WILLIAM BUSH
STATE REPRESENTATIVE
29th District

HOUSE OF REPRESENTATIVES
STATE OF DELAWARE
411 LEGISLATIVE AVENUE
DOVER, DELAWARE 19901

COMMITTEES
Economic Development, Banking, Insurance & Commerce, Chair
Energy, Chair
Agriculture, Vice-Chair
Education
Judiciary
Natural Resources
Public Safety & Homeland Security
Transportation, Land Use & Infrastructure
Veterans Affairs

House Economic Development, Banking, Insurance & Commerce Meeting Minutes

6.9.21

Chair Bush called the virtual meeting to order at 5:08 p.m. He stated that the meeting was planned in accordance with HCR 1 and took the roll call of the committee's members. Members present included Vice-Chair Bennett, and Reps. Griffith, Dorsey Walker, Bolden, Baumbach, Wilson-Anton, Ramone, Smith, Spiegelman, and Yearick. For a list of guests present, please see the speaker list below.

Chair Bush introduced **SB 127, AN ACT TO AMEND TITLE 29 OF THE DELAWARE CODE RELATING TO ECONOMIC DEVELOPMENT.** As the bill's House prime sponsor, he explained the bill establishes the site readiness fund to provide grants to businesses and local governments to construct, renovate or improve commercial and industrial sites. He noted the bill promotes economic growth and stability through job creation.

Chair Bush opened the floor for public comment.

Jennifer Kmiec, on behalf of the Committee of 100, voiced support for the bill. She noted the bill will attract new and growing businesses.

Joseph Fitzgerald, on behalf of the New Castle Chamber of Commerce, voiced support for the bill. He stated the bill will create economic growth.

Rep. Ramone requested to be added as a sponsor of the bill.

A motion was made by Rep. Ramone and seconded by Rep. Spiegelman to release SB 127 from committee; motion carried. Yes= 7 (Bush, Bennett, Griffith, Dorsey Walker, Wilson-Anton, Ramone, and Spiegelman); No= 0; Absent= 6 (Bolden, Baumbach, Lambert, Hensley, Yearick, and Smith). SB 127 was released from committee with a F= 3, M= 8, U= 0 vote.

Chair Bush introduced **SB 103, AN ACT TO AMEND TITLE 12 OF THE DELAWARE CODE RELATING TO UNCLAIMED PROPERTY.** As the bill's House prime sponsor, he explained the bill requires virtual currency to be recorded as unclaimed property and liquated to U.S. dollars before being reported to the State. He noted the bill comes from the Department of Finance.

Chair Bush opened the floor for public comment.

Seeing none, a motion was made by Rep. Ramone and seconded by Rep. Bennett to release SB

103 from committee; motion carried. Yes= 7 (Bush, Bennett, Griffith, Dorsey Walker, Wilson-Anton, Ramone, and Spiegelman); No= 0; Absent= 6 (Bolden, Baumbach, Lambert, Hensley, Yearick, and Smith) SB 103 was released from committee with a F= 1, M= 9, U= 0 vote.

Chair Bush introduced **SB 104, AN ACT TO AMEND TITLE 12 OF THE DELAWARE CODE RELATING TO UNCLAIMED PROPERTY.** As the bill's House prime sponsor, he explained the bill makes technical changes to the State's unclaimed property program, including promoting and determining holder compliance, processing owner claims, and preventing fraudulent claims. He noted the bill is from the Department of Finance.

Rep. Ramone asked to for an overview of the bill from the Department of Finance.

Rick Geisenberger, Secretary of Finance, stated fairness and predictability have been the main approaches to unclaimed property for holders and claimants. The bill creates a permanent expedited exam process, lowers interest rates on past due properties, and prohibits contingency fees from third-party auditors. He noted the bill requires holder consent for multi-state examination.

Brenda Mayrack, Director of the Office of Unclaimed Property, explained the bill expands access to the voluntary disclosure agreement program and gives holders more time to opt into the program. She stated the expedited examination gives holders three years to complete the exam with nominal one percent interest.

Chair Bush opened the floor for public comment.

Patrick Reynolds, on behalf of the Council on State Taxation, voiced concerns for the twenty percent interest level and the delegation of document verification, audits, and record requests to third party auditors with potential self-interests.

Rep. Ramone asked if the high interest level is meant as penalty for non-compliance.

Secretary Geisenberger stated all non-compliant holders can opt in the expedited voluntary disclosure program and avoid the high interest rate. He noted the 20 percent interest rate is not compounded and is a reduction from the current rate.

Ms. Mayrack noted the high interest rate acts as a deterrent and encourages compliance and voluntary reporting.

A motion was made by Rep. Spiegelman and seconded by Rep. Bennett to release SB 104 from committee; motion carried. Yes= 9 (Bush, Bennett, Griffith, Dorsey Walker, Baumbach, Wilson-Anton, Ramone, and Spiegelman); No= 0; Absent= 4 (Bolden, Lambert, Hensley, Yearick, and Smith). SB 104 was released from committee with a F= 1, M= 9, U= 0 vote.

