MARY FELZKOWSKI
STATE SENATOR • 12TH SENATE DISTRICT

Senate Bill 203: Regulation of Pharmacy Benefit Managers
Senate Committee on Heath
Testimony of Senator Mary Felzkowski
May 28, 2025

Thank you, Chair Cabral-Guevara and members of the committee, for hearing our legislation to reform Pharmacy Benefit Managers, also known as PBMs.

Most people have not even heard of a PBM before since they are middlemen hired by insurers to manage a patient's prescription drug benefit program. PBMs are supposed to negotiate better drug prices for insurers so patients can access affordable drugs. Instead, these companies have vertically integrated and are monopolizing the market, resulting in only three PBMs controlling 89% of the market. The top PBMs have become some of the largest Fortune 500 companies by engaging in harmful practices at the expense of patients and independent pharmacies.

Senate Bill 203 provides a number of accountability measures intended to protect patients' access to pharmacies and medications:

- Protects pharmacies from cumbersome dispensing fees
- Ensures pharmacies may join preferred or non-preferred networks
- Prevents PBMs from reimbursing pharmacies below the cost of the prescription
- Prohibits retaliation against pharmacies who report PBM violations
- Provides regulation for fair audit practices limited to waste, fraud and abuse
- Establishes fiduciary responsibility to the insurance company that hires the PBM
- Requires that co-pay assistance coupons that help pay for a patient's drug count toward their deductible
- Prohibits PBMs from removing coverage of a drug on the formulary, except at the time of coverage renewal
- Protects 340B providers from discriminatory practices that PBMs engage in to pocket dollars meant for serving low-income and uninsured communities

You are going to hear arguments from opponents of this legislation that drug costs will increase for patients and employers, and this bill will limit innovative approaches to control the costs of healthcare. However, if we look to other states and research done on the reforms we are proposing, we know this is not true. Red and blue states across the country are actively passing laws to protect their patients and independent pharmacies.

In Wisconsin, we are calling SB 203 "Cole's Act" in memory of Cole Schmidtknect, who passed away at the age of 22 after the PBM changed the coverage of his daily steroid inhaler without proper notice. Unfortunately, Cole's story represents the experience of far too many Wisconsinites. It's why we are proposing this bill to reign in this predatory industry and increase access, safety, and transparency while lowering drug costs.

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TODD NOVAK

STATE REPRESENTATIVE • 51ST ASSEMBLY DISTRICT

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P.O. Box 8953
Madison, WI 53708-8953

DATE: Wednesday, May 28th, 2025

RE: Testimony on Senate Bill 203

TO: Senate Committee on Health

FROM: State Representative Todd Novak

Thank you Chair Cabral-Guevara and members of the Senate Committee on Health for holding a public hearing on SB 203, or Cole's Act, which makes various changes to the regulation of Pharmacy Benefit Managers in Wisconsin.

This legislation is the continuation of the legislation that Senator Felzkowski has authored for several sessions. I want to thank the Senator for her willingness to work with me this session. I also want to thank Cole's family who are here today to testify. We appreciate your willingness to share your story and why this bill will help save lives and prevent future tragedies.
SB 113 makes necessary changes to the treatment of PBM's in state statute. These changes provide a number of accountability measures that will protect patient's access to pharmacies and medications. Changes include the following:

- Protects pharmacies from cumbersome dispensing fees
- Ensures pharmacies may join preferred or non-preferred networks
- Prevents PBMs from reimbursing pharmacies below the cost of the prescription
- Prohibits retaliation against pharmacies who report PBM violations
- Provides regulation for fair audit practices limited to waste, fraud and abuse
- Establishes fiduciary responsibility to the insurance company that hires the PBM
- Requires that co-pay assistance coupons that help pay for a patient's drug count toward their deductible
- Prohibits PBMs from removing coverage of a drug on the formulary, except at the time of coverage renewal
- Protects 340B providers from discriminatory practices that PBMs engage in to pocket taxpayer dollars meant for serving low-income and uninsured communities

I have experienced these issues personally with my own prescription medications. After speaking with my local independently owned pharmacy, I learned that they were no longer carrying one of my prescriptions due to the exorbitant fees being placed on them by my insurance company's PBM.

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While I am fortunate that I was able to fill my prescription at a nearby pharmacy, others are not. I have heard from constituents that have traveled over an hour roundtrip just to pick up their prescription. That is not right, and this bill addresses that issue to ensure that patients can access their medications at a pharmacy of their convenience.

Thank you for your consideration.

HOMETOWN PHARMACY

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COMMENTARY

FTC Releases Second Interim Report on Prescription Drug Middlemen

Ann W. Latner, JD

03/27/2025

The Federal Trade Commission (FTC) published its second interim staff report on the prescription drug middlemen industry in early 2025. The report focuses on pharmacy benefits managers' (PBMs') influence over specialty generic drugs. The report analyzed all specialty generic drugs dispensed from 2017 to 2022 for members of commercial health plans and Medicare Part D drug plans managed by the big 3 PBMs. This includes an analysis of 51 specialty generic drugs which include the generic versions of Ampyra (used to treat multiple sclerosis), Gleevac (used to treat leukemia), Sensipar (used to treat renal disease), and Myfortic (used by transplant recipients).

Key Findings

The latest report revealed that the 3 big PBMs—Caremark, Express Scripts, and OptumRx—significantly marked up the prices of numerous specialty generic drugs by as much as hundreds or thousands of percent. These drugs are used to treat cancer, HIV, and other serious conditions. The PBMs also reimbursed their affiliate pharmacies at higher rates than they paid unaffiliated pharmacies on nearly every specialty generic drug.

Findings also revealed that dispensing patterns suggest that the big 3 PBMs may be steering highly profitable prescriptions to their own affiliated pharmacies, away from unaffiliated pharmacies.

The report uncovered that the 3 PBMs generated over $7.3 billion in dispensing revenue in excess of their estimated acquisition cost, as measured by the National Average Drug Acquisition Cost (NADAC). PBM-affiliated pharmacy dispensing revenue in excess of NADAC increased dramatically at a compound annual growth rate of 42% from 2017 to 2021. The top 10 specialty generic medications generated $6.2 billion of dispensing revenue in excess of NADAC.

Other findings showed that the PBMs had also generated an estimated $1.4 billion in income from spread pricing—billing plan sponsor clients more than they reimbursed pharmacies for the drugs.

This second interim report builds on the report issued by the FTC in July 2024, which revealed that pharmacies affiliated with the 3 big PBMs received 68% of the dispensing revenue generated by specialty drugs in 2023, up from 54% in 2016. The current report looked at a broader set of specialty generic drugs (compared with the 2 specialty generic drugs analyzed in the July 2024 report) and concluded that the big 3 PBMs imposed significant markups on a wide variety of generic specialty medications.

FTC Speaks

"FTC staff have found that the Big 3 PBMs are charging enormous markups on dozens of lifesaving drugs," said Hannah Garden-Monheit, director of the FTC's Office of Policy Planning in a press release. "We also found that this problem is growing at an alarming rate, which means there is an urgent need for policymakers to address it."

"The FTC staff's second interim report finds that the three major pharmacy benefit managers hiked costs for a wide range of lifesaving drugs, including medications to treat heart disease and cancer," said FTC chair Lina M. Khan in a press release. "The FTC should keep using its tools to investigate practices that may inflate drug costs, squeeze independent pharmacies, and deprive Americans of affordable, accessible healthcare—and should act swiftly to stop any illegal conduct."

The FTC study into PBMs is ongoing, and future reports from the Commission are expected.

Reference

FTC releases second interim staff report on prescription drug middlemen. Press release. Federal Trade Commission. Published January 14, 2025. Accessed March 27, 2025. https://www.ftc.gov/news-events/news/press-releases/2025/01/ftc-releases-second-interim-staff-report-prescription-drug-middlemen

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Why PBM Reform Is Needed Now

- Patients endure daily harm due to a PBM system that places profits over their health.
- PBMs, big pharma, and insurers are exploiting and price-gouging patients while reaping massive financial gains.
- Patients are forced into costly and unsafe mail-order systems, exposing them to significant risks.
- Independent pharmacies are being driven out of business, tightening PBM monopolies and worsening patient access.
- Reform is urgently needed to stop exploitation, protect patient rights, and hold the Big 3 PBMs accountable for their purposeful profiteering and harmful actions.

Evidence

Scan Here for Digital Copy to Access Links

- Tip of the Iceburg - violations by PBMS
- Money States Saved by Passing PBM Reform
- FTC Initial Findings
- FTC Second Findings
- House Oversight Committee Report
- APCI Report on Mail Order Prices
- STATES SUING OVER OPIOD MANIPULATION
- FTC SUING OVER INSULIN MANIPULATION
- STATES SUING OVER INSULIN MANIPULATION
- New York Times Article on Opioids and PBMs
- New York Times Article on Mail Order Safety Issues
- RFK Says Trump Administration is Committed to PBM Reform
- Article on COLE SCHMIDTKNECHT
- Smith Insulin Article
- 3 Axis Advisors report on PBM Spread Pricing New York
- West Virginia Success against PBMs
- Oklahoma Lawsuit Against Caremark
- Rutledge vs PCMA
- Walgreens Collapse
- Bloomberg - Why PBM Lack of Transparency Can Hurt Employers
- Vermont Complaint Against PBMs
- Utah Medicaid Review
- Express Scripts Consent Order
- Graph of Independent Pharmacy Decline
- What was, Is No More: Community Pharmacy Economics
- Us Drugstores Vanish as Pressure Mounts on Business Model
- Independent Pharmacies in the United States
- Evolution of Pharmacy Practice 1920-2020
- Aids organization wins $10million against Prime Therapeutics
- Video of Bipartisan Press Conference, December: https://youtu.be/aXOAKRiIFaY?feature=shared
- Video of Trump Recognizing PBMs are a Big Problem: https://www.facebook.com/share/v/12DaaUxxbiV/
- Senate Judiciary Committee with Senator Cory Booker
- Senator & Healthcare Exec Get into Heated Debate Over US Pharmaceutical Costs

For more information, visit:
Patientprotector.us
Modernmedicalmafia.com

STATES THAT PASS PBM REFORM SEE SIGNIFICANT SAVINGS

West Virginia
$54 million

And a little over $6 per individual prescription saved by West Virginia in the first year that they removed PBMs from their state Medicaid plan for prescriptions.

Ohio
$224.8 million

Pocketed by PBMs in 1 year through spread pricing alone (off of the $2.5 billion spent annually through PBMs on Medicaid prescription drugs) – found by the Ohio State Auditor.

California
$500 million

Savings California expects after dropping their PBM. CVS Caremark admitting creating prescription drug costs 10-15%.

Louisiana
$42 million

Amount Louisiana PBMs retained due to incorrectly listing it as "medical costs."

Kentucky
$123.5 million

Kentucky PBMs made in 1 year through spread pricing alone.

Maryland
$72 million

Pocketed by PBMs in spread pricing alone – found by Maryland state agencies.

Michigan
$64 million

Amount PBMs overcharged Michigan Medicaid by manipulating drug pricing.

Virgina
$29 million

Pocketed by PBMs in spread pricing alone – found by a Virginia state-commissioned report on Medicaid.

Louisiana
$1.2 million

Saved by Louisiana by moving to a pass-through PBM model.

Pennsylvania
$1.41 to $2.86 billion

Pennsylvania state auditor found that between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled.

New York
Immense profit at detriment of all others

New York Legislative committee investigated PBM practices and found "PBM entities use vertical integration and rebate management tools to generate revenue for themselves in a manner that detrimentally impacts health plan sponsors, patients, and pharmacies."

18-109x profit

From PBM-affiliated pharmacies: PBMs allegedly shift prescriptions from unaffiliated, high-quality, low-cost pharmacies to their own high-cost, profit-generating pharmacies and charge higher prices.

Source: The SIP for Independent Reform

Source: United Pharmacy Network

NAVITUS

May 28, 2025

Chair Rachel Cabral-Guevara
& Members of the Committee on Health
Committee Room 323 South
State Capitol
PO Box 8953
Madison, WI 53708

RE: 2025 SENATE BILL 203

Dear Chair Cabral-Guevara, Vice-Chair Testin, and members of the Committee on Health:

Thank you for the opportunity to provide written comments on Senate Bill 203. We expect to supplement this written comment with in-person testimony at a hearing before this Committee.

We appreciate your dedication to the citizens of Wisconsin. Navitus is a transparent fully pass-through Pharmacy Benefit Manager (PBM) that:

- Returns **100%** of manufacturer rebates and fees that we receive directly to plan sponsors;
- Never engages in pharmacy spread – meaning we charge our clients the same amount we pay pharmacies;
- Our clients may audit our data and have access through a portal; and
- Focuses on health outcomes and affordability when developing the formularies we recommend to our clients.

Navitus knows the complicated landscape that comprises pharmacy benefits. Navitus is privileged to have served employers and citizens of Wisconsin for over 20 years. Currently, we provide pharmacy benefits for nearly 600,000 Wisconsinites, including beneficiaries of:

- The Wisconsin Employee Trust Fund (ETF)
- Universities
- Fully insured health plans
- Exchange plans
- Self-funded plans

- Cities, towns, and local school districts

As we have discussed with President Felzkowski, we are registered against SB 203 at this time. However, we are supportive and/or neutral on certain provisions of SB 203. We sincerely desire collaboration with the Author, Committee, Legislature, and interested parties to achieve meaningful improvements and access to quality, affordable healthcare in Wisconsin.

Supported Provisions:

Provisions we support include:

- The audit provisions;
- 30-day clean claims payment provisions for electronic claim submissions (we request that additional time be permitted for paper or manual submissions); and
- The transparency provisions - including payments to consultants or brokers.

In addition to supporting the transparency provisions required under this bill, we would encourage this Committee to expand transparency to the other participants in the drug supply chain.

Comments on Neutral or Opposed Provisions

Our concerns include:

- Increased costs for individuals through increased copays and premiums;
- Increased costs for employers/plan sponsors, who shoulder most of the burden;
- Increased costs for taxpayers who support cities, villages, towns, and state health plans;
- Aside from the transparency provisions, we do not see solutions to the rising costs of prescription drugs; and
- Patient protection by ensuring health care providers have appropriate training and certifications to support the most vulnerable patients suffering from complicated/chronic/life-threatening conditions.

We will go through various sections of the bill offering information as to our observations and/or concerns to support a collaborative discussion to improve the protections afforded by this bill while minimizing unintended consequences.

Overall, our conservative estimates suggest increased costs for Navitus' Wisconsin clients and their employees of more than $100 million dollars.

Choice of Provider

This provision appears to limit the ability of a plan sponsor - even one that is a health provider themselves - to limit its network or provide incentives to utilize preferred pharmacies, including their own in-facility pharmacies (*e.g.* hospital plans). Regardless of whether the state, a municipal government, university, hospital, or private-sector employer, a plan sponsor should be allowed the choice and ability to control quality and costs in a constructive manner. Additionally, plan sponsors, not PBMs, choose cost-sharing, network access and co-pays as part of their plan design.

Pharmacy Networks Provision

A requirement to pay all pharmacies at the same rate will increase plan costs. This provision does not take into account the cost differences experienced in rural or underserved areas versus larger chain pharmacy retailers who are likely to experience economies of scale. Plan sponsors could be faced with limiting networks to larger retail chain pharmacies that agree to lower reimbursements and excluding independent pharmacies, since including them would force the employer to pay all pharmacies a higher rate. We suspect this is not the intention of this language. Furthermore, accommodation for additional patient management, enhanced precautions, and delivery of life saving drugs is not taken into account for specialty pharmacies.

Minimum Dispensing Fees

If the bill passes as it is currently drafted, we anticipate increased dispensing fees for our clients, including public sector clients:

- The Wisconsin Employee Trust Fund would see an increase between $18.8 million and $20.1 million.
- The total increase for all Navitus clients, including cities, towns, and self-funded plans would be between $47.6 million and $51.4 million.

Formulary

The notice requirement and restriction on changing the drug formulary throughout the year prevents innovation and adaptability to the developing drug market that has been increasing the availability of biosimilar and generic drugs. Limiting formulary updates to annually prior to renewal imposes significant costs for Wisconsin plan sponsors, and more importantly members, who would not be able to take advantage of lower cost biosimilars or generics:

1) These new requirements are estimated to cost between $20 and $30 million annually for

Navitus' clients in Wisconsin due to delayed moves to generic or biosimilars; and,

2) It would create an administrative burden, forcing plans to maintain 14 possible different formularies in a single calendar year. This could create confusion for pharmacies and members, and lead to access issues for patients.
3) This would negatively affect pharmacies in Wisconsin and their ability to facilitate patient transitions due to the number of changes occurring at the same time across various plans. This sudden surge of size of demand can delay care and increase patient risk of a timely transition to a lower cost product.

To provide a specific example, Navitus safely transitioned more than 97% of patients from Humira to a significantly lower cost biosimilar. This transition has saved ETF almost $6 million in the last 7 months. We have also negotiated a lower price for a biosimilar of Stelara which brings the cost down from $30,000/dose to less than $1,000/dose. The transition to the biosimilar is planned for July and is expected to save ETF an estimated $4.5 million in the second half of 2025. The transition also means that a patient with a 20% coinsurance would go from possibly paying $6,000 with Stelara to only paying $200 with the biosimilar. If midyear changes are not permitted, these savings would be lost for both plan sponsors and patients.

Copay Assistance Programs

Copay assistance provided by pharmaceutical manufacturers assists patients in paying high drug costs. However, instead of lowering the costs of these drugs for everyone, manufacturers seek to maintain an overall high drug cost and take advantage of citizens and plan sponsors by crediting the coupons to the overall high deductible or out-of-pocket maximum. This can often be met with one coupon or treatment. Subsequent treatments would be shouldered by the plan sponsor, taxpayers, and other members the following year as the cost for the plan is significantly increased. It is worth noting that as soon as the out-of-pocket or deductible is met, the patient no longer qualifies for the coupon and the overall cost of the drug is not lowered.

Plan sponsors wish to provide equitable and consistent benefits to their employees/beneficiaries. In the case of a coupon, an employee with a family member suffering from a severe spinal cord injury is forced to meet all deductibles, coinsurance and out-of-pocket costs, while someone suffering from eczema or psoriasis treated with specialty medications can meet their deductible by simply signing up for a coupon. Plan sponsors select copay/coinsurance/out-of-pocket plan designs with the intention that they be applied similarly across all beneficiaries and do not want some beneficiaries subsidizing others.

Copay assistance optimizer programs seek to take full advantage of the generous marketing budget allocation for the benefit of both the patient and the employer. The numbers and impact are staggering. Further, there is a disparate impact as patients who have significant conditions, need surgeries, or extensive therapy are denied the benefit of the allocation of an expedited deductible or out-of-pocket maximization. The result of crediting coupons to coinsurance/out-of-pocket maximums would result in increased costs of approximately:

Fully Insured Health Plans	$8.6 million
Public Sector (counties, towns, and school districts)	$2 million
Self-Insured	$9.7 million
Total Impact	$20.3 million

In the past, there has been confusion concerning what PBMs, plan sponsors and pharmacists retain from these payments. The coupon simply lowers the cost paid by the patient and the plan sponsor or employer. Patients receive this benefit and are simply required to meet their deductible and/or out-of-pocket costs with payments made by them like any other member of that plan. Depending on the type of program utilized and the plan deductible, patients accessing the coupon programs are often able to stabilize their out-of-pocket costs over the course of the plan year even if the coupon amount is exhausted. As a pass through PBM, Navitus transfers any savings to our clients in real time.

Finally, it is worth pointing out that neither Medicaid nor Medicare allow the use of drug coupons as they are considered an illegal inducement.

We would ask that consideration be given to an amendment that would require payments made on behalf of a patient through programs that are based on financial need apply to deductibles, coinsurance and out-of-pocket costs. Programs that are not financial need based should not apply as they are an inducement to purchase the medication over another.

Accreditation Requirements

Although we do not support unnecessary accreditation requirements that could be used as a barrier to entry for independent pharmacies, we do believe that meaningful accreditation

requirements support high quality of care, particularly for patients with rare and difficult to treat diseases. **Independent** specialty pharmacy accreditation ensures a standard of care where enhanced pharmacist support and stricter storage/shipment/administration protocols should apply. We have discussed this with the Pharmacy Society of Wisconsin and will continue to work with them on amendments that support the goal of patient safety, while not serving as a barrier to entry for qualified and trained pharmacies.

