health insurers ("payers") who take money from patients, pay some to healthcare providers, and keep some for themselves. These multiple payers cause the U.S. to spend about twice per capita what other industrialized nations with "single payer" spend for better universal healthcare.[2]

In the middle of payers, patients and pharmacies, there are Pharmacy Benefit Managers (PBMs).

PBMs: Middlemen for middlemen

PBMs are for-profit companies that "manage" prescription drug benefits for more than 266 million Americans **on behalf of payers,** including private insurers, Medicare Part D drug plans, government employee plans, large employers, and Medicaid Managed Care Organizations (MCOs).[3]

PBMs help payers:

1) create a list of covered drugs for plans ("a formulary");
2) manage drug utilization by enrollees (e.g., by setting co-pays, prior authorization policies, etc.);
3) reimburse pharmacies for providing the enrollee drugs.

This article will focus on:

- Who Are Pharmacy Benefit Managers (PBMs)
- How PBMs Harm Consumers and Taxpayers
- PBM Oversight in Other States
- Potential Roadblocks to RI Reforms
- How RI Can Rein in PBMs

WHO ARE PHARMACY BENEFIT MANAGERS (PBMS)

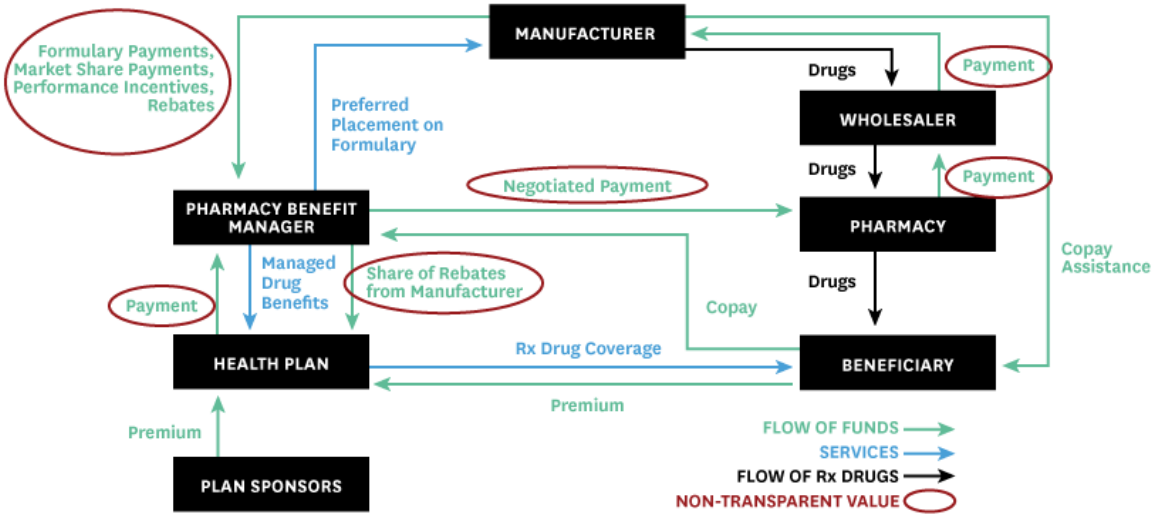
PBMs began in the 1970s as small independent middlemen between insurers and pharmacies, taking a set fee for processing claims.

Today, three PBMs control 80% of the market and are part of large vertically integrated conglomerates that include health insurance companies and pharmacies (including "specialty pharmacies"):[4]

- CVSCaremark - 32% market share – parent company: CVS (Aetna
- Express Scripts - 24% market share – parent company: Cigna
- OptumRx - 21% market share – parent company: UnitedHealth

PBMs are also part of a complex non-transparent distribution system that gets drugs from manufacturers to beneficiaries (see Figure 1).[5]

Figure 1: Unknown Flows of Funds in Drug Distribution System



Source: https://healthpolicy.usc.edu/research/state-drug-pricing-transparency-laws-numerous-efforts-most-fall-short/, adapted from, Sood, N., et al., "Flow of Money Through the Pharmaceutical Distribution System," USC Schaeffer Center for Health Policy white paper.

In this system, businesses can keep payments and discounts between themselves confidential, but analyses show that pharmaceutical manufacturers make the most profits for developing and manufacturing prescription drugs AND:

Revenues of top PBM conglomerates exceed those of top pharmaceutical manufacturers.[6]

PBM conglomerates rank 4th (CVS), 5th (UnitedHealth Group) and 13th (Cigna) on the Fortune 500 list ranking largest corporations by revenue.[7]

PBMs drive revenues for their parent companies:[8]

- **"**CVS Health's Pharmacy Services (PBM) segment will make 46% of $324 Billion in 2021 revenues for the company and remains key to its revenue growth.**"[9]**
- In 2019, Cigna's total revenues more than doubled ($14.3 billion to $38.2 billion) and its Express Scripts Holding Co. unit was the "driving force" behind the $22 billion surge.[10]
- UnitedHealth's Optum subsidiaries collected more profit in the fourth quarter of 2019 ($3 billion) than United Healthcare insurance ($2.1 billion). [11]

HOW PBMs HARM CONSUMERS AND TAXPAYERS

1. PBMs get legal kickbacks ("rebates") from drug manufacturers for putting certain drugs on formularies

When PBMs create a list of covered drugs, they negotiate with drug manufacturers for legal kickbacks ("rebates") in exchange for giving certain drugs preferred placement on formularies (e.g., Tier 1 with no co-pay, etc.).[12]

Kickbacks are generally illegal under federal law, but PBMs are given a "safe harbor" and a federal rule making PBM rebates illegal has been delayed.[13]

PBMs have a **conflict of interest** developing formularies because they get more money for shareholders by choosing an expensive drug with a higher rebate than by choosing the most effective or affordable drug for consumers.[14]

Although PBMs pass rebates to insurers (who may be their parent companies) and claim this will result in lower premiums and co-pays,[15] analyses show there is no such trickle down to consumers.[16]

In fact, drug manufacturers cover PBM rebates by *raising* their list prices for drugs and consumers pay a *higher* co-pay because they pay a % of the higher list prices.[17]

At $143 billion in 2019, it is estimated that rebates added nearly 30 cents per dollar to the price consumers pay for prescriptions.[18]

2. PBMs overcharge payers (including state Medicaid) and underpay pharmacies because they can keep the difference ("spread") between what they are paid and how much they reimburse pharmacies

Multiple states have found PBMs problems related to their keeping the "spread."[19] An Ohio audit, for example, found that in one year, "CVS Caremark and UnitedHealth's OptumRx PBMs reaped more than $223 million—and made an 8.8% profit—by overcharging Medicaid managed care plans, underpaying pharmacies, and pocketing the difference."[20]

Ohio found the spread came to $5.70 per prescription across all brand-name and generic drugs and that Ohio could have gotten the same services for $1.90 per prescription or less by switching to a fee-based model – where pharmacies are reimbursed their acquisition cost plus a set administrative fee.[21]

Ohio ordered managed-care plans in the state to terminate PBM spread pricing contracts for 2019.[22]

3. PBMs "claw back" and keep excess consumer co-pays

Consumers are often unaware they could have paid less if they had NOT used their insurance (for example, when a co-pay is $10, but the drug price without insurance is $7).[23]

Although consumers should be allowed to recover such overpayments, PBMs are the ones who "claw back" overpayments - and keep them.

A study by researchers at the University of Southern California Schaeffer Center for Health Policy & Economics found that because of PBM claw backs, customers overpaid for their prescriptions 23 percent of the time.[24]

4. **PBMs profit from a federal program ("Section 340B") meant to help low income patients**

In 1992, Congress enacted Section 340B of the Public Health Service Act mandating that pharmaceutical manufacturers provide outpatient drugs at significant discounts to certain "covered entities."[25] 340B's original purpose was to allow a handful of safety-net hospitals that cared for the poor to obtain drugs at substantially reduced prices.[26]

Changing federal laws caused the number of entities eligible for 340B discounts to explode so that today, there are now about 5,000 covered entities and 20,000 affiliated sites,[27] as well as, "30,000 pharmacy locations—half of the entire U.S. pharmacy industry—now act[ing] as contract pharmacies for the hospitals and other healthcare providers that participate in the 340B program."[28] 340B discounted drugs make up "more than 8% of the total U.S. drug market and about 16% of the total rebates and discounts that manufacturers provide."[29]

This large, complex and relatively unknown program is detailed here, but PBM problems generally involve their engaging in "discriminatory reimbursement," e.g., offering 340B entities lower reimbursement rates than those offered to non-340B entities.[30]

Currently, the federal 340B statute allows PBMs to make significant revenues and not pass money to those Section 340B intended to help.[31]

5. **PBM conglomerates own retail, mail order and specialty pharmacies and can work against consumer interests by:**

- **Setting low reimbursements for their competitors –** a cause of local independent pharmacies disappearing.[32]
- **Pharmacy Steering –** PBMs "steer" customers to pharmacies, including mail order and specialty pharmacies, with whom they are affiliated, e.g., by requiring a higher copay if the patient obtains the drug from a non-affiliated pharmacy.[33]
- **Pharmacist gag orders –** despite a federal law[34] and a new 2021 Rhode Island law[35] that prohibits PBMs from preventing pharmacists from discussing cheaper options, the consumer still has to ask and may not be told all options.[36]

6. **PBMs can hide profits**

Reasons for the lack of transparency noted in Figure 1 include:

- PBMs keeping their negotiated discounts and rebates confidential - even from a recent federal Senate committee investigating insulin prices.[37]
- PBMs disguising profits, e.g., as "rebate management fees" and "savings."[38]
- PBMs controlling their own audits, e.g., by having the right to veto auditors, determine frequency of audits, require auditors to sign "Confidentiality Agreements," etc.[39]

7. PBM "Utilization Management" can harm patients

PBMs claim to implement "utilization management" strategies on behalf of payers to benefit payers AND consumers. These strategies can include:

- "**Prior authorization,"** which requires patients to get third-party approval prior to getting the medicine prescribed by their healthcare provider.
- **"Step therapy**," also known as "fail-first," "sequencing," and "tiering," which requires patients to start with lower-priced medications before being approved for originally prescribed medications.
- "**Non-medical drug switching**" which forces patients off their current therapies for no reason other than to save money. "Tactics include increasing out-of-pocket costs, moving treatments to higher cost tiers, or terminating coverage of a particular drug."[40]

