From:	Ben Vondra
To:	ETF SMB Board Feedback; ETF SMB Board Feedback
Subject:	Pharmacy Benefit Manager Feedback - November GIB Meeting
Date:	Monday, November 7, 2022 3:00:11 PM
Attachments:	AMA Transparency, regulation needed to rein in pharmacy benefit .pdf AHA urges FTC to investigate certain pharmacy benefit manager practices.pdf Remarks-Lina-Khan-Economic-Liberties-National-Community-Pharmacists-Association.pdf Stat news. What does PBM stand for In many states, it"s programs bilking millions.pdf Oregon PBM New Study Inequity in PBMs' Drug Pricing Practices in OR Raises Serious Qu.pdf

---

TO: Group Insurance Board (GIB)
RE: Pharmacy Benefit Manager (PBM) Feedback

Links referenced in this message are also attached as PDFs.

Recently, several of my family members covered by the Group Health Insurance Pharmacy Benefit Program received a letter from the PBM (Navitus) with the heading "PHARMACY TERMINATION NOTICE" informing us that our beloved local, independent pharmacy would no longer be included in the Pharmacy Benefit Program due to an impasse in contract negotiations. The letter urged us to quickly shift our prescriptions and services to another pharmacy in order to avoid a gap in covered benefits. We love our pharmacy. We were devastated.

Several days later we contacted our pharmacy to discuss the process of transitioning to a new provider. We were surprised to learn from the pharmacy that they were aware of the letter and that it was no longer accurate - a contract had been signed between the parties, allowing us to continue to patronize the pharmacy. While this news brought significant relief it also created questions of why such a letter would be sent. Upon further investigation it appears that Navitus provided similar letters to any affected member who had services at an independent pharmacy under contract negotiations. It also became clear that Navitus sent the letters with the knowledge that contract negotiations will likely result in an agreement and not require covered members to change pharmacies. It's unclear if members who were customers of large pharmacies under contract negotiation at the same time were sent similar letters.

What was Navitus' motive for sending out a "PHARMACY TERMINATION NOTICE" to customers of independent pharmacies months before the end of the calendar year if they suspected contract negotiations would result in a signed contract? While Navitus argued that their motive was to allow ample time for members to transition their prescriptions and services we strongly suspect the motive is connected to the demonstrated PBM business practice of reducing competition by favoring large pharmacies. Indeed, Navitus is owned by companies who themselves have interest in consolidating pharmacy services - and are large pharmacies themselves, and have a controlling interest in the Navitus Governance Board. This motive is not in line with the ETF's mission to support members.

I urge the Board to take the following action at the November 16 meeting.

1. Reject ETF staff recommendation to extend Navitus contract for one year beyond the period authorized in the original solicitation

Agenda Topic #9 includes Board Action to approve a request from ETF staff to forgo standard solicitation practice by extending the current PBM contract period for an additional year, beyond the maximum period identified in the original solicitation. ETF staff cite Navitus' positive reviews and avoiding disruption due to a change in provider. Staff's assertions are reasonable but do not outweigh the importance of issuing a new solicitation for the following reasons:

- Proper solicitations for services ensures competitive bidding results in the most cost effective and appropriate vendor chosen
- Potential disruptions are present with any vendor change at any time, and are not cause to delay a solicitation
- Navitus has been the PBM for many years, and delaying the solicitation risks loosing additional savings provided by a competitive bid
- ETF staff will be unable to negotiate beneficial terms if Navitus knows a competitive bid is not being issued
- The PBM market continues to experience consolidation and vertical integration, making waiting to solicit bids another year risky due to dwindling PBM competition
- IT modernization efforts are neither temporary nor take precedence over the Pharmacy Benefit Program. There will always be some degree of IT disruption when contracts are rebid or vendors change.