Navitus does have a wholly owned specialty pharmacy with headquarters here in Madison called Lumicera. Similar to the Navitus PBM model, Lumicera is transparent and has operated as a cost-plus specialty pharmacy for 11 years.

Cost-plus simply means that if Lumicera acquires a specialty drug at $10,000, it charges the patient/plan $10,000 plus a fully disclosed fee that includes the care described below as well as shipping, which can require temperature controls, etc. The model is completely transparent, down to Lumicera's purchase invoice. If Lumicera purchases a drug at a lower cost the next week, they will sell it to the next client at the lower price. Lumicera's revenue is derived completely from the disclosed, fixed fee, and not from profit margin based on drug prices like specialty pharmacies. In short, Lumicera is not motivated to dispense higher cost drugs and can focus on improving the quality of life for their patients.

Since January 1, 2024, Lumicera proudly has served approximately 8,200 patients in Wisconsin. This constituted approximately 77,400 shipments of lifesaving medication at a cost of approximately $462 million. Although these patients comprise between 1% to 2% of the population, they are among the sickest, often suffering from rare and/or difficult to treat medical conditions. Lumicera provides critical care with compassion and expertise that yield better health outcomes due to higher adherence rates, clinical expertise, and patient copay support resulting in a best-in-class Net Promotor Score (NPS) of 85.5. Lumicera also works to decrease costs for plan sponsors through innovative programs, clinical care coordination, the use of data analytics and insights, and a cost-plus pricing approach.

Lumicera's commitment to patients is validated through the accreditation process, providing the enhanced care necessary to save lives in Wisconsin. Here are the high standards are held to:

- 24-hour access to pharmacists
- Clinical pharmacists and nursing staff trained and certified to treat specified diseases. Their

specializations allow them to tailor drugs for each unique patient and provide truly compassionate care. (allowing for tailored and compassionate care).
    - Complete care path explanation
    - Training on administration of medication and experience upon taking the medication, including contraindications and safety precautions
    - Storage and disposal instruction
    - Education, community, and other resources available for patient advocacy
- Provide a comprehensive initial drug and disease assessment, with no time limit. This assessment focuses on overall health conditions, understanding of the medication and possible side effects. They provide patient support, assessing financial ability to acquire medication and possible options assist to the patient. The focus is on the patient and attaining the best possible outcome.
- Annual disease state reassessments
- Patients are supplied with supporting materials and items (free of charge) – swabs, bandages, sharps containers, syringes/needles and even EpiPens in the event of an adverse reaction.

Lumicera's expertise and focus on the patient means patients receive medication as quickly as possible with the necessary support to maximum health outcomes. Further, 92% of Lumicera patients pay less than $20 and 73% pay $0 per dose because of the day-to-day interaction with various support systems (foundations, manufacturer coupons, community grants and resources) for these complex conditions. When a Lumicera medical professional speaks with a patient, they have already secured any required prior authorization, copay assistance or other funding and any other administrative hurdles with which most patients struggle. This allows Lumicera to help the patient focus on improving their health.

We support meaningful **independent** accreditation that demonstrates the expertise and commitment to the high level of quality care patients deserve when dealing with chronic, complicated, and often life-threatening conditions. Lumicera has both URAC and ACHC accreditation with additional accreditation for oncology distinction. In specialty and rare disease pharmacy, quality and accreditation are essential. Clinical programs, service and quality metrics and the use of analytics are designed to ensure the best possible patient outcomes and the highest patient safety. An array of pharmacist clinicians certified in specialty pharmacy, oncology, and pharmacotherapy guide patients through therapy in conjunction with nurse

clinicians and case workers. Patients seen by specialty pharmacies are 60% more likely to be adherent and experience optimal outcomes compared to those that use a retail pharmacy.[1] Lack of adherence results in missed health outcomes, diminished quality of life and wasted healthcare dollars, increasing the premiums for all of us. We ask that you consider a compromise that a PBM may require no more than two accreditations from independent organizations to participate in their specialty networks.

We welcome any of the Committee members to tour our facility and would be pleased to discuss these important issues further.

Conclusion

As indicated, Navitus registered opposed to SB 203. However, we are supportive of many provisions, neutral on others and hope to work with members and staff to improve the overall drug chain, protect patients, lower total drug costs and improve outcomes.

Thank you for your time and commitment to the citizens of Wisconsin.

Respectfully submitted,

Robyn S. Crosson
Vice President of Government Affairs
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[1] The Role of Specialty Pharmacy in Medication Adherence, https://www.pharmacytimes.com/view/the-role-of-specialty-pharmacy-in-medication-adherence

Providing quality coverage to nearly 3 million Medicaid and private sector enrollees in Wisconsin.

To:	Members, Senate Committee on Health
From:	Abbey Rude, Legislative & Policy Director at the Alliance of Health Insurers
Date:	May 28, 2025
Re:	Testimony on Senate Bill 203

The Alliance of Health Insurers (AHI) is a nonprofit state advocacy organization created to preserve and improve upon consumer access to affordable health insurance in Wisconsin, both via the private sector and public programs.

Prescription medications are an important part of medical treatment. Over the past several decades, health plans' prescription drug benefits have provided access to needed medications for tens of millions of Americans. In addition, under the Affordable Care Act (ACA), every health insurance policy must include a comprehensive "essential health benefits" package covering ten categories of services, including prescription drug coverage.

Prescription drug costs in the United States are skyrocketing. In 2023, $449.7 billion was spent on prescription drugs – an increase of 11.4% over the previous year.[1] Today, nearly 25 cents of every dollar spent on health insurance premiums goes to pay for prescription drugs – an amount that is increasing and is more than any other individual category.[2]

In response, over the past decade, employers, health care insurers, and various government entities have turned to pharmacy benefit management companies (PBMs) as an efficient and effective way to administer prescription drug benefits. PBMs are the primary lever available to health plans to ensure that their customers can obtain the medications they need at the lowest possible cost; and that providers and pharmacies are providing quality care.

Our members and employers work with PBMs because they attempt to contain increasing costs by using their expertise and technology solutions to administer certain essential functions of a prescription drug benefit for health plans, such as:

- Using clinically based services to reduce medication errors, achieve higher rates of medication adherence, and improve health outcomes.
- Negotiating directly with manufacturers and pharmacists to obtain discounts for their customers in the form of lower out-of-pocket costs. The level of comparable volume and cost reductions PBMs can generate cannot be achieved by many health plans, most employers, or individuals.
- Implementing cost-cutting strategies that include discount pharmacy networks, incentives to use therapeutic alternatives, formulary management (including manufacturer rebates), mail-order pharmacies, drug-use reviews, and disease management.
- Educating their consumers about safe, effective, and lower cost generic drugs.

[1] CMS NHE Fact Sheet, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=Historical%20NHE%2C%202023%3A,18%20percent%20of%20total%20NHE

[2] AHIP, Where Does Your Health Care Dollar Go? 2024, https://ahiporg-production.s3.amazonaws.com/documents/AHIP_HealthCareDollar.pdf

Because of these strategies, PBMs have been found to save payers and patients nearly $1,040 per enrollee per year and reduce costs by $6 for every $1 spent on their services.[3]

This bill jeopardizes cost-cutting strategies PBMs and health insurers use to manage the increasing costs of prescription drugs. This bill will eliminate or modify, amongst other provisions – all of which are associated with increased costs:

1. The current structure of pharmacy networks and pharmacy reimbursement
2. Incentives to utilize mail order options for prescription drug delivery
3. When and how a drug can be removed from a formulary
4. The use of copay accumulators

This is a wide-ranging bill and for the purposes of this testimony I have only touched on the highlights. For a more comprehensive summary of the bill's provisions, please see the 17-page document shared with the committee and full legislature by the groups representing health plans.

In a rapidly evolving and dynamic healthcare market, this legislation will suppress innovation, hinder improvements to quality and patient safety, remove incentives for cost-savings and efficiencies, and increase costs for employers and their employees. Our healthcare system is complex and removing many of the tools that are utilized by one of the few entities that exist to negotiate lower healthcare costs is not the solution.

We remain eager to work with pharmacies to ensure our members and plan sponsors have access to high quality providers in their network. We are open to other solutions that would empower pharmacies to be able to deliver other valuable services within their communities.

Ultimately, the payers of health care - the employers of Wisconsin - simply cannot afford the bill presented today.

Thank you for this opportunity to testify.

[3] The Return on Investment (ROI) on PBM Services, Prepared by Visante on behalf of PCMA, 2023

10 East Doty Street, Suite 500 • Madison, WI 53703 • 608-258-9506
R.J. Pirlot, Executive Director, pirlot@hamilton-consulting.com
www.allianceofhealthinsurers.com

To: Wisconsin State Legislators

From: America's Health Insurance Plans
Alliance of Health Insurers
Pharmaceutical Care Management Association
Wisconsin Association of Health Plans

Date: April 21, 2025

Re: Opposition to Assembly Bill 173 / Senate Bill 203 – PBM Legislation

Dear Legislators:

As advocacy organizations that are committed to market-based solutions that improve consumer affordability and access to high-quality, high-value health care in Wisconsin, we appreciate the opportunity to share our serious concerns with, and opposition to, Assembly Bill 173 / Senate Bill 203, relating to pharmacy benefit managers (PBMs).

As drafted, Assembly Bill 173 / Senate Bill 203 does far more than provide "accountability measures" to protect independent pharmacies – it has significant harmful and far-reaching consequences for the cost and quality of prescription drug management in Wisconsin. Employers and their employees already bear the unreasonable and growing cost of prescription drugs through higher health insurance premiums and out-of-pocket costs. The Legislature should not make this problem worse by passing a suite of mandates that will cost Wisconsin employers millions of dollars annually, will do nothing to address the root causes of high drug costs, and will only serve to hamstring payer efforts to provide affordable access to prescription drugs.

The description of our many concerns with the bill begins on page 7 of this memo. However, before we outline the harmful effects of Assembly Bill 173 / Senate Bill 203 , we would like to provide background information on how prescription drugs are covered and accessed and how Wisconsin currently regulates PBMs.

How are Prescription Drugs Covered and Accessed?

Patients in Wisconsin generally access prescription drugs through a health insurance benefit, such as an employer-sponsored plan, an individual market plan, or via government programs like Medicaid and Medicare. The cost of prescription drugs and prescription drug coverage has increased over time.

According to the Centers for Medicare & Medicaid Services (CMS), in Wisconsin, annual per capita spending on drugs and other non-durable products by all payers has increased from $230 in 1991 to $1,040 in 2020 – an average annual growth of 5.3%.[1] National spending on retail prescription drugs has followed a similar trend, increasing from $101 per capita in 1960 to $1,147 in 2021, after adjusting for inflation.[2] In 2024, net of rebates, retail drugs accounted for about 25%

[1] *Health Expenditures by State of Residence: Summary Tables.* Accessed November 22, 2023. Center for Medicare & Medicaid Services. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health- expenditure-data/nhe-fact-sheet.

[2] What are the recent and forecasted trends in prescription drug spending? September 15, 2023. Peterson-KFF Health System Tracker. Available at: https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends- prescription-drug-spending/#Nominal%20and%20inflation-adjusted%20per%20capita%20spending%20on%20retail%20prescription%20drugs,%201960-2021.

of fully-insured private health plan premiums nationally.[3]

This increase in prescription drug spending has been driven by several key factors since the 1990s, including the introduction of numerous new drugs to the market, higher use of prescription drugs per capita, and increasing prices for brand-name drugs. Studies have shown that increasing prices for brand drugs largely reflect drug manufacturers setting higher launch prices for new brand drugs and increasing the prices of brand drugs already on the market.[4]

In this rapidly changing and increasingly expensive prescription drug environment, health insurance providers, employers, and government programs are responsible for balancing increasing prescription drug costs with affordability, access, and quality of care for individuals and families. Thus, private and public payers frequently contract with PBMs for their specialized expertise on prescription drug pricing and clinical issues.

What services do PBMs provide?

PBMs provide many services to drive access, value, efficiency, and effectiveness in the administration of prescription drug benefits, including:

- Negotiating directly with drug manufacturers to obtain discounts on prescription drugs, including volume-based discounts, that usually cannot be achieved by many health plans, most employers, or individuals.
- Negotiating directly with pharmacies for discounts and network design, including establishing value-based arrangements that incorporate clinical performance standards and metrics. This "value-based contracting" is increasingly common throughout the health care industry as a mechanism to drive higher quality care and better patient outcomes.
- Assisting with the development of formulary designs to help enrollees obtain safe and effective medications at the best value, including incentivizing the use of the high-value and clinically appropriate therapeutic options.
- Designing and implementing consumer-driven and data-supported medication management and other innovative pharmacy programs to prevent medication errors, increase adherence, and improve health outcomes.
- Offering enrollee education services around the drug benefit and prescription drugs generally, including the availability of safe, effective, and lower cost generic drugs.

How are prescription drugs covered?

The drugs covered under an insurance benefit, the patient's cost-sharing for the drug, and any specific requirements that might apply for a drug to be covered (e.g., prior authorization, step therapy) are specified via a formulary. PBMs negotiate with drug manufacturers to receive price concessions in exchange for a drug earning a certain formulary placement and/or coverage criteria. Formularies deliver cost savings by making drug manufacturers compete on value, which we define as delivering the best outcomes for the lowest net cost.

Some drugs are required to be covered by federal law,[5] while other decisions about covered drugs are made by a Pharmacy and Therapeutics Committee (P&T Committee). A P&T Committee includes practicing physicians, pharmacists, and other licensed prescribers, and meets for the purposes of reviewing clinical, safety, quality, and cost-effectiveness evidence on various prescription drugs and discussing how specific drugs should be covered.

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[3] https://ahiporg-production.s3.amazonaws.com/documents/202410-AHIP_HealthCareDollar.pdf.
[4] *Prescription Drugs: Spending, Use, and Prices.* January 2022. Congressional Budget Office. Available at: https://www.cbo.gov/system/files/2022-01/57050-Rx-Spending.pdf.
[5] Individual and small group plans that are required to cover essential health benefits (EHBs) must cover certain drugs based on EHB rules (45 CFR 156.122) and the state's EHB benchmark plan (see more on the website of the Wisconsin Office of the Commissioner of Insurance).

All commercial health plans are required under federal law[6] to provide enrollees a written summary of benefits and coverage (SBC) that includes a link to their formulary. Individual and small group qualified health plans (QHPs) are required under federal law[7] to keep their formularies up-to-date and publish their formularies in an easily accessible format that can be viewed by the general public.

Where do patients access prescription drugs?

Patients access prescription drugs through a variety of mechanisms, depending on the drug they have been prescribed and any special considerations for the shipping, handling, storage, and/or administration of that drug. Some drugs must be administered by a clinician, but many drugs can be safely taken at home. Patients who take their drugs at home may receive them from a chain pharmacy, independent pharmacy, other clinic/outpatient pharmacy, mail-order pharmacy, or specialty pharmacy.

The pharmacy industry is highly competitive, which has led the market to change significantly over the past several decades.[8] [9] From 2010 to 2020, there was significant consolidation among retail pharmacy chains. Meanwhile, regional pharmacies have also experienced changes, with both large and small grocers (supermarkets that also have a pharmacy) undergoing acquisitions and mass retail pharmacies (large consumer goods retailers that also have a pharmacy) using their brand name and size to attract customers. Mail-order and direct-to-consumer online pharmacies have also grown, with established retail pharmacies and new entrants establishing a larger presence. Finally, since 2000, the number of independent pharmacies has leveled off at about 20,000 locations – and independent pharmacies have generally remained competitive by gaining scale through collaboration with other independent pharmacies and wholesalers.

According to the National Alliance of State Pharmacy Associations'(NASPA) 2024 state fact sheet [10], there are 5,250 pharmacists in Wisconsin, and 8,700 pharmacy technicians. According to data available on the Department of Safety and Professional Services, there are currently 1,229 in-state pharmacies. In terms of pharmacy access, NASPA further states that "89% of Americans live within 5 miles of a community pharmacy.[11]

In contrast to "brick and mortar" pharmacies, mail-order pharmacies and specialty pharmacies directly ship prescription drugs to patients' homes. Mail-order pharmacies can be lower-cost and more convenient for patients, including those with limited mobility or access to transportation. Mail-order pharmacies are especially valued by employers as both a matter of convenience for their employees and as a cost-saving tool.[12]

Specialty pharmacies dispense medications that are less commonly used, have serious side effects, and/or treat complex conditions. Specialty pharmacies are owned and operated by a variety of entities, including PBMs, wholesalers, providers, integrated delivery networks, and large chain pharmacies. Specialty pharmacies have evolved to meet the unique requirements for dispensing specialty drugs, such as sophisticated

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[6] 45 CFR 147.200
[7] 45 CFR 156.122
[8] Meeting changing consumer needs: The US retail pharmacy of the future. March 17, 2023. McKinsey & Company. Available at: https://www.mckinsey.com/industries/healthcare/our-insights/meeting-changing-consumer-needs-the- us-retail-pharmacy-of-the-future.
[9] Competition, Consolidation, and Evolution in the Pharmacy Market. August 12, 2021. The Commonwealth Fund. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2021/aug/competition-consolidation- evolution-pharmacy-market
[10] https://naspa.us/wp-content/uploads/2024/11/Wisconsin.pdf
[11] https://naspa.us/wp-content/uploads/2024/11/Wisconsin.pdf
[12] Concerns with the Proposed Pharmacy Benefit Manager (PBM) Legislation.. March 19, 2025. WMC & MMAC. Available at: https://wheeler-files.s3.amazonaws.com/upload/files/frontpage/doc_97004716967ed57be6a41b0.31011860.pdf.

storage conditions and processes for drug handling and dispensing. In addition, specialty pharmacy staff coordinate a patient's care by providing close monitoring, collecting data, and sharing that information between the patient's health care providers. Drug manufacturers' pricing power and the unique features of specialty drugs have caused these drugs to be some of the most expensive available.

How Wisconsin Law Regulates PBMs

The federal and state laws that define and impact the management of prescription drug benefits are numerous, and the requirements that were mentioned previously are just a small sample of the parameters that health insurance providers must follow when administering these benefits. In addition to the many existing rules governing the administration of prescription drug benefits, Wisconsin also directly regulates PBMs under the framework established by 2021 Wisconsin Act 9.[13] Act 9 was enacted into law on March 26, 2021.

We recognize that the below summary of the provisions included in Act 9 is lengthy.[14] However, precisely because Act 9 established the many new statutory requirements outlined below, we believe including this description is important for legislators to understand current Wisconsin law with respect to direct regulation of PBMs and other consumer protections.

2021 Wisconsin Act 9

Requiring PBM Licensure & Reporting

- PBMs must be licensed by OCI, either as a PBM or as an employee benefit plan administrator.
- PBMs are subject to OCI's authority to examine or audit their records.
- OCI may revoke, suspend, or limit the license of a PBM for unprofessional conduct, based on a finding that the PBM:
  - Is unqualified to perform responsibilities.
  - Has repeatedly or knowingly violated an applicable law, rule, or order.
  - Has methods or practices that endanger the interests of the enrollees or the public.
  - Has inadequate financial resources to safeguard the interests of the enrollees or the public.
- PBMs must submit annual reports to OCI that contain, for contracted Wisconsin pharmacies:
  - The aggregate rebate amount that the PBM received from all pharmaceutical manufacturers but retained and did not pass through to health benefit plan sponsors.
  - The percentage of the aggregate rebate amount that is retained rebates.

Regulating Business Interactions Between PBMs & Pharmacies

- PBMs are prohibited from changing their pharmacy accreditation requirements more frequently than once every 12 months, and must, in response to a request from a pharmacy, provide any certification or accreditation requirements used as a determinant of network participation.
- PBMs (and health insurance providers) must follow the following statutory parameters for conducting audits of pharmacies:

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[13] We remind legislators that, while states can regulate fully-insured health insurance products, they are generally preempted from regulating self-funded ERISA plans. Accordingly, states do not have open-ended approval for pharmacy benefit regulation in general.

[14] The Legislative Council summary of 2021 Wisconsin Act 9 can be found here.

