



## STOP PHARMACEUTICAL BENEFIT MANIPULATION PRINCIPLES FOR PBM REFORM

### Help to Preserve Patient Access to Pharmacies by Addressing PBMs' Retroactive Pharmacy Fees

- **Retroactive DIR Fees/Claw backs** – Pharmacy access can be undermined when health plans and their middlemen, PBMs, arbitrarily “claw back” fees retroactively from pharmacies weeks or months after a claim has been adjudicated/processed. This manipulation of pharmacy reimbursement may diminish access to care (*e.g., pharmacies being forced to close their doors or pare back hours and healthcare services*) when PBMs are unpredictable and not transparent, and when payment falls below a pharmacy’s costs to acquire and dispense prescription drugs. Policymakers should prohibit payers or PBMs from retroactively reducing and/or denying a processed pharmacy drug claim payment, and obligate them to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points for care.

### Provide Fair and Adequate Payment for Pharmacy Patient Care Services

- **Reasonable Reimbursement & Rate Floor** – Pharmacy access remains at risk when PBMs reimburse pharmacies below the cost to acquire and dispense prescription drugs. Pharmacy reimbursement that falls below the costs to acquire and dispense prescription drugs threatens future sustainability for pharmacies to provide valuable medication and pharmacy care services to communities. To help maintain robust public access to pharmacies, policymakers should adopt a reimbursement rate floor that requires PBMs to use comprehensive reimbursement models that are no less than the true cost to purchase and dispense prescription drugs.
- **Standardized Performance Measures** – A crucial part of comprehensive DIR fee reform is advancing pharmacy quality that improves outcomes for beneficiaries and drives value in care – which are essential to controlling costs in the healthcare system. Arbitrary performance measures developed by PBMs assess the performance of the pharmacy without pharmacies’ input, and they create a moving target for pharmacies to show value and improve health outcomes. Measures vary across the various plans and dictate DIR fees (or claw backs at the state level) imposed on pharmacies, as well as help create substantial system dysfunction and unnecessary spending in the Part D program. Policymakers should standardize PBMs’ performance measures for pharmacies to help set achievable goals for pharmacies before signing a contract, and to promote harmonization in the healthcare system and improvements in health outcomes.

### Protect Patient Choice of Pharmacies

- **Specialty** – Some PBMs require patients with rare and/or complex diseases to obtain medications deemed “specialty drugs” from designated “specialty pharmacies” or mail-order pharmacies. This impedes patients’ access to their convenient local pharmacies where specialty drugs are filled as well. Prescription drugs should not be classified as “specialty drugs” based solely on the cost of the drug or other criteria used to limit patient access and choice—instead, definitions should focus on clinical aspects such as requiring intensive clinical monitoring. Policymakers should establish appropriate standards for defining and categorizing specialty drugs to ensure comprehensive and pragmatic patient care and access. Policymakers should prohibit PBMs from steering patients to only specialty pharmacies, including those owned by the PBMs, for their prescription needs.

- **Mail Order** – Medication access and care can be weakened when PBMs manipulate the system by requiring patients to use mail-order pharmacies only. Some plans impose penalties such as higher copays or other financial disincentives for choosing a retail pharmacy instead of a mail-order pharmacy which is often owned by the PBM. Policymakers should support patient choice and access by enacting laws to prohibit PBMs from requiring or steering patients to use mail-order pharmacies.
- **Any Willing Pharmacy** - Due to PBMs' network and contract barriers, pharmacies willing and ready to serve patients may be ineligible to provide important pharmacy services, and patients may experience unnecessary delays and interruptions in patient care. Patients should have the choice and flexibility to utilize the pharmacy that best meets their healthcare needs. Policymakers should require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM. This will help to maximize patient outcomes and cost savings.

### **Enforce Laws to Stop PBM Manipulation and Protect Pharmacies and Patients**

- **Audits** – PBMs routinely conduct audits to monitor a pharmacy's performance and reverse or claw back pharmacy payments when there are alleged issues with a particular pharmacy claim. PBM audits interrupt the pharmacy workflow, can extend wait times, and detract attention from the quality of care patients receive. Policymakers should support fair pharmacy audit practices to ensure timely patient care delivery at community pharmacies and bring efficiency, transparency, and standardization to the PBM audit process.
- **Oversight Authority** – There are growing concerns that pro-patient, pro-pharmacy public policy successes might be undercut if PBMs fail to comply with new laws and regulations – and/or if states fail to fully enforce them. Such failure could significantly impact pharmacy reimbursement and overall patient access. Policymakers should establish and enforce laws already on the books to regulate harmful PBM reimbursement practices that may harm patients and the healthcare system as we know it, especially at the pharmacy counter, and empower state regulators to do the same to enforce PBM transparency and fair and adequate pharmacy reimbursement.