2. Direct ETF staff to begin investigations to decouple the Pharmacy Benefit Manager model from Group Health Insurance

Recent studies and reports continue to show PBM's value to health outcomes and health plans is overstated and possibly detrimental. Indeed, the American Medical Association (AMA)(1) and American Hospital Association (AHA)(2) have publicly called for more scrutiny of PBMs and recently urged the Federal Trade Commission to investigate questionable PBM business practices such as "white bagging" and vertical integration with health plans, which drive down choice for patients and drive up costs for health plans. Moreover, a recent review in Oregon(3) revealed the startling realities of a PBM model gouging the state for millions while ill patients had medications either unavailable or unattainable due to high costs. Oregon is not the only state that's been bilked for millions by PBMs.(4)

Further, I urge you to review recent remarks from Federal Trade Commission Chair Lina M. Khan regarding PBM business practices(5). The FTC received one of the largest number of comments on a single issue when they requested feedback on PBM's business practices. The FTC Chair acknowledges PBM's role in increased drug pricing and reduced patient access, as well as the troubling connection between PBMs and the accelerated closure of independent community pharmacies.

Congress has taken notice and introduced legislation that, "requires the Government Accountability Office to report on the role of pharmacy benefit managers in the

pharmaceutical supply chain and recommend legislative actions to lower the cost of prescription drugs". The alarm bells are sounding at the Federal Government about PBMs and their questionable value to health care in America. The Wisconsin Group Insurance Board must take notice and act to divest Wisconsin Group Health Insurance from the PBM model.

In closing, I'd like to share a few ways that our family and community has benefitted by partnering with a local, independent pharmacy for many years. This pharmacy has provided:

- my children with critical medicines (and compassion and patience when those medicines are delivered via needle);
- personalized counseling and exceptional customer service;
- our school district with major vaccine clinics on short notice;
- our youth groups and community events with numerous sponsorships;
- local vendors with a location to showcase their products;
- local, high paying jobs and internship opportunities;
- local accountability - no corporate structure to report to;
- and much more value to our family and community.

I fear that GIB's continued reliance on Navitus and the PBM model will result in higher drug costs, lower access, and the loss of a treasured local pharmacy.

Thank you,

Ben Vondra
Mount Horeb, WI

Links
(1) https://www.ama-assn.org/press-center/press-releases/transparency-regulation-needed-rein-pharmacy-benefit
(2) https://www.aha.org/news/headline/2022-05-24-aha-urges-ftc-investigate-certain-pharmacy-benefit-manager-practices
(3) https://insurancenewsnet.com/oarticle/new-study-inequity-in-pharmacy-benefit-managers-drug-pricing-practices-in-oregon-raises-serious-questions
(4) https://www.statnews.com/2018/06/29/pharmacy-benefit-managers-profits-ohio/
(5) https://www.ftc.gov/system/files/ftc_gov/pdf/Remarks-Lina-Khan-Economic-Liberties-National-Community-Pharmacists-Association.pdf

Newswires

N

O P

New t dy l eq ty P a macy Be efit Ma age s D g P c g P act ces O ego Ra ses e o s Q est o s

n m d v d n d dv n d
n nd n n n m d

W B W R
P P
PB
d d
d PB
W B
PB
P B
$ B
$ 8 $
W
P P W

B
B
PB 7
B
B

B P
P

W

P P
W

A P A
P P 8

7 7 8

P
8
P

O g
S
w PW
y

u P v y y DISQUS

O D R N R
M U C G M ffi m C N G
m C m
N N H m
N
M
M M
M
M
O D O N
O H H P O N N MO U NC

AMERICAN EQUITY
O U N

P S O S C NS U C MP N
M
M

GN P O U N
C N P ON

O O R OR
NS R NC N SN
V G D N

PR DS R S
M

UR D O S
M
M
M

P SSR S S P
M
M

STAT

UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

Office of the Chair

Remarks of Chair Lina M. Khan
American Economic Liberties Project and the
National Community Pharmacists Association
How Pharmacy Benefit Managers Impact Drug Prices,
Communities, and Patients

June 22, 2022

Thank you to the American Economic Liberties Project and the National Community Pharmacists Association for organizing this important event. Thank you to Senator Brown and Representative Carter for your unrelenting efforts to shed light on the problems in these markets, and thank you to all the patient advocates and medical professionals for sharing your thoughts and expertise to help me and the FTC fully grasp the business practices we're seeing and their effects.