- Refrain from paying an auditor based on a percentage of the amount recovered in an audit.
- Provide at least two weeks' notice for onsite audits.
- Refrain from conducting an audit during the first five business days of the month, unless the pharmacy agrees otherwise.
- Conduct an audit by or in consultation with a licensed pharmacist if the audit involves clinical or professional judgement.
- Limit review periods to claims submitted within two years of the audit, unless required otherwise by state or federal law.
- Limit the audit review to no more than 250 separate prescriptions.
- Allow pharmacies to use other providers' records to validate the pharmacy's records relating to delivery of a drug and to use any valid prescription to validate claims in connection with a prescription.
- Allow pharmacies to use either paper or electronic signature logs to document the delivery of drugs or services.
- In the case of on-site audits, provide a complete list of records reviewed before leaving the pharmacy.
- Deliver a preliminary audit report, which must contain certain information specified by statute, within 60 days.
- Allow pharmacies, within the 30 days following receipt of the preliminary report, to provide documentation to address any discrepancies found in the audit.
- Deliver a final audit report within 90 days of the preliminary report or the date of the final audit appeal, whichever is later.
- Establish and follow a written appeals process for a pharmacy to appeal the final audit report and arrange, at their own cost, an independent audit.
- Maintain the confidentiality of the results of an audit.

- PBMs (and health insurance providers) must follow the following statutory parameters for recouping funds from pharmacies:
  - Refrain from assessing recoupments or penalties related to an audit until the appeal process is exhausted and a final report has been delivered to the pharmacy.
  - Refrain from accruing or charging interest between the time the notice of an audit is given and the final report is delivered to the pharmacy.
  - Exclude dispensing fees from calculations of overpayments.
  - Refrain from seeking recoupment or recovery for a clerical or record-keeping error in a required document or record, unless the error resulted in an overpayment.
  - Refrain from retroactively denying or reducing an adjudicated claim unless:
    - The claim was submitted fraudulently.
    - The payment for the original claim was incorrect.
    - The services were not rendered.
    - The pharmacy violated state or federal law in making the claim or performing the service.
    - The reduction is related to a quality program and is permitted by the contract between the two entities.

Establishing Consumer Protections

- PBMs and health insurance providers must allow an enrollee to pay at the point of sale the lower of: 1) their cost-sharing for the drug under their insurance plan, or 2) the cash price. This is a protection that PBMs and health insurance providers supported, and it was an industry best practice before being required by state law.
- Codifies a federal prohibition on so-called "gag clauses," by specifying that PBMs and health insurance providers may not restrict or penalize a pharmacy from informing an enrollee of the difference between the individual's cost-sharing for the drug under their insurance plan and the cash price.
- Pharmacies must disclose to consumers:
  - A pharmacist's ability to substitute a less expensive drug product equivalent or interchangeable biological product unless the consumer or prescribing practitioner has indicated otherwise.
  - A list of the 100 most commonly prescribed generic drug product equivalents.
  - Information on how to access the Food and Drug Administration's (FDA) list of all currently approved interchangeable biological products.
  - The retail price, updated no less than monthly, of the 100 most commonly prescribed prescription drugs available for purchase at the pharmacy.
- PBMs and health insurance providers must, with some narrow, common-sense exceptions, provide 30 days advance notice to patients if a prescription drug they are using will be removed from their plan's formulary or reassigned to a benefit tier with higher cost-sharing. The notice must include information on the procedure for the patient to request an exception to the formulary change.
- Pharmacists must notify a patient if a prescription drug they are filling or refilling is removed from their plan's formulary and the health insurance provider or PBM has added to the formulary either: 1) a generic alternative, or 2) another prescription drug with the same mechanism of action that has been assigned the same or lower benefit tier (i.e., with lower cost-sharing) as the original drug. The pharmacist can also extend the original prescription for a 30-day supply if the patient has had an adverse reaction to the new drug.

As noted above, Act 9 was enacted into law on March 26, 2021. Many of the provisions took effect on June 30, 2021, but others did not become effective until policy and plan years that began on or after January 1, 2022. In the case of disclosures that must be made by pharmacies, the Pharmacy Examining Board's final rule implementing this provision (CR 23-015) was made effective on May 1, 2024.

PBM Legislation from the 2023-24 Session.

The first iteration of the legislation that became 2021 Wisconsin Act 9 was introduced in the 2019-2020 Legislative Session. The original version of that bill proposed not just to establish state authority to directly regulate certain PBM activities, but to fundamentally and harmfully overhaul prescription drug management in Wisconsin. Organizations representing health insurance providers and PBMs – the entities responsible for providing access to prescription drugs at a cost that individuals and employers can afford – raised strong concerns with the bill as drafted because of its negative impact on the many important dimensions of: cost; patient access; patient safety; market competition; pharmacy quality and value-based contracting; fraud, waste, and abuse; freedom of contract; and government regulation. Other stakeholders also raised concerns about the impact of the proposed legislation.

Stakeholder representatives, including our associations, met in good faith with legislators over the course of many months to reach a compromise: the bill that became 2021 Wisconsin Act 9. During the 2023-24 Legislative Session, some of the same stakeholders who worked on the

compromise pushed for passage of Senate Bill 737 and Assembly Bill 773, which contained many of the same ideas the Legislature declined to pass out of concern for their harmful impact. Assembly Bill 173 / Senate Bill 203 largely reflects last session's Senate Bill 737 and Assembly Bill 773. In the closing days of the 2023-24 legislative session, stakeholders from all sides were convened to work on a package of provisions to further regulate PBMs. Ultimately, an agreement was reached by all parties to Assembly Amendment 2 to Assembly Bill 1088. The provisions include:

1. Decrease the number of business days from '21' to '7' for pharmacies to appeal a dispute regarding maximum allowable cost pricing;
2. Decrease the number of business days from '21' to '7' for PBMs to investigate and resolve appeals;
3. Mandate that Office of the Commissioner of Insurance respond to a pharmacist or pharmacy's complaint of a PBM's violation of the law, within 14 days after receiving the request;
4. Create an appropriation of $450,000 for 4 full-time positions in the Office of the Commissioner of Insurance that will help the "division fulfill its responsibilities in new areas of regulation, including enforcement of pharmacy benefit manager regulations enacted by 2021 Wisconsin Act 9 and enforcement of any other laws or regulations that apply to pharmacy benefit managers."

   This legislation passed the Assembly but did not pass the Senate and, therefore, did not become law.

Payer Concerns with Assembly Bill 173 / Senate Bill 203

Because of the strong similarities, as well as the incorporation of other mandates that health insurance providers and PBMs also oppose, many of our concerns do not materially differ from what we have previously conveyed to legislators. The remainder of this memo is dedicated to outlining our concerns in detail, organized by the following themes: **cost and competition; quality of care; patient safety; fraud, waste, and abuse; and freedom of contract**. Within these themes, we identify provisions of concern and provide the rationale for our opposition. In most instances, a provision is listed under more than one theme due to its broad implications.

Cost & Competition Concerns

Individually and collectively, most provisions in the PBM bill invoke significant cost and competition concerns. Eliminating health insurance providers and PBM tools to promote high-quality, lower-cost care will make the drug cost problem worse, not better, for employers and patients

Mail-order and Specialty Pharmacy Restrictions: *Provisions 632.861(3g); 632.861(3r)(a); 632.865(5h)(c)*

Specifically, these provisions prevent health insurance providers and PBMs from providing patients with incentives (i.e., lower cost-sharing) to use lower-cost pharmacies, including mail-order and specialty pharmacies. Mail-order pharmacies have introduced competition into the retail pharmacy setting, with an increasing number of entities entering this market. Mail-order pharmacies are especially valued by employers as both a matter of convenience for their employees and as a cost-saving tool.[15] Under the PBM bill, higher-cost pharmacies would not be incentivized to provide lower prices because market pressure to do so would be removed. In addition, some patients' out-of-pocket costs would increase because they could no longer financially benefit from using lower-cost pharmacies. Providing a patient with lower cost-sharing is

a **reward**—not a penalty.

Further, in addition to removing patient incentives to use lower-cost pharmacies, these provisions would prohibit health insurance providers and PBMs from requiring specialty drugs to be dispensed by a specialty pharmacy. As described earlier in this memo, specialty pharmacies dispense medications that are less commonly used, have serious side effects, and/or treat complex conditions. Specialty pharmacies have evolved to meet the unique requirements for dispensing specialty drugs, such as sophisticated storage conditions and processes for drug handling and dispensing. In addition, specialty pharmacy staff coordinate a patient's care by providing close monitoring, collecting data, and sharing that information between the patient's health care providers. Because of the unique requirements for the handling and dispensing of specialty drugs, specialty pharmacies are more appropriately thought of as competitors to outpatient drug administration sites rather than competitors to "brick and mortar" retail pharmacies. Specialty pharmacies are owned and operated by a variety of entities, including PBMs, wholesalers, providers, integrated delivery networks, and large chain pharmacies.

On top of providing these valuable, tailored services, specialty pharmacies can provide drugs at a significant discount, including through volume-based discounts. Although specialty medications comprise a small proportion of total prescriptions, they account for an outsized share of drug spending. This means that the discounts offered by specialty pharmacies lead to significant cost savings.[15]

One-Size-Fits-All Pharmacy Reimbursement: *Provision 632.861(3r)(b)*
This proposal would require health insurance providers and PBMs to completely ignore the many important factors that underpin contracting with individual providers – like the underlying costs of goods and services provided by a pharmacy, the volume of goods and services provided, the quality of services provided, local market conditions, patient demand, and competition – and instead reimburse all pharmacies in the same network at the same rate. This one-size-fits-all approach will lead to increased costs for Wisconsin employers and employees, with no additional value provided.

Frozen Formulary: *Provisions: 632.861(4)(a), 632.861(4)(e),*
These proposals revisit negotiated provisions of 2021 Wisconsin Act 9 and advance a similar "frozen formulary" concept that was removed from the initial version of the PBM bill due to concerns about its impact, especially from employers. [16] [17] We oppose these provisions for the same reasons we opposed them several years ago – they assume a static drug market that does not exist, and render health insurance providers and PBMs unable to respond to the changing market in real time.

The prescription drug market is dynamic, which means the relative cost, value, and safety of drugs is constantly in flux. New drugs (which may be a generic/biosimilar drug, a competing brand drug, or an over-the-counter drug) come to market on an ongoing basis, drug manufacturers increase the cost of their products multiple times each year, and safety or efficacy information on a drug may be updated.

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[15] The Department of Employee Trust Funds (DETF) specifically addressed this provision in its fiscal estimate for the bill, noting that "the use of specialty pharmacies increases the quality of clinical services provided to participants and provides costs savings to the state due to negotiated prices with the preferred specialty pharmacy."

[16] Concerns with LRB 1683, Pharmacy Benefit Manager (PBM) Legislation. November 17, 2023. WMC & MMAC. Available at: https://media.wmc.org/wp-content/uploads/2023/11/17103240/WMC-MMAC-Memo-on-LRB- 1683.pdf.

[17] *DETF also specifically addressed a similar "frozen formulary" provision in its fiscal estimate for the initial PBM bill, saying, "The state's PBM makes* periodic updates to the formulary throughout the year when, for example, new drugs are introduced to the market, brand name drugs lose their patent rights, or drug manufacturer costs significantly fluctuate. This provides the PBM and the state program the ability to manage the formulary and is a tool to contain costs for the state's group health insurance programs."

Formularies deliver cost savings by making pharmaceutical manufacturers compete on value, which is delivering the best outcomes for the lowest net cost. When drug companies increase their prices multiple times each year, health insurance providers and PBMs may be forced to revisit their formularies to ensure drugs are available at an affordable price. Under this proposal, drug manufacturers could increase their prices mid-year, or decline to provide mid-year price concessions if there is new competition, without consequences.

Furthermore, if a new drug comes to market that costs less and is at least as effective or has a better safety profile than an existing option, patients should get the benefit of accessing that new drug at a lower price. There are usually many equivalent drugs to treat a condition, which are evaluated for inclusion and placement on a formulary by P&T Committees[18] based on the best-available evidence. When a formulary is adjusted, it is because a group of experienced clinicians have determined it is clinically appropriate.

Health insurance providers and PBMs make good faith efforts to minimize the frequency of formulary changes that adversely impact patient cost-sharing and/or access, and to minimize the impact of formulary changes on patients when they do occur. However, statutorily taking away the option to respond to changing market conditions, as the PBM bill proposes to do, will lead to increased costs.[19]

Drug "Coupons" and Copay Accumulators: *Provision 632.862*
We oppose this provision, which is a direct incorporation of 2023-24 Assembly Bill 103/Senate Bill 100 and relates to the application of third-party (i.e., drug manufacturer) prescription drug payments to health insurance cost-sharing requirements.

Drug manufacturers offer cost-sharing assistance, often in the form of copay coupons, for certain brand name drugs under the guise of helping patients afford their medications. Copay waivers obscure a drug's true cost, incentivize the use of high-cost drugs, and make pharmaceutical manufacturers less accountable for both their prices and price increases. Imposing mandates on health plan benefit design does not address the root problem of drug manufacturers' high prices. Drug manufacturers often represent their cost-sharing assistance programs as being charitably designed. The reality is that these programs are an anti-competitive marketing tool used to circumvent prescription drug benefit design and drive sales of their product over other, usually lower cost, alternatives. Industry estimates suggest drug manufacturers earn a 4:1 to 6:1 return on copay coupon programs.[20]

Copay coupons hide the real cost of a drug by creating a divide between the purchase price and the consumer's out-of-pocket cost. With coupons, drug manufacturers have an incentive to raise prices and offer coupons to offset consumer cost sharing. This means coupons have the perverse and undesirable effect of undermining health insurance provider and PBM efforts to negotiate lower prices for patients – thus resulting in higher premiums.[21] [22]In fact, the prices for drugs with manufacturer coupons increase faster (12-13% per year) compared to drugs without coupons (7-8% per year).[23]

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[18] See page 2 of this memo additional information about P&T Committees.

[19]. *Estimated cost of potential "frozen formulary" legislation.* January 25, 2021. Milliman. Available at: https://www.pcmanet.org/wp-content/uploads/2021/02/Milliman_Frozen-Formulary-Report_FINAL.pdf.

[20] When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. October 2016. Dafney, L. et al. Available at: https://www.nber.org/system/files/working_papers/w22745/w22745.pdf.

[21] Copay Assistance for Expensive Drugs: A Helping Hand That Raises Costs. October 11, 2016. Ubel, P. & Bach, P. Available at: https://www.acpjournals.org/doi/abs/10.7326/M16-1334?journalCode=aim.

[22] *Eliminating Prescription Drug Copay Coupons.* Dafney, L. et al. Available at: https://onepercentsteps.com/wp-content/uploads/brief-epdcc-210208-1700.pdf.

[23] When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. October 2016. Dafney, L. et al. Available at: https://www.nber.org/system/files/working_papers/w22745/w22745.pdf.

Drug manufacturer assistance programs are not allowed under federal programs like Medicare and Medicaid because they are considered remuneration offered to induce the purchase of specific items and, therefore, violate federal anti-kickback laws. In an advisory bulletin[24] regarding copay coupons, the U.S. Department of Health and Human Services Office of Inspector General said the following:

> "Cost-sharing requirements for Federal health care program drugs serve an important role in protecting both Federal health care programs and their beneficiaries. These cost-sharing requirements promote: (1) prudent prescribing and purchasing choices by physicians and patients based on the true costs of drugs and (2) price competition in the pharmaceutical market. While copayment coupons provide an immediate financial benefit to beneficiaries, they ultimately can harm both Federal health care programs and their beneficiaries. The availability of a coupon may cause physicians and beneficiaries to choose an expensive brand-name drug when a less expensive and equally effective generic or other alternative is available. When consumers are relieved of copayment obligations, manufacturers are relieved of a market constraint on drug prices. Excessive costs to Federal programs are among the harms that the anti-kickback statute is intended to prevent (emphasis added)."

The prohibition on the use of copay coupons in Medicare, even for a drug that does not have an FDA-approved pharmacological treatment alternative (a scenario that would apply to commercial plans under Assembly Bill 103/Senate Bill 100 and the proposed PBM bill), was recently affirmed by the U.S. Court of Appeals in *Pfizer v. HHS.*[25]

Finally, no healthcare provider in Wisconsin is permitted to offer the kind of copay waivers that pharmaceutical companies provide. Doing so would constitute a violation of Wis. Stat. 146.905, as well as federal anti-kickback and civil monetary penalty laws. The Office of the General Counsel of the Wisconsin Medical Journal has advised healthcare providers to "Do not offer routine waivers of copays and deductibles" and "Give only very small gifts to patients" to avoid violating state and federal law.[26] Drug manufacturers' copay coupons certainly do not abide by this guidance.

Copay coupons deliberately circumvent health insurance provider and PBM efforts to encourage equally effective, lower cost treatments. State law should not legitimize the use of copay coupons, nor force employers and employees to bear the increased costs that result from their use.

Maximum Allowable Cost List *Provisions: 632.865(1)(an), (aq) & (at), 632.865(1)(bm),632.865(1)(cr), 632.865(2), 632.865 (2d)*
Pharmacies are reimbursed by PBMs for generic drugs via maximum allowable cost (MAC) lists. Multiple drug manufacturers may make clinically identical generic products – but the price of the product, and thus a pharmacy's acquisition cost, can differ across manufacturers and wholesalers. MAC lists cap the amount a PBM will reimburse a pharmacy for clinically identical products and thus encourage pharmacies to buy their inventory as efficiently as possible. To purchase generic drugs at a greater discount, independent pharmacies may join larger buying groups and/or pharmacy services administrative organizations (PSAOs) to use their pooled purchasing power. PBMs do not control how and from whom retail pharmacies purchase their drug inventory. But

[24] Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons. September 2014. U.S. Department of Health and Human Services Office of Inspector General. Available at: https://oig.hhs.gov/documents/special-advisory-bulletins/878/SAB_Copayment_Coupons.pdf.
[25] The court opinion can be found here: https://cases.justia.com/federal/appellate-courts/ca2/21-2764/21-2764-2022- 07-25.pdf?ts=1658759410.
[26] Five Things Every Physician Needs to Know About Freebies and Discounts. 2010, Volume 109, No. 4. Wisconsin Medical Journal. Available at: https://wmjonline.org/wp-content/uploads/2010/109/4/233.pdf.

MAC reimbursement helps ensure that health insurance providers and PBMs – and, ultimately, employers and their employees – do not over-pay for drugs that are clinically the same. The MAC will change frequently in response to the complex and dynamic nature of market pricing for generic drugs. MAC prices are driven by competitive factors, including how long the drug has been generic, how many manufacturers are making generic versions, how available the generic drug is for purchase, and whether there have been manufacturing challenges like access to basic ingredients or product recalls. To determine a fair and up-to-date reimbursement rate for generic drugs, PBMs frequently survey market data to calculate the average acquisition cost for those drugs.

Since 2015, PBMs have been required under Wisconsin law[27] to include certain pricing transparency practices in their contracts with pharmacies, including:

- Updating MAC pricing information at least every 7 business days and providing a means for contracted pharmacies to promptly review pricing updates in a readily available and accessible format.
- Reimbursing pharmacies subject to MAC pricing that has been updated at least every 7 business days.
- Eliminating prescribed drugs or devices from the MAC or modifying the MAC in a timely fashion, consistent with drug availability and pricing changes.
- Providing a process for a pharmacy to appeal, investigate, and resolve disputes regarding MAC pricing that includes all of the following:
    - A 21-day limit on the right to appeal following the initial claim.
    - A requirement that the appeal be investigated and resolved within 21 days after the date of the appeal.
    - A dedicated phone number at the PBM for the pharmacy to speak to a person responsible for processing appeals.
    - A requirement that a PBM provide a reason for any appeal denial and the FDA's national drug code for the drug that may be purchased at or below the MAC price.
    - A requirement that a PBM make a pricing adjustment no later than one day after the date of the final determination of the appeal.

The PBM bill abandons the current market-driven framework, which balances competition with parameters for fair pricing and disclosure, and instead creates an environment that actively discourages pharmacies from being efficient purchasers of generic drugs. Most notably, the proposed legislation mandates that PBMs reimburse pharmacies at-cost in certain circumstances. If a pharmacy is guaranteed reimbursement at or above their acquisition cost, no matter what that acquisition cost is and if a lower-cost option could have been purchased instead, employers and their employees will bear the unnecessary expense of a higher price for an identical product. We oppose proposals that will result in this negative outcome.

We are also concerned about the impact 632.865(2d)(e) would have on patient access by allowing pharmacies to decline to dispense a drug if the pharmacy would be reimbursed less than its acquisition cost. As described previously, MAC lists cap the amount a PBM will reimburse a pharmacy for clinically identical products and thus encourage pharmacies to buy their inventory as efficiently as possible. Patients should not be penalized because a pharmacy did not purchase a drug efficiently.