Unfortunately, such utilization management can also harm consumers by making providers spend excessive time on administrative tasks, delaying and discouraging patient care, and adversely affecting clinical outcomes.[41]

PBM Oversight in Other States

Rhode Island has some PBM-related laws and regulations,[42] but other states are more aggressively investigating and reining in PBMs to better protect consumers and tax payers.[43]

A recent Supreme Court case, *Rutledge v. PCMA*, supports states taking more actions to regulate PBMs.[44]

Some actions other states are taking include:

1. Imposing transparency reporting requirements

27 states with private insurance companies (Managed Care Organizations - MCOs) managing their Medicaid programs reported they will have transparency reporting requirements in place in FY 2020.[45] For example:

- **Texas** passed a 2019 law requiring PBMs to report information to the state and discovered, "Since 2016, through a complex rebate and price concession process, the PBM industry in Texas pocketed more than $350 million in revenue, while passing a mere $16 million in savings to enrollees."[46]

2. Investigating PBMs

Several states have investigated or are currently investigating PBMs.[47]

- **Florida**: State audit found "prescription markups" by PBMs cost Florida's Medicaid system $113.3 million in 2020 ($89.6 million in "spread costs").[48]

- **Kentucky:** Attorney General investigating PBMs for overcharging the state and discriminating against independent pharmacies after state discovers PBMs kept $123.5 million in spread annually.[49]
- **Massachusetts**: Investigation found prices charged by PBMs for generic drugs were often "markedly higher" than the actual cost of the drug in both Mass Medicaid Managed Care and Commercial Plans, "contributing to higher health care spending" (e.g., up to 111% more for certain drugs than in fee-for-service state-managed Medicaid program).[50]
- **Mississippi**: Auditor General is investigating PBMs suspected of overcharging state Medicaid and the Mississippi State and School Employees' Life and Health Insurance Plan, which covers nearly 200,000 state employees, retirees and their families after audit found PBMs were paid more than $1.1 billion; sometimes as much as $25 million a month.[51]
- **Pennsylvania**: Auditor General found between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from $1.41 billion to $2.86 billion[52] and is urging greater transparency and more state control.[53]

3. Carving out PBMs from managing Medicaid pharmacy benefits

- **Four states reported in 2019 that they generally "carve out" pharmacy benefits from their Medicaid managed care programs** (Missouri, West Virginia, Tennessee and Wisconsin) and other states were considering doing so.[54]
  - **West Virginia** "carved out" PBMs, including Express Scripts and CVS, from its Medicaid managed-care program and began running the program as a fee-for-service program - eliminating spreads and reducing administrative fees. It expected to save $30 million a year—about 4 percent of the state Medicaid drug spending.[55] In fact, WV Medicaid **saved $54.4 million in its first year** and $122 million that used to go to out-of-state PBMs instead went to West Virginia pharmacies in the form of fixed dispensing fees.[56]
- **Ohio contracted with a single PBM for Medicaid [57]** after undertaking the state audit described above and the State Auditor concluding, "It is now overwhelmingly apparent that PBMs are operating the biggest shell game in modern history, and we are all paying for it."[58]

Prohibiting spread pricing

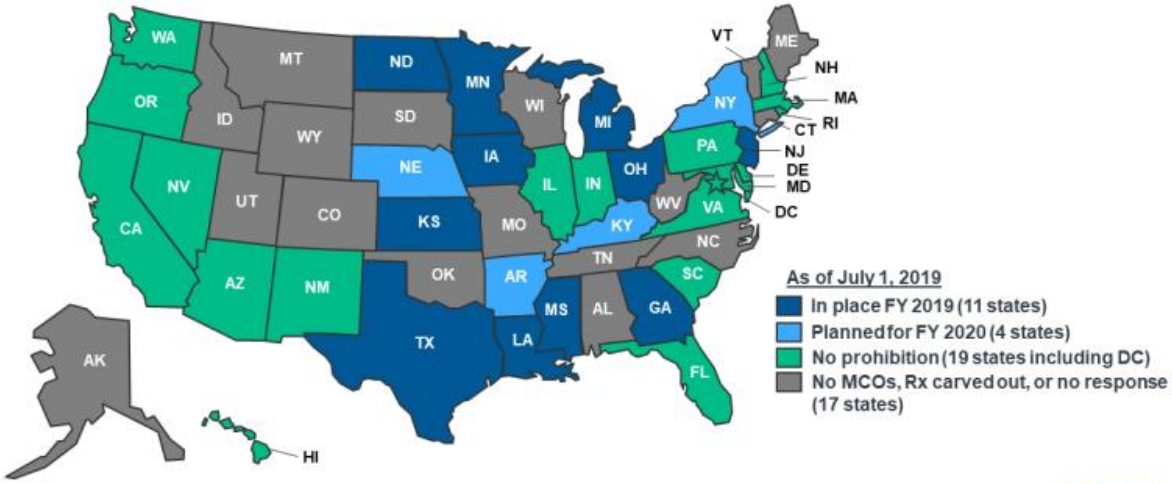
About 17 states reported a spread pricing prohibition would take effect by January 2021 (Figure 3)."[59]

- **Arkansas:** Passed a law, upheld by the Supreme Court, that required all PBMs to reimburse pharmacies at a price equal to or higher than what the pharmacy paid to buy the drug from a wholesaler.[60]

- **Maryland:** Banned spread pricing[61] after a state Medicaid report found PBMs pocketed "spread" of $72 million annually.[62]
- **Ohio:** Ended spread pricing contracts with PBMs and switched to a pass-through model following a state audit that found PBM profit accounted for 31.4% ($208.4 million) of the $662.7 million paid by Ohio Medicaid MCOs for generic drugs.[63]

Figure 3

States reporting spread pricing prohibitions as of July 1, 2019



NOTES: MD reported a prohibition on spread pricing that was added to MCO contracts in FY 2020, but MCOs would have until FY 2021 to comply. UT and CO did not respond.
SOURCE: 2019 KFF/HMA survey of Medicaid officials in 50 states and DC, April 2020.

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4. Restricting PBM rebates

- **Ohio**: rebates and discounts must be passed back to the state. [64]
- **Maine**: required PBMs to pass rebates and other "compensation" to consumers or insurers (who must in turn apply the funds to "offset the premium for covered persons").[65]
- **West Virginia**: now handles pharmacy benefits for both state workers and Medicaid recipients through the West Virginia State University of Pharmacy, saving $38 million in its first year. [66]
- **About 17 states**: have enacted stronger laws requiring PBMs to disclose rebate information.[67]

5. Prohibiting "claw backs"

- **About 38 states** have prohibited PBM "claw backs." [68]

6. Prohibiting pharmacy discrimination

- **Georgia, Louisiana, Minnesota and Utah** have passed legislation banning the practice of "pharmacy steering."[69]
- **Kentucky** created an act that requires PBMs to provide greater transparency and "fair and reasonable" reimbursements.[70]

7. Restricting Section 340B reimbursements

- **About 11 states:** have passed legislation to prohibit PBMs from reimbursing 340B covered entities less than other entities who get their standard reimbursement rate.[71]

8. Limiting "Utilization Management"

- **Prior Authorization** - 12 states (including RI) have legislation protecting drug classes or categories from using Prior Authorization in some or all circumstances, and most (excluding RI) also apply such statutory limits to Medicaid MCOS.[72]
- **Step Therapy -** 11 states have passed and **many more** are considering legislation to limit Step Therapy, [73] e.g., **Arkansas** became the first state to pass a comprehensive step-therapy ban.[74]
- **Non-Medical Drug Switching -** Several states have prohibited or introduced bills limiting non-medical switching.[75]

Potential Roadblocks to RI Reforms

1. CVS-Aetna-Caremark

- CVS Caremark is a large Rhode Island-based corporation[76] whose single biggest source of revenue is its PBM business.[77]
- Although the full extent of corporate influence is difficult to discern, it can be significant,[78] and:
    - CVS pays lobbyists large sums (e.g., Pharmacy Care Management Association - PCMA,[79] $3,962,000 in 2020) to advocate in RI against PBM reforms.[80]
    - CVS contributes to RI elected leaders who have not voted to investigate nor control middlemen payers and PBMs as healthcare cost drivers.[81]
    - CVS has threatened to cut RI jobs to influence proposed legislation.[82]
    - Since 2010, CVS has secured over $240 million in Rhode Island tax breaks[83] despite apparently cutting its RI workforce from about 12,000[84] to 3,000[85] (including getting over $20 million in FY2016 and cutting 247 jobs without notice to the state[86]) and despite taxpayers paying for at least 300 RI CVS employees on Medicaid.[87]

2. The RI Executive Office of Health and Human Services (EOHHS)

- RI EOHHS has advocated for RI Medicaid to be "managed" by private insurance companies[88] - despite lack of evidence that privatizing Medicaid serves consumers and taxpayers better than the fee-for-service state-run Medicaid program previously in place.[89]
- Today, about 90% of RI Medicaid is run by managed care organizations (MCOs): **Neighborhood Health Plan of Rhode Island**, **Tufts Health Plan** and **United Healthcare Community Plan)** who are paid approximately $1.7 billion annually (about 40% state/60% federal funds) - even though the RI Auditor General, since 2009, has flagged inadequate state MCO oversight.[90]
- RI MCO contracts, scheduled to expire in April 2022, are missing PBM oversight and restrictions, e.g., they:
    - do not have reporting requirements to identify the amount of PBM spread.[91]
    - do not make statutory limitations on prior authorizations also apply to Medicaid managed care PBMs.[92]

3. RI Office of Health Insurance Commissioner

- Rhode Island is the only state in the country to have a separate "Office of Health Insurance Commissioner" (OHIC) whose #1 listed purpose is to "guard the solvency of health insurers." See RIGL § 42-14.5-2.
- Although OHIC may also seek to protect consumers,[93] it appears to prioritize health insurer economic interests, e.g., raising health insurance premiums during the COVID-19 pandemic.[94]
- OHIC recognizes prescription drug costs are major healthcare cost drivers,[95] however, its analyses fail to consider what role insurers and PBMs play in skyrocketing healthcare costs.[96]