Pharmacy benefit managers ("PBMs") and other intermediaries now play a critical role that have enormous consequences on people's day-to-day lives. Their decisions help to determine which medicines are prescribed, which pharmacies patients can use, and the prices that patients ultimately pay at the pharmacy counter. They also can determine whether independent pharmacies can compete and thrive, which—given the key role that community pharmacies play in providing efficient and affordable access—is critical.

Not only does the PBM industry play a central role in determining which medicines and pharmacies we can access and at what price, the market in which they operate is also extremely opaque and complex. This combination—of, on the one hand wielding extraordinary influence that can have life-and-death consequences, and, on the other, of being extraordinarily opaque and complex, is a combination that's always worth scrutinizing.

As the FTC has sought to update its understanding of this important market, we've been aided by many people in the patient advocacy community and the pharmacy and medical community. In February, we put out a call for comments on PBMs' practices and their impact, and we received more than 1,200 individual comments from more than 24,000 parties, which is one of the largest number of comments the FTC has received on a single issue.[1] We've also had many patient advocates, pharmacists and health care professionals come speak at our open

[1] Regulations.gov, Solicitation for Public Comments on the Impact of Prescription Benefit Managers' Business Practices, FTC-2022-0015, https://www.regulations.gov/docket/FTC-2022-0015 (comment period closed on Apr. 25, 2022).

meetings. The participation and engagement has been remarkable, and I'm extremely grateful.[2] I always find that hearing directly from market participants—the people on-the ground level that are actually producing and consuming goods and services and operating directly in these markets—is vital for understanding how markets are functioning.

As you know, partially in response to this striking number of comments, the Federal Trade Commission recently voted to conduct a market inquiry of pharmacy benefit managers.[3] In practice this means that we sent out orders requesting information from PBMS that will shed light on a variety of issues. We're looking at a number of issues—many of the issues that we heard recurring concerns about. This includes unfair fees and clawbacks, reimbursement terms that may pay pharmacies below their costs of acquisition, methods that steer patients to PBM-owned specialty and mail-order pharmacies, pharmacy audits, the impact of PBM rebates on generic and biosimilar competition and ultimately patient's costs, as well as the increasing use of prior authorization and related requirements and their impacts on physicians.

The FTC also recently voted in favor of an enforcement policy statement, which lays out how our existing legal tools and authorities apply to PBMs' rebating practices.[4] Specifically, we noted our intention to examine the effects of the rebates that drug manufacturers pay to PBMs.[5] We've heard concerns that these rebates might function as "kickbacks," and that drug manufacturers may effectively be paying PBMs to exclude cheaper drugs—like generics and biosimilars—from their formularies, which in practice means that fewer patients have access to more affordable medicines, and they're instead left paying more money, or not being able to afford medicine at all.

At our commission meetings, we've heard devastating accounts of how people have lost family members who've had to forego or ration essential medicines because of the high cost.[6] We've heard a striking number of these stories in the context of insulin, where the wholesale price nearly tripled between 2009 and 2017.

---

[2] *See e.g.*, Fed. Trade Comm'n, Tr. of Open Comm'n Meeting, at 14-15, 19-20 (Oct. 21, 2021), www ftc.gov/openmeetingtranscript.pdf.

[3] Press Release, Fed. Trade Comm'n, FTC Launches Inquiry Into Prescription Drug Middlemen Industry (June 7, 2022), https://www ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry.

[4] *See* Press Release, Fed. Trade Comm'n, FTC to Ramp Up Enforcement Against Any Illegal Rebate Schemes, Bribes to Prescription Drug Middleman That Block Cheaper Drugs (June 16, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-ramp-up-enforcement-against-illegal-rebate-schemes; *see also* Fed. Trade Comm'n, Policy Statement of the Federal Trade Commission on Rebates and Fees in Exchange for Excluding Lower Cost Drug Products, FTC File No. P221201 (June 16, 2022), https://www ftc.gov/legal-library/browse/policy-statement-federal-trade-commission-rebates-fees-exchange-excluding-lower-cost-drug-products.