Mandated Cost Increases in Dispensing Fees: *Provision: 632.865(2h)*
Dispensing fees are designed to cover reasonable costs associated with the dispensing of a drug. The PBM bill would require PBMs to pay a dispensing fee that is no less than the

[27] Wis. Stat. 632.865 (2)

dispensing fee paid under Wisconsin's Medicaid program, which is currently $15.69 for a total annual prescription volume of 34,999 or less and $10.51 for a total annual prescription volume of more than 35,000.[29] Because of differences in how pharmacists are reimbursed in Medicaid versus the commercial market, these amounts are well above the average commercial market dispensing fee of $2.[30] Mandating minimum dispensing fees, especially at such a significantly higher amount than is currently negotiated in the commercial market, will result in millions of dollars in increased costs to Wisconsin employers and employees, with no additional value provided.

Fiduciary Duties: *Provision: 632.865 (2t)*
The Employee Retirement Income Security Act of 1974 (ERISA) defines a fiduciary, in relevant part, as a person who "exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets," or "has any discretionary authority or discretionary responsibility in the administration of such plan. PBMs typically serve in administrative and advisory roles and do not make decisions about whether the plan should offer pharmaceutical benefits or the scope or design of those benefits, therefore PBMs are not plan fiduciaries. Simply put, PBMs cannot be a fiduciary.

"Any Willing Provider" Provisions: *Provision: 632.865(5h)*
Any Willing Provider" (AWP) rules prevent the use of preferred pharmacy networks. PBMs create networks of pharmacies that offer savings to employers and their employees by securing discounted rates in exchange for higher patient volume. Nationally, 76% of employers report using some type of narrowed pharmacy network, and their employees can save 38% out- of-pocket using the in-network pharmacies versus out-of-network pharmacies.[28] The PBM bill requires PBMs to contract with any pharmacy that can meet the contract terms, interfering both with the freedom of contract and PBMs' ability to secure cost savings for employers and employees.

All pharmacies in a network negotiate contracts with the PBM acting on behalf of the plan sponsor, and these typically include performance measures to incentivize better patient service and quality in areas such as generic dispensing, adherence, and patient counseling. By leveraging the power of large pharmacy collectives to negotiate with PBMs on their behalf, independent pharmacies can secure favorable contract terms and, on average, higher reimbursements than chain drugstores. Pharmacy Service Administrative Organizations, or PSAOs, and PBMs also provide pharmacies with software, such as Pharmacy Quality Solutions' Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP), which allows pharmacies to access their contracted pharmacy measures, track their own performance against those measures, and compare benchmark measures of their contracts across plans and against other pharmacies.

Eliminating this puts patients at risk and increases costs as they reduce the usage of cost-efficient specialty pharmacies and preferred pharmacies that previously provided the deepest discounts as they can no longer count on getting added volume in exchange. The Federal Trade Commission (FTC) has noted that "requiring prescription drug plans to contract with any willing pharmacy would reduce the ability of plans to obtain price discounts based on the prospect of increased patient volume and would thus impair the ability of prescription drug plans to negotiate the best prices with pharmacies[29].

[28] Unlocking an Affordable Future. January 2023. PCMA. Available at: https://www.pcmanet.org/wp- content/uploads/2023/01/PCMA-Affordable-Future-whitepaper_FINAL.pdf.
[29] U.S. Federal Trade Commission. 2014. Letter to CMS re: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff- comment-centers-medicare-medicaid-services-regarding-proposed-rule/140310cmscomment.pdf

340B Program Restrictions: *Provision: 632.865(5d)(2)*
This legislation prohibits PBMs from taking certain actions with respect to 340B covered entities, pharmacies and pharmacists contracted with 340B covered entities, and patients who obtain prescription drugs from 340B covered entities.

The 340B program's intent is to ensure patients of safety net providers ("covered entities") have access to affordable drugs, allowing these providers to purchase drugs at a steep discount. The number of covered entities and their contracting pharmacies has increased dramatically over the years,[30] with little evidence that discounts benefit those in need.[31]

Because drugs are purchased by providers at a steep discount under the 340B program, claims for those drugs do not qualify for additional price concessions that would otherwise be provided to health insurance providers and PBMs by a drug manufacturer. This means that health insurance providers and PBMs sometimes pay more than their usual contracted price for drugs purchased through the 340B program. Health insurance providers and PBMs should not be required to pay higher than their usual rates, especially when the drugs are being purchased at a discount, as would be required under the PBM bill. Rather, health insurance providers and PBMs should be able to continue to manage networks and reimbursement models to reduce the overall cost of prescription drugs.

Quality of Care Concerns
Health insurance providers and PBMs play an important role in facilitating high-quality patient care through accreditation standards, quality standards, and network design. The proposed PBM bill takes several steps to remove health insurance providers and PBMs from this role.

Prohibition on Enhanced Pharmacy Accreditation Standards: *Provision: 632.865(4)(b)*
This bill creates a prohibition on PBMs requiring a certification or accreditation that is inconsistent with or more stringent than federal and state requirements for pharmacy licensure. We oppose this proposal for the same reason we opposed a similar provision in the initial version of the previous PBM bill – because health insurance providers and PBMs should be free to require higher standards for their patients, rather than being statutorily required to accept the lowest common denominator.

Health insurance providers and PBMs often voluntarily seek or are required by government programs to obtain accreditation from independent entities such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC). These entities measure quality across many dimensions, including clinical performance (e.g., quality management and improvement, population health management, health equity) and consumer experience. To achieve the high standards of care required by these entities, health insurance providers and PBMs may in turn require pharmacies to adhere to certain practices and standards. The PBM bill would impede these quality improvement efforts and cause health insurance providers and PBMs in Wisconsin to fall behind their peers nationally.

We are especially concerned about the impact of this proposal on the dispensing of specialty drugs. Again, drug manufacturers' pricing power and the unique features of specialty drugs have caused these drugs to be some of the most expensive available. Specialty pharmacies have

[30]Increase in covered entities from 9700 in 2010 to 12,700 in 2020, and 31,937 contract pharmacies. Drug Channels Institute. July 2022. "Exclusive: Five Pharmacy Chains and PBMs Dominate 2022's StillBooming 340B Contract Pharmacy Market. " https://www.drugchannels. net/2022/07/exclusive-five-pharmacies-and-pbms.html#:~:text=As%20of%202022%2C%20DCI%20found,acting%20as%20340B%20contract%20pharmacies

[31] Peter J. Pitts & Robert Popovian, Food and Drug Law Institute. "340B and the Warped Rhetoric of Healthcare Compassion." https://www. fdli.org/2022/09/340b-and-the-warped-rhetoric-of-healthcarecompassion/. "72% of private nonprofit hospitals had a fair share deficit, meaning they spent less on charity care and community investment than they received in tax breaks."

arisen in response to these pressures and have further evolved to adopt standards that improve quality of care and safety for patients. Simply being licensed to operate a pharmacy does not demonstrate the level of operational capability and quality of service that is required for the handling and dispensing of specialty drugs. Specialty pharmacy accreditation programs established by independent entities like NCQA and URAC set important standards for best practices for patient-centered care and help pharmacies be equipped to enter value-based payment arrangements that reward quality.

Finally, whether to meet accrediting body standards or to voluntarily drive better patient outcomes, health insurance providers and PBMs currently can negotiate with pharmacies to establish quality programs or performance-based contracting. Such programs and contractual arrangements are common across the entire health care system as a means to encourage high-quality, high-value services. Health insurance provider and PBM arrangements with pharmacies may include disease state or medication-specific pharmacist training for high-cost and rarely used medications, or patient outcomes management programs and quality metric reporting. These activities indicate a consistent commitment to safe, coordinated, and quality patient care.

Specialty Pharmacy Prohibitions: *Provision: 632.861(3g)*
This provision would prohibit health insurance providers and PBMs from requiring specialty drugs to be dispensed by a specialty pharmacy. As we have described throughout this memo, specialty pharmacies dispense medications that are less commonly used, have serious side effects, and/or treat complex conditions. Specialty pharmacies have evolved to meet the unique requirements for dispensing specialty drugs and coordinate a patient's care, and often meet quality standards set by independent entities.

Quality Program Restrictions: *Provisions: 632.865(5)(e); 632.865(6r)*
These provisions repeal a statutory parameter that was agreed to in negotiations over 2021 Wisconsin Act 9, and reverse course from that language to prohibit a PBM from basing "any criteria of a quality program...on a factor for which the pharmacy does not have complete and exclusive control."

As mentioned above, health insurance providers and PBMs are held to high quality standards by national accrediting bodies, not to mention the expectations set by employers and government programs for the quality of care their enrollees receive. Health insurance providers and PBMs must work with all their contracted providers, including pharmacies, to meet these standards and deliver the high-value care that patients deserve. Health insurance providers, PBMs, and many types of health care providers are routinely evaluated on – and held financially accountable for – quality factors over which they do not have "complete and exclusive control." Quality programs should be fair, achievable, and oriented toward delivering high-value care but it is disingenuous to suggest that it is appropriate or desirable for quality programs to only include measures that are completely controllable by a single entity

Mandated Pharmacy Reimbursement Regardless of Value: *Provisions: 632.865(1)(cg); 632.865(2d)(d)*
This is a prohibition on PBMs reimbursing a pharmacy less than the amount the PBM reimburses an affiliate for providing the same product. We oppose this proposal for the same reason we opposed a similar provision in the initial version of the previous PBM bill – because it would interfere with innovative pay-for-performance contracting, which rewards high-performing pharmacies for activities such as improving patient medication adherence or reducing gaps in-patient treatment. These value-based activities benefit patients by ensuring safety, improving outcomes, and reducing costs. Value-based, quality-driven contracting focuses on improving patients' health outcomes and should be supported—not obstructed like it is under this bill.

Patient Safety
In addition to playing a role in promoting high-quality patient care, health insurance providers and PBMs also routinely take steps to help ensure patient safety. The proposed PBM bill inhibits these efforts in several ways.

Specialty Pharmacy Prohibitions: *Provision: 632.861(3g)*
This provision would prohibit health insurance providers and PBMs from requiring specialty drugs to be dispensed by a specialty pharmacy. As we have described throughout this memo, specialty pharmacies dispense medications that are less commonly used, have serious side effects, and/or treat complex conditions. Specialty pharmacies have evolved to meet the unique requirements for handling and dispensing specialty drugs, typically help coordinate a patient's care, and often meet quality standards set by independent entities. Typical retail pharmacies are often not equipped to meet the higher-than-normal standards for specialty drugs to ensure patient safety. Because of the unique requirements for the handling and dispensing of specialty drugs, specialty pharmacies are more appropriately thought of as competitors to outpatient drug administration sites rather than competitors to "brick and mortar" retail pharmacies. We oppose this provision out of concern for its potential impact on patient safety.

Frozen Formulary: *Provisions: 632,861(4)(a); 632.861 (4)(e))*
These proposals implement a "frozen formulary" We oppose these provisions for the same safety concerns we opposed them several years ago – because the known risks and benefits of a drug change over time, and health insurance providers and PBMs need to be able to respond to prescription drug safety and efficacy data in real time. For example, additional safety concerns can emerge after a new drug is brought to market and used on a broader, more diverse population than was tested in clinical trials. Based on new data, a drug can be labeled with new safety warnings or even pulled from the market. Health insurance providers and PBMs take safety concerns seriously and should be able to expeditiously change their formularies when new data emerge in order to favor drugs that have less dangerous side effects or are comparatively more effective. The PBM bill gives no consideration to and no exceptions for these kinds of circumstances.

Pharmacist Ability to Refuse to Dispense a Drug: *Provision: 632.865(2d)(e)*
We are also concerned about the impact 632.865(2d)(e) would have on patient access by allowing pharmacies to decline to dispense a drug if the pharmacy would be reimbursed less than its acquisition cost. Patients should not be penalized because a pharmacy did not purchase a drug efficiently.

Prohibition on Enhanced Pharmacy Accreditation Standards: *Provision: 632.865(4)(b)*
This session's PBM bill revisits a concept negotiated in 2021 Wisconsin Act 9, which is a prohibition on PBMs requiring a certification or accreditation that is inconsistent with or more stringent than federal and state requirements for pharmacy licensure. Again, we are concerned about the impact of this proposal on the dispensing of specialty drugs. Simply being licensed to operate a pharmacy does not demonstrate the level of operational capability and quality of service that is required for the handling and dispensing of specialty drugs. Specialty pharmacy accreditation programs established by independent entities like NCQA and URAC set important standards that play a role in helping keep patients who take specialty drugs safe.

Fraud, Waste, and Abuse
This session's PBM bill revisits several of the same provisions that were negotiated out of the initial version of the previous PBM bill, as well as expands upon the audit requirements that were included in 2021 Wisconsin Act 9 (as a reminder, page 5 of this memo describes the audit requirements PBMs must follow under current law). Health insurance providers and PBMs raised concerns about the audit requirements proposed in the last PBM bill because extremely prescriptive parameters on audit procedures detract from efforts to safeguard individual, employer, and government program dollars from fraud, waste, and abuse. We have similar concerns with this session's PBM bill (provisions: 632.865(6)(bm); 632.865(6)(c)3; 632.865(6)(c)3m; 632.865(6g); 632.865(8)).

For example, the bill prohibits funds from being recouped for errors that have no "actual financial harm" (which is not defined under the bill) to the enrollee, policy, or plan unless the error is the result of failure to comply with a corrective action plan. We oppose this provision because it would prohibit PBMs from holding pharmacies responsible for common errors, not complying with applicable laws and rules, and/or contributing to waste or abuse. All health care organizations, including pharmacies, are held responsible for errors through audits and recoupment.

As another example, the bill prohibits the use of extrapolation to calculate recoupments. We oppose this provision because extrapolation can benefit everyone by avoiding the resource- and time-intensive alternative of auditing all claims. Auditing a sample of claims and projecting those findings saves all parties significant time and money. Furthermore, this provision effectively absolves pharmacies from the financial consequences of their errors, because the circumstances under which a recoupment or penalty can be applied are significantly narrowed. This provision would likely result in higher costs from fraud, waste, and abuse.

Finally, the bill introduces a new legal avenue through which pharmacies can claim "retaliation" from PBMs if they engage in normal business practices like terminating or refusing to renew a contract or requiring additional audits. This not only raises freedom of contract concerns, but also increases the chances for frivolous lawsuits by bad actors, who could levy a "retaliation" charge against PBMs when they take necessary steps to investigate and/or address fraud, waste, or abuse. *632.865(1)(bm), 632.865 (2d), 632.865.(5d), 632.865(6)(bm),632.865(6g), 632.865 (8),*

Freedom of Contract
As did the initial version of the previous PBM bill, this session's PBM bill inappropriately imposes requirements on contracts that are freely negotiated between private parties. We oppose the following provisions for other reasons mentioned elsewhere in this document, and we also oppose these provisions because they represent government interference with freedom of contract:

1. 632.861(1m),
2. 632.861(3g),
3. 632.861(3r),
4. 632.861(4)(a),
5. 632.861(4)(e),
6. 632.862,
7. 632.865(1)(bm),
8. 632.865 (2d),
9. 632.865(2p),
10. 632.865 (2t),
11. 632.865(4)(b),
12. 632.865.(5d),
13. 632.865(5h),
14. 632.865(5t),
15. 632.865(4m),
16. 632.865(6g)
17. 632.865(6r)
18. 632.865 (8)

Conclusion

We appreciate the opportunity to share our perspective on the many harmful impacts of the PBM bill. Prescription drugs are a vital and increasingly expensive component of health care benefits, which means payers must carefully balance costs, affordability, access, and quality of care. Through this memo, we have attempted not only to convey our concerns with the PBM bill, but also describe the complexity of the prescription drug supply chain and management of prescription drug benefits. Many interdependent market forces – not just PBMs, as bill proponents claim – make the prescription drug industry generally and the pharmacy industry specifically a competitive, and at times challenging, business environment. Legislative mandates imposed in the name of protecting a specific market player – in this case, independent pharmacies – are a blunt and ineffective approach that always have spillover effects. In this case, those effects would be felt directly by Wisconsin employers and employees who already struggle to afford their health care costs.

Wisconsin Association of Health Plans

Senate Bill 203
Senate Committee on Health
May 28, 2025

Chair Cabral-Guevara, members of the Committee, thank you for the opportunity to provide testimony today regarding Senate Bill 203 (SB 203). My name is Kyle Caudill and I am the Director of Government Affairs for the Wisconsin Association of Health Plans. The Association is the voice of 14 community-based health plans that serve employers and individuals across the state in a variety of commercial health insurance markets. Member health plans are also key partners in state-administered programs, including the Group Health Insurance Program and Medicaid managed care programs.

Though Association member health plans do not own any pharmacy benefit managers (PBMs), many of our plans contract with PBMs to negotiate with drug manufacturers to obtain better prices on drugs for their plan participants. Our member community-based health plans have significant concerns over the harmful and far-reaching consequences that SB 203 would have on the cost and quality of prescription drug management in Wisconsin, and the Association respectfully opposes this legislation.

Our Association, together with other trade associations, recently circulated a memo to lawmakers detailing our concerns with SB 203. For the sake of brevity, I will not cover in my testimony today the many provisions of this bill with which our Association has concerns that are outlined in that memo. I would like to focus my comments today on just one portion of SB 203—the provision relating to the application of prescription drug payments to health insurance cost-sharing requirements.

Association member health plans share the goal of the bill authors of making prescription drugs more affordable for Wisconsin patients. Drug prices set by pharmaceutical manufacturers are often excessive and unreasonable, and prescription drugs constitute a significant and fast-rising portion of total health care spending. However, this proposal will not reduce this trend. SB 203, through its prohibition of so-called co-pay accumulator programs, constitutes state endorsement of bait-and-switch marketing strategies used by pharmaceutical companies to induce consumers to use more expensive branded drugs.

Specifically, this legislation purports to save patients money by prohibiting insurers from managing the total cost of prescription drugs through co-pay accumulator programs. Drug manufacturers offer cost-sharing assistance, often in the form of co-pay coupons, and represent this assistance as being designed to lower the cost of a prescription drug. The reality, however, is that these programs are anti-competitive marketing tools used to drive sales of brand-name drugs. Co-pay coupons obscure a drug's true cost, incentivize the use of high-cost drugs, and make pharmaceutical manufacturers less accountable for both their prices and price increases, ultimately leading to increased costs for all members of a health coverage plan. SB 203 would restrict the use of a tool health plans may employ to better manage total drug costs for plan participants, and undermines health plan efforts to negotiate lower prices for patients. Imposing mandates on health plan benefit design does not address the root problem of the high prices set by drug manufacturers. Barring the use of co-pay accumulator programs will increase health care costs for all consumers by limiting the downward market pressure these programs have on the price of prescription drugs.

Committee members should also know that pharmaceutical manufacturer assistance programs are not permitted under federal programs like Medicare and Medicaid because they are considered a violation of federal anti-kickback laws. Additionally, under state law, no health care provider in Wisconsin is permitted to offer the kind of copay waivers that pharmaceutical companies provide. These prescription drug co-pay coupons are specifically intended to undermine and circumvent health plan efforts to constrain costs and encourage equally effective, lower cost treatments, and in doing so, actually serve to increase – not lower – costs for all plan members.

For these reasons, we respectfully urge committee members to take no action on SB 203. I am happy to answer any questions you may have at this time.

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STATEMENT

PhRMA
RESEARCH • PROGRESS • HOPE

In Support of SB 203
May 28, 2025

Position: The Pharmaceutical Research and Manufacturers of America (PhRMA) supports SB 203, which will help patients better access and afford their medicines by prohibiting the use of accumulator adjustment programs (AAPs).

Spending on medicines is growing at the slowest rate in years. Unfortunately, it doesn't feel that way for patients because health insurers are increasingly using deductibles and coinsurance, which results in patients paying the full list price for their medicines, not the discounted price paid by the insurer or PBM. This higher cost sharing can impact patients' ability to adhere to their prescribed treatment, which can be devastating for patients with chronic conditions who rely on medicines to keep their symptoms in check. Moreover, new tactics implemented by insurers and PBMs to block manufacturer cost sharing assistance, through programs known as accumulator adjustment programs (AAPs), threaten to make it even harder for patients to get important treatments for chronic illnesses such as asthma, diabetes, HIV, arthritis, hemophilia, and others. By prohibiting the use of AAPs, SB 203 will help Wisconsinites pay less for their medicines.