Chair Bush introduced **HB 10, AN ACT TO AMEND TITLE 29 OF THE DELAWARE CODE RELATING TO THE AGREEMENT TO PHASE-OUT CORPORATE GIVEAWAYS ACT.** He referred to the bill's co-sponsor, Rep. Baumbach, to explain the bill.

Rep. Baumbach explained the bill ends corporate giveaways through a multi-state anti-poaching agreement. He stated the bill prohibits member states from offering company-specific tax incentives or grants to an entity to relocate from another member state. He noted the bill has no impact until it is passed by another state.

Rep. Kowalko, the bill's sponsor, shared a study from the University of Texas which found 85 percent of firms who received Chapter 313 benefits would have relocated to Texas without benefits. He stated Amazon has collected over $4 billion in subsidies to build their facilities which has had little impact on where they locate.

Rep. Baumbach noted the bill is an effort in states nationwide and referred to Michael Farren, a researcher at George Mason University, as an expert witness.

Dr. Farren stated $95 billion is spent annually by state and local government for economic growth. He noted 15 other states have introduced this legislation this year. He shared research that found 90 percent of subsidies did not play a major role in location selection and explained local conditions are more important than subsidy amounts. He noted subsidies can have more negative impacts than positive as funds could be reallocated to improve the local conditions, such as education and infrastructure.

Rep. Dorsey Walker asked if the bill is deemed not friendly to corporations looking to expand in Delaware.

Rep. Baumbach stated the money can be used to better conditions which would benefit corporations and Delaware residents.

Rep. Kowalko noted Delaware is difficult position to compete with subsidy amounts due to its size and stated the court systems are favorable for corporations, ranked fourth in the country for corporate tax reliability.

Rep. Bush stated two states must join before it goes into effect and asked if the strategic fund and acquisition fund would be eliminated.

Rep. Baumbach noted all states must join before those funds are eliminated and stated Delaware may still financially compete against non-member states.

Chair Bush opened the floor for public comment.

Joseph Fitzgerald, on behalf of the New Castle Chamber of Commerce, voiced opposition to the bill. He stated subsidies and grants are important tool for economic development.

A motion was made by Rep. Baumbach and seconded by Rep. Wilson-Anton to release HB 10 from committee; motion failed. Yes= 4 (Bennett, Dorsey Walker, Baumbach, and Wilson-Anton); No= 5 (Bush, Griffith, Ramone, Smith, and Spiegelman); Absent= 4 (Bolden, Lambert, Hensley, and Yearick).

Chair Bush introduced **HB 219, AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO PHARMACY BENEFITS MANAGERS.** He referred to the bill's sponsor, Vice-Chair Bennett, to explain the bill.

Vice-Chair Bennett explained the bill increases transparency of Pharmacy Benefits Managers ("PBMs") who establish networks for patients to receive reimbursements for drugs and manage approximately 75 percent of prescriptions. The bill requires the PBM to provide the national drug code number of wholesalers in Delaware that have the drug in stock below maximum allowable cost. She stated the bill authorizes a pharmacy or pharmacist to decline services if the amount reimbursed by a PBM is less than the pharmacy acquisition cost.

Rep. Bennett continued by stating that if a pharmacy or pharmacist declines to provide a drug or service, the pharmacy or pharmacist must inform the patient that the pharmacy or pharmacist did this because of the costs of providing the drug or service and provide the patient with a list of pharmacies in the area that may provide the drug or service. She noted that the bill requires PBMs to provide a reasonably adequate and accessible pharmacy benefits manager network and increases increases transparency by requiring PBMs to provide reports to the Insurance Commissioner on network adequacy and the amount of rebates received by PBMs and distributed to insurers or patients. She stated several other provisions outlined in the bill and noted neighboring states have introduced or passed similar bills, with 14 states having passed similar legislation.

Rep. Smith voiced support for the bill.

Chris Hass, from the Department of Insurance, noted the bill protects local pharmacies. She explained PBMs low reimbursement rates leads to pharmacy closures in more rural areas which decreases consumer choice. She stated Delaware has begun registering PBMs and is the first state to examine their practices.

Kim Robbins, on behalf of the Delaware Pharmacists Society, voiced support for the bill. She shared an audit from Ohio which found PBMs overcharged the state by over 30 percent on generic drugs, nearly four times the amount reported for all drugs, for a difference of $224 million from 2017 to 2018. She noted an increase of government oversight ensures accessible care and medication for all patients.

Chair Bush opened the floor for public comment.

Heather Cascone, on behalf of Pharmaceutical Care Management Association, voiced opposition to the bill. She stated the bill creates regulations beyond the PBM supreme court ruling and the state may face legal action. She noted NADAC pricing is inconsistent with actual drug costs.

Chris DiPietrio, on behalf of EPIC Pharmacies, voiced support for the bill. He stated PBM practices put a strain on located and independent pharmacies which lowers patient access to care and medication.

Pat Carroll-Grant, owner of Cape Pharmacy, voiced support for the bill. She noted government oversight over PBM practices is critical for patient and pharmacy protection.

Edward Sotherden, on behalf of Biotek Remedys, voiced support for the bill. He noted the difficulties running a specialty pharmacy and the predatory nature of PBMs.

Christine Schiltz, on behalf of America's Health Insurance Plans (AHIP), voiced opposition to the bill. She stated AHIP concerns were not considered by the Pharmacy Reimbursement Taskforce.

