Kentucky Bill Will Cost the State Over $5 Billion In Increased Prescription Drug Costs

The core mission of pharmacy benefit managers (PBMs) is to reduce prescription drug costs for health plan sponsors so that consumers have affordable access to needed prescription drugs. PBMs offer a variety of services to their health-plan-sponsor clients and patients that improve prescription adherence, reduce medication errors, and manage drug costs.

The proposed Kentucky legislation will seriously undermine the ability of PBMs to control drug costs and manage their pharmacy networks, and as a result drug spending in Kentucky will soar. The proposed legislation includes provisions to restrict the use of preferred pharmacy networks, require PBMs to become a fiduciary, implement a dispensing fee reimbursement mandate, and restrict white bagging policies. Although some of the provisions are subject to interpretation, enacting just the bill provisions discussed below could cost the state of Kentucky almost **$400 million in excess drug spending** in the first year alone, and more than **$5 billion** over the next 10 years.

Projected 10-Year Increases in Prescription Drug Spending In Kentucky, 2023–2032 (millions)

	Fully Insured Group Market	Self-Insured Group Market	Individual Direct Purchase Market	Total
Restrict Pharmacy Networks	$422	$845	$105	**$1,372**
Adopt Fiduciary Mandates (Liability Insurance Only)	$78	$156	$19	**$253**
Implement Dispensing Fee Mandates	$862	$1,727	$215	**$2,804**
Restrict White Bagging	$311	$623	$78	**$1,012**
Maximum Costs – Four Provisions	**$1,673**	**$3,351**	**$417**	**$5,441**

Methodology: The methodology used to create these cost projections for adopting a fiduciary mandate and pharmacy restrictions was that used in the April 2020 paper "Increased Costs Associated With Proposed State Legislation Impacting PBM Tools." The methodology used to create the white bagging cost projections is described in "Appendix: White Bagging Dispensing." The methodology to create cost projections for increased dispensing fee spending used a $2 dispensing fee was assumed as a baseline for all prescription fills.[1] Projected increases in costs for dispensing fees are the difference between all prescriptions filled with a $2 dispensing fee and all prescriptions filled with a $10.64 dispensing fee. Count of prescription fills in each state was held constant at 2019 levels, the most recent year for which fill data is available. Given the increasing trajectory of prescription drug fills, this is likely an undercount of the number of drug fills and therefore an underestimation of the costs associated with dispensing fee mandates. The upper dispensing fee limit of $10.64 is used because the bill mandates that dispensing rate. The commercial market includes prescriptions covered by commercial payers (group fully insured, group self-insured, and individual direct purchase) as well as some government programs, such as the Children's Health Insurance Program (CHIP), Veterans Administration (VA) and Indian Health Service (IHS). The number of commercial prescriptions is divided into each insurance market segment proportional to their population.

Data: Commercial market prescriptions is the number of prescriptions filled at retail pharmacies in Kentucky using commercial group and non-group insurance in 2019 from Kaiser Family Foundation "Number of Retail Prescription Drugs Filled at Pharmacies by Payer." This count does not include prescriptions filled at other types of pharmacies, and is likely an undercount of the total number of prescriptions filled in Kentucky using commercial insurance.

1. The Menges Group. "Pennsylvania Medicaid MCO Prescription Drug Repricing: Cost Impacts of Using NADAC Payment Structure."

PCMA

Bill Provisions Descriptions

Proposal would restrict the use of preferred pharmacy networks, specialty pharmacies and mail-order pharmacies.

- PBMs require pharmacies to compete on service, price, convenience, and quality to be included in preferred networks. Pharmacies that agree to participate in such arrangements are designated as 'preferred' and become members of a preferred pharmacy network. These types of networks have gained traction among plan sponsors and deliver tangible out-of-pocket savings for patients.
- The bill guts the ability for health plans and PBMs to create preferred pharmacy networks for self-insured plans by mandating an "any willing provider" requirement. According to the FTC and academic analysis, this type of mandate leads to less competition and higher prices for consumer.[2]
- When applied to specialty pharmacies, the consequences of AWP legislation are even greater. Because specialty drugs are dispensed in such low volumes and target rare conditions, it is infeasible for most retail drugstores to stock these medications and provide the specialized services patients require. States do not legally differentiate specialty pharmacies from traditional pharmacies. These payer-aligned specialty pharmacies must meet payers' terms and conditions to be included in preferred pharmacy networks. Of the roughly 64,000 pharmacies in the U.S., only about 400—less than 1%—are accredited as specialty pharmacies by the independent Utilization Review Accreditation Commission (URAC).

Proposal would adopt fiduciary mandates

- Requiring PBMs to become a fiduciary would increase the costs of liability insurance and increase overall costs. According to the Department of Labor, PBMs "who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform [certain] administrative functions for an employee benefit plan…are not fiduciaries of the plan."[3] Likewise, PBMs have no "discretionary authority" over plan assets as defined by DOL, which is an essential threshold requirement for fiduciary status under federal law.
- Fiduciary mandates would subject PBMs to broader legal liabilities than under current law because they would transform an arm's length contractual relationship into one where one party is responsible for assets that belong to another, such as a trustee relationship. Increased legal risk could result in PBMs needing to purchase additional liability insurance. The added cost of this insurance would then drive prescription drug benefit costs higher for both PBM clients and the individuals enrolled in their plans.

Proposal would implement prescription drug reimbursement mandates

- Requiring PBMs to reimburse pharmacies at mandated levels of the National Average Drug Acquisition Cost (NADAC) plus a $10.64 dispensing fee will cause spending on prescription drugs to soar. Research also shows that mandating reimbursement at NADAC levels will cause drug spending to go up,[1] adding to the hundreds of millions of dollars in extra costs.

Proposal would ban white bagging

- Legislation that would bar health insurers from implementing white bagging will seriously undermine the ability of health plans and PBMs to manage their medical specialty pharmacy expenditures, and as a result, drug spending in Kentucky would soar. Use of white bagging has real benefits for patients, providers, and health plan sponsors.

2."Contract year 2015 policy and technical changes to the Medicare advantage and the Medicare prescription drug benefit programs,"," FTC letter to CMS, Mar. 7, 2014.
3. 29 CFR 2509.75-8 - Questions and answers relating to fiduciary responsibility under the Employee Retirement Income Security Act of 1974.