Over twenty states have enacted legislation to address this issue. We encourage Wisconsin to follow their lead to protect patients and enable them to better afford their medicines.

SB 203 would prohibit health insurance carriers from unfairly increasing cost-sharing burdens on patients by refusing to count third-party assistance toward patients' cost-sharing contributions.

To help patients better afford and stay adherent to their medicine, many third-party entities, including pharmaceutical manufacturers, offer cost-sharing assistance. Historically, commercial health insurance plans have counted this cost-sharing towards a patient's deductible and maximum out-of-pocket limit, providing relief from high cost-sharing and making it easier for patients to get their medicines. Unfortunately, health insurance carriers and PBMs are increasingly adopting policies, often referred to as "accumulator adjustment programs" (AAPs), that block manufacturer cost-sharing assistance from counting towards patient cost-sharing requirements.

When health plans implement such programs, they can substantially increase patients' out-of-pocket costs, financial burdens, and health risks. Many patients who have benefited from cost-sharing assistance to afford their medicines have no idea that health insurers and PBMs are no longer counting cost-sharing assistance toward their annual out-of-pocket limits. As a result, patients may face thousands of dollars in surprise out-of-pocket costs for their prescription medicines because manufacturer cost-sharing assistance isn't counted as if paid by patients themselves. Surprise out-of-pocket costs are a significant problem for patients—Nearly 2 in 5 (37%) Americans say they could not

cover emergency expenses costing $400.[1]

Patients subject to these cost-sharing surprises have a significantly greater risk of treatment discontinuation and lower refill adherence. In many cases, patients leave the pharmacy empty-handed as a result. One recent study found that implementing AAPs for specialty autoimmune medicines was correlated with reductions in medication adherence among high deductible health plan enrollees. The research included patients subject to a deductible for their medicines and those not subject to a pharmacy deductible. Those patients subject to a deductible had four times higher treatment discontinuation and 12% lower refill adherence after implementing accumulators than patients in a plan that was not subject to a pharmacy deductible.[2]

Health plans claim that AAPs help prevent cost-sharing assistance from driving patients towards a more expensive branded drug when a generic equivalent is available. However, the influence of manufacturer assistance in allegedly undermining formularies and other utilization management methods that promote the use of low-cost therapies is overstated. In fact, cost-sharing assistance is most commonly used for medicines without a generic equivalent. In 2021-2022, cost-sharing assistance for a brand medicine where a generic equivalent was available accounted for less than one percent of all commercial market medicine claims.[3] Another study found that among the most utilized drugs by spending, a majority of brand drugs with manufacturer assistance had no generic substitute.[4]

SB 203 would prevent health insurers and PBMs from implementing copay maximizer programs that inflate patients' cost-sharing to deplete cost-sharing assistance available to the patient.

As more states have passed laws to ban AAPs, insurers and PBMs have started implementing new programs, called copay maximizer programs, so they can continue to profit from cost-sharing assistance meant for patients. To implement a copay maximizer, plans and PBMs do two things: (1) use a loophole under the Affordable Care Act (referred to as "the EHB loophole") to target and designate specific medicines with available manufacturer cost-sharing assistance as "non-essential health benefits" so that the ACA cost-sharing limitations do not apply, and (2) increase individual patient cost sharing obligations to exhaust the full value of the manufacturer-provided cost-sharing assistance available for those medicines.

By focusing on medicines with available cost-sharing assistance programs, these copay maximizer programs affect certain patients based solely on their medical condition or need for a specific medicine. This targeting of certain medicines—and thus certain patients—is concerning and could run afoul of federal nondiscrimination requirements.[i] Copay maximizers can also result in patients paying more for other care because payments for drugs are excluded as essential health benefits (EHBs), meaning these expenditures don't count toward the out-of-pocket maximum, which might otherwise be reached if the payments for the drugs were counted. In some cases, copay maximizers may even result in patients being denied coverage at the pharmacy as a lever to force enrollment in the maximizer program.
We encourage Wisconsin policymakers to protect patients and enable them to better afford their medicines by prohibiting the administration of benefit designs and policies—including AAPs and maximizers—that exploit patient assistance and ultimately put patient's access to medicines at risk.

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1 Empower. https://www.empower.com/the-currency/money/over-1-in-5-americans-have-no-emergency-savings-research. 2024.
[2] PhRMA Catalyst Blog. Guest post: Copay accumulator adjustment programs lead to four times higher treatment discontinuation for patients with high deductible. February 21, 2019.
https://catalyst.phrma.org/guest-post-copay-accumulator-adjustment-programs-lead-to-four-times-higher-treatment-discontinuation-for-patients-with-high-deductibles.
[3] IQVIA analysis for PhRMA. 2023.
[4] Van Nuys, K, et al. USC Schaeffer. A perspective on prescription drug copayment coupons. 2018.
https://healthpolicy.usc.edu/wp- content/uploads/2018/02/2018.02_Prescription20Copay20Coupons20White20Paper_Final-2.pdf.

PhRMA is committed to promoting policies that protect Wisconsin patients and enable them to better afford their medicines. PhRMA respectfully supports the passage of SB 203, which offers patient-centered solutions that will help patients pay less for their medicines.

Written Testimony of Kurt Oettel MD
Wisconsin Association of Hematology and Oncology
In support of Senate Bill 203 "Cole's Act"
Senate Committee on Health

May 28th, 2025

Chairwoman Cabral-Guevara and Members of the Committee:

My name is Dr. Kurt Oettel, and I am a medical oncologist practicing at Emplify Health/Gundersen Health System in La Crosse, Wisconsin, where I currently serve as the Cancer Center Director. I am also the past president of the Wisconsin Association of Hematology and Oncology (WAHO), and I submit this testimony on behalf of WAHO.

Founded in 1991, WAHO is the largest professional oncology organization in Wisconsin. Our membership represents a multidisciplinary community of oncologists, nurse practitioners, physician assistants, pharmacists, and other healthcare professionals dedicated to providing high-quality, evidence-based care to patients with cancer.

Cancer is a diagnosis that patients never anticipate. It is often discovered unexpectedly, and it brings with it not just a medical crisis, but a life-altering emotional and financial burden. When diagnosed, patients put their trust in their health insurance and in their physician to deliver the appropriate treatment without unnecessary delay or interference.

Unfortunately, that trust is increasingly challenged by the role of pharmacy benefit managers (PBMs), which are contracted by insurers to manage prescription drug benefits. PBMs determine which medications are available under a given plan through negotiated formularies—often without regard to individual patient needs or clinical nuance.

Once a patient requires treatment, many cancer-related and supportive care medications are subject to prior authorization, delaying access to time-sensitive therapies. Worse, PBMs may change formularies at any time, even mid-treatment, disrupting continuity of care. These changes are frequently based on cost alone, with the assumption that all medications within a class are equally effective—an assumption that is not clinically valid, particularly in oncology.

PBMs often apply this same cost-driven approach to chemotherapy regimens, making critical decisions about patient care independent of the treating physician's clinical judgment. This practice jeopardizes both the quality and timeliness of cancer treatment.

WAHO strongly supports Senate Bill 203, "Cole's Act," particularly the provisions that prohibit insurers and PBMs from removing or reassigning a prescription drug from the formulary outside the plan's coverage renewal period. We also support the requirement that patients and providers be given at least 90 days' advance written notice of any formulary change. These are common-sense protections that preserve the patient-physician relationship and ensure patients continue receiving the appropriate therapy without harmful disruptions.

Thank you for considering SB 203. On behalf of WAHO and the oncology professionals across Wisconsin, I urge you to support this critical legislation to protect cancer patients and uphold the integrity of their care.

Sincerely,
Kurt Oettel, MD
Medical Oncologist
Cancer Center Director, Gundersen Health
Past President, Wisconsin Association of Hematology and Oncology (WAHO)

Senate Committee on Health
Wednesday, May 28th, 2025

Oral Testimony: Rob Gundermann | Public Hearing on Senate Bill 203

Good afternoon Chair Cabral-Guevara and members of the Committee. Thank you for holding this hearing today.

I'm Rob Gundermann, President and CEO of the Coalition of Wisconsin Aging and Health Groups and I lead the Wisconsin All Copays Count Coalition, comprising more than 40 national and Wisconsin-based patient and provider groups serving the interests of patients with chronic and serious health conditions that rely on copay assistance to access critical medications.

Seated next to me are Tamra Varebrook and Deb Constien, who will share their experiences as patients dealing with copay accumulator programs. Also, with me today is Bill Robie, Senior Director of Government Relations with the National Bleeding Disorders Foundation.

On behalf of the Coalition, we are here to express our strong support for Senate Bill 203, especially the copay accumulator provisions in the bill. We urge the Committee to support this legislation and protect copay assistance for patients and ensure that those in greatest need of treatment are able to access consistent, effective care.

Copay assistance programs were first created by drug manufacturers in response to efforts from health plans to shift the cost burden of prescription medications on to patients. As a result, countless patients with chronic and complex conditions that require specialty medications depend on copay assistance to access life-saving treatments and manage their health. In response, health plans began implementing "copay accumulator adjustment programs", which don't count the value of copay assistance towards the patients' cost-sharing responsibility.

Please note that SB 203 only applies to drugs that have no medically appropriate generic equivalent. This legislation will not push patients to higher cost drugs.

We also now have studies showing that states which have passed similar legislation do not have higher insurance premiums. Conversely, states like Wisconsin, which have not yet passed copay accumulator legislation, do not have lower insurance premiums either. I believe Bill Robie will speak more on this subject.

On behalf of the Wisconsin All Copays Count Coalition and the countless patients and providers we represent, I thank you for listening to us today, and urge you to support Senate Bill 203, which includes a simple solution to a devastating problem and would alleviate a great deal of pain and fear for patients across our state. Thank you and now Tamra will share her story.

May 28, 2025

Members of the Senate Committee on Health, I would like to share my story regarding my Asthma and the journey it has taken me on.

My pulmonologist always said I was "a hard nut to crack" in managing my asthma. I had almost constant respiratory issues and wasn't considered under control. During the winter months I was sick more than I wasn't and was put on prednisone often, with higher and higher doses for up to 6-8 weeks at a time. That meant all the side effects that go with prednisone, like sleeplessness, headaches, increased appetite and weight gain, swelling and fluid retention and heartburn. I also used an in-home nebulizer regularly (to avoid visits to the ER), along with a daily corticosteroid inhaler and a rescue albuterol inhaler. Prednisone can lower your immunity, making me more susceptible to infections, so the cycle with upper respiratory infections continued. It can also weaken bones, and I now do have osteoporosis at age 63 and need to take Prolia, a very expensive medication. I am taking prescription medication for heartburn now as well. One thing leads to another, all with complications of their own.

At some point, my pulmonologist sent me to an allergy and asthma physician who positively diagnosed me with Eosinophilic Asthma. The treatment he used for me is Fasenra. It is a biologic treatment given by injection every 8 weeks, after the initial 3 starter doses. This medication literally changed my life! After starting this medication, my asthma was "under control". I was no longer constantly sick, no longer needed to be on/off prednisone and I could live a normal life again! With continued use of Fasenra, I now very seldom even need to use a rescue inhaler. rarely use a nebulizer, maybe once a year, if even that. I still take a daily corticosteroid inhaled medication along with my every 8 week injection of Fasenra. The impact of this medication has made a substantial difference in my life to say the least.

The negative side of this is the cost. I could never afford this medication on my own! I do get copay assistance from the manufacturer in the amount of 13,000.00 a year. This amount, along with my medical insurance, does not cover a full year of medication. I have a copay plan with a maximum out of pocket of 9,100.00. The problem comes because my copay assistance amount does not count toward my out of pocket maximum. I am then faced with a very large bill that I cannot afford to pay or the option of not taking my medication needed to live a normal life. I fiercely do not want to go back to the life I lived prior to Fasenra!

The specialty pharmacy used will show the amount paid by my copay assistance as being applied to out-of-pocket, yet it never shows on my actual insurance company website. The disconnect there is what leaves me struggling for an answer. I desperately want to continue to live a healthy lifestyle of walking, biking, being an active Grandma and doing all the things that make life worth living.

In summary, please help to solve this gap and make it feasible for people with debilitating diseases to continue to get the life changing medications needed.

Sincerely,

Nancy M. Wydeven
N1776 Emery Lane
Kaukauna, WI 54130

To the Members of Senate and Committee of Health:

My name is Deb Constien and I am a patient who has had Rheumatoid Arthritis since I was 13 years old, a total of 42 years having this disease. I urge you to support the legislation of SB 203 and protect copay assistance for patients like me. This bill would require health insurers to count the value of copay assistance towards patients' out-of-pocket cost-sharing responsibilities, a simple solution to provide peace of mind to patients who are struggling to access critical medications and imaging to manage their health. I typically would reach my out-of-pocket cost sharing by the end of February; this year it took until the middle of May. For example, I have had 2 MRIs, and 1 CT scan this year...all of which were very important to my disease management. I had to fight to get approval for all 3. One MRI was for a breast MRI, as I am high risk for breast cancer, the second MRI was for correct imaging to detect the damage above my 2 cervical neck fusions, to recommend neck injections in the 3 vertebrae above my fusions, not seen on x-rays. My CT scan was to monitor my kidney stones as I have had urosepsis 2 times, to avoid further issues. Each of these imaging cost me $550 out of pocket expenses. Most patients wouldn't be able to afford this additional cost to everyday life. These additional out of pocket expenses are a significant burden to patients with Chronic Diseases. Many of my medications for Rheumatoid Arthritis are very costly. My last infusion in Feb. was for Rituxan, Cost was $32, 929.37, my out-of-pocket cost was $469.93. I have been switched since to a pen injectors given every 2 weeks and have not found out the cost of these yet. I also have many comorbidities, heart disease from having inflammation in my body for 42 years, high blood pressure, eye issues from the uncontrolled high blood

pressure, GERD, acid reflux disease from the use of medications over the years, among others.

I never asked for Rheumatoid Arthritis and any of these other issues. The costs associated with maintaining my health are incredibly steep. Most wouldn't be able to afford these costs. I'm one of the lucky ones. It doesn't mean that it doesn't take a large bit out of our budget. Sadly, my 26-year-old son has been diagnosed with Rheumatoid Arthritis as well. I am helping him navigate all the insurance company hoops as well. It's really tough...

I have learned the hard way over the years that I have to stay on top of everything. Nothing is easy either, it usually takes 2-3 phone calls with many hoops. I am glad I am educated to help me through all the paperwork, etc. I worry about those who are not educated or that don't have the money to pay these high medical bills. I can pay these bills, not that I enjoy it. This issue is not disease agnostic...I am speaking from the arthritis side, but it affects MS patients, COPD, Diabetes, Hemophilia, etc. Every patient is affected. We need help in this fight. Copay Assistance is supposed to help patients like me, not my insurance company.

My Experience with Copay Accumulators, Rheumatoid Arthritis, and Asthma – Tamra Varebrook

Living with chronic illnesses such as rheumatoid arthritis and asthma presents numerous challenges. The physical pain and limitations are hard enough, but the financial burdens created by insurance companies' copay accumulators make managing these diseases even more difficult. This is my personal experience of the negative impact I've had with copay accumulators while dealing with rheumatoid arthritis and asthma.

The copay accumulator used by my insurance company prevents the PATIENT assistance payments made by drug manufacturers on my behalf to help the ME, from counting toward my deductible and out of pocket maximum.

I was diagnosed with rheumatoid arthritis at the age of 32. The pain and stiffness can be debilitating, often making it difficult to perform everyday tasks. Over the years, I have tried various medications to manage my symptoms, many of which are expensive biologic drugs.

In addition to rheumatoid arthritis, I have also been living with asthma since childhood and had a recent cancer battle. I rely on a semi-monthly biologic to manage my asthma symptoms and prevent asthma attacks and I'm on an ongoing medication as part of my cancer treatment.
Patient Copay assistance programs have been a lifeline for me, helping to cover the cost of my medications until the Copay Accumulators began their double dipping game.

Innovative Biologic medications for rheumatoid arthritis and asthma and cancer are costly.
Many pharmaceutical companies offer copay assistance programs to help reduce the financial burden on patients. However, with the implementation of copay accumulators by my insurance company, the assistance provided by these programs no longer count toward my deductible and out-of-pocket maximum. This means that even when a manufacturer provides assistance to me with medication costs, I am still required to pay the full deductible amount before insurance coverage kicks in. My deductible is $6,600. With the copay accumulator, the insurance company gets approximately $35,000 extra every calendar year on TOP of my deductible and out of pocket maximum due to me being on multiple biologics.

- $10,000 from one drug company
- $25,000 from another drug company
- $10,000 out of pocket from me

The lobbyists in Wisconsin ***who are against*** this bill argue with me saying "I don't want to have to pay my deductible". My argument back is, they are stealing my assistance to DOUBLE or TRIPLE their money, receiving tens of thousands over the amount of my deductible, off the back of me, the patient.

I will also point out that my deductible is FAR from the total cost of living with RA. I have thousands of dollars a year in health-related costs not covered by insurance. I have a $10,000 out of pocket maximum which I meet every year. They are double dipping off of the backs of chronically ill patients. This is money not expected by, or due to, the insurance companies, this is INTENDED to assist patients with drug costs and high deductibles.

Conclusion

The implementation of copay accumulators has had a profound negative impact on my ability to manage my rheumatoid arthritis and asthma. This greedy policy of insurance companies places an enormous financial burden on me, forcing me to choose between my health and financial stability. I hope that by sharing my story, I can raise awareness of the challenges faced by individuals with chronic illnesses.

Living with rheumatoid arthritis and asthma and battling cancer is difficult. Adding the stress and financial strain of copay accumulators only exacerbates the challenge.

If this practice of theft by insurance companies hasn't affected you or your family's life yet, chances are high it will at some point. As of now there are 745 biologics and biosimilars treating skin conditions, diabetes, cancers including breast, colon, and forms of leukemia and lymphoma, asthma, osteoporosis, hemophilia, cystic fibrosis, sickle cell disease, autoimmune diseases, including rheumatoid arthritis, psoriatic arthritis, psoriasis, Crohn's disease, ulcerative colitis, multiple sclerosis, and many other chronic conditions. You most likely know someone suffering now.

It is time for insurance companies in Wisconsin to be banned from double dipping off of the backs of chronically ill patients and prioritize the well-being of patients. 21 states have banned Co-Pay accumulators and Wisconsin should be next.

WMC
Wisconsin's Chamber

MMAC
METROPOLITAN MILWAUKEE
ASSOCIATION OF COMMERCE

TO: Members, The Wisconsin Legislature

FROM: Rachel Ver Velde, Associate Vice President of Government Relations, Wisconsin Manufacturers & Commerce
Andrew Davis, Vice President of Governmental Affairs, Metropolitan Milwaukee Association of Commerce

DATE: May 28, 2025

RE: Concerns with Senate Bill 203, Pharmacy Benefit Manager (PBM) Legislation

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The high cost of health care has consistently been a top concern of our organizations' membership over the years – and for good reason. Wisconsin's healthcare costs are higher than the national average[1]. According to WMC's most recent *Wisconsin Employer Survey* from January of this year, 41% of employers answered that making healthcare more affordable is the top policy action state government can take to help businesses in Wisconsin[2]. In the same survey, 25% of employers expect health care costs to increase by more than 10% in the next year.

A large driver of increased health care costs are prescription drugs, particularly for employers. Prescription drugs account for 16.1% of fully insured private health plan premiums after rebates[3]. Our members are taking innovative approaches to control the costs of health care and prescription drugs for their employees. Unfortunately, we are concerned that this legislation will have the opposite effect on employers and their employees.

In particular, we are concerned with a few provisions contained within the proposed pharmacy benefit manager (PBM) legislation:

> **Any Willing Provider**. Any-willing-provider (AWP) mandates require health plans to contract with any health provider or pharmacy group willing to meet the plan's contract terms. Besides going against the basic right to contract, these mandates would make it nearly impossible to negotiate favorable payment rates with a pharmacy in exchange for guaranteed patient volume. Requiring health plans to contract with any willing provider greatly diminishes employers and health plans' ability to obtain price discounts. The cost of the drugs will only go up under any-willing-provider mandates. If you limit a payer's ability to bargain based on volume, prices rapidly increase.