[5] *See* Policy Statement of the Federal Trade Commission on Rebates and Fees in Exchange for Excluding Lower Cost Drug Products, at 5-6.

[6] *See* FTC Open Meeting Tr., *supra* note 2, at 14 -15, 18-19 (public commenters Matthew Dinger, Anna Squires, and Nicole Smith Holt).

I am so thrilled that the FTC was able to make headway on getting these two important actions started. These actions are just the first steps, and we still have a long road ahead. As we noted last week, if we find any illegal practices in these markets—be it unfair methods of competition, or commercial bribery practices, or unfair or deceptive practices—we'll be sure to bring our full authorities to bear and enforce the law.

I want to close with two broader observations.

First, it's so critical to remember that the current structure of the market, the current structure of the industry, and the types of business practices that occur are not inevitable or some inexorable force of nature. These features of our current system are the result of policy choices and legal decisions that were made by people, including officials at the FTC and Antitrust Division, but also public officials who are elected and directly accountable to you.

It was policy choices that permitted PBMs to merge with one another, creating a more concentrated market. It was policy choices that permitted PBMs to vertically merge with health insurance companies on one side and specialty and retail pharmacies on the other side, which many have noted can create a sharp conflict of interest. It was policy choices that allowed the largest insurance companies and hospitals and private equity companies to buy up thousands of physician practices, which many have claimed has degraded patient care. And it was policy choices that have created a situation where Americans pay tens of billions of dollars for prescription drugs that were originally researched and developed with taxpayer funding, sometimes many decades ago.

There is nothing inevitable about the current structure of the market or the current business practices that occur and are permitted—these are all the result of policy and legal choices, that were made by public officials, and that can also be remade by public officials through the democratic process.

Second, while the FTC has a critical role to play here, we are just one of many public entities whose work can make a difference here. The responsibility for crafting how our healthcare markets work is divided among dozens of state and federal authorities who are ultimately accountable to elected members of local, state, and federal legislative bodies. It's vitally important that this remarkable advocacy community remains engaged with this broader group of decisionmakers to educate them about which policies will make our markets work so that we can access affordable medicines and high-quality healthcare, including at pharmacies.

I say this to encourage everybody to view these questions of commerce as key democratic choices for all of us. These decisions and choices will be made regardless—it's just a question of who is making them and with what goals and what accountability.

I hope everybody here—the patient advocates, the pharmacists, the other healthcare providers, and the concerned citizens—will remain fully engaged to ensure your voices are heard

at all levels of government. We've certainly benefited from your active engagement at the FTC, for which I'm very grateful, and I'm hopeful that together we'll be able to make real progress.

***

AHA urges FTC to investigate certain pharmacy benefit manager practices

May 24, 2022 - 02:40 PM

AHA today urged the Federal Trade Commission to scrutinize commercial health plans that steer patients to third-party specialty pharmacies in which they have a financial interest. These practices, commonly referred to as "white bagging," disallow health care providers from procuring and managing the drugs they administer to patients, resulting in significant patient safety concerns, frequent delays in care, and a tremendous administrative burden on hospitals to reconcile these policies on behalf of their patients, AHA wrote, responding to a request for public comments on PBM business practices.

"As large health plans engage in broad vertical integration efforts, including the acquisition of PBMs and specialty pharmacies, the practice of mandated white bagging has increased dramatically," forcing hospitals and health systems "to navigate substantial supply chain and logistical challenges in order to continue to provide safe and effective care to the patients they treat," the letter notes.

AHA also urged the agency to scrutinize "the impact of PBM-negotiated rebates and other business practices on the 340B drug discount pricing program and overall drug prices and drug price increases."

Learn more about AHA's concerns with white bagging policies in this AHA podcast and infographic.