Kimberly Robinson, on behalf of Cigna, voiced opposition to bill and recommended amendments to address the legal concerns of insurance companies.

Pamela Price, on behalf of Highmark Blue Cross Blue Shield Delaware, requested the bill stay in committee to allow the Pharmacy Reimbursement Task Force to be reconvened.

Gail Novak voiced support for the bill. She noted the increasing difficulty to access affordable care and prescriptions with the rise of PBMs. She shared experiences of traveling to Pennsylvania and Maine to access a pharmacy covered by her insurance for life-saving medicine.

Hooshang Shanehsaz voiced support for the bill. He noted 80 percent of the prescription drug market is controlled by three PBMs owned by the three largest insurance companies. He noted PBMs can dictate which wholesalers pharmacies buy from.

Jay Patel voiced support the bill. He noted some PBMs have stricter guidelines the Delaware State Board of Pharmacies which limits patient care and increases pharmacy expenses.

Rep. Smith stated feedback from PBMs was considered.

Vice-Chair Bennett noted the bill was drafted with consumer protections in mind.

A motion was made by Rep. Smith and seconded by Rep. Wilson-Anton to release HB 219 from committee; motion carried. Yes= 11 (Bush, Bennett, Griffith, Dorsey Walker, Bolden, Baumbach, Wilson-Anton, Ramone, Smith, Spiegelman and Yearick); No= 0; Absent= 2 (Lambert and Hensley). HB 219 was released from committee with a F= 3, M= 8, U= 0 vote.

Chair Bush introduced **SB 81, AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO INSURANCE RATE FILINGS.** As the bill's House prime sponsor, he explained the bill allows for deviations from rating organization filings to be effective continuously until terminated with the approval of the Commissioner or subsequently modified.

Chair Bush opened the floor for public comment.

Seeing none, a motion was made by Rep. Baumbach and seconded by Rep. Bennett to release SB 81 from committee; motion carried. Yes= 11 (Bush, Bennett, Griffith, Dorsey Walker, Bolden, Baumbach, Wilson-Anton, Ramone, Smith, Spiegelman and Yearick); No= 0; Absent= 2 (Lambert and Hensley). SB 81 was released from committee with a F= 3, M= 8, U= 0 vote.

Chair Bush adjourned the meeting at 6:15 p.m.

Respectfully submitted by:

A’lece Moore

Speaker List

- Jennifer Kmiec (Committee of 100)
- Joseph Fitzgerald (New Castle Chamber of Commerce)
- Rick Geisenberger (Department of Finance)
- Brenda Mayrack (Office of Unclaimed Property)
- Patrick Reynolds (Council on State Taxation)
- Michael Farren (Mercatus Center at George Mason University)
- Chris Haas (Department of Insurance)
- Kim Robbins (Delaware Pharmacists Society)
- Heather Cascone (Pharmaceutical Care Management Association)
- Chris DiPietro (EPIC Pharmacies)
- Pat Carroll-Grant (Cape Pharmacy)
- Edward Sotherden (Biotek Remedys)
- Christine Schiltz (America’s Health Insurance Plans)
- Kimberly Robinson (Cigna)
- Pamela Price (Highmark Blue Cross Blue Shield Delaware)
- Gail Novak
- Hooshang Shanehsaz
- Jay Patel

Attendance List

- Andrew O'Connor
- Bailey Brooks
- Becky Harrington
- Bethany Haefner
- Bonnie Metz
- Carla Sparkler
- Clive Cohen
- David Walsh
- Heather Gabell
- Jenevieve Worley
- Jonathan Patterson
- Kathleen Rutherford
- Kevin Musto
- Kim Hemsley
- Kim Willson

- Kimberly Micha
- Kris Hathaway
- Lincoln Willis
- Lizzie Lewis
- Mary Dugan
- Mary Sherlock
- Michael Hogg
- Patricia Redmond
- Paul Speidell
- Percy Dhamodiwala
- Rebecca Byrd
- Rebecca Kidner
- Reginia Benjamin
- Xavier Perez

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William.Bush@delaware.gov

6.9.21 House Economic Development Meeting

Public Comment

HB 10 (Sponsor: Kowalko)

1. ***Submitted by Michael Ferren | June 8, 2021 at 2:24 p.m.***
2. ***Submitted by American Economic Liberties Project | June 9, 2021***

HB 219 (Sponsor: Bennett)

1. ***Submitted by National Community Pharmacists Association | June 9, 2021 at 9:32 a.m.***
2. ***Submitted by America's Health Insurance Plans | June 9, 2021 at 12:52 p.m.***
3. ***Submitted by Pharmaceutical Care Management Association | June 9, 2021 at 5:12 p.m.***

House Economic Development/Banking/Insurance & Commerce Committee
Delaware Assembly
411 Legislative Avenue
Dover, DE 19901

June 9, 2021

Statement in Support of HB10 – Pat Garofalo, Director of State and Local Policy, American Economic Liberties Project

I write today in strong support of HB10, a bill to adopt the Agreement to Phase Out Corporate Giveaways Act. Forming an interstate compact to curb and eventually eliminate the use of company-specific tax incentives, thereby creating a legally-binding agreement with like-minded states to abandon decades of failed economic development strategies, will help save Delaware taxpayers money, level the playing field for small businesses, and allow elected officials to focus state resources on policies that boost overall economic growth and quality of life for Delaware residents.