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[1] RAND Corporation, Prices Paid to Hospitals by Private Health Plans: https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html

[2] Wisconsin Manufacturers & Commerce, Wisconsin Employer Survey, Winter 2025: https://media.wmc.org/wp-content/uploads/2025/01/21141255/CEO-Survey-Report_Winter-2025_STATE-POLICY-REPORT.pdf

[3] Peterson-KFF, Health System Tracker: https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#Retail%20drugs%20as%20a%20share%20of%20national%20health%20spending%20and%20as%20a%20share%20of%20fully-insured%20private%20health%20plan%20premiums,%202021

Restricting Mail Order Pharmacies. Mail-order pharmacies are often lower-cost and more convenient for patients, especially those with chronic conditions or who live in rural areas. Every employer wants to offer the best and most comprehensive health care and prescription drug benefit plans they and their employees can afford, and mail order pharmacies are often utilized to help drive costs down. Restricting mail order pharmacies will make access to prescription drugs more expensive, resulting in workers and their families losing their prescription drug benefit.

Frozen Formulary. The proposed bill contains a "frozen formulary" provision. At first glance this may seem good for patients, but in reality, it will increase costs. According to a 2021 study by Milliman, a frozen formulary provision would increase prescription drug costs in the fully insured commercial health insurance market by about $4.3 billion to $7.1 billion over five years[4]. Marketplace events occur throughout the year that impact the price of prescription drugs. By implementing a frozen formulary, payers and plans will be limited in their ability to take advantage of new reduced prices, generic drug launches, new medications, new over-the-counter medications, or manage utilization to the best of their abilities.

Drug Manufacturing Coupons. Drug manufacturers offer "coupons" to patients to encourage usage of their name brand, higher cost drugs instead of lower cost alternatives. This legislation would require PBMs and health plans to apply drug coupons to satisfy patients' deductibles and out-of-pocket maximums. This will put in place a pricing scheme that allows drug coupons to cover high prices for consumers until the full costs are shouldered by health plans and employers. This drives up the cost of health care benefits for employers and employees, including for employees that do not utilize these high-priced drugs.

ERISA Plans. Self-funded health plans make up 68% of employer-sponsored coverage. The federal Employee Retirement and Income Security Act (ERISA) regulates these plans. This bill applies to ERISA plans due to the restrictions it places on PBMs. This is particularly concerning for self-insured employers that are trying to innovate and control costs for their employees.

The first three provisions mentioned above were initially included in PBM legislation that was proposed in the 2019-2020 legislative session. A compromise bill was passed in the 2021-2022 legislative session (2021 Act 9) that removed these provisions at the request of employers. These provisions were removed because employers were concerned that they would raise costs for them and their employees.

Employers want to provide affordable, high quality health care to their employees and their families, including pharmaceutical benefits. PBMs are a part of the employer solution to manage the costs. PBMs negotiate price discounts, saving employers and their employees millions on their annual prescription drug spend. In order to do so, however, they must be free to work in the marketplace without unnecessary government regulation. PBMs need to be able to contract with providers willing to negotiate the best price and adjust their pricing structure in real time in response to marketplace conditions that may move drug prices up and down.

WMC and MMAC are very concerned with the addition of the employer provisions to this legislation. We ask that you do not support this legislation.

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[4] Milliman Report, Estimated Cost of Potential "Frozen Formulary" Legislation: https://www.pcmanet.org/wp-content/uploads/2021/02/Milliman_Frozen-Formulary-Report_FINAL.pdf

Wisconsin Manufacturers & Commerce (WMC) is the largest general business association in Wisconsin, representing approximately 3,800 member companies of all sizes, and from every sector of the economy. Since 1911, WMC's mission has been to make Wisconsin the most competitive state in the nation to do business.

The Metropolitan Milwaukee Association of Commerce (MMAC) has been serving area businesses as a private, not-for-profit organization for more than 150 years. Today the MMAC represents 1,800+ member businesses with more than 300,000 employees in Milwaukee, Waukesha, Washington and Ozaukee counties and beyond.

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Waupaca Foundry (self-insured) partners with a large international Broker and PBM to help manage costs of healthcare and prescriptions. To manage costs, we must be forward-thinking, and we must realize where the cost comes from. When we realize where the cost is coming from, we can then make laws to protect the people of Wisconsin and the companies who choose to do business here.

After reviewing the Mandated Increased Dispensing Fee legislation, we believe the proposal will negatively impact the people and businesses of Wisconsin. I have provided our real data to help support our opinion of the proposal. The data shows our costs are rising year after year, which also causes a cost increase back to us the employer and to our employees.

This is where we were in 2022/23 and where we are today:

	Plan Year	Plan Year
	5/1/22-4/30/23	5/1/24-4/30/25
Total Drug Costs	$25.6 M	$32.7 M
Network Savings and Mail Discounts:	$12.9 M	$16.3 M
Gross Cost:	$12.7 M	$16.5 M
SaveonSP (Manufacturer coupons applied to our cost share)	$1.1M in Savings	$1.0M in Savings
Rebates	$4.3m in savings	$6.0M in Savings
Plan Net Cost	$7.3 Million or 28.5% of Total Drug Cost	$7.8 Million or 23.8% of Total Drug Cost
Savings BEFORE Member Cost Sharing	$18.3 million	$25 million

By partnering with a PBM, having Mail Order provisions for drug classes, Waupaca Foundry has access to the best networks, with negotiated savings, the best access to prescriptions for employees who live and work in Rural Wisconsin. Because of the bulk purchasing discounts and mail order services by using the network, $16.3M in savings and discounts is AVOIDED as pass through costs to employees and their families. These are true savings to our people in Wisconsin. The $16.3M alone would represent 7% of our net profit as a company. A question we have to ask ourselves: Can companies survive cost increases or be willing to pass on costs back to employees and their families if we allow these changes? What impact will exist on the State of Wisconsin if we allow this? Waupaca Foundry is just one example of the economic impact.

Lastly, as the pharmacy landscape changes with Generics and better clinical prescriptions made available, it's important to be forward-thinking and act quickly to allow these changes to happen not just for Waupaca Foundry, but for our employees and their families. Because these changes impact them directly when they go to fill prescriptions.

Lastly, I want to say thank you for your time and attention to our opinion regarding Dispensing Fee Legislation.

Thank you,

Rachel Lockwood

Rachel Lockwood
Benefits and Health Services Manager
Waupaca Foundry, Inc.

The Rice Lake Area School District (RLASD) has employed multiple strategies to control healthcare costs. The key to all of these strategies is to create consumerism. The RLASD health plan focuses on encouraging staff, through plan design, to access high-quality low-cost care. This often results in significantly reduced costs for the employee (care is often provided at no cost) and a lower cost for the school district. The district is willing to shoulder a larger share of the cost if the employee selects a quality provider that is more cost effective than typical system-based healthcare. This approach redirects all sorts of care to include primary care, surgical and non-surgical specialist visits, surgical procedures, infusions, hospital administered medications, and PBM sourced medications. In 2017 the RLASD made a choice to move away from a traditionally provided fully insured plan toward a highly effective consumer driven health plan. The results are astounding. RLASD offers employees either free or very low-cost care options for both medical and pharmacy benefits, and as a result the employees have benefited by receiving great care at a significantly reduced cost.

Over the last 7 years the RLASD has saved, on average, almost 2 million dollars a year in healthcare costs. The employee share of premium has been significantly reduced and the number of employees meeting their deductible has been cut in half. This has all been done while providing free primary care, a broad array of free medical care, and low-cost Pharmacy benefits to staff. The data below shows actual paid claims data outlining the impact of these plan changes on the cost of healthcare in the RLASD. The RLASD had a significant increase in 2023-2024 due to a large number of high-cost claims. Claims data for the 2024-2025 plan year appears be to coming in line with previous trend down below 4 million.

	Rice Lake Self-Funded CDP vs Projected Fully Insured costs							
	2016-17 Base Year	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
Fully Insured Plan	3,950,000	4,752,000	4,942,080	5,139,763	5,345,354	5,559,168	5,781,535	6,012,796
Consumer Driven Plan		2,459,000	2,950,000	3,537,315	3,406,000	3,489,773	3,594,130	4,514,791
Cost Reduction		2,293,000	1,992,080	1,602,448	1,939,354	2,069,395	2,187,405	1,498,005
Total Savings								**13,581,686**
	Note: Grey highlighted boxes show projected fully insured cost using a 4% annual trend Orange box represents the best fully insured bid offered for the 2017-2018 school year.							

Opposition to the employer changes in the PBM bill: The PBM bill is really a bill that focuses on creating an anti-competitive environment in healthcare by largely supporting big pharma and anti-competitive practices.

1. Any willing provider- The Rice Lake Plan is built on creating consumerism through free market principles. Employees have choice, but the cost is lower if they make cost effective choices. Additionally, the plan will not contract with some providers because they are not viewed as being of high quality and/or the costs do not justify their use. Taking away the ability to choose who employers do business with limits their ability to negotiate fair and competitive prices for care. Creating steerage programs based upon negotiating completive prices for care is at the center of the success of the Rice Lake Health Plan. This provision is counterproductive for all involved. It would actually drive costs up and in general reduce effectiveness.

2. Restricting Mail order- The Rice Lake Plan uses mail order pharmacies extensively. It is more convenient for the employee often times reducing cost significantly. Again, this bill is anti-competitive and will result in either increased costs to health plans or aggressive restrictions on formularies.
3. Frozen Formulary- This would be a costly restriction to the Rice Lake plan. For example, Humira was being offered to our plan for $70,000 year and shortly after the plan year started, a biosimilar became available. The plan moved to this medication reducing the cost of accessing this medication by $50,000 a year per person taking the medication. A frozen formulary would have prevented Rice Lake from changing to the chemically identical medication that was at a fraction of the cost.
4. Drug Manufactures Coupons and copay accumulators. The main purpose of these coupons is to incentivize the use of high-cost medications. Manufacturers put an excessive price on a medication, offer it to the plan at a high cost, pay PBM's to place the drug in a preferred tier in the formulary, and then pay the patient through a coupon to reduce their cost. These practices lead to excessive costs for the employer plan. Many times, these medications are either no better or even worse than other medications used for the condition, but because they are incentivized through PMB rebates, and via coupons to make it lower cost to the employee, the drugs are prescribed. This bill would add further insult to injury by further incentivizing drug companies to expand this practice. It would encourage employees to select medications with the highest copay coupons so they can get their deductible reduced.

The Rice Lake School District has, by changing its PBM, saved an average of $350,000/yr on Pharmaceutical. By selecting an ethnical, transparent, and supportive PBM, the RLASD's drug spend went down from approximately $750,000/year when fully insured to a low of $250,000/year in 2021. Requirements to contract with any willing provider, restrictions on mail order, applying perverse PBM incentives via copay accumulators, and creating a frozen formulary would all significantly impact the savings generated from using our effective PBM solution. Currently, the RLASD plan can often provide medications for free because it is able to source medications cost effectively. The implementation of these barriers would negate much of the savings achieved.

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May 5, 2025

Members of the Wisconsin State Legislature
Wisconsin State Capitol
Madison, WI 53703

Subject: Opposition to Assembly Bill 173 – A Step Backward for Wisconsin Workers and Employers

Dear Members of the Wisconsin State Legislature,

I am writing to express our strong opposition to Assembly Bill 173. This bill represents a significant step backward in Wisconsin's efforts to create a fair, competitive, and affordable health care system for both employees and employers.

Assembly Bill 173, by undermining collective efforts to negotiate and manage pharmacy benefits, directly limits the ability of employers to implement innovative cost-saving strategies. Employers in both the public and private sectors are constantly seeking ways to control rising health care costs while maintaining quality care for their workers. This bill ties their hands, increasing long-term costs and reducing flexibility.

For employees, the consequences are even more dire. Affordable and comprehensive health care is not just a benefit—it's a necessity. By restricting employer strategies to pool resources or negotiate better terms, AB 173 will lead to higher premiums, fewer plan options, and greater out-of-pocket expenses for working families. It undermines local decision-making and weakens efforts to build community-based solutions that work for Wisconsin.

Furthermore, this bill disrupts collaboration among employers and pharmaceutical resources that have successfully managed health care costs through cooperative agreements. Eliminating or restricting these models doesn't foster competition, it sabotages it.

At a time when Wisconsin should be moving toward policies that improve transparency, expand access, and reduce health care expenses for all stakeholders, AB 173 does the opposite. It imposes unnecessary limitations that benefit no one except large, drug manufacturing lobbyists.

I urge you to vote **NO** on Assembly Bill 173. Let's keep Wisconsin moving forward by supporting practical, local solutions that help workers, strengthen employers, and promote truly affordable health care.

Sincerely,

Renae Langel
Vice President Human Resources

WMC
Wisconsin's Chamber

Nolato Contour, Baldwin, WI:

As a self-funded employer, we continuously collaborate with our Benefit Consultant to explore and implement cost-containment strategies that allow us to maintain competitive wages, offer high-quality benefits, and reinvest in our business and employees. Unfortunately, the proposed PBM legislation seems to pose a risk of increasing healthcare costs for both employees and employers across the state.

We rely on the cost-efficiency of mail-order pharmacy services.

Gamber Johnson, Stevens Point, WI:

I want to share another brief example of the impact of a frozen formulary: In 2025, Stelara, a specialty drug for Crohn's Disease, Ulcerative Colitis, and other conditions, came off-patent, allowing biosimilars (essentially generic equivalents for injectable medications) like Wezlana to enter the market. These biosimilars/generic drugs are available at a fraction of the cost of Stelara and will save both employees and employers tens of thousands of dollars (or more). However, with a frozen formulary, you would not be able to make the biosimilar the preferred medication, resulting in the unnecessary continued use of the most expensive drug option. A similar situation occurred a few years ago with Humira, which is now essentially a non-issue for most employers because multiple biosimilars, such as Yusimry and Amjeveta, can be procured. There are other medications such as Humalog and Novolog (analogs for Insulin) that are also coming off patents this year which will hopefully drastically reduce the cost of diabetes medications.

Walker Forge, Clintonville, WI:

Pharmacy Network: The legislation requires PBMs to allow patients to use any licensed pharmacy in the state without facing penalties.

- Risk for overcharging: TDRx has seen some pharmacies charge higher prices for certain "specialty" generic drugs (e.g. generic HIV or cancer drugs). This may limit the ability to avoid this type of pricing tactic. A recent example includes the medication dimethyl fumarate one of our members was utilizing. In this case, the pharmacy chain procures the medication via their specialty pharmacy network and

Ross Bjella – Testimony against SB 203 **May 28, 2025**

Honorable Members of the Wisconsin State Legislature,

My name is Ross Bjella, and I'm honored to address you today as a Milwaukee resident with over 15 years leading Alithias, a patient advocacy company serving over 100 WI companies to help their employees navigate healthcare costs. Before founding Alithias, I served as a pharmaceutical product manager at Allergan and Schwarz Pharma, and later as a pharmaceutical industry consultant through my firm, Pharmexsys. I also served as the President of Dohmen Life Science Logistics, where I helped launch over 70 pharmaceutical companies in the United States. I've seen the inner workings of drug pricing and pharmaceutical marketing firsthand, and I'm here to **urge you to reject Senate Bill 203**, a proposal that will drive up healthcare costs, undermine patient choice, and burden Wisconsin employers.

I want to be clear that I fully understand the plight of independent pharmacies, and my advocates guide patients to the value independent pharmacies bring every day. The independent pharmacies' fight is with the big 3 PBMs who have both the money and the data to drive patients to their own vertically integrated pharmacies. **SB 203 simply shifts the cost of servicing patients to employers, which will result in higher premiums and co-pays to employees**.

As a product manager and pharmaceutical industry consultant, I witnessed pharmaceutical companies deploy coupon programs as a deliberate strategy to steer patients toward expensive, brand-name drugs. These weren't acts of charity—they were calculated marketing tactics. For a drug retailing at $5,000 a month—or $60,000 a year—a manufacturer might offer coupons valued at $2,500 to $5,000 to cover a patient's copays until their deductible was met. This was a brilliant move: spend $5,000 to lock in $60,000 in revenue. Once patients started the drug, they stayed on it, often unaware of lower-cost generics or alternatives that could save thousands. I consulted with one company that explicitly built coupon or "patient assistance program" (PAP) costs into their drug's price to help Medicare patients bypass the Part D donut hole, ensuring sales while inflating costs for payors.

SB 203 mandates that these coupons count toward patients' out-of-pocket deductibles and maximums, a policy that sounds patient-friendly but delivers a devastating blow to Wisconsin's employers and health plans. Here's why:

First, **it fuels skyrocketing drug prices**. Coupons incentivize manufacturers to raise list prices, knowing patients won't feel the sting. The Kaiser Family Foundation, the National Business Group on Health and the Pharmaceutical Care Manufacturers Association all agree **that coupon programs contribute to increased drug prices**, adding billions to national healthcare costs. Wisconsin employers, especially self-insured ones, will face premium hikes of 5–10%, forcing tough choices: higher employee contributions, reduced benefits, or layoffs.

Second, **it strips patients of incentives to choose cost-effective options**. When coupons make a $5,000 drug feel free, patients have no reason to explore generics that cost 80–90% less. This distorts the free market where informed choice drives competition. As a patient advocate, I've

seen employees thrive when empowered to select affordable drugs, saving their plans—and their employers—hundreds of thousands of dollars annually.

Third, **it shifts crushing costs to employers**. Once a patient's deductible is met—often with coupon "monopoly money"—employers pay 100% of that $60,000 drug price, plus all other medical costs for the year. **For a 1,000-employee firm, this could mean $500,000 in added costs,** funds that could have supported wages, innovation, or expanded coverage. At Alithias, we've helped Wisconsin companies avoid these traps through copay accumulator programs, which ensure only patient-paid amounts count toward deductibles. SB 203 would ban these tools, handing manufacturers a blank check at employers' expense.

If you want to protect independent pharmacies, better solutions would be to prohibit PBMs from incentivizing patients to use PBM owned pharmacies and disclose reimbursement rates and rebates. Or mandate wholesalers to offer independent pharmacies the same drug acquisition prices and discounts as chain pharmacies, based on volume-adjusted tiers.

Legislators, you have the power to support the free market and protect Wisconsin's economic vitality. Reject SB 203 and preserve the free market principles that keep healthcare affordable. **Instead, champion transparency laws to expose drug pricing, promote generics, and empower payers to negotiate lower costs**. These are the solutions that align with Wisconsin's values—supporting workers, businesses, and communities without padding pharmaceutical profits.

Thank you for your time and consideration. I'm happy to answer any questions or provide data from my decades in pharmaceutical sales, marketing, distribution and business development to support your decision.

Ross Bjella
Founder, Alithias
Milwaukee, Wisconsin
Ross@alithias.com
414 469 9265

Statement to the Senate on SB203 – Opposition to Frozen Formularies and Minimum Dispensing Fees (Mark Gelhaus, CFO, Walker Forge)

Intro

Good afternoon. My name is Mark Gelhaus. As the CFO of Walker Forge, a 400-employee manufacturer with locations in Milwaukee and Clintonville, I devoted lots of time to making health care affordable for our employees and to Walker Forge. Maintaining a qualify health plan is a huge expense for us, as it is for all businesses. Health care costs are out of control.

The SB203 Problem

The biggest threat to safety in health care, in my opinion, is unaffordability. Avoiding health care or drug procurement *because of cost* is real. SB203 removes strategies and imposes required fees which will increase our cost of care much of which is born by our employees. The portion that we absorb also results in less money available for employee compensation.

Walker Forge Approach

Our strategies are three-prong: First, make primary care convenient and affordable; our employee clinic, staffed with doctors and nurse practitioners, is free. Second, contract with quality medical service providers outside the large hospital systems, and incent/direct employees to those. Third, aggressively attack Rx spend, the fastest growing slice of the medical plan spend pie. Our Rx strategies include providing acute medications free at our clinic, free-market contracting with a local pharmacy for low-cost drugs which we also offer free, patient assistance programs, international sourcing, and, lastly, drug competitive research effectiveness (CRE) analysis.

Frozen Formulary

This last strategy, CRE, requires that we have a flexible formulary. We research all high-cost drugs and compare effectiveness with other lower cost drugs. It is not uncommon for a lower cost drug to be more effective than a higher priced drug. We and our employees save tens of thousands of dollars each year when our employees use lower cost alternatives via this analysis. Freezing the formulary is anti-free market and would severely harm this strategy, jeopardizing affordability and accessibility. The same logic would apply to a PBM who wants to adjust its formulary for lower cost drugs. If an employee insists upon a higher cost drug, there is a process for them to get it approved. The absolute number-one requirement for all our strategies is that our employees will receive as good or better health care than without the strategy.