4. RI Health Care Costs Trends Project

- The latest major research effort to study Rhode Island healthcare costs is the **RI Health Care Cost Trends Project** ("Cost Trends Project"), a "private-public partnership" funded by a $550,000 grant from the Peterson Center on Healthcare (PCH),[97] founded by Pete Peterson, a "power from Wall Street to Washington," who championed the theory that "entitlement programs" like Medicare, Medicaid and Social Security, would wreck the US economy.[98] PCH-sponsored analyses do not analyze whether middlemen insurers and PBMs could be cost drivers.[99]
- The Cost Trends Project's goals are to "identify cost and utilization drivers, develop an annual health care cost growth target, and inform system performance improvements."[100]
- After spending its initial $550,000 grant,[101] the Cost Trends Project has produced analyses that ignore how insurers and PBMs affect health care costs[102] and could not establish an accurate "annual health care cost growth target."[103]
- A majority of the Cost Trends Project's steering committee and staff:
    - have ties to insurance company or PBM middlemen occupying current or former leadership roles,[104] or
    - are employed by organizations that rely heavily on insurer/PBM funding,[105] or

- have a history of producing healthcare cost analyses that fail to analyze middlemen and focus on reining in providers,[106] despite evidence that such policies are ineffective.[107]

What RI Should Do

Rhode Island legislative and executive branch officials should follow the lead of other states more aggressively reining in PBMs, including:

1. ***Require PBMs to disclose information that results in effective ongoing state oversight and control of PBMs.***

2. ***Pursue appropriate civil and criminal investigations and actions.***

3. ***Carve out PBMs from Medicaid Managed Care Organization (MCO) contracts set to renew in April 2022.***

4. ***Restrict Insurer/PBM middlemen unjustified revenues, such as those arising from spread pricing, "claw backs," "pharmacy steering," discriminatory reimbursements, manufacturer rebates, and Section 340B transactions.***

5. ***Restrict harmful Insurer/PBM utilization management practices, such as, Prior Authorization, Step Therapy and Non-medical Drug Switching.***

6. ***Establish an unbiased research group to analyze ALL potential healthcare cost drivers, including private middlemen insurers and PBMs.***

WHAT YOU CAN DO

Sign this petition to ask state legislators, OHIC and EOHHS to reform oversight and control over RI PBMs.

Linda L. Ujifusa, Esq.
Chair, RI Healthcare Access & Affordability Partnership
www.rihealthcare.org
401-655-1446

J. Mark Ryan, MD, FACP
Chair, Physicians for a National Health Program – RI Chapter

[1] See, e.g., https://www.goodrx.com/blog/health-insurance-aside-americans-still-struggle-to-pay-for-their-medications/ , "Impact of cost-sharing on specialty drug utilization and outcomes: a review of the evidence and future directions," https://www.ajmc.com/view/impact-of-cost-sharing-on-specialty-drug-utilization-and-outcomes-a-review-of-the-evidence-and-future-directions, and https://www.goodrx.com/blog/survey-covid-19-effects-on-medication-affordability/

[2] The lack of single payer adds administrative costs and prevents the U.S. to negotiate as a country for prescription drugs results in about 1/3 of every U.S. healthcare dollar spent to NOT go towards actual healthcare. See e.g., https://pnhp.org/resource/pnhp-research-the-case-for-a-national-health-program/

[3] https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending.

[4] See, "The Emerging Role of PPP Value Chain Integrators in the U.S. Pharmaceutical Ecosystem," https://hmpi.org/2020/06/10/the-emerging-role-of-ppp-value-chain-integrators-in-the-u-s-pharmaceutical-ecosystem/, " Pharmacy Benefit Managers –PBMs" https://www.healthcaremedicalpharmaceuticaldirectory.com/PBMs.html (noting ever increasing complexity of PBM ownership), "The Real Reason CVS Wants to Buy Aetna? Amazon,"https://www.wsj.com/articles/the-real-reason-cvs-wants-to-buy-aetna-amazon-com-1509057307 , "[AIDS Healthcare Foundation] Sounds Alarm to FTC and DOJ on how Vertical Integration in Healthcare Harms Patients, Providers and Pharmacies," "https://www.streetinsider.com/Business+Wire/AHF+Sounds+Alarm+to+FTC+and+DOJ+on+how+Vertical+Integration+in+Healthcare+Harms+Patients%2C+Providers+and+Pharmacies/16533101.html, "The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation," https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html#:~:text=We%20estimate%20that%20for%202020,of%20all%20equivalent%20prescription%20claims.&text=The%20largest%20PBMs%20operate%20with%20different%20overall%20business%20strategies%20and%20structures, "CVS completes acquisition of Caremark," https://www.modernhealthcare.com/article/20070322/NEWS/303210006/cvs-completes-acquisition-of-caremark#:~:text=Drugstore%20chain%20operator%20CVS%20Corp,under%20the%20symbol%20''CVS

[5] "State Drug Pricing Transparency Laws: Numerous Efforts, Most Fall Short," https://healthpolicy.usc.edu/research/state-drug-pricing-transparency-laws-numerous-efforts-most-fall-short/, adapted from, Sood, N., et al., "Flow of Money Through the Pharmaceutical Distribution System," USC Schaeffer Center for Health Policy, https://healthpolicy.usc.edu/research/flow-of-money-through-the-pharmaceutical-distribution-system/ See also, The Emerging Role of PPPs [Payers-Pharmacy-PBM Combinations] Value Chain Integrators in the US Pharmaceutical Ecosystem. See also Colleen Becker, National Conference of State Legislatures, "States Policy Options and Pharmacy Benefit Managers," https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx;
"Comparison of State Pharmacy Benefit Managers Laws, National Academy for State Health Policy," includes interactive map with information on PBM legislation by state https://nashp.org/comparison-state-pharmacy-benefitmanagers-laws/;
Janet Leduc, National Community Pharmacists Association, "State Laws Concerning Pharmacy Benefit Managers – PBM Regulation by State; http://www.ncpa.co/pdf/pbm-regulation-by-state.pdf;
Pharmacists United for Truth and Transparency, "A Few Things PBMs Don't Want You To Know," https://www.truthrx.org/pbmpractices.html.

[5] See, e.g., "Pricing and Payment for Medicaid Prescription Drugs," https://www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicaid-prescription-drugs/, "A Comparison of Brand-Name Drug Prices Among Selected Federal Programs," https://www.cbo.gov/system/files/2021-02/56978-Drug-Prices.pdf , "Understanding Drug Pricing," https://www.uspharmacist.com/article/understanding-drug-pricing and "States and the 340B Drug Pricing Program,"https://www.ncsl.org/research/health/340b-drug-pricing-program-and-states.aspx Terminology and pricing formulas further complicate the process. See, e.g., "Pricing and Payment for Medicaid Prescription Drugs," https://www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicaid-prescription-drugs/, "A Comparison of Brand-Name

Drug Prices Among Selected Federal Programs," https://www.cbo.gov/system/files/2021-02/56978-Drug-Prices.pdf , "Understanding Drug Pricing," https://www.uspharmacist.com/article/understanding-drug-pricing and "States and the 340B Drug Pricing Program,"https://www.ncsl.org/research/health/340b-drug-pricing-program-and-states.aspx

See, e.g., https://web.archive.org/web/20170503065805/http://pharmacybenefitconsultants.com/site/wp-content/uploads/2013/11/Painful-Prescription-Fortune-Magazine-10-28-13.pdf
"Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees: A proposed rule," https://www.federalregister.gov/documents/2019/02/06/2019-01026/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals, https://caseforconsumers.org/2018/04/03/pbms-get-aggressive-to-keep-their-drug-profits-secret-from-consumers/ , and "The Secret Drug Pricing System Middlemen Use to Rake in Millions," https://www.bloomberg.com/graphics/2018-drug-spread-pricing/ , and https://www.axios.com/drug-rebate-curtain-express-scripts-d3c93f14-e699-4a60-ac1d-9f81e5a658c0.html

[6] See e.g., "From Benefit Cards to Billions in Profits: The Evolution of the Modern PBM," https://www.withmehealth.com/newsroom/from-benefit-cards-to-billions-in-profits-the-evolution-of-the-modern-pbm (Multiple PBM conglomerates now rank in the top 10 on the Fortune 500 list).
The Evolving Pharmaceutical Benefits Market. JAMA. 2018;319(22):2269–2270. doi:10.1001/jama.2018.4269, https://jamanetwork.com/journals/jama/article-abstract/2678286
[7] https://fortune.com/company/cvs-health/fortune500/, https://fortune.com/company/cigna/fortune500/
[8] See, e.g., Abelson, Reed. "Major U.S. Health Insurers Report Big Profits, Benefiting From the Pandemic," *NYTimes.com*, New York Times, August 5, 2020, https://www.nytimes.com/2020/08/05/health/covid-insurance-profits.html. Accessed August 14, 2021. Maddipatla, Manojna. "CVS boosts 2021 profit forecast after strong first-quarter, shares rise," *Reuters.com*, Reuters, May 4, 2021, https://www.reuters.com/business/healthcare-pharmaceuticals/cvs-health-raises-2021-profit-outlook-higher-drug-store-sales-2021-05-04/. Accessed July 15, 2021. "Cigna bottom line rises with Express Scripts acquisition," https://www.journalinquirer.com/business/cigna-bottom-line-rises-with-express-scripts-acquisition/article_edf0bbb4-4c23-11ea-a8c0-3fda225b46f3.html; and "Where UnitedHealth is making its money,"https://www.axios.com/unitedhealth-money-profit-unitedhealthcare-optum-c12551d8-6e84-493d-9e8f-564a30213a84.html .