RELATED TOPICS: Mergers & Acquisitions | Commercial Insurer Accountability | Patient Safety Risk

Related News Articles

CHAIRPERSON'S FILE

Chair File: Helping Americans Get Affordable, Comprehensive Health Coverage

Two issues that a majority of Americans have agreed on during this election cycle are concerns about the economy and inflation. People are worrying about the…

HEADLINE

AHA survey: Some commercial health insurer policies delay care, raise costs

AHA today released a new report and infographic showing how some commercial health insurers, including Medicare Advantage plans, can cause dangerous delays in…

HEADLINE

AMA study: Pharmacy benefit manager market highly concentrated, integrated with insurers

The market for pharmacy benefit manager services is highly concentrated, with commercial insurers often sharing ownership in the PBM, according to an analysis…

BLOG

CBO's Proposals Do Not Address The Real Causes of Rising Commercial Health Insurance Premiums

The Congressional Budget Office (CBO) recently released a paper that includes several policy options ostensibly intended to reduce health insurance premiums.…

PERSPECTIVE

Speak Up, Be Heard and Exercise Your Right to Vote

Forty-six days from now on Nov. 8 millions of Americans will cast their ballots and exercise their most sacred right – the right to vote. That means that for…

HEADLINE

AHA calls for end to commercial insurer policies that hurt patients, raise costs

Some commercial insurer policies may hurt patients, contribute to clinician burnout and drive up the cost of care, AHA President and CEO Rick Pollack notes in…

PRESS RELEASES

Transparency, regulation needed to rein in pharmacy benefit

Bookmark

JUN 10, 2019

CHICAGO —With pharmacy benefit managers playing an increasingly pivotal role not only in drug pricing but also in administering patient drug benefits, the American Medical Association (AMA) today called for oversight and transparency for the lightly regulated industry.

The new policy, part of a report adopted at the AMA's Annual Meeting, responds to pharmacy benefit managers (PBMs)–middlemen–operating in a "black box" with limited transparency to show what goes on behind closed doors. As drug prices rise year after year, the AMA is concerned that the rebate process results in list prices above what they would be absent rebates, as neither PBMs nor manufacturers have an incentive to lower list prices.

The new AMA policy supports applying manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale to benefit patients – who rarely see the negotiated discounts that PBMs strike with drug companies and health plans. In addition, the new policy supports improved transparency of PBM operations, including disclosing financial incentive information as well as formulary information.

"It's time to pull back the curtain on pharmacy benefit managers and how their practices negatively impact patients. How is it that PBMs and health plans profit from negotiated discounts on prescription drugs, while patients pay co-pays based on high drug list prices that even the plans themselves are not paying?" said Russell Kridel, M.D., a member of the AMA Board of Trustees. "Because of market concentration and lack of transparency, patients and physicians are essentially powerless in the face of PBM pricing and coverage decisions."

The AMA's TruthinRx campaign seeks to expose the role PBMs play in drug pricing, along with pharmaceutical companies and insurers.

"Overall, regulators must better understand and control the costs to patients and the systems that are resulting from PBM practices," the report noted. The report's recommendations call for PBMs to be actively regulated under state departments of insurance. On the federal level, new policy underscores that PBMs, like health plans, should be subject to federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.

"PBMs have assumed the role of insurers but without having to face similar oversight. The ability of patients and physicians to have the information they need to make key decisions regarding medication, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by the often byzantine and confidential arrangements that are driving increased medication prices without a clear and justifiable reason.," Dr. Kridel said. "This lack of transparency makes it exceedingly difficult for physicians to determine what treatments are preferred by a particular payer at the point-of-care, what level of cost-sharing their patients will face, and whether medications are subject to any step therapy or other utilization management requirements. For patients, lack of transparency in their drug coverage may lead to delays in necessary medication treatment. Enough is enough. It's time to strongly regulate PBM practices and operations to protect our patients."

Media Contact:

Jack Deutsch
ph: (202) 789-7442
jack.deutsch@ama-assn.org

About the American Medical Association

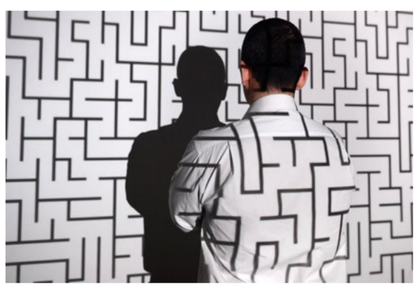
The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises and, driving the future of medicine to tackle the biggest challenges in health care.