Minimum Dispensing Fee

SB203 requires minimum dispensing fees to Pharmacies tied into rates paid under Medicaid. These fees will be passed on to us, increasing our plan costs and employee contribution costs. As we all know, Medicaid is not a free-market model; it is a government health care program that relies on government funding, regulation, and centralized control; it is something to stay away from, not go to.

Where Is The Solution?

The problem in pharmacy must ***not*** be addressed by eliminating Wisconsin employers' free-market strategies, the removal of which increases costs to employers and employees, and makes health care less affordable and accessible. Look behind the Big Pharma curtain instead; big pharma integrates/colludes with the big insurance carriers. Require them to disclose their reimbursement formulas, fee structures and rebate details, so contract favoritism and discriminatory pricing can be revealed, and we can move toward a free market. Thank you. Next up is Ross....drug coupon concerns.

Statement to the Senate on SB203 – Opposition to Eliminating Mail Order Pharmacy Services

Good Afternoon. My name is Renae Langel. I am the Vice President of Human Resources for Midwest Carriers, a transportation company with 200 employees located in Kaukauna. Thank you for this opportunity to speak.

I am here today to express serious concerns regarding SB203, which would effectively eliminate mail order pharmacy services. This move would be a mistake—both fiscally and operationally—for our employees, employers, and the sustainability of our healthcare system.

Let me be clear: mail order pharmacy is not just a convenience—it's a proven cost-saving measure. Over the past two and a half years, our organization has saved **over $700,000**—specifically, **$701,355**—by leveraging international and PAP mail order pharmacy programs. The majority of these prescriptions were for specialty, high cost drugs. These numbers are not hypothetical; this is real money retained by our health plans and not spent unnecessarily.

In 2023 alone, we saved nearly **$292,000** through mail order services. In 2024, that number increased slightly to **$296,516**. And this year, despite being only partway through 2025, we've already saved **$112,937**.

These savings are not the result of cutting corners—they come from strategic sourcing and partnerships that maintain quality while reducing pharmacy benefit manager (PBM) markups. For example, international mail order saved us **$362,232** and patient assistance programs contributed another **$339,123**. Eliminating these services would force employees and employers alike to absorb these costs elsewhere—either through higher premiums, reduced benefits, or both.

This bill would not only eliminate a smart financial strategy, but it would also harm patient adherence. Mail order improves medication access, for those in rural areas, for truck drivers like ours who aren't home very often, or for those managing chronic illnesses. Fewer trips to the pharmacy means better compliance, better outcomes, and fewer hospitalizations.

In short: SB203 increases costs, decreases access, and punishes efficiency. I urge this body to look at the data and the people behind it. Let's support solutions that work—for everyone.

Thank you.

Illustrating the Impacts of Drug Coupons on Patients and Health Plans

Scenario 2 – Therapeutic Alternative: Two coworkers, Joe and Betty, are enrolled in their employer's health plan that features a $10,000 deductible with a $10,000 maximum out of pocket (MOOP) for families, which the employer offsets with contributions to an HRA for qualified medical expenses. Both Joe and Betty have narcolepsy and are prescribed two different medications to treat it. The employer and employee both contribute to the plan's $1,500/mo premium.

There are different approaches to treating narcolepsy. Betty's doctor prescribes modafinil which is a tier 1 generic available to Betty for a $10 copay. The total price of the drug is $43/mo.

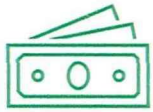
In discussing Joe's options for treatment, his doctor tells him that a drug company rep just dropped off several coupons for Xywav to treat narcolepsy. It's a fairly new therapeutic alternative to modafinil. Xywav's actual price is $15,298/mo. It is a tier 4 drug under the terms of the health plan, but Joe will get it for $10 with the coupon, which is limited to $16,000/year.

The total annual cost of the modafinil is $516. The total annual cost of the Xywav is $183,576, minus the value of the drug coupon which we will calculate under two scenarios below.

IF AB 773 SHOULD PASS

Betty pays $10 each time she fills her prescription, and after 12 months $120 has counted toward her deductible/MOOP.

The first fill for Joe's medication costs $15,298. Joe pays $10 and the drug coupon picks up $9,990 which satisfies Joe's deductible/MOOP. The employer plan pays the remaining $5,298. Joe pays nothing for subsequent fills nor any other covered health service for the remainder of the plan year. He decides to continue on this medication even though he still feels sleepy during the day – a known risk of taking this drug.



Betty: Has contributed $120 toward the cost of her medication and her employer plan paid the remaining $396.

Joe: Has contributed $10 toward the cost of his medication and gets all his subsequent medical care at no cost to him. The drug coupon covered $9,990 and his employer plan paid the remaining $173,576 plus the cost of any other care.

WITH A COPAY PROGRAM IN PLACE

Betty pays $10 each time she fills her prescription, and after 12 months $120 has counted toward her deductible/MOOP.

Joe pays $10 for the first fill of his medication, and the drug manufacturer coupon pays the remaining $15,288. He still feels sleepy during the day. When he goes to pick up his next prescription, he realizes he'll have to pay a lot more for Xywav going forward. He talks to his doctor about other options.

Betty: Contributed $120 toward the cost of her medication and her employer plan paid the remaining $396 for the year.

Joe: Contributed $10 toward the cost of Xywav. The drug coupon covered $15,288 for the first fill, then his doctor helped him find another option that worked better for him also for a $10 copay. Joe paid $110 and the employer paid $363 for 11 months of the alternative drug.

Note the considerable difference in the cost to the employer/employees

WPHCA

Serving Wisconsin Community Health Centers

May 28, 2025

Chair Cabral-Guevara and members of the Senate Committee on Health:

On behalf of the 19 Community Health Centers in Wisconsin, WPHCA supports Senate Bill 203, Cole's Act, as a crucial step forward to address predatory practices such as discriminatory pricing and overly burdensome audits by Pharmacy Benefit Managers (PBMs) and increase access to affordable health care for Wisconsinites. In particular, we appreciate the collaboration with bill authors to include provisions that protect the integrity of the 340B Drug Pricing Program, which is an essential tool for Community Health Centers that helps them provide affordable medications and services to their patients.

WPHCA is the membership organization for the 19 Federally Qualified Health Centers (FQHCs or Community Health Centers) in Wisconsin. Community Health Centers are non-profit, community-directed medical, dental, and behavioral health providers. Provision of pharmacy services is also an essential component of the primary care model. In 2024, Wisconsin Community Health Centers served over 300,000 patients, providing more than 1 million total visits for preventative medical care, behavioral health services, dental care, and enabling services such as case management and addressing social determinants of health. According to 2023 data, 76% (205,500) of Community Health Center patients live at or below 200% of the Federal Poverty Level. 55% of Community Health Center patients are enrolled in Medicaid and 20% are uninsured. Relative to 2022, 9,500 more Community Health Center patients were uninsured in 2023, a 3% increase. WPHCA appreciates this opportunity to provide comments in support of Cole's Act, SB 203, and appreciates the continued leadership of Sen. Felzkowski and Rep. Novak on this issue, along with the current 38 bipartisan co-sponsors.

340B Covered Entity Protections

Community Health Centers work with PBMs to meet the needs of patients utilizing private insurance or Medicare for prescriptions. Half of the state's Community Health Centers operate in-house pharmacies, some rely strictly on contract pharmacies, and several use both methods for prescription distribution or supplement with mail order options. Community Health Centers report that PBMs implement unfair auditing practices mired in non-value add administrative burdens, frequently change networks resulting in reducing patient access to medications, and unfairly target entities participating in the federal 340B Drug Pricing Program through discriminatory contracting.

Established in 1992, the 340B Drug Discount Pricing Program enables "covered entities" (these are the health care organizations outlined in the federal 340B program) to purchase outpatient drugs (prescription drugs and biologics other than vaccines) at reduced prices, allowing them to expand access to affordable prescription drugs for patients. Covered entities include Federally Qualified Health Centers, tribal clinics, certain hospitals, and others that disproportionately provide care for individuals with limited resources, such as low-

income individuals or the uninsured. In addition, covered entities receive savings through the program on certain prescriptions covered by commercial insurance and Medicare.

Administered by the federal Health Resources and Services Administration (HRSA), the 340B program goal is to "stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services" and extend reach for entities that serve large populations of low-income and uninsured patients. By federal law, drug manufacturers must offer 340B discounts to covered entities in order to have their drugs covered under Medicaid. HRSA calculates a 340B ceiling price for each covered outpatient drug, which represents the maximum price a manufacturer can charge a covered entity for the drug. This is based on a formula; if manufacturers raise prices too steeply there are penalties and price reductions for 340B purchases.

The 340B program allows Community Health Centers to purchase outpatient medications at reduced costs, enabling them to provide affordable discounted or free medications to uninsured and underinsured patients. By law and statute, Community Health Centers are required to invest *every penny* of 340B savings into activities that expand access for their patients. The 340B program generates savings that are reinvested in the Community Health Center to meet the unique needs of their communities like dental care, behavioral health, chronic disease management, translation services, food access programs, and co-pay assistance programs. In particular, Community Health Centers in Wisconsin commonly use 340B savings to fund pharmacy staffing and pharmacy services such as reducing or eliminating the out-of-pocket cost of medications which can be a significant barrier for many patients. This applies to the sliding fee scale that Community Health Centers are required to provide to patients who are uninsured or underinsured, used not only for medical services but also prescription medications. The savings from the program are often used to make those prescriptions more affordable and reduce the out-of-pocket costs to patients.

SB 203 provides various protections to 340B covered entities like Community Health Centers regarding PBM contracts and operations. It prohibits PBMs from:

- Refusing to reimburse a 340B covered entity or contract pharmacy from dispensing 340B drugs;
- Imposing requirements or restrictions that are not applied to other entities;
- Reimbursing 340B entities at a different rate relative to non-340 entities; and
- Applying network restrictions to 340B entities, among other provisions.

At least 16 states have passed laws protecting Community Health Centers from discriminatory 340B pricing in PBM contracts. Without these protections, the benefit of the program towards patient care is essentially transferred from the intended non-profit, local community-based entities and their patients to for-profit organizations - the PBMs. That is not the intent of the program and it reduces the Community Health Center's ability to provide affordable medications and health care services to their patients.

My colleague from Lakeshore Community Health Center will share specific examples about their PBM contracts where the PBM provides the pharmacy for a *lower* dispensing fee as a 340B covered entity than it would for a non-340B entity. Through this practice, the PBM

unfairly targets the health care entity simply on the basis of its participation in the 340B program, intended to benefit patients and health care organizations that disproportionately provide care for medically under-served populations.

Additional examples from Community Health Centers further demonstrate the ways in which PBMs target entities whose entire purpose is improving access to high-quality for high-need patients. Recently, a Milwaukee Community Health Center established their own pharmacy and had to reject a PBM contract because they would actually take a loss on providing medications and cannot sustainably run their pharmacy program under those terms. Now, the patients covered by that insurance plan do not have access to the Community Health Center's on-site pharmacy. This creates access barriers for the patients, as well as affordability issues relative to use of a sliding fee scale and other supports available at the in-house pharmacy.

There are multiple federal proposals that aim to reform the 340B program and WPHCA agrees that Congressional action is needed, for example to reinstate and protect the use of contract pharmacies which are especially important in rural areas, where drug manufacturers have limited or eliminated patient access to affordable medications. WPHCA is supportive of such federal reforms, and would be aligned with additional program reporting requirements. Notably, Community Health Centers already provide 340B reporting to HRSA, and are subject to external auditing from federal regulators. However, as we encourage and await federal action, Community Health Centers and their patients are collateral damage in the broader dispute over program integrity, and we cannot wait for Congress to fix the issue. Patients need access to affordable medications today.

Predatory Auditing Practices

PBMs also disrupt Community Health Center operations and needlessly force clinics to jump through hoops during auditing processes with no value-add for patients or clinical quality measures. WPHCA appreciates this bill's efforts to address these unfair auditing processes. Audits regularly exclusively target high-cost prescriptions (e.g., a clinic processed a $4,000 injection, received a paid claim for the prescription, and had an audit arrive the next morning from a third party). This is a clear indicator that quality or patient safety is not the focus, rather, financial motivation for the PBM. Audits are also extremely burdensome, unreasonable to comply with, and often include scopes that are overly broad. Below are recent examples from Wisconsin Community Health Centers working through PBM audits.

Administrative Burden of Audits

- Required individual faxes (documentation could not be submitted via any other method, such as email); and
- Even with a full-time pharmacy student, it took approximately 60 hours of clinic time to compile the physician and patient attestations, retrieve hard copies and submit them to the PBM. Responding to frequent, unnecessary audits pulls pharmacy staff away from operations and patient care.

Unreasonable Compliance Requirements in Audits and Application of Findings

- Audit findings with a prescription list of those being audited was only faxed to the clinic upon request, and arrived only *two days prior to the site visit*. Since the PBM blinded the last two digits on the entire listing of prescriptions, it was nearly impossible to retrieve all of the boxes of prescriptions and get them to the clinic before the scheduled audit;
- Requests to provide the original hardcopy and signature as proof of delivery. Hard copies are often stored off-site and must be retrieved and presented for the audit, which can take time;
- The PBM audit indicates, "missing signature for proof of delivery; copy of manual sig log not accepted; only electronic documentation or patient affidavit accepted." The majority of the prescriptions audited were for injections that are administered internally to clinic patients, such as by the clinic's behavioral health nursing staff, when the patients are seen either in clinic or at home. The PBM's stated compliance provision would require the clinic to implement *manual signature logs* so that 25+ caseworkers can retrieve their patients' medications and not have to wait to be "rung out" at the register by a technician. The point-of-sale process of selling prescriptions and capturing "pickup signatures" is also not applicable to these patients because they are all on in-house charge accounts, meaning they are not required to pay at the time of dispensing. Essentially, the clinic cannot implement a workflow to meet this arbitrary provision and therefore funds were recouped.
- During the COVID pandemic, third party payers explicitly advised clinics <u>not</u> to collect patient signatures due to the public health risk. Now, PBMs are recouping funds for this lack of patient signatures. Clinics receive conflicting information, then are penalized for compliance; and
- Audits regularly apply findings from a single prescription to all others, recouping adjudicated amounts each fill date, not the actual specific prescription that was audited, but rather for each fill date.

Scope of Audits

- Required short turnaround times: 20-45 calendar days to respond to the initial audit findings before the entire amount was recouped;
- Audits may span an extensive time period, such as a recent one for October 2021 through Feb 2023; and
- Some audits are frequent, approximately 10 times per month. For example, one PBM regularly audits an expensive injectable prescription that was administered nearly two years prior.

Examples from a rural western Community Health Center outline several of these issues. According to their Pharmacist, "performance-based fees and claim-processing fees have been getting out of hand. Both of these fees have downstream repercussions that are almost impossible to calculate into financials. Our pharmacy would have to pay a fee with [a PMB-affiliated data platform] just to see our performance. If we don't figure out what our current

performance is, there is no way to hold the PBM accountable for the increased reimbursement we should be receiving due to a good performance rating. On the flip side, they are quick to recoup any money if we are below a certain performance level. As for claim-processing fees, they can add up quickly. Even if a prescription gets returned/voided, our pharmacy still has to pay a processing fee, even though the patient did not end up receiving a prescription, and this leads to a net loss for the prescription.

Our pharmacy loses anywhere from 8 to 15% of its business at the beginning of each year due to insurance forcing patients to switch to other pharmacies. Over the course of the year, patients tend to come back. With every new year, patients frequently call our pharmacy telling us they have to switch pharmacies, as they were told by their insurance that we are no longer a covered pharmacy. However, we usually are a covered (contracted) pharmacy, although we may not be preferred meaning a patient's copay might be higher. Notifying patients of this information can help them continue to use our pharmacy, which is what they prefer to do in the first place. Due to our rural location, patients prefer to pay the extra fee and continue to use our pharmacy but why should they pay more to use their pharmacy of choice? If there are instances where a patient has to use a different pharmacy due to insurance requirements, (we may be contracted but insurance still requires the patient to use a different pharmacy), we have seen patients choose to pay cash for the prescription and forgo the use of their drug coverage. In other words, they are paying for drug coverage but not even using it."

In conclusion, savings from the 340B program were intended for health care organizations that serve a high share of low-income and under-resourced patients, not PBMs or insurers. This bill would put guardrails in place to ensure that organizations like Community Health Centers and their patients benefit from the program, which doesn't cost tax payers a dime, instead of for-profit third parties that are reaping the program savings for themselves. Thank you for the opportunity to share information regarding the impacts of PBM practices on Community Health Centers and our patients, and for your consideration of SB 203, Cole's Act. WPHCA encourages you to support the bill, and is available to discuss questions about the 340B provisions in the legislation.

Richelle Andrae

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We envision a future where all individuals and communities in Wisconsin achieve their highest potential.

Our mission is to improve health through the work of Community Health Centers and their partners.

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2024

WISCONSIN'S COMMUNITY

HEALTH CENTERS

WPHCA
Wisconsin Primary Health Care Association

PROGRAM BACKGROUND

For over 50 years, the Health Resources and Services Administration (HRSA)-supported Community Health Centers have provided comprehensive primary and preventive health care services, including medical, dental, behavioral health, and substance use care, plus connections to social services.