[9] "What are CVS Health's key sources of revenue?" https://www.forbes.com/sites/greatspeculations/2020/01/03/what-are-cvs-healths-key-sources-of-revenue/?sh=6452942a2837, see also "CVS Health Revenues: How Does CVS Make Money?" https://dashboards.trefis.com/data/companies/CVS/no-login-required/MX1D0hKT/CVS-Health-Revenues-How-Does-CVS-Make-Money-, "Financial Analysis of CVS Caremark Pharmacies and Pharmacy Benefit Manager," https://truecostofhealthcare.org/wp-content/uploads/2018/02/CVS-Caremark.pdf
[10] "Cigna bottom line rises with Express Scripts acquisition," https://www.journalinquirer.com/business/cigna-bottom-line-rises-with-express-scripts-acquisition/article_edf0bbb4-4c23-11ea-a8c0-3fda225b46f3.html , https://fortune.com/company/cigna/fortune500/
[11] "Where UnitedHealth is making its money,"https://www.axios.com/unitedhealth-money-profit-unitedhealthcare-optum-c12551d8-6e84-493d-9e8f-564a30213a84.html
[12] See, e.g., "Pharmacy Benefit Managers and Their Role in Drug Spending," https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending , "What Determines How Much Your Patient Pays for Their Medication in the United States?" https://pubmed.ncbi.nlm.nih.gov/27131775/ , "The Crazy Math Behind Drug Prices," https://www.bloomberg.com/news/articles/2017-06-29/the-crazy-math-behind-drug-prices / ,

"Fraud and Abuse: Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees: A proposed rule," https://www.federalregister.gov/documents/2019/02/06/2019-01026/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals

[13] https://www.federalregister.gov/documents/2019/02/06/2019-01026/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals and https://www.jdsupra.com/legalnews/biden-administration-already-impacting-2691434/ (Biden delays implementation until 2023.)

[14] See, e.g., "The Crazy Math Behind Drug Prices," https://www.bloomberg.com/news/articles/2017-06-29/the-crazy-math-behind-drug-prices / , and http://www.medpac.gov/-blog-/factors-increasing-part-d-spending-for-catastrophic-benefits/2017/06/08/factors-increasing-part-d-spending-for-catastrophic-benefits

[15] https://www.pcmanet.org/the-value-of-pbms/

[16] See, e.g., "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug," US Senate Finance Committee Staff Report, https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf and "The drug rebate curtain," https://www.axios.com/drug-rebate-curtain-express-scripts-d3c93f14-e699-4a60-ac1d-9f81e5a658c0.html

[17] See, e.g., "Why prescription drug list prices matter," https://www.modernhealthcare.com/technology/why-prescription-drug-list-prices-matter Michael A. Carrier, "Response to Senator Grassley's Questions for the Record Sen. Jud. Comm. Hearing on "IP and the Price of Prescription Drugs: Balancing Innovation and Competition," May 28, 2019, https://www.judiciary.senate.gov/imo/media/doc/Carrier%20Responses%20to%20QFRs.pdf (hereinafter, "Carrier Response to Senate Judiciary Committee Hearing") (noting "nearly every drug company taking a January 2019 price increase announced that all or nearly all of the increase was being paid to PBMs or insurers as rebates," quoting "HHS, Fact Sheet, Jan. 31, 2019,"), https://www.hhs.gov/sites/default/files/20190131-fact-sheet.pdf , "New Evidence Shows Prescription Drug Rebates Play a Role in Increasing List Prices," https://healthpolicy.usc.edu/article/new-evidence-shows-prescription-drug-rebates-play-a-role-in-increasing-list-prices/ , "Pharmacy Benefit Managers and Their Role in Drug Spending," https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending, "How PBMs Affect Cost," http://www.pbmwatch.com/how-pbms-affect-cost.html (Noting: "While PBMs market themselves as being well-positioned to bring savings to plans and consumers, a lack of transparency in their practices enables them to wield their power to increase their profits, often at the expense of the consumer"), and "Ohio's Medicaid Managed Care Pharmacy Services Auditor General State Report, August 16, 2018," https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf (Auditor states: "Every state and every payer in the country is grappling with these overinflated costs."), Insulin "Access and Affordability Working Group: Conclusions and Recommendations," https://care.diabetesjournals.org/content/41/6/1299, and "The Truth About Pharmacy Benefit Managers: They Increase Costs and Restrict Patient Choice and Access," https://ncpa.org/sites/default/files/2020-09/ncpa-response-to-pcma-ads.pdf. "Secretive 'Rebate Trap' Keeps Generic Drugs For Diabetes And Other Ills Out Of Reach," https://khn.org/news/secretive-rebate-trap-keeps-generic-drugs-for-diabetes-and-other-ills-out-of-reach/ , "New Evidence Shows prescription drug rebates play a role in increasing list prices,"https://healthpolicy.usc.edu/article/new-evidence-shows-prescription-drug-rebates-play-a-role-in-increasing-list-prices/ citing "The Association Between Drug Rebates and List Prices," https://healthpolicy.usc.edu/wp-content/uploads/2020/02/SchaefferCenter_RebatesListPrices_WhitePaper.pdf, "Data Proves PBM Industry Maximized Profit At Patient Expense," https://www.prnewswire.com/news-releases/data-proves-pbm-industry-maximized-profit-at-patient-expense-301077011.html (Insurance company enrollees pay a % of the list prices as co-pays, so rebates do not lower co-pays); and "How Health Plans Profit—and Patients Lose—From Highly-Rebated Brand-Name Drugs," https://www.drugchannels.net/2019/02/how-health-plans-profitand-patients.html

[18] "The Truth About Pharmacy Benefit Managers: They Increase Costs and Restrict Patient Choice and Access," https://ncpa.org/sites/default/files/2020-09/ncpa-response-to-pcma-ads.pdf (National Community Pharmacists

Association citing data from IQVIA) and "Drug Costs Driven By Rebates," http://bionj.org/wp-content/uploads/2015/11/drug-costs-driven-by-rebates.pdf (noting: "As a percent of all brand medicine spending, rebates were 71 percent of the total increase from 2014-2015. This means much of the price increase imposed on patients reflects the cost of rebates that PBMs and others claim make medicines 'affordable'.") See also https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-report-rebate-walls/federal_trade_commission_report_on_rebate_walls_.pdf (noting problems with "rebate walls" created by pharmacy manufacturers with the help of PBMs).

[19] "Pharmacy Benefit Managers and Their Role in Drug Spending," https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending. See also, https://www.bloomberg.com/graphics/2018-drug-spread-pricing/ , "HPC DataPoints, Issue 12: Cracking Open the Black Box of Pharmacy Benefit Managers," https://www.mass.gov/info-details/hpc-datapoints-issue-12-cracking-open-the-black-box-of-pharmacy-benefit-managers and https://www.modernhealthcare.com/supply-chain/pbms-spread-pricing-inflates-healthcare-spending-commission-finds

[20] https://www.managedcaremag.com/archives/2019/9/spread-pricing-largely-unknown-much-scrutinized-and-criticized/ , https://www.dispatch.com/story/news/healthcare/2021/01/11/pharmacy-benefit-managers-ohio-medicaid-saving-pbm/6556793002/ See also https://www.massbio.org/news/recent-news/pbms-profits-prescription-drugs-examining-the-impact-of-spread-pricing-in-massachusetts/ (MA study finds excessive profits from spread pricing), https://www.modernhealthcare.com/supply-chain/pbms-spread-pricing-inflates-healthcare-spending-commission-finds and https://www.managedcaremag.com/archives/2019/9/spread-pricing-largely-unknown-much-scrutinized-and-criticized/ https://www.dispatch.com/story/news/politics/elections/2021/04/14/revamp-ohios-pbm-setup-now-complete-award-new-contract-ohio-medicaid-mike-dewine/7221089002/ (noting that OH had to go beyond just replacing the spread with required pass-through billing because PBMs were directing many prescriptions for the most expensive specialty drugs toward pharmacies owned by the same firms as the PBMs).
[21] https://www.wsj.com/articles/states-probe-business-practices-of-pharmacy-benefit-managers-11620730804
[22] https://www.bloomberg.com/graphics/2018-drug-spread-pricing/

[23] "Patients Overpay For Prescriptions 23% Of The Time, Analysis Shows," https://khn.org/news/paying-cash-for-prescriptions-could-save-you-money-23-of-the-time-analysis-shows/ , https://khn.org/news/filling-a-prescription-you-might-be-better-off-paying-cash/
[24] Ibid., see also https://www.truthrx.org/pbmpractices.html
[25] https://www.drugchannels.net/2021/06/exclusive-340b-continues-its-unbridled.html, https://www.340bhealth.org/members/340b-program/overview/ , https://www.nytimes.com/2013/02/13/business/dispute-develops-over-340b-discount-drug-program.html?emc=eta1
[26] "Cost Consequences of the 340B Drug Discount Program," https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4036617/
[27] https://www.iqvia.com/locations/united-states/blogs/2021/04/340b-drug-discount-program-growth-drivers
[28] https://www.drugchannels.net/2021/06/exclusive-340b-continues-its-unbridled.html
[29] https://www.iqvia.com/locations/united-states/blogs/2021/04/340b-drug-discount-program-growth-drivers (noting other issues include, "(2) establishing barriers to 340B pharmacies' participation in PBM pharmacy networks or to PBM members using 340B pharmacies, and/or (3) excluding covered entity pharmacies from PBM networks entirely"), https://www.drugchannels.net/2020/06/new-hrsa-data-340b-program-reached-299.html
[30] https://340breport.com/wp-content/uploads/2021/06/PBMs-and-340B-White-Paper-June-29-2021.pdf , Government Accountability Office, Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization, GAO-19-498, 9 (Jul. 2019), https://www.gao.gov/assets/gao-19-498.pdf , https://340binformed.org/2021/05/more-states-acting-to-protect-340b-safety-net-hospitals/

[31]See e.g., https://340breport.com/wp-content/uploads/2021/06/PBMs-and-340B-White-Paper-June-29-2021.pdf, https://www.drugchannels.net/2020/07/how-hospitals-and-pbms-profitand.html (also noting that consumers, including Medicare Part D enrollees, fund profits).