States across the country spend tens of billions of dollars on company-specific corporate tax incentives annually. Delaware's state and local governments, according to disclosed records, have spent almost half a billion dollars on such incentives, most of that since 2009.[1]

According to the vast bulk of the research done on this policy area, that money is buying next to nothing, as corporate tax incentives have a negligible effect on economic growth, job creation, or incomes.[2]

There are several reasons why that is the case, but one of the most important is that the vast majority of the time, incentives don't entice corporate leaders to do anything they wouldn't have done anyway, because location decisions are based on several other business factors, such as workforce requirements, supply chains, access to transportation and other infrastructure, and other local laws. According to Tim Bartik of the Upjohn Institute, between 75 and 98 percent of granted incentives have no bearing on where a firm ultimately chooses to locate.[3]

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[1] Good Jobs First, Subsidy Tracker, Accessed June 7, 2021

[2] See: Garofalo, Pat, "The Billionaire Boondoggle: How Our Politicians Let Corporations and Bigwigs Steal Our Money and Jobs," Thomas Dunne Books, March 2019; LeRoy, Greg, "The Great American Jobs Scam: Corporate Tax Dodging and the Myth of Job Creation," Berrett-Koehler Publishers July 2005; Florida, Richard, "The Uselessness of Economic Development Incentives," CityLab, Dec. 7, 2012 https://www.bloomberg.com/news/articles/2012-12-07/the-uselessness-of-economic-development-incentives; and Slattery, Cailin, and Owen Zidar, "Evaluating State and Local Business Tax Incentives," Journal of Economic Perspectives 34.2. Spring 2020, among many works. https://scholar.princeton.edu/zidar/publications/evaluating-state-and-local-business-tax-incentives

[3] Bartik, Timothy J., "'But For' Percentages for Economic Development Incentives: What percentage estimates are plausible based on the research literature?" Upjohn Institute Working Paper 18-289. July 1, 2018 https://doi.org/10.17848/wp18-289

So, at best, incentives are influencing location decisions a quarter of the time. Every other incentive given out is quite simply wasted taxpayer money.

Why, then, do incentives persist? Because there is a prisoner's dilemma at work: No state, understandably, wants to unilaterally disarm while every other state continues to use incentives. No officeholder wants to appear to be doing nothing for their constituents, while those in the next state over are announcing deal after deal, even if the promised benefits of those deals don't actually materialize once the ink is dry. Research has shown that governors' use of incentives increases during the years in which they are up for re-election, because there is political capital to be gained, even if actual capital doesn't follow in its wake.[4]

This is, at its core, a political problem, not an economic one.

The interstate compact aims to solve this issue by having states multi-laterally disarm, together. By instituting a cease-fire amongst the states, the compact can short-circuit the political attractiveness of incentives and, in the long term, foster the development of more impactful, equitable, and cost-effective economic policies that focus on small businesses and the concrete needs of communities. Because the compact's terms only apply to other compact states, there's no danger of Delaware having to go it alone.

Kansas and Missouri implemented a version of this in 2019 in order to prevent corporations from moving across the greater Kansas City metro area — which straddles the border — to claim incentives. That solution deserves to go national, with more robust enforcement mechanisms.

This is about more than dollars and cents. Entering the compact is also good for democratic accountability. Too often, incentive deals are cloaked in secrecy, with corporate leaders having more information about what states are promising in terms of public resources than elected leaders themselves, or the general public. By facilitating information sharing and the development of best practices, the compact can foster the introduction of transparency and accountability to a policy area desperately lacking both.

Ideally, the debate about economic development should be about what builds the best overall economic climate: That means trying to figure out the optimal levels of overall taxation, the right amount of social spending, the proper education and infrastructure investments, and the best policies for promoting quality of life and workplace protections. Instituting the interstate compact would help move the debate there, instead of the problematic place in which it resides today.

Delaware, the first state, should be the first to approve the compact, and lead the charge toward a brighter economic future, not just for its residents, but for all Americans.

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[4] Slattery and Zidar, "Evaluating State and Local Business Tax Incentives."

June 9, 2021

The Honorable William Bush
Chair, House Economic Development/Banking/Insurance & Commerce Committee
411 Legislative Avenue
Dover, DE 19901

RE: NATIONAL COMMUNITY PHARMACISTS ASSOCIATION SUPPORT OF HB 219

Dear Chair Bush and members of the House Economic Development/Banking/Insurance & Commerce Committee:

I am writing on behalf of the National Community Pharmacists Association in support of HB 219. This bill will bring transparency to prescription drug benefit programs and protect patients from pharmacy benefit managers' (PBMs') conflicts of interest in Delaware.

NCPA represents the interest of America's community pharmacists, including the owners of more than 21,000 independent community pharmacies across the United States and 38 independent community pharmacies in Delaware. These Delaware pharmacies filled over 2 million prescriptions last year, impacting the lives of thousands of patients in your state.