Community Health Centers are:

- Private or public not-for-profit organizations
- Located in or serving high need communities
- Governed by a patient-majority Board of Directors
- Providers of supportive services that promote access to health care
- Providers of services to everyone regardless of insurance status,
  with fees adjusted based on a patient's ability to pay
- Responsible for meeting performance and accountability requirements and publicly reporting clinical and financial data

WI COMMUNITY HEALTH CENTERS

1 Access Community Health Centers
Madison • Sun Prairie • Dodgeville
accesscommunityhealthcenters.org

2 Bridge Community Health Clinic
Wausau • Antigo | bridgeclinic.org

3 Community Health Systems, Inc
Beloit | chsofwi.org

4 Family Health Center Of Marshfield, Inc
Black River Falls • Chippewa Falls • Ladysmith • Marshfield • Medford • Menomonie • Neillsville • Park Falls • Rhinelander • Rice Lake
familyhealthcenter.org

5 Gerald L. Ignace Indian Health Center, Inc
Milwaukee | gliihc.net

6 Kenosha Community Health Center, Inc
Kenosha • Silver Lake | kenoshachc.org

7 Lakeshore Community Health Care
Sheboygan •Manitowoc• West Bend
lakeshorechc.org

8 Lake Superior Community Health Center
Superior • Duluth, MN • Carleton, MN
lschc.org

9 Milwaukee Health Services, Inc
Milwaukee | mhsi.org

10 Muslim Community and Health Center
Milwaukee | mchcwi.org

11 N.E.W. Community Clinic
Green Bay | newcommunityclinic.org

12 Noble Community Clinics
Wautoma • Mauston • Beaver Dam • Friendship • Stevens Point
famhealth.com

13 Northlakes Community Clinic
Ashland • Hayward • Iron River • Minong • Turtle Lake • Balsam Lake Washburn • Birchwood • Park Falls Lakewood • Oconto • White Lake Hurley • Eau Claire • Marinette • Augusta | northlakesclinic.org

14 Outreach Community Health Centers
Milwaukee | orchc-milw.org

15 Partnership Community Health Center
Appleton • Oshkosh • Waupaca
partnershipchc.org

16 Progressive Community Health Centers
Milwaukee | progressivechc.org

17 Rock River Community Clinic
Whitewater • Watertown • Fort Atkinson | rockrivercommunityclinic.com

18 Scenic Bluffs Community Health Centers
Cashton • Norwalk • Viroqua • La Crosse | scenicbluffs.org

19 Sixteenth Street Community Health Center
Milwaukee • Waukesha | sschc.org

BY THE NUMBERS

PATIENTS SERVED

SITES AND STAFF

19
Community Health Center Organizations

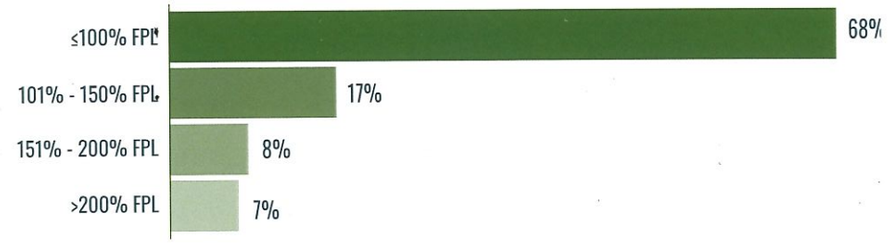
2,863
Employees (FTE)

242
Service Delivery Sites

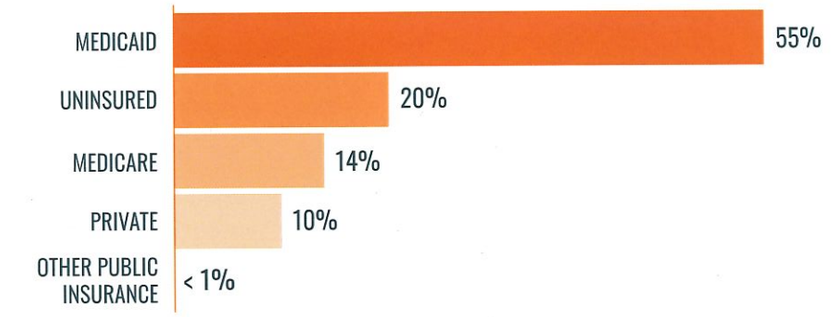
PATIENT DEMOGRAPHICS

INCOME STATUS

(Annual income in 2023 for a family of 4 at 100% of the Federal Poverty Level is $26,500)

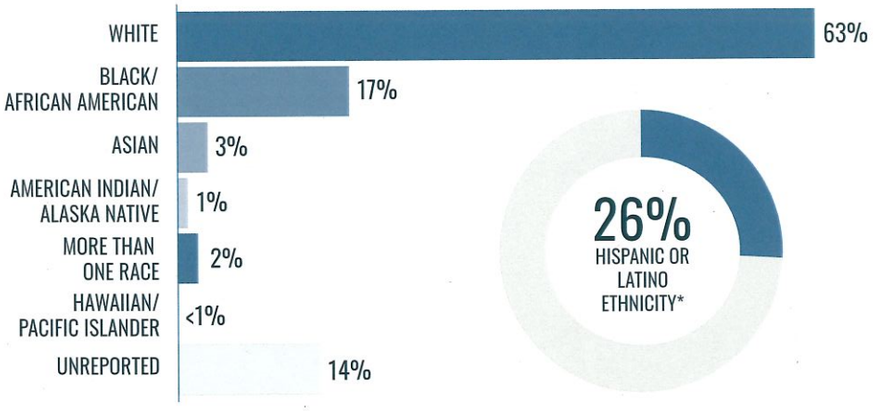


INSURANCE STATUS



RACE AND ETHNICITY

*Percentage of all races identifying as Hispanic or Latino



SPECIAL POPULATIONS

4,331
Individuals Experiencing Homelessness

7,468
School-Based Patients

1,392
Seasonal Agricultural Workers

3,408
Veterans

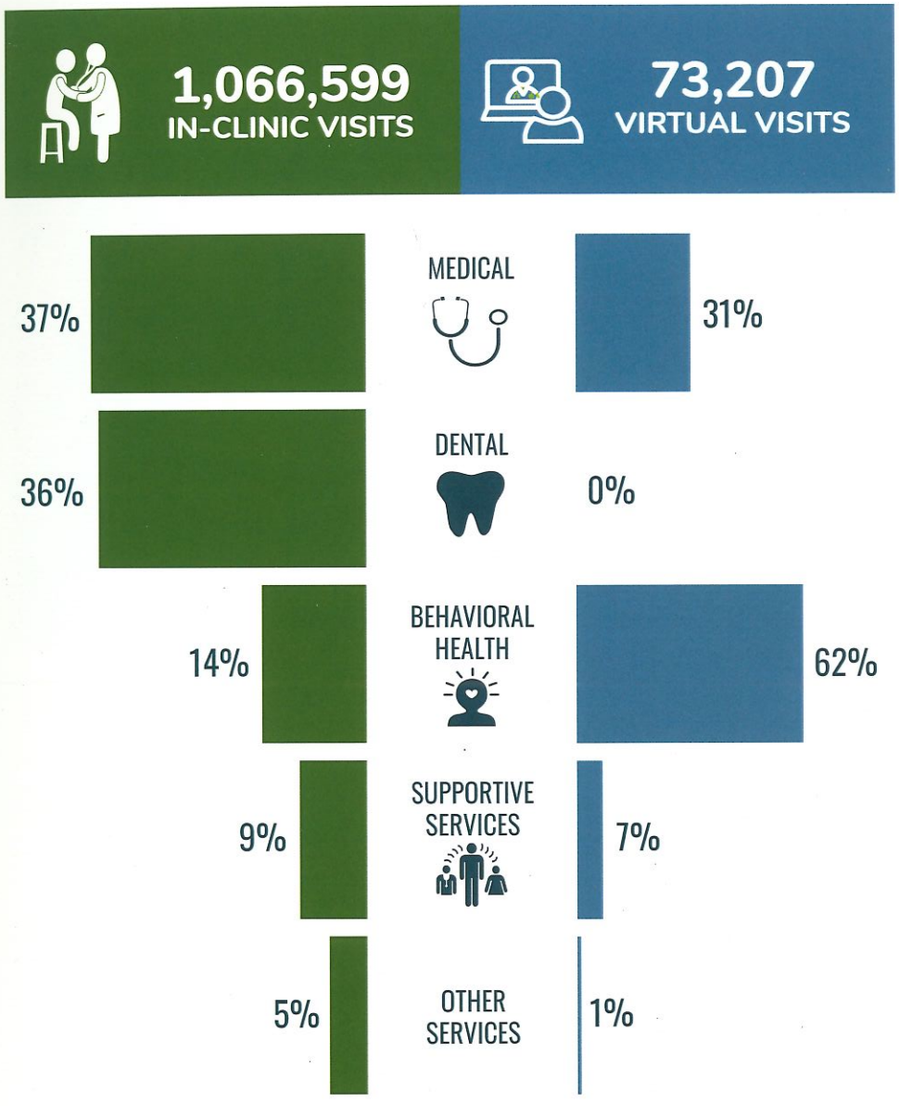
MATERNAL HEALTH

3,254
Pre-Natal Care Patients

1,758
Deliveries

PATIENT VISITS BY TYPE

1,139,806
TOTAL NUMBER OF VISITS



Data Source: 2021 Health Center Program Uniform Data System (UDS). Includes 1/2 of LSCHC reported data.

HEALTH CENTERS RESPONDING TO COMMUNITY NEED

Since the beginning, Wisconsin Community Health Centers have adapted and aligned their services in response to the needs of the communities they serve as well new communities in need. Below are a few examples from 2024.

New Service Expansions

Sixteenth Street Community Health Centers in the south side of Milwaukee, opened a community pharmacy at their Chavez location. The pharmacy offers bilingual care, cost-saving medication reviews, seamless care integration, and more.

Sixteenth Street Community Health Centers

NEW Community Clinic hosted walk-in appointments with their mobile clinic named MOBY (Mobile Outreach Brought to You) at Samaritan Heart Mission Church and the Micah Center in Green Bay.

NEW Community Clinic

New Service Delivery Sites

In response to the exit of a major provider in the Chippewa Valley region, **NorthLakes Community Clinic (NLCC)** worked with local communities to fill the gap by opening clinics in Eau Claire and Augusta and breaking ground for a new clinic in Oconto.

Pillar Health, a division of **Kenosha Community Health Center (KCHC)** took part in the groundbreaking of the New Lincoln-King Community & Health Care Center in Racine - the future home of Pillar Health. Medical, dental and behavioral health services will be offered.

NLCC, Eau Claire

Pillar Health/KCHC, Racine

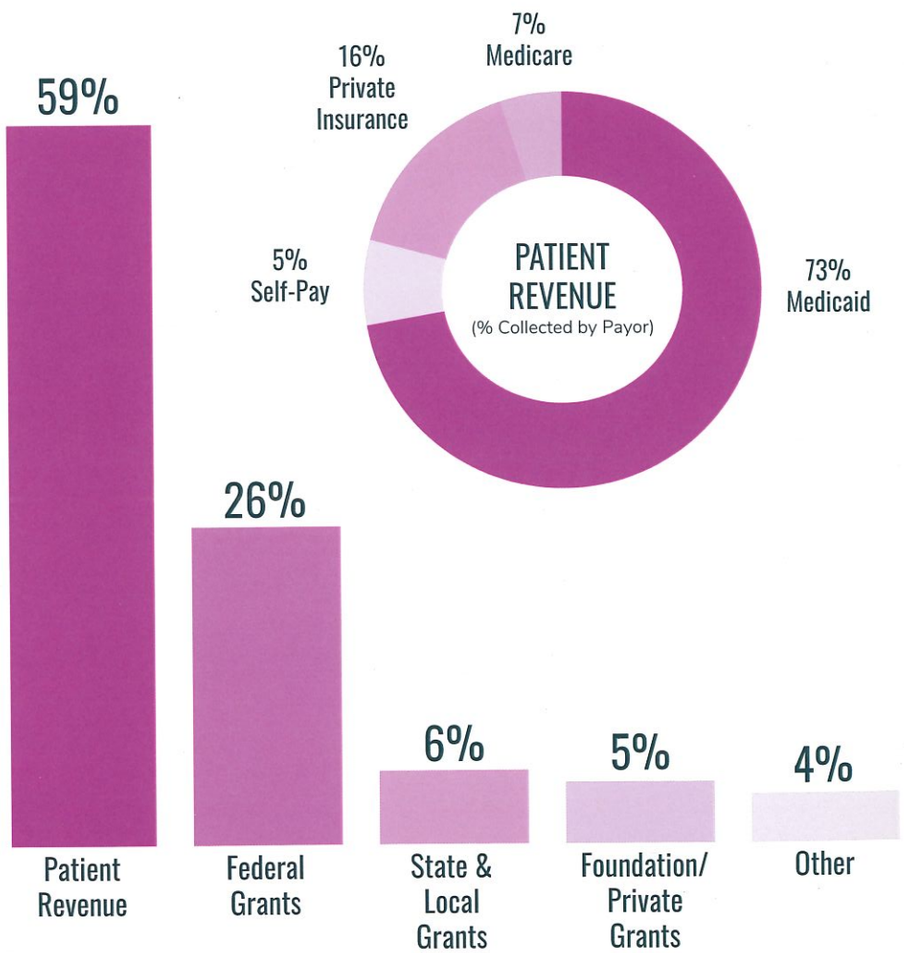
Behavioral Health Expansions

In 2024, 6 CHCs recieved Behavioral Health Services Expansion grants awarded by the Health Resources and Services Administration (HRSA). The funding allows them to expand their mental health and substance use disorder services.

- Access Community Health Centers, Inc. in Madison
- Community Health Systems Inc. in Beloit
- Lakeshore Community Health Care Inc. in Sheboygan
- Primary Connection Healthcare, Inc. in Wausau
- Progressive Community Health Centers, Inc. in Milwaukee
- Scenic Bluffs Health Center Inc. in Cashton

REVENUE

Community Health Centers receive grant funding from HRSA, a division of the US Department of Health and Human Services, to support operations and provide sliding fee discounts to low-income, uninsured, and under-insured patients. In addition to grant revenue, Community Health Centers receive revenue from patients including self-pay, Medicaid, Medicare, and private insurance.



Data Source: 2023 Health Center Program Uniform Data System (UDS). Includes 1/2 of LSCHC reported data.

QUALITY OF CARE

13 Community Health Centers are certified as Patient Centered Medical Homes (PCMH)

Health Centers primarily hold recognition from three organizations: National Committee for Quality Assurance, Joint Commission and Accreditation Association for Ambulatory Health Care.

Research has shown that PCMH recognition increases health outcomes, improves health equity and lowers cost for patients and Health Centers. Completing the certification process ensures that the Health Center has met criteria related to quality and patient safety and measures against national standards in quality improvement, risk management and care coordination.

HRSA Community Health Quality Recognition (CHQR)

HRSA Community Health Quality Recognition (CHQR)
CHQR badges recognize Health Center Program awardees and look-alikes (LALs) that have made quality improvement achievements in access, quality, equity and health IT

In 2024:

6 Health Centers - Addressing Social Risk Factors of Health
12 Health Centers - Advancing Health Information Technology
3 - Access Enhancer
3- Health Disparities Reducer
2 - Health Center Quality Leader - Silver

LAKESHORE
community health care

MAILING ADDRESS
P.O. Box 959
Sheboygan, WI 53082
lakeshorechc.org

May 28th, 2025

Senate Committee on Health,

Hello, and thank you for allowing me to speak today. My name is Kaytlyn Dummer and I am a clinical pharmacist at Lakeshore Community Health Care. We are a Federally Qualified Health Center with three locations serving the communities of Manitowoc, Sheboygan, and Washington counties. We are proud to offer a plethora of services for our patients including medical, dental, behavioral health, chiropractic, and pharmaceutical services all under one roof at each location. In 2023, Lakeshore provided nearly 53,000 visits for our patients. 86.2% of the patients we see have an annual income under 200% of the federal poverty level. To put that into perspective, for a family of four, this equates to $55,550 or less of total household income for one year.

Lakeshore staffs an onsite pharmacy that participates in the federal 340B program. With the savings gained through the 340B program, we are able to reinvest and provide several services to help our patients break down the potential barriers they may face when trying to access affordable healthcare. A few of the services we offer are delivery of medications, monthly packaging of medications, and medication therapeutic management. The savings gained also help us determine the sliding scale discounts for our medications.

Currently, Lakeshore Pharmacy has two contracts with pharmacy benefit managers that include discriminatory verbiage due to our status of being a 340B pharmacy. We are not being reimbursed nor provided a professional dispensing fee at the same rate as non-340B pharmacies. These plus potential charge backs after claims have been processed can lead to a net loss when dispensing medications. Repeated losses like this further cut into our ability to provide the services previously stated, or create the need to increase our sliding scale discount that our under- and uninsured patients use. These types of contracts diminish our ability to fully serve our patients who need our help the most.

I want to tell you about two of my patients. The first patient I have changed her name for privacy reasons, but her story is worth telling. Clara came to our clinic in 2022 to establish care and help treat her diabetes. Her initial A1c reading, which is a laboratory marker that provides the average amount of sugar in a person's body over a period of three months, was 13.1, an extremely high reading. Through our pharmacy, we were able to supply her diabetic medications for $38 per month based on our sliding scale discount. If she were to receive those same medications from a non-340B pharmacy, her monthly cost would have been $629. I am happy to report that, with the help of our 340B pricing, along with diet and lifestyle changes, Clara was able to lower her A1c to 7.1, which is the goal for patients with diabetes.

My next patient is Rebecca. Rebecca has been a patient of Lakeshore Pharmacy since moving to Wisconsin over five years ago. Currently, Rebecca lives below the 200% of the Federal Poverty Level. She is able to afford most of her medications through her commercial insurance, except for when it comes to one of her diabetic medications, she utilizes our sliding scale discount. That is until this last month. When trying to process her medications, I received rejections from her insurance stating she could no longer use Lakeshore Pharmacy, and instead must pick from a pharmacy of her insurances' choosing. This was devastating to Rebecca, as we have been her one and only pharmacy since coming to Wisconsin. She knows us, and more importantly, we know her. We know her past medical history, we know which medications work and do not work for her, and her financial situation. She is not the first patient this has happened to. There are countless patients who receive this type of news from their pharmacy and feel disappointed and frustrated.

Patients should have the opportunity to afford their medications. They should also be able to choose freely which pharmacy they receive their medications from. Patients should have the opportunity to freely change pharmacies for when issues arise with their medications, whether it be inventory issues, need for monthly packaging, or simply a closer drive from home. Patients should have these opportunities without the threat of increased co-pays or limiting day supplies of medications.

Kaytlyn Dummer

Kaytlyn Dummer
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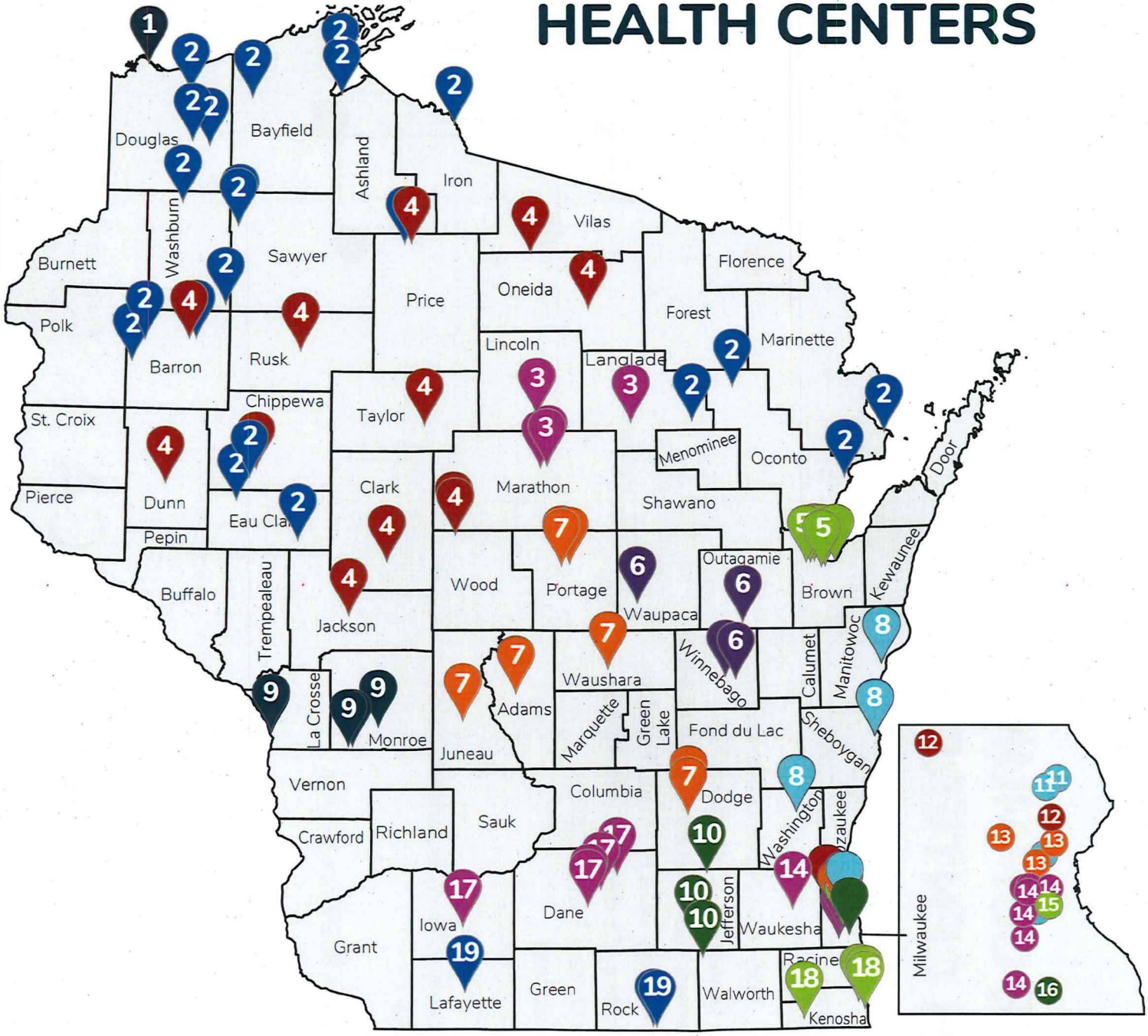
WISCONSIN COMMUNITY HEALTH CENTERS



1. Lake Superior Community Health Center
2. NorthLakes Community Clinic
3. Bridge Community Clinic
4. Family Health Center of Marshfield, Inc.
5. N.E.W. Community Clinic
6. Partnership Community Health Center
7. Noble Community Clinics
8. Lakeshore Community Health Care
9. Scenic Bluffs Community Health Centers
10. Rock River Community Clinic
11. Outreach Community Health Centers
12. Milwaukee Health Services, Inc.
13. Progressive Community Health Centers
14. Sixteenth Street
15. Gerald L. Ignace Indian Health Center
16. Muslim Community & Health Center
17. Access Community Health Centers
18. Kenosha Community Health Center
19. Community Health Systems

WPHCA