[32] "The hidden players putting independent pharmacies out of business," https://whyy.org/segments/the-hidden-players-putting-independent-pharmacies-out-of-business/
[33] "While PBMs market themselves as being well-positioned to bring savings to plans and consumers, a lack of transparency in their practices enables them to wield their power to increase their profits, often at the expense of the consumer," http://www.pbmwatch.com/how-pbms-affect-cost.html , citing "PBM Practices Powerpoint," http://www.pbmwatch.com/uploads/8/2/7/8/8278205/ncpa_pbm_practices_that_drive_up_costs.pptx
And "Aetna unveils plan nudging members to CVS clinics, pharmacies," https://www.healthcaredive.com/news/aetna-unveils-plan-nudging-members-to-cvs-clinics-pharmacies/584475/
[34] "Pharmacy Benefit Manager Legislation," http://www.pbmwatch.com/pbm-legislation.html
[35] RI Senate bill 497 (2021), http://webserver.rilin.state.ri.us/BillText/BillText21/SenateText21/S0497A.pdf
[36] See, e.g., Appleby, J. "Filling a prescription? you might be better off paying cash." https://khn.org/news/filling-a-prescription-you-might-be-better-off-paying-cash/
[37] "PBM Prices that Drive Up Costs," http://www.pbmwatch.com/uploads/8/2/7/8/8278205/ncpa_pbm_practices_that_drive_up_costs.pptx (e.g., PBM will not disclose manufacturer fees paid to PBMs for health plan's aggregated clinical data; and hide spreads by claiming that their contracted Average Wholesale Price (AWP) rates with their pharmacies are confidential), Michael A. Carrier, "Response to Senator Grassley's Questions for the Record Sen. Jud. Comm. Hearing on "IP and the Price of Prescription Drugs: Balancing Innovation and Competition," May 28, 2019, https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf
[38] http://www.pbmwatch.com/uploads/8/2/7/8/8278205/ncpa_pbm_practices_that_drive_up_costs.pptx (e.g., "savings" generated when a PBM exceeds its "generic dispensing rate" (GDR), i.e., the number of generic fills divided by the total number of prescriptions).
[39] "PBM Practices That Drive Up Costs," http://www.pbmwatch.com/uploads/8/2/7/8/8278205/ncpa_pbm_practices_that_drive_up_costs.pptx
[40]https://www.acponline.org/acp_policy/policies/step_therapy_nonmedical_switching_prescription_drugs_policy_2020.pdf
[41]See, e.g., https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf , "As COVID-19 peaked, prior authorization's harmful burdens continued," https://www.ama-assn.org/practice-management/sustainability/covid-19-peaked-prior-authorization-s-harmful-burdens-continued?gclid=Cj0KCQjw24qHBhCnARIsAPbdtlK2EksLiEdyDTO06H_1DOa8UJi3HBlOtyUFcpnhlK5xn5MY5LUJipIaApbcEALw_wcB , (prior authorization requires physician/healthcare providers to spend significant time away from providing actual patient care and dealing with "submission and approval through the telephone, an online portal/website, or written coverage request for the health plan to cover the drug),"Payer Administrative Barriers Limit Access to Cancer Care," https://www.acponline.org/acp_policy/policies/step_therapy_nonmedical_switching_prescription_drugs_policy_2020.pdf noting *"By 2017, 14% of total treatment denials for insured Americans were based on step therapy or nonmedical drug switching policies (9% and 5%, respectively). Up to 14 million Americans could be subject to step therapy when they try to access a medication prescribed to treat a chronic illness. Step therapy and nonmedical drug switching are particularly prevalent among high-cost drugs, including biologics and specialty drugs for autoimmune conditions, which can cost thousands of dollars per month."*

https://patientengagementhit.com/news/payer-administrative-barriers-limit-access-to-cancer-care , "A Consumer Guide to Drug Formularies: Understanding the Fundamentals of Behavioral Health Medications," https://www.paritytrack.org/issue-briefs/a-consumer-guide-to-drug-formularies-understanding-the-fundamentals-of-behavioral-health-medications/ and "Management and Delivery of the Medicaid Pharmacy Benefit," https://www.kff.org/medicaid/issue-brief/management-and-delivery-of-the-medicaid-pharmacy-benefit/

[42] See, R.I. Gen Laws §§ 27-41.38.2 & 27-18- 33.2 (Maximum Allowable Cost – MAC - List Requirements), "State Policy Options and Pharmacy Benefit Managers (PBMs)," https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx and https://www.cga.ct.gov/2018/rpt/pdf/2018-R-0083.pdf.

[42]See, e.g., Colleen Becker, National Conference of State Legislatures, "States Policy Options and Pharmacy Benefit Managers,"https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx; See also, "State Policy Options and Pharmacy Benefit Managers (PBMs)," https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx and https://www.cga.ct.gov/2018/rpt/pdf/2018-R-0083.pdf

[43]See, e.g., Colleen Becker, National Conference of State Legislatures, "States Policy Options and Pharmacy Benefit Managers,"https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx; "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-appendix/, "Medicaid Pharmacy Benefits State Fact Sheets," https://www.kff.org/statedata/medicaid-pharmacy-benefits-state-fact-sheets/, "2021 State Legislative Action to Lower Pharmaceutical Costs," https://www.nashp.org/rx-legislative-tracker/ (noting in 2021, 47 states introduced 216 PBM bills), "20 States Pass Pharmacy Benefit Manager (PBM) Transparency Legislation in 2019—State Drug Pricing Legislation Likely to Continue in 2020," https://www.nashp.org/new-pbm-laws-reflect-states-targeted-approaches-to-curb-prescription-drug-costs/, "PBM Practices Powerpoint," https://www.nashp.org/pbm-laws-and-trends-over-time/, https://www.ourindependentvoice.com/latest-updates/news-item/2019/10/08/20-states-pass-pharmacy-benefit-manager-(pbm)-transparency-legislation-in-2019-state-drug-pricing-legislation-likely-to-continue-in-2020; https://ohiocapitaljournal.com/2021/07/01/attempts-to-reform-drug-middlemen-surge-in-nearly-every-state/ and Alliance for Transparent and Affordable Prescriptions, "Solving the Problem," http://www.pbmwatch.com/uploads/8/2/7/8/8278205/ncpa_pbm_practices_that_drive_up_costs.pptx and information at Alliance for Transparency and Affordable Prescriptions, https://atapadvocates.com/

See, e.g., "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020,"

https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-appendix/ (Appendix 9),

https://www.nashp.org/pbm-laws-and-trends-over-time/,

https://www.kff.org/statedata/medicaid-pharmacy-benefits-state-fact-sheets/ , https://www.nashp.org/rx-legislative-tracker/ (noting in 2021, 47 states introduced 216 PBM bills),

https://www.nashp.org/new-pbm-laws-reflect-states-targeted-approaches-to-curb-prescription-drug-costs/,

"PBM "PBM Practices Powerpoint,"
http://www.pbmwatch.com/uploads/8/2/7/8/8278205/ncpa_pbm_practices_that_drive_up_costs.pptx and https://atapadvocates.com/, "…Major Wins on PBM reforms…,"
https://www.texaspharmacy.org/page/2021Wrapup

[44] The Supreme Court, in *Rutledge v. Pharmacy Care Management Association*, https://www.supremecourt.gov/opinions/20pdf/18-540_m64o.pdf, put states on much firmer footing in regulating PBMs. See https://www.healthaffairs.org/do/10.1377/hblog20201216.909942/full/
Background: In response to seeing PBMs drive independent and rural pharmacies out of business by reimbursing them below the price they paid to acquire drugs, **Arkansas** passed a law requiring PBMs to reimburse pharmacies at a price equal to or higher than what the pharmacy paid to buy the drug from a wholesaler. The PBM trade association (PCMA) sued, arguing among other things that this violated the Employee Retirement Income Security Act of 1974 (ERISA)[44] which preempts laws that require private plans to structure benefit plans in particular ways.

The court ruled that ERISA did not preempt the Arkansas law because: 1) it only had an "indirect economic influence" on ERISA plans and 2) because it was not aimed exclusively at ERISA plan PBMs. See, e.g., https://today.westlaw.com/Document/I4fc444f5d5de11ebbea4f0dc9fb69570/View/FullText.html?contextData=(sc.Default)&transitionType=Default&firstPage=true, https://apa.memberclicks.net/assets/Interactions/NewInteRxActions/2017/November/Act%20900%202015%20SB%20688%20Mac%20law%2090th%20gen%20assembly%20AR.PDF (Arkansas Pharmacy Association summary of bill), and https://www.pharmacytoday.org/article/S1042-0991(20)30303-0/fulltext
Commentators believe *Rutledge* permits states to pass more aggressive laws aimed at regulating PBMs. See, e.g., "340B Update: Recent Supreme Court Ruling," https://www.jdsupra.com/legalnews/340b-update-recent-supreme-court-ruling-71867/ "Supreme Court Holds that ERISA Does Not Preempt Arkansas PBM Law: The Impact on Employer Sponsored Group Health Plans, https://www.natlawreview.com/article/supreme-court-holds-erisa-does-not-preempt-arkansas-pbm-law-impact-employer ,"Legal Challenges to State Rx Laws," https://www.nashp.org/wp-content/uploads/2019/10/Legal-Challenges-to-State-Rx-Laws-final-9_12_2019.pdf and https://wvpharmacy.org/2021-legislative-updates/ and note: lower courts have upheld challenges to other state PBM laws, see, e.g., "Legal Challenges to State Rx Laws," https://www.nashp.org/wp-content/uploads/2019/10/Legal-Challenges-to-State-Rx-Laws-final-9_12_2019.pdf

[45] See, e.g., See, e.g., West Virginia "Pharmacy Audit Integrity Act passes both houses, sent to Governor for his signature," https://wvpharmacy.org/2019/02/pharmacy-audit-integrity-act-passes-both-houses-sent-to-governor-for-his-signature/ , "State Drug Pricing Transparency Laws: Numerous Efforts, Most Fall Short," https://healthpolicy.usc.edu/research/state-drug-pricing-transparency-laws-numerous-efforts-most-fall-short/ , "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/ , "State Drug Transparency Laws," https://healthpolicy.usc.edu/research/data-visualization-state-drug-transparency-laws/. See also 2021 RI legislation seeking Medicaid Managed Care Organization (MCO) audit and Medicaid deprivatization: H. 6046 and S. 0049, and H. 5449 and S. 379.
[46]"Prescription Drug Cost Transparency," https://www.tdi.texas.gov/reports/documents/drug-price-transparency-PBMs.pdf (26 states), "Virginia Enacts Drug Price Transparency Law," https://www.jdsupra.com/legalnews/virginia-enacts-drug-price-transparency-5497669/ (VA is 27th state).
[47]See, e.g., Massachusetts studies at https://www.mass.gov/info-details/hpc-datapoints-issue-12-cracking-open-the-black-box-of-pharmacy-benefit-managers and Massachusetts' Health Care Trends Project; "States Probe Business Practices of Pharmacy Benefit Managers,"https://www.wsj.com/articles/states-probe-business-practices-of-pharmacy-benefit-managers-11620730804; and the National Community Pharmacists Association suggests that even more investigations are necessary because of other potential problems, e.g., mis-classifying generic drugs as brand drugs. "PBM Practices Powerpoint," http://www.pbmwatch.com/uploads/8/2/7/8/8278205/ncpa_pbm_practices_that_drive_up_costs.pptx, and see https://www.axios.com/algorithm-black-box-express-scripts-18f3d873-77ce-40eb-9a0c-578b608d1b6e.html (explaining why determining whether something is a generic or brand drug is a "black box")