HB 219 would limit the PBM conflicts of interest that limit patient choice and raise out-of-pocket costs. It is not uncommon for a PBM to usurp a patient's authority to make his or her own healthcare decisions by steering the patient to a PBM-owned pharmacy, often a mail-order pharmacy. The PBM is then free to reimburse its pharmacy at higher rates than other pharmacies, thereby forcing patients and plan sponsors to pay higher costs to the PBM. The bill would control this conflict of interest by prohibiting a PBM from reimbursing non-affiliated pharmacies at lower rates than the PBM's affiliated pharmacies.

The bill also protects patient choice by prohibiting PBMs from creating arbitrarily narrow networks. By requiring a PBM to contract with any pharmacy that is willing to accept the PBM's conditions of network participation and establishing network adequacy standards, the bill will encourage pharmacies to compete for patients' business, instead of having PBMs making the decision for those patients. This bill would ensure a patient's choice of pharmacy is left to the patient and is informed by what's in the patient's best interest, instead of what's in the PBM's best interest.

Not only will the bill protect patient choice, it will bring transparency to prescription drug reimbursements and ensure that PBM-determined reimbursement amounts accurately reflect the true market costs for Delaware pharmacies. The National Average Drug Acquisition Cost (NADAC) is an objective, evidence-based drug pricing benchmark. By tying the drug ingredient costs to NADAC and prohibiting "spread pricing," the bill would ensure that plan sponsors and payers have more information about how their money is being used by their PBMs.

Additionally, HB 219 would hold PBMs accountable for their reimbursement practices by allowing pharmacies to decline to dispense when the reimbursement amount does not meet their

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acquisition costs. This will allow pharmacies to prevent frequent under-water reimbursements from keeping them from serving their communities. The bill, however, requires the pharmacy to provide a list of pharmacies that "may provide the pharmacy goods or services." A pharmacy is unlikely to know what goods or services its competitor "may provide" or whether a specific patient's PBM has included the competitor in the network. For these reasons, we ask the committee to amend line 117 to read "(2) Provide the patient with a list of pharmacies in the area."

HB 219 would also prohibit retroactive clawbacks that end up increasing out-of-pocket costs for patients. When a PBM has reimbursed a pharmacy for filling a prescription, it is not uncommon for the PBM to claw back a portion of the reimbursement days, weeks, or even months later, and often under the guise of effective rate reconciliations or "transaction fees." However, a patient's cost share is not similarly retroactively adjusted. This means that a patient's cost share is based on an arbitrarily inflated figure. By prohibiting retroactive claim reductions, HB 219 will ensure patients' cost shares more accurately reflect the true cost of their health care services.

For these reasons, NCPA respectfully requests your support of HB 219 with the requested amendment to line 117. Similar legislation has protected patients in other states, and I am confident this bill will do the same for Delaware patients. If you have any questions about the information contained in this letter or wish to discuss the issue in greater detail, please do not hesitate to contact me at matthew.magner@ncpa.org or (703) 600-1186.

Sincerely,

Matthew Magner
Director, State Government Affairs

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ahip.org

June 9, 2021

Representative William Bush
Chair, House Economic Development/Banking/Insurance & Commerce Committee
Delaware General Assembly
Legislative Hall
411 Legislative Ave
Dover, DE 19901

RE: HB 219 – Title 18 Amendments Regarding Pharmacy Benefit Managers

Dear Chairman Bush,

On behalf of AHIP and its members, I write to share our concerns regarding HB 219 concerning pharmacy benefit managers (PBM) and how the proposed bill will not only significantly impact health plans' ability to administer prescription drug benefits but also potentially increase drug spending and hinder the quality of care to be provided to our enrollees.

AHIP and multiple health care stakeholders have been participating as part of the Pharmacy Reimbursement Task Force, which understandably stopped meeting during the COVID pandemic. HB 219 was introduced on June 3, without discussion or feedback from the Task Force. There are multiple issues included within the legislation that have not been discussed with the Task Force, including ramifications on self-funded plans, which opens the state to litigation. In addition, providing only 3 business days prior to hosting a hearing late in the session on such a critical piece of legislation is extremely concerning.

- **AHIP recommends HB 219 be forwarded to the Pharmacy Reimbursement Task Force for thoughtful review and discussion and requests the Committee table the legislation until the General Assembly reconvenes in January of 2022.**

ERISA
This legislation may eliminate the long-standing Employee Retirement Income Security Act of 1974 (ERISA) preemption intended to provide employers consistency and uniformity of plan administration. In *Rutledge v. PCMA*, the Supreme Court affirmed its longstanding precedent that state laws are preempted by ERISA when they impact a core function of plan administration or directly relate to the plan. The Court clarified states could regulate very limited activities by

PBMs that do not closely relate to planning activities, but it did not create a new category of permissive state regulation.

This bill may go beyond the discrete and limited category of PBM activities upheld in *Rutledge* and, if enacted, has the potential to open the state to ERISA litigation. Subtle changes to definitions interwoven throughout HB 219 need to be further reviewed so their intent and consequences can be fully understood. These include:

- Section 2203: changes the definition of PBM from the work they do on behalf of "an insurer or third-party administrator" to "a person to any of the following."
- Section 3331: eliminates the definition of "health insurance", "Insured" and "Insurer" and replaces "an insured" with "a patient."
- Section 3351: changes the definition of "Purchaser" from "means an insurance company, health service cooperation, health maintenance organization, managed care organization, and any other entity" to "means a person."