More about: AMA Policies | Annual Meeting of the AMA House of Delegates

FEATURED STORIES

SCOPE OF PRACTICE

Keeping the scalpel and laser in ophthalmologists' hands



PRIOR AUTHORIZATION

8 prior authorization terms that drive every doctor crazy

PUBLIC HEALTH

What doctors wish patients knew about COVID-19 vaccine boosters

STATE OF WISCONSIN
Department of Employee Trust Funds
A. John Voelker
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

November 9, 2022

Ben Vondra
[redacted]

Dear Mr. Vondra:

Thank you for your email regarding the pharmacy termination notice from Navitus Health Solutions (Navitus), the Group Insurance Board's (Board's) Pharmacy Benefit Manager (PBM), your thoughts on potential Board action at the upcoming November 16, 2022, meeting, and the two pharmacy benefit related articles.

Receiving a letter stating that a long-trusted local pharmacy will no longer be in-network must have been very alarming to you and many of our members. Local pharmacies are the backbone of many communities throughout Wisconsin. Please know that ETF monitors all our vendors to make sure unwarranted communications are not sent.

Navitus alerted the Department of Employee Trust Funds (ETF) that AlignRx had stopped negotiating with Navitus in early September. Navitus stated that they would be sending the letter you received not only to ETF members but to all their clients' participants that use those pharmacies. Navitus also informed ETF that while these pharmacies had hired AlignRx to negotiate on their behalf as a group, the individual pharmacies could still come to Navitus and negotiate on their own.

Under section 135B, page 30, of the "State of Wisconsin Pharmacy Program Agreement" between the Board and Navitus, Navitus is required to issue written notices to members enrolled in the pharmacy benefit before the It's Your Choice Open Enrollment period and identify participating pharmacies that will not be in-network for the upcoming benefit period. This provision allows members to make informed decisions about pharmacy networks and providers during the Open Enrollment period. This requirement also gives members—some of whom have 90-day prescriptions—enough time to find an in-network pharmacy for their next prescription fill, which could happen shortly after the first day of the new benefit year.

Open Enrollment for 2023 took place from September 26, 2022–October 21, 2022. Navitus sending the September 22, 2022, letter to members is consistent with the requirements of Navitus's contract with the Board. At the time the letter was sent by Navitus, the pharmacy referenced in your letter was not under contract with Navitus to be an in-network pharmacy on January 1, 2023.

On October 3, 2022, Navitus informed ETF that they and AlignRx had come to an agreement. Navitus would be issuing another letter to all participants who had received the September 22, 2022, letter informing them that an agreement had been reached and that their pharmacy would not be leaving the network. Navitus sent this second letter to ensure members had all the information about their pharmacy coverage in 2023 before the end of the Open Enrollment period.

ETF requires their PBM to be fully transparent and to fully pass through all savings back to the plan and its members. Navitus is one of the few PBMs that offer the level of transparency ETF requires. Those transparency requirements include:

- All operational aspects (e.g. policies, processes, clinical protocols, etc.) are documented, and those documents are readily available to ETF program staff;
- All contracts between the Navitus and network pharmacies, drug manufacturers, and any other subcontractors are fully auditable and available without redaction.
- Any legal actions either initiated by or against Navitus are fully disclosed to ETF staff; and
- 100% pass-through of all drug manufacturer revenue (from rebates, chargebacks, grants, etc.), regardless of type or source, as well as 100% pass-through of manufacturer pricing of drugs to the members and the methodology for determining such pricing.

The ability to directly view and audit all contracts creates a level of access that has historically been unusual in the PBM industry but is increasingly called for by employers, plans, and payer groups as a means to control costs. This level of both financial and operational transparency is crucial to how ETF staff manage the relationship with Navitus.

ETF, along with the Board's third-party auditor of the pharmacy benefit PillarRx, and the Legislative Audit Bureau will continue to monitor and evaluate Navitus' performance. PillarRx routinely reviews Navitus's contracts with pharmacies for any abnormalities or questionable behavior. If any issues are found, PillarRx and the Legislative Audit Bureau would report that information immediately to ETF and the Board.