[48] "Florida lawmakers to consider heatedly-opposed PBM reform again in 2021," https://www.thecentersquare.com/florida/florida-lawmakers-to-consider-heatedly-opposed-pbm-reform-again-in-2021/article_932bdca8-6668-11eb-9e28-6babfefc10ff.html
[49]"Medicaid Managed Reform," https://ncpa.org/sites/default/files/2020-05/medicaid-managed-care-reform-one-pager.pdf
[50]"New HPC Analysis Highlights Need For Transparency in Drug Pricing Practices of Pharmacy Benefit Managers," https://www.mass.gov/news/new-hpc-analysis-highlights-need-for-transparency-in-drug-pricing-practices-of-pharmacy. Key findings from MCO PBMs study included:

- In 2018, MCO/PBM drug prices were higher than the acquisition prices for 95% of the unique drugs analyzed by the HPC and exceeded FFS prices for 42% of unique drugs.

- For the drugs where the MCO/PBM price was higher than the FFS price, the difference was often substantial, leading to higher average drug prices overall. MCO prices exceeded FFS prices by an average of $15.97 per unique drug.
- The MCO/PBM price exceeded the FFS price per prescription by at least $10 for nearly 25% of unique drugs and was at least $50 higher for approximately 10% of unique drugs.
- Buprenorphine-Naloxone (generic Suboxone) had the highest aggregate spending difference in late 2018, totaling $252,536 in Q4. MCOs paid an average $159 per prescription of buprenorphine, 111% higher than the average FFS price of $75.
- For several widely prescribed generic drugs, a drop in acquisition costs has not translated to lower prices for the MassHealth MCO program. For example, from 2016 Q1 to 2018 Q4, the average acquisition cost for Buprenorphine fell by 60% while the MCO/PBM price increased by 13%.

PBM prices for generic drugs were markedly higher than the drugs' acquisition costs in the commercial market. The price for generic Gleevec, used in treatment of leukemia, was an average of $1,811 more per prescription than the pharmacy acquisition cost. This per prescription difference translated to more than $278,000 in aggregate spending above acquisition cost. "Pharmacy Reimbursement Trends in Massachusetts," http://www.mipanet.org/MIPA.nsf/22422372cf304f59852586b10060fe97/$FILE/PBM%20Report%20Final%20April%202021.pdf. Higher generic drug prices paid by MCOs come out of the fixed per-member (capitation) payment rate from MassHealth Medicaid to cover a beneficiary's medical and pharmacy benefits. Therefore, while higher drug prices do not necessarily translate to direct state spending in the short term, these prices can lead to MCOs allocating fewer resources for other medical services and can raise spending in the long term through higher capitated rates." "New HPC Analysis Highlights Need For Transparency in Drug Pricing Practices of Pharmacy Benefit Managers," https://www.mass.gov/news/new-hpc-analysis-highlights-need-for-transparency-in-drug-pricing-practices-of-pharmacy

See also "2018 Massachusetts Report on Health Care Cost Trends," https://www.mass.gov/doc/2018-report-on-health-care-cost-trends/download (recommending study of PBMs);

[51] https://www.djournal.com/news/state-news/mississippi-started-investigating-its-largest-medicaid-contractor-2-years-ago/article_bc5ab565-b03e-5053-9805-e799975d82e8.html, https://www.clarionledger.com/story/news/politics/2021/04/19/centene-medicaid-pharmacy-provider-investigation-mississippi-attorney-general-auditor/7203951002/, and https://www.djournal.com/news/local/mississippi-was-investigating-drug-middlemen-at-state-s-health-insurance-plan/article_75406187-e42a-518d-a2e4-77563dfddaff.html

[52] https://ncpa.org/medicaid (no ERISA violations)

[53] https://www.paauditor.gov/press-releases/auditor-general-depasquale-calls-on-senate-to-join-fight-for-lower-prescription-costs-by-passing-bills-to-increase-oversight-of-pbms#:~:text=23%2C%202020)%20%E2%80%93%20Auditor%20General,between%20drug%20manufacturers%20and%20pharmacists, and http://www.philly.com/business/pbms-pennsylvania-medicaid-drug-prices-cvs-auditor-general-20181211.html

[54] "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/, https://www.drugtopics.com/view/pharmacy-benefit-changes-coming-for-medi-cal-beneficiaries , https://www.kff.org/statedata/custom/ and 15 states carving out one or more drugs or classes. https://www.kff.org/statedata/custom-state-report and https://files.kff.org/attachment/Fact-Sheet-Medicaid-Pharmacy-Benefits-MO.pdf, https://www.kff.org/statedata/custom/ and earlier https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/ and https://aishealth.com/drug-benefits/more-states-choose-to-carve-out-medicaid-drug-benefits/ ,https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-pharmacy-benefit-administration/

[55] "The Secret Drug Pricing System Middlemen Use to Rake in Millions," https://www.bloomberg.com/graphics/2018-drug-spread-pricing/

[56] https://ncpa.org/newsroom/news-releases/2019/03/13/west-virginia-medicaid-saves-%2454.4-million-with-prescription-drug-carve-out, https://dhhr.wv.gov/bms/News/Documents/WV%20BMS%20Rx%20Savings%20Report%202019-04-02%20-%20FINAL.pdf and https://www.kentuckytoday.com/stories/wanting-to-set-record-straight-with-wva-medicaid,24487 An analysis disputing the savings, https://www.ahip.org/wp-content/uploads/WV-Medicaid-Pharmacy-Savings-Report-brief-0419.pdf, has been refuted https://www.ahip.org/wp-content/uploads/WV-Medicaid-Pharmacy-Savings-Report-brief-0419.pdf and

[57] https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/single-pharmacy-benefit-manager, "As part of revamp, Ohio Medicaid hires watchdog for state-run pharmacy benefits manager," https://www.dispatch.com/story/news/politics/elections/2021/04/14/revamp-ohios-pbm-setup-now-complete-award-new-contract-ohio-medicaid-mike-dewine/7221089002/

[58] https://www.ohiopharmacists.org/aws/OPA/pt/sd/news_article/184063/_PARENT/layout_interior_details/false

[59]"How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-appendix/ and Tennessee just passed a law that takes effect July 1, 2021, that a PBM may not charge a covered entity an amount greater than the reimbursement paid by a PBM to a contracted pharmacy for a prescription drug or device. https://www.clarksvilleonline.com/2021/07/01/new-tennessee-laws-to-improve-health-welfare-of-tennesseans-to-go-begin-today-july-1st/

[60] https://www.supremecourt.gov/opinions/20pdf/18-540_m64o.pdf

[61]"Maryland bans spread pricing following report on the practice's cost," https://insidehealthpolicy.com/inside-drug-pricing-daily-news/maryland-bans-spread-pricing-following-report-practice%E2%80%99s-cost

[62] "The Truth About Pharmacy Benefit Managers: They Increase Costs and Restrict Patient Choice and Access," https://ncpa.org/sites/default/files/2020-09/ncpa-response-to-pcma-ads.pdf

[63] Ohio Auditor of State. Ohio's Medicaid Managed Care Pharmacy Services. Aug. 16, 2018. Available at: https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf

[64] https://www.ajmc.com/view/ohio-tells-medicaid-pbms-that-2019-will-be-a-time-for-transparent-contracts

[65] http://legislature.maine.gov/bills/getPDF.asp?paper=SP0466&item=4&snum=129 and see "Governor Mills Signs Into Law Comprehensive Prescription Drug Reform Package," https://www.maine.gov/governor/mills/news/governor-mills-signs-law-comprehensive-prescription-drug-reform-package-2019-06-24 ,

[66] https://www.ajmc.com/view/ohio-tells-medicaid-pbms-that-2019-will-be-a-time-for-transparent-contracts

[67] "How state Medicaid programs are managing prescription drug costs" (appendix Table 9), https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-appendix/

[68] https://www.ourindependentvoice.com/latest-updates/news-item/2019/10/08/20-states-pass-pharmacy-benefit-manager-(pbm)-transparency-legislation-in-2019-state-drug-pricing-legislation-likely-to-continue-in-2020

[69] https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx

[70] https://www.ajmc.com/view/ohio-tells-medicaid-pbms-that-2019-will-be-a-time-for-transparent-contracts

[71]States have rejected PBM arguments that that they should be allowed to reimburse 340B covered entities less because the covered entities paid less for drugs. "Health Policy Brief: The 340B Drug Discount Program," Health Affairs, September 14, 2017. DOI: 10.1377/hpb20171409.00017, https://www.healthaffairs.org/do/10.1377/hpb20171024.663441/full/ (noting, however, that efforts to determine who counts as a "patient" of a 340B purchaser for purposes of the discount got derailed). "More States Acting to Protect 340B safety net hospitals," https://340binformed.org/2021/05/more-states-acting-to-protect-340b-safety-net-hospitals/ , "New PBM State Laws Indicate a Shifting Battlefront over 340B Program Drug Pricing," https://www.americanbar.org/groups/health_law/section-news/2019/09/new-pbm/ , "Ohio Lawmakers Aim to Protect Clinics for Poor from Pharmacy Middlemen," https://www.dispatch.com/news/20200128/ohio-lawmakers-

aim-to-protect-clinics-for-poor-from-pharmacy-middlemen;
https://www.americanbar.org/groups/health_law/section-news/2019/09/new-pbm/, see also
https://www.dispatch.com/news/20200128/ohio-lawmakers-aim-to-protect-clinics-for-poor-from-pharmacy-middlemen. States should also likely investigate reforming 340B profit regulations more broadly, see, e.g., Zeta, L. (2015) and Comprehensive Legislative Reform to Protect the Integrity of the 340B Drug Discount Program. Food and Drug Law Journal, 70(4), 481-500. Retrieved July 22, 2021, from https://www.jstor.org/stable/26661081, and RI PBM 340B legislation proposed, but not passed,
http://webserver.rilin.state.ri.us/BillText/BillText21/HouseText21/H5913.pdf