The state needs to do its due diligence and conduct further legal analyses investigating the impact HB 219 will have on self-funded employer plans.

Reimbursements
Section 3372A(7) requires pharmacy reimbursement rates to be determined based on the National Average Drug Acquisition Cost (NADAC) or drugs without a NADAC price to be based on the "wholesale acquisition cost" (WAC). NADAC is a **voluntary** database, maintained by the Centers for Medicare and Medicaid Services, that pharmacists send their invoice costs to. The methodologies used to collect this data aren't transparent and therefore the validity and reliability of information such as the demographics of reporting pharmacies, information regarding what is included on the invoice, and the geographic variety of pharmacies included in this database are unclear. Drug store chains often do not report to NADAC which distorts the data. Additionally, NADAC data does not include off-invoice discounts, which results in inflated reimbursement rates since actual acquisition costs are lower.

This section of the bill also requires PBMs to pay the manufacturer's list price, also known as the WAC, instead of lower negotiated rates. AHIP opposes mandated specified reimbursement structures, as health plans need flexibility on how to reimburse pharmacies to encourage all payers in the drug cycle to negotiate for lower drug prices with pharmaceutical manufacturers.

Health plans and PBMs utilize different reimbursement structures to encourage pharmacies and their Pharmacy Services Administrative Organization (PSAO) partners to negotiate for the lowest priced drugs available on the market. If pharmacies and PSAOs are guaranteed to never lose money per Section 3325, no matter what they paid for a drug, where is the incentive for them to shop for the lowest-priced drug? The same section also allows for pharmacies to decline services to a patient dependent on the pharmacist's reimbursement of a drug.

All stakeholders in the prescription drug supply chain need to do their part to keep drug manufacturers accountable and keep costs low for patients. The establishment of a government rate-setting provision and interference in private business contracts will increase the total cost for prescription drugs and make it difficult for Delaware to encourage health plans to operate in the state. Instead of improving access to medicines or decreasing drug costs for patients, these reimbursement restrictions eliminate important tools that employers, health insurance providers, and PBMs rely upon to improve affordability, quality, and access for patients.

Any Willing Pharmacy
Section 3362A(b) requires a PBM to accept any pharmacies which meet terms and conditions to participate in a network at preferred status. PBMs should be able to determine which pharmacies to include in their networks based on performance, features for enrollees, location, savings, and a variety of other factors. By selectively contracting with providers and pharmacies, PBMs and health plans can assure that patients can receive the high-quality care, have adequate access to the services they need, and reduce the likelihood of overutilization of valuable health care resources.

Spread Pricing
Section 3372A(1) prohibits a PBM from engaging in spread pricing. PBMs offer health plan clients a variety of options to pay for PBM services and they choose the one that best suits the needs of the plan. Many health insurance providers choose a spread pricing arrangement because it provides clients with more certainty in their pharmacy costs and allows them to budget in a more predictable manner. Health plan requires audit provisions in their contracts, they require substantial reporting and data to justify the fees and charges made for PBM services. These and other terms in their agreements enable health insurance providers to know or easily find out how the money flows in their agreements with PBMs. The predictability incorporated into this type of private contract is key in maintaining lower premiums as plans have less risk they need to account for.

Accreditation

Section 3372A(4) includes the requirement that a PBM may not require pharmacy accreditation standards or certification requirements that are inconsistent with, more stringent than, or in addition to requirements of the Board of Pharmacy. Health plans are mandated by the state to meet their own accreditation standards through URAC, NCQA, and others accreditation companies that set these standards. State licensure evaluations by the Board of Pharmacy do not include measures to validate a pharmacy's ability to comply with contractual provisions and regulatory requirements, such as inventory control for claim payment audits, quality management, liability, patient compliance and adherence, safety, and clinical programs, etc. This bill would restrict the ability of health plans and employers to ensure that pharmacies are meeting such critical requirements through their network contracts.

For these and other reasons, AHIP and its members have serious concerns regarding HB 219 and respectfully oppose any efforts that could hinder the affordability of care and prescription drug spending for consumers. Again, we ask that the bill be forwarded to the Pharmacy Reimbursement Task Force for additional discussion prior to being reintroduced next session.

Thank you for the opportunity to provide feedback on this proposed regulation. If you have any questions or concerns regarding our feedback and would like to discuss the matter further, please contact me at khathaway@ahip.org or by phone at (202)-870-4468.

Sincerely,

Kris Hathaway

Kris Hathaway
Vice President, State Affairs
America's Health Insurance Plans

cc: House Economic Development/Banking/Insurance & Commerce Committee

America's Health Insurance (AHIP) is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

June 9, 2021

The Honorable William Bush
Chair, Committee on House Economic Development/Banking/Insurance & Commerce
Legislative Hall
411 Legislative Avenue
Dover, DE 19901

House Bill 219 - AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO PHARMACY BENEFITS MANAGERS

Dear Chairman Bush, & Members of the House Committee:

I am writing on behalf of the Pharmaceutical Care Management Association ("PCMA"), which is the national association representing America's pharmacy benefit managers ("PBMs") who administer prescription drug benefits for over 270 million Americans. In Delaware, PCMA members include CVS Health, Cigna, among others. Our members manage prescription drug benefits on behalf of health plans, large and small employers, labor unions and government programs. I am grateful for this opportunity to share our respectful opposition to HB 219. Given the complexities of the issues in this bill, we'd very much appreciate granting the PBM Task Force the opportunity for further consideration.