On March 27, 2021, the Governor signed 2021 Wisconsin Act 9 (Act 9) into law. Act 9 which was supported by the Wisconsin Pharmacy Society implemented new laws surrounding the relationship between PBMs and pharmacies in Wisconsin. Some of the new provisions in Act 9 included:

- Outlawing PBMs from restricting or penalizing pharmacies from providing information to customers about the difference between the out-of-pocket cost of a drug under the policy or plan and the amount a person would pay without using the policy or plan coverage.
- Requires a PBM to provide a written notice to a pharmacy of any certification or accreditation requirements used by the PBM as a determinant of network participation within 30 days of a receipt of a written request from the pharmacy for that information. A PBM cannot change its accreditation requirements more

frequently than every 12 months.
- Sets parameters and frequency for PBM audits of pharmacies and pharmacists.
- Establishes when a PBM can and cannot request recoupment from a pharmacy.

Act 9 was passed and signed into law to protect pharmacies and their customers from unethical treatment by PBMs and health insurers. ETF is not aware of any complaints that have been filed against Navitus with the Wisconsin Office of the Commissioner of Insurance as a result of the provisions established in Act 9.

The decision to ask the Board to extend Navitus's contract a year is not one that ETF staff came to without hesitation. As you may have read in the September 29, 2022, memo to the Board for the November meeting, ETF staff who would onboard a new PBM during the second through the fourth quarter of 2024 are already committed to ETF's new Insurance Administration System (IAS) that will be beginning during that same time. The IAS project replaces critical, aging technology systems that support all ETF-provided benefits, and there is not enough staff or staff time available to onboard IAS and a possible new PBM.

At the November 17, 2021, Board Meeting ETF staff presented a report on specialty drugs and site of care. In this report, many different options for keeping pharmacy costs low while not interrupting members' experience were discussed including white bagging as you mentioned in your email. As ETF staff explained to the board options such as white bagging and brown bagging are not viable options in Wisconsin because so many hospital systems have policies that do not allow for the administration of drugs that do not originate in their facilities.

ETF has a seat on Navitus's Pharmacy & Therapeutics (P&T) Committee which makes the decisions on which drugs are included or excluded from the Navitus formulary. The committee's decisions are based on each drug's effectiveness, side effects, interactions, and cost/value. The Centers for Medicare & Medicaid sets the drug formulary for Medicare Part D.

The article you sent about the inequity in pharmacy benefit managers' drug pricing in Oregon is very interesting. There are some PBM's that retain rebates for the benefit of the company rather than returning savings to the customer. The Northwest Prescription Drug Consortium, which among many other public sector entities provides prescription drug benefits to Oregon State Employees, recently hired Navitus as their PBM due in part to the transparent, full-passthrough model of the organization. It will be interesting to see how the Northwest Prescription Drug Consortium and its members work with Navitus and its pass-through business model.

The 2018 article from STAT+ is one ETF staff is very familiar with. At the November 14, 2018, Board meeting ETF staff spoke about this article in their presentation on pharmacy benefit manager payment models.

As was presented at the November 2018 meeting, the pass-through PBM business model that Navitus uses as opposed to the traditional/spread business model used by many other PBMs including those mentioned in the STAT+ are different.

Besides the contract being fully transparent, as previously discussed, the PBM in a pass-through model is only paid an administrative fee for services. Any other revenue sources such as rebates are passed back to the payer/plan. A PBM that uses a traditional/spread model keeps all or a portion of rebates and other revenue sources. In the traditional/spread business model the PBM retains a portion of drug ingredient costs, dispensing fees, and usual and customary costs.

Again, thank you for your email. If you have any other questions, comments, or concerns please do not hesitate to contact me using the contact information provided below.

Sincerely,

Tricia Sieg, Pharmacy Benefits Program Manager
Office of Strategic Health Policy
Department of Employee Trust Funds
tricia2.sieg@etf.wi.gov
(608) 261-6006