[72] See https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx#/ and "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/

[73] See https://www.steptherapy.com/step-therapy-legislation-by-state/ , "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/, and "States Use Various Approaches to Manage Drug Spending," https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/02/states-use-various-approaches-to-manage-drug-spending

[74] See Arkansas law:
https://www.arkleg.state.ar.us/Acts/FTPDocument?path=%2FACTS%2F2021R%2FPublic%2F&file=97.pdf&ddBienniumSession=2021%2F2021R, "Arkansas Becomes First State to Pass Comprehensive Step Therapy Reform Legislation in 2021,"
https://www.psoriasis.org/arkansas-step-therapy-reform/, "Aid Access to Critical Medications,"
https://www.arkansasonline.com/news/2021/feb/03/for-the-patients/?opinion

[75] See, "Non-medical switching enacted laws,"https://aimedalliance.org/nonmedical-switching-enacted-laws/ "Non-medical switching," https://www.50statenetwork.org/all-issues/non-medical-switching/#TX , and "Non-medical switching bills announced in three more states," https://uspainfoundation.org/news/non-medical-switching-bills-announced-three-states/. See also, "Non-Medical Switching of Medications in Select States," https://www.cga.ct.gov/2017/rpt/2017-R-0201.htm, noting limits on formulary changes can also discourage switching, e.g., Maryland law http://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gin&section=15-1633&enactments=False&archived=False, Note RI Senate Bill 496 did not pass http://webserver.rilin.state.ri.us/BillText/BillText21/SenateText21/S0496.pdf (requiring formularies only be changed at renewal), and article also notes California requires insurers to cover medically necessary drugs, even if they are not in the formulary, and this kind of law may also act to lower instances of non-medical switching).

[76] CVS is the 4th largest U.S. corporation (by revenue), https://www.marketwatch.com/story/walmart-amazon-and-apple-top-the-2021-fortune-500-list-heres-what-they-have-in-common-11622655756

[77] See https://www.forbes.com/sites/greatspeculations/2020/01/03/what-are-cvs-healths-key-sources-of-revenue/?sh=6452942a2837, and https://dashboards.trefis.com/data/companies/CVS/no-login-required/MX1D0hKT/CVS-Health-Revenues-How-Does-CVS-Make-Money-, noting, "CVS's Pharmacy Services (PBM) segment expected to be the single-biggest revenue driver with $149 Billion in revenues (46% of Total Revenues) in 2021" and "CVS Pharmacy Services (PBM) segment will also be the fastest-growing segment (in percentage terms) - growing 11% over 2018-2021 to add $14 Billion to the top line over this period (15% of $96 Billion in incremental revenues)"

[78] See, e.g., "Tax-Exempt Lobbying: Corporate Philanthropy as a Tool for Political Influence, "
https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20180615

[79] See https://cvshealth.com/social-responsibility/corporate-social-responsibility/political-activities-contributions, and separate annual statements, e.g., CVS 2019-11 political contributions:
https://cvshealth.com/sites/default/files/cvs-health-political-activities-and-contributions-2011-to-2019.pdf, see also , https://theintercept.com/2021/04/21/cvs-lobby-health-insurance-medicare-for-all/ , ($5 million to Partnership for America's Healthcare Future, who heavily lobbies against single payer)

[80] See, e.g., https://www.rilegislature.gov/Special/comdoc/House%20Corporations/03-02-2021--H5438--PCMA.pdf , March 2, 2021 PCMA testimony by Sam Hallemeier opposing H.5438, a 2021 RI bill that would have allowed patients to have coupons count towards their co-pay or deductible, http://webserver.rilin.state.ri.us/BillText/BillText21/HouseText21/H5438.pdf

[81] See https://cvshealth.com/social-responsibility/corporate-social-responsibility/political-activities-contributions, and separate annual statements, e.g., CVS 2019-11 political contributions: https://cvshealth.com/sites/default/files/cvs-health-political-activities-and-contributions-2011-to-2019.pdf, and see, e.g., http://webserver.rilin.state.ri.us/BillText/BillText21/SenateText21/S0381A.pdf (proposal to prohibit health plans that provide prescription drug coverage from including an annual or lifetime dollar limit on drug benefits) passed Senate, no House version.

[82] "CVS Threatens Job Loss Because Of Chafee Tax Credit Cuts," https://www.golocalprov.com/news/cvs-threatens-job-loss-because-of-chafee-tax-credit-cuts

[83] https://subsidytracker.goodjobsfirst.org/prog.php?parent=cvs-health ,

[84] https://drugstorenews.com/news/report-cvs-caremark-contributes-12-billion-rhode-island-economy

[85] https://www.careerinfonet.org/oview6.asp?printer=&next=oview6&id=&nodeid=12&stfips=44&group=1, a site Sponsored by the U.S. Department of Labor. 3,000 is about 0.6 % of the approximately 500,000 people employed in RI and about 1% of the 300,000 people CVS employs nationally.

[86]http://www.tax.ri.gov/reports/Tax%20Credit%20and%20Incentive%20Reports/FYE2016%20Tax%20Credit%20&%20Incentive%20Report.pdf and https://turnto10.com/i-team/nbc-10-i-team-massive-layoffs-at-cvs.

[87] https://www.providencejournal.com/news/20190318/ri-medicaid-tax-targets-many-of-states-biggest-employers

[88] EOHHS has stated it seeks, "Transition the Medicaid payment system away from fee-for-service to alternative payment models." And "Implement value-based payment models that create incentive structures to orient the system to better respond to individual's comprehensive needs and reward models of accountable care delivery that demonstrate improved health outcomes and cost containment." https://files.constantcontact.com/9309e48c001/b857e0c1-14ff-4fe1-b870-2a468ed64cab.pdf. MCO contracts may be found here: https://eohhs.ri.gov/providers-partners/medicaid-managed-care

[89] "Want to cut Rhode Island Medicaid costs? Stop ignoring the elephant in the room: MCOs," https://upriseri.com/want-to-cut-rhode-island-medicaid-costs-stop-ignoring-the-elephant-in-the-room-mcos/ , and https://e1754d9001b9.filesusr.com/ugd/f4ce4b_a73b12ecdae646c4aa6b1909dd1e8b7e.pdf (research in support of bills asking for RI MCO investigation and deprivatizing Medicaid)

[90] See http://www.oag.state.ri.us/reports/sa2009.pdf ,
http://www.oag.state.ri.us/reports/sa2010.pdf ,
http://www.oag.state.ri.us/reports/sa2011.pdf
http://www.oag.state.ri.us/reports/sa2012.pdf
http://www.oag.state.ri.us/reports/sa2013.pdf
http://www.oag.state.ri.us/reports/SA_RI_2014.pdf
http://www.oag.state.ri.us/reports/SA_RI_2015.pdf
http://www.oag.state.ri.us/reports/SA_RI_2016.pdf
http://www.oag.state.ri.us/reports/SA_RI_2017.pdf
http://www.oag.state.ri.us/reports/SA_RI_2018.pdf
http://www.oag.state.ri.us/reports/SA_RI_2019.pdf

[91] "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-pharmacy-benefit-administration/

[92] See "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx#/ and "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020," https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/

[93] According to its website:

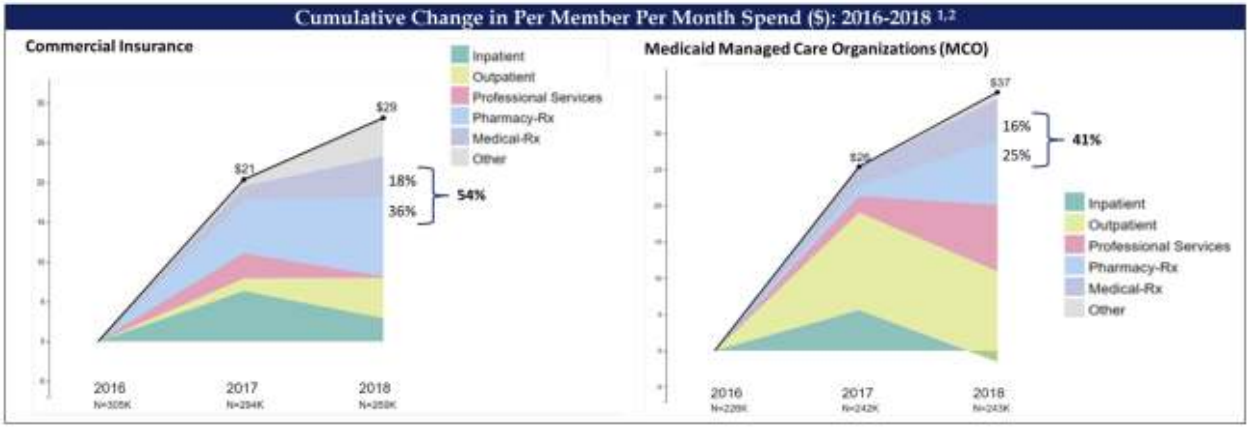
When insurers violate Rhode Island law, the commissioner has broad powers to step in and set things right. Not only can the commissioner write a legally-binding order forcing the insurer to ceasing [sic] its harmful practices, but he or she can also fine the company or demand that it pay damages to consumers.[93]