Definitions
In various places in the bill, definitions are changed from "insured," or "purchaser," to "person." By doing so, these sections would expand the state's authority over PBMs as recently ruled upon in the recent U.S. Supreme Court decision in *Rutledge v. PCMA.* While the court clearly ruled that rate regulation is within the scope of a given state's authority, other matters of PBM law or plan administration are not, and are still preempted by federal ERISA law. As a result, by expanding PBM laws to include previously preempted employer and self-insured plans (i.e. government employee plans), the state may be exposing itself to complicated legal challenges.

Section 5 – Affiliated Pharmacies
This section eliminates the ability of plan sponsors to elect plan designs with pharmacies that demonstrably lower costs for their members. As consumers and payers search for ways to reduce out of pocket costs and the overall cost of healthcare, this legislation runs contrary to these goals and does not help Delaware plan sponsors who are trying to control costs for their members and removes several tools they elect to use to design a robust and cost effective pharmacy benefit.

In September 2018, when the U.S. Department of Justice approved the merger of health care corporations that operate in the PBM and insurance markets, the Antitrust Division said that one

merger “is unlikely to result in harm to competition or consumers[1].” In October 2018, the Antitrust Division said that another merger would “allow for the creation of an integrated pharmacy and health benefits company that has the potential to generate benefits by improving the quality and lowering the costs of the healthcare services that American consumers can obtain.”[2]

In the run-up to the implementation of Medicare Part D, Congress asked the Federal Trade Commission (FTC) to study if PBM-owned mail order pharmacies would pose a conflict of interest.[3] The FTC produced a voluminous study concluding that no such conflict existed.

Moreover, concerns about plan-pharmacy negotiations and ownership interests are unwarranted. The Federal Trade Commission found accusations of “self-dealing” that might arise when PBMs both administer a pharmacy benefit and ship drugs via their own mail-order pharmacy are “without merit.”

One of the many tools that employers and other PBM clients use to provide significant cost savings and convenience for their enrollees are mail-service pharmacies. Mail-service pharmacies can contain the increasing cost of prescription drugs due to their unmatched efficiency and lower overhead costs compared to retail pharmacies.

Health plans and PBMs often incentivize patients to use mail-service pharmacies by providing lower copayment options for 90-day supplies of maintenance medications, like those prescribed for asthma, for example.

This legislation will eliminate a health plan’s ability to use mail-order programs removes the lowest cost pharmacy option available. Retailers are not offering to lower copays to patients to provide price parity – instead this legislation mandates that mail order pharmacies raise prices.

When an employer or health plan contracts with a PBM to administer their pharmacy benefit, the employer maintains authority over the terms and benefit plan design. The employer or plan – not the PBM – makes decisions regarding cost-sharing requirements, mail-service, formulary, etc. This bill removes the option for the employer or health plan to use mail order and specialty pharmacy mail-order as cost savings tools.

The Centers for Medicare and Medicaid Services (CMS) studied drug costs and mail-service pharmacies. The CMS study showed that drug costs were 16% lower at mail-service pharmacies compared to brick-and-mortar drug stores. Mail-service pharmacies not only deliver monetary savings, but actually increase adherence to a prescription’s regimen, resulting in improved health outcomes for patients who are able to lead healthier lives.

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[1] U.S. Department of Justice. “Statement of the Department of Justice Antitrust Division on the Closing of Its Investigation of the Cigna–Express Scripts Merger.” September 17, 2018. Available at: https://www.justice.gov/atr/closing-statement

[2] U.S. Department of Justice. “Justice Department Requires CVS and Aetna to Divest Aetna’s Medicare Individual Part D Prescription Drug Plan

[3] Federal Trade Commission. (August 2005). Pharmacy Benefit Managers: Ownership of Mail order Pharmacies.

Section 5 – Decline to dispense
When employers and other plan sponsors are required to reimburse pharmacies at whatever cost the pharmacy purchases a drug or using a specific cost-based methodology, an important cost and quality restraint is removed from the drug supply chain. These kinds of "guaranteed profit" requirements impose a "blank check" approach to reimbursement and undermine affordability for patients.[4] If the goal is to understand exactly how much drugs cost, it is necessary to consider all discounts and rebates associated with pharmacies' actual purchase price – whether they appear on an invoice or are recorded elsewhere. Survey-based reimbursement methodologies or reliance on pharmacy invoices cannot do that. Rather, they can lead to cost inflation, guaranteed profits for certain drug supply chain actors, and reduced transparency – all at the expense of patients.

Because pharmacies purchase different drugs at different times and in different volumes, the price of a particular drug can vary significantly among pharmacies—even within a specific drug class or type. If patients can fill their prescription at lower-cost pharmacy locations, they, and, if they are insured, their health plans, can spend less. Employers and other plan sponsors, with their PBMs, contract with pharmacies for a set price for the same reason. These pharmacies, which typically form a plan's pharmacy network, are incented to purchase the drugs that they dispense efficiently and based on competitive market rates.

Reimbursement requirements discourage pharmacies from joining plans' preferred pharmacy networks, which undermines value for patients. In addition to lowering total drug spending and patients' out-of-pocket costs, preferred networks improve health outcomes, promote high-quality care, and advance the transformation to value-based care by incorporating risk sharing with preferred pharmacies to encourage higher use of cost effective generics and other evidence-based health promotion strategies, including pharmacists in teams that integrate care for high-risk patients, and incentivizing pharmacies to provide patient care services and supports as part of accountable care arrangements and other ways to further health outcomes.

Section 13 – Fees
PBMs maintain robust IT systems to allow them to administer benefits for their clients. Fees help support access to the PBM's IT systems that allow pharmacies to fill prescriptions from nearly any benefit plan. This system assists in streamlining the process for pharmacies that would otherwise have to contract with individual employers and plans to provide services to their beneficiaries. Fees also support maintaining help lines, benefit manuals, and other services provided to the pharmacy by the PBM.

Moreover, pharmacies agree to certain fees in their contractual arrangements with PBMs. These fees are not unlike those paid by retailers to credit card companies in exchange for the risk of consumer fraud and for immediate payment for purchases, or the fees that banks charge consumers for ready access to cash through ATMs. Pharmacies freely enter contracts with PBMs, agreeing to pay these fees in return for access to PBM services that enhance their own

[4] The inflationary consequences of similar cost-based reimbursement systems are well known. For many years, the federal government relied heavily on cost-based procurement for defense contracts, only to discover that this approach resulted in large cost over-runs, because defense contractors knew their costs would be reimbursed, however much they were.

business practices.

Section 13 – National Average Drug Acquisition Cost
Moreover, National Average Drug Acquisition Cost (NADAC), is a voluntary, national survey of pharmacies who are willing to self-report their invoices for their drug dispensing claims to CMS. These pharmacy-submitted invoices include prices that do not reflect any discounts, rebate or prices concessions that the pharmacy might have received, and as a result are not indicative of the true cost of dispensing the prescription drug, instead they are artificially skewed to a higher rate.

Because NADAC is self-reported, which means that pharmacies are not obligated to report it, nor are they obligated to report all of the invoices for all of the drugs they dispense, the system allows for only selective invoices to be reported. In utilizing NADAC as a reference price, the state of Delaware would be paying at the highest cost possible for the prescription drugs dispensed.

Additionally, NADAC is recognized to be flawed in that is a retrospective look at drug pricing that often lags so much that it can be inaccurate to current pricing levels. In a commodity-like market, drug prices can change on a weekly or even daily basis. A price could be completely irrelevant by the time it is reported to CMS, and then used as the "NADAC" price. Given these limitations, and the fact that this proposal could arbitrarily skew prices higher, it raises questions as to who would like the state to use this model and why.

Section 13 – Accreditation
This section would limit a plan's ability to provide their beneficiaries with high quality, affordable care by prohibiting the use of accreditation and recertification standards for network pharmacies that helps ensure quality and safety. Certification standards are the foundational requirements that health plans, employers, and their PBMs use to validate pharmacy providers prior to enrollment and network contracting. State licensure evaluations by the Board of Pharmacy do not include measures to validate a pharmacy's ability to comply with contractual provisions and regulatory requirements, such as inventory control for claim payment audits, quality management, liability, patient compliance and adherence, safety, and clinical programs, etc. This section would restrict the ability of plan sponsors to ensure that pharmacies are meeting such critical requirements through their network contracts.

Additionally, the Board of Pharmacy is charged with overseeing pharmacy practice and does not have expertise or visibility in managing a pharmacy benefit or creating provider networks. Certification of pharmacies is an important part of establishing a high-quality pharmacy network and necessarily goes beyond a standard pharmacy license requirement.

Regarding specialty pharmacy, this legislation would allow any pharmacy to dispense specialty medications to patients without being required to meet the accreditation and certification standards used to ensure quality and patient safety. Accreditation and recertification are designations that demonstrate a pharmacy's commitment to safety by adhering to required, proper patient care standards that must be met to ensure appropriate dispensing of highly complex specialty drugs. It is important to note that accreditation standards are not set by PBMs, but instead by independent standard setting organizations recognized for establishing high

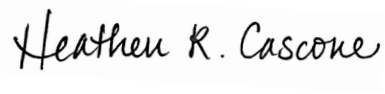
quality standards, as many other providers in the healthcare system are responsible for achieving, as well.

Allowing any pharmacy to dispense highly complex specialty medications would not only lead to patient safety issues that would result in increased costs, but it would also interfere with the use of pharmacy networks comprised of pharmacies with the necessary expertise and service level, which health plans and employers use to help lower costs while providing a robust pharmacy benefit.

Given the complexities of the issues outlined herein, as well as other which have not yet been fully contemplated by this Association given the quick call for this bill's hearing, we respectfully request that these issues be referred to the state's PBM Task Force for further consideration of impact.

I appreciate the opportunity to weigh in and am happy to answer any questions you may have.

Sincerely,



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