[94] E.g.,

- allowed premium increases during the pandemic despite high insurer profits and requests from the RI Attorney General not to raise premiums because increases were unjustified, see https://www.ri.gov/press/view/39087 , (RI Attorney General submitted actuarial reports to OHIC concluding that, even before the affordability of an increase is factored in, there is not an actuarial basis for an increase of more than 1.2% for BCBSRI and 0.6% for NHPRI)
- instituted a "reinsurance" program that pumps federal taxpayer subsidies to insurers without lowering premiums for low income and uninsured patients. See https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/benefits-limitations-state-run-individual-market-reinsurance#append1, and https://www.cbpp.org/research/health/reinsurance-basics-considerations-as-states-look-to-reduce-private-market-premiums
- created a "Market Stability Workgroup" whose mission was to develop "state-level solutions to keep Rhode Island's health insurance markets stable," i.e., profitable for insurers, http://healthsourceri.wpengine.com/state-of-rhode-island-convenes-workgroup-to-address-health-insurance-market-stability-protect-against-threats-to-coverage-and-affordability/
- allowed Blue Cross Blue Shield of RI (BCBS-RI) to "donate" $5 million to The Rhode Island Foundation, rather than pay a traditional fine, for improperly denying members medical benefits – thus, allowing BCBS-RI to avoid negative publicity and compensating actual victims. See https://www.usnews.com/news/best-states/rhode-island/articles/2018-09-18/blue-cross-to-pay-5-million-for-mental-health-fund , http://www.ohic.ri.gov/documents/OHICpressreleaseBCBSRIexamreport09.17.2018.pdf,

See also, https://upriseri.com/2020-12-08-patrick-tigue/

[95] See, e.g., https://www.pgpf.org/blog/2018/09/how-will-the-rising-cost-of-prescription-drugs-affect-medicare (noting, "The rise in prescription drugs costs can be attributed to many factors," and citing another "report" that also ignores insurers and PBMs at https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-review-of-2017-outlook-to-2022). http://www.ohic.ri.gov/documents/2021/April/April%202021%20Newsletter%20(1).pdf (OHIC April 2021 report citing: https://www.pgpf.org/blog/2019/11/why-are-prescription-drug-prices-rising-and-how-do-they-affect-the-us-fiscal-outlook (Peterson Foundation study concluding: "The rising cost of prescription drugs is a key driver of overall healthcare spending in the U.S."); and http://newsletter.convergenceri.com/stories/prescription-drugs-not-utilization-are-driving-high-health-costs-in-ri,6264, showing this OHIC chart:



According to the 2020 OHIC report:

"Pharmacy spend is a significant and growing fraction of total per capita health care costs in Rhode Island. The analysis found that pharmacy price increases, not number of prescriptions, is driving spending in the state, showing

more than half (54%) of the increase in total commercial medical spending was driven by growth in pharmacy costs. In Medicaid managed care, pharmacy cost growth accounted for nearly half (41%) of total medical spend." http://www.ohic.ri.gov/documents/2021/January/Annual%20Cost%20Trends%20Report%202020.pdf

[96] See, e.g., http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php, e.g., In its latest April 2021 report, OHIC notes:

> *A best-practice example of cost driver analysis comes from the Washington Health Alliance. The Alliance looks at four factors contributing to cost growth by major service category. The four factors are change in a) service intensity, b) unit price, c) patient characteristics, and service frequency.*
> *http://www.ohic.ri.gov/documents/July%202019/Stakeholder%20Meeting/Data%20Use%20Strategy%20Recommendations%202019%205-17.pdf*

And fails to even mention PBMs in its annual December 2020 Annual report, *http://www.ohic.ri.gov/documents/2021/January/Annual%20Cost%20Trends%20Report%202020.pdf*
In sharp contrast to Massachusetts studies at https://www.mass.gov/info-details/hpc-datapoints-issue-12-cracking-open-the-black-box-of-pharmacy-benefit-managers and Massachusetts' Health Care Trends Project.

[97] Is a "private-public partnership" funded by a $550,000 grant from the Peterson Center on Health Care (PCHC), PCHC-sponsored health care cost analyses fail to analyze middlemen insurers and PBMs as cost drivers.

[98] https://www.nytimes.com/2018/03/20/obituaries/peter-g-peterson-dies-power-from-wall-st-to-washington.html?.?mc=aud_dev&ad-keywords=auddevgate&gclid=CjwKCAjw64eJBhAGEiwABr9o2HAxOJ6sfuOo69iLmZwe6_lPZVgyOXazkm-zvmkxTVsKFXOXASj-gBoCoGoQAvD_BwE&gclsrc=aw.ds and "The Deficit Hawks' Attack on Our Entitlements," https://pnhp.org/news/the-deficit-hawks-attack-on-our-entitlements-2/

[99] See, e.g., Peterson Center on Healthcare, "Strategies for Change," https://petersonhealthcare.org/strategies-for-change, and "A Data Use Strategy for State Action to Address Health Care Cost Growth," https://www.milbank.org/wp-content/uploads/2021/06/Peterson-Milbank-Data-Use-Strategy_6.pdf

[100] RI Health Care Cost Trends Project, http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php

[101] Legislation asking for another $500,000, paid for by private insurers, was held for further study http://webserver.rilin.state.ri.us/BillText/BillText21/SenateText21/S0984.pdf (note: sponsor alleges the Cost Trends Project was necessary to allow OHIC to keep premiums lower, but cites no proof and does not explain why RI Attorney General analyses were not sufficient).

[102] See, e.g., RI Health Care Cost Trends Project, http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php and http://www.ohic.ri.gov/documents/2021/January/Annual%20Cost%20Trends%20Report%202020.pdf

[103] See, "The high cost of living – and health care," http://www.convergenceri.com/stories/the-high-cost-of-living-and-health-care,6519, noting, "The per capita total health care expenditures in Rhode Island rose from $7.001 billion in 2017 to $7.309 billion in 2018, a 4.4 percent increase, 28 percent higher than the [RI Health Care Cost Trends project] goal of 3.2 percent." In addition, the Rhode Island "all-payer claims database" – which does not cover a significant portion of payer claims – may not have provided useful data.
See https://health.ri.gov/materialbyothers/RIAllPayerClaimsDatabaseTechnicalSpecificationsManual.pdf

[104] E.g., (from 2018 steering committee list)

- **Kim Keck**, Project Co-Chair, President and CEO - Blue Cross Blue Shield of Rhode Island;
- **Stephen Farrell**, President and CEO - United Healthcare of New England;
- **Peter Marino,** President and CEO, Neighborhood Health Plan of RI
- **Tom Croswell,** CEO, Tufts Health Plan
- **Peter Hollmann, MD** - 20 years as a part-time medical director of Blue Cross and Blue Shield of RI;
- **Anya Rader Wallack -** Held key positions (including the presidency) at the Blue Cross Blue Shield of Massachusetts Foundation.

[105] E.g.,

- **Al Charbonneau,** Executive Director, RI Business Group on Health (RIBGH). The "platinum" and "gold" sponsors of RIBGH include: Blue Cross Blue Shield of RI, Aetna, UnitedHealth, Neighborhood Health Plan, and Tufts Health Plan.
- **Sam Salganik,** Executive Director, Rhode Island Parent Information Network (RIPIN) - RIPIN lists as its major "funders and partners:"
    - CVS Health Care Classic
    - Neighborhood Health Plan of RI
    - Tufts Health Plan
    - Tufts Health Plan Foundation
    - United Healthcare

  RIPIN Board Chair, Casey L. Stockman, PharmD, works for Neighborhood Health Plan of RI

Also note: Corporate donations are also difficult to track, see, e.g., https://www.theatlantic.com/education/archive/2017/04/public-universities-get-an-education-in-private-industry/521379/

[106] E.g.,

- **Betty Rambur,** University of RI College of Nursing – Accountable Care Organization advocate from Vermont, See https://vtdigger.org/2020/12/20/patrick-flood-onecare-the-unaccountable-aco/ and https://www.healthaffairs.org/do/10.1377/hblog20161122.057616/full/ (identifies fee-for-service as cause of high healthcare costs, not middlemen insurers) https://www.youtube.com/watch?v=_Gl3--psFx0&ab_channel=UpriseRI
- **Al Kurose,** MD, MBA, Co-chair, Coastal Medicine (an ACO) – A member of the OHIC's Alternative Payment Methodology Committee that developed "affordability initiatives" that focused on reining in providers and never considered how middlemen insurers and PBMs were imposing unnecessary costs. http://www.ohic.ri.gov/documents/PressRelease-Affordability-Standards-2016-2017-New-Plans-FINAL.pdf
- **Neil Steinberg,** Rhode Island Foundation (RIF) – In 2020, co-chaired an RIF study, Health In Rhode Island: A Long-term Vision, with many of the same parties involved in the RI Health Care Cost Trends Project, which ALSO does not mention middlemen insurers or PBMs as possible healthcare cost drivers.
- **Michael Bailit**, President of Bailit Health, a lead author of the RI Health Care Cost Trends Project final report and other Peterson-Milbank Program for Sustainable Health Care Costs reports which do not consider insurers or PBMs as potential health care cost drivers. See, e.g., "A Data Use Strategy for State Action to Address Health Care Cost Growth, https://www.milbank.org/wp-content/uploads/2021/06/Peterson-Milbank-Data-Use-Strategy_6.pdf

[107] See, e.g., "Transformation of the Health Care Industry: Curb Your Enthusiasm?" https://onlinelibrary.wiley.com/doi/abs/10.1111/1468-0009.12312, and "[CMS head] Verma says value-based care provides a 'very poor return in investment'," https://pnhp.org/news/verma-says-value-based-care-provides-a-very-poor-return-in-investment/ (Noting: "Value-based payment," i.e., paying a fixed amount per patient regardless of the amount of care rendered or "capitation," incentivizes a lower volume of care, but unfortunately, "programs that disproportionately serve high-risk patients may be at particular risk of receiving financial penalties."); ,"Medicare Value-Based Payment Program penalizes more dedicated physicians," https://pnhp.org/news/medicare-value-based-payment-program-penalizes-more-dedicated-physicians/ and "Projected costs of single-payer healthcare financing in the United States: A systematic review of economic analyses," https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003013.

Widely practiced by HMOs in the 1990s, capitation was an utter failure and an enormous distraction from the actual causes of the rising costs of care: the inefficient multi-payer system, which causes about 1/3 of every health care dollar spent by the US to not go towards actual healthcare. https://pnhp.org/news/managed-cost-mismanaged-care/ . Capitation has never been shown to improve quality of care and necessarily pits the financial interests of physicians against those of their patients because it creates a financial incentive for providers to get rid of patients who are non-compliant or unable to achieve the "quality measures" that are tied to their

reimbursement. Providers should not be encouraged to do what is currently practiced by all private insurance companies and is referred to as “cherry picking” and “lemon dropping.”
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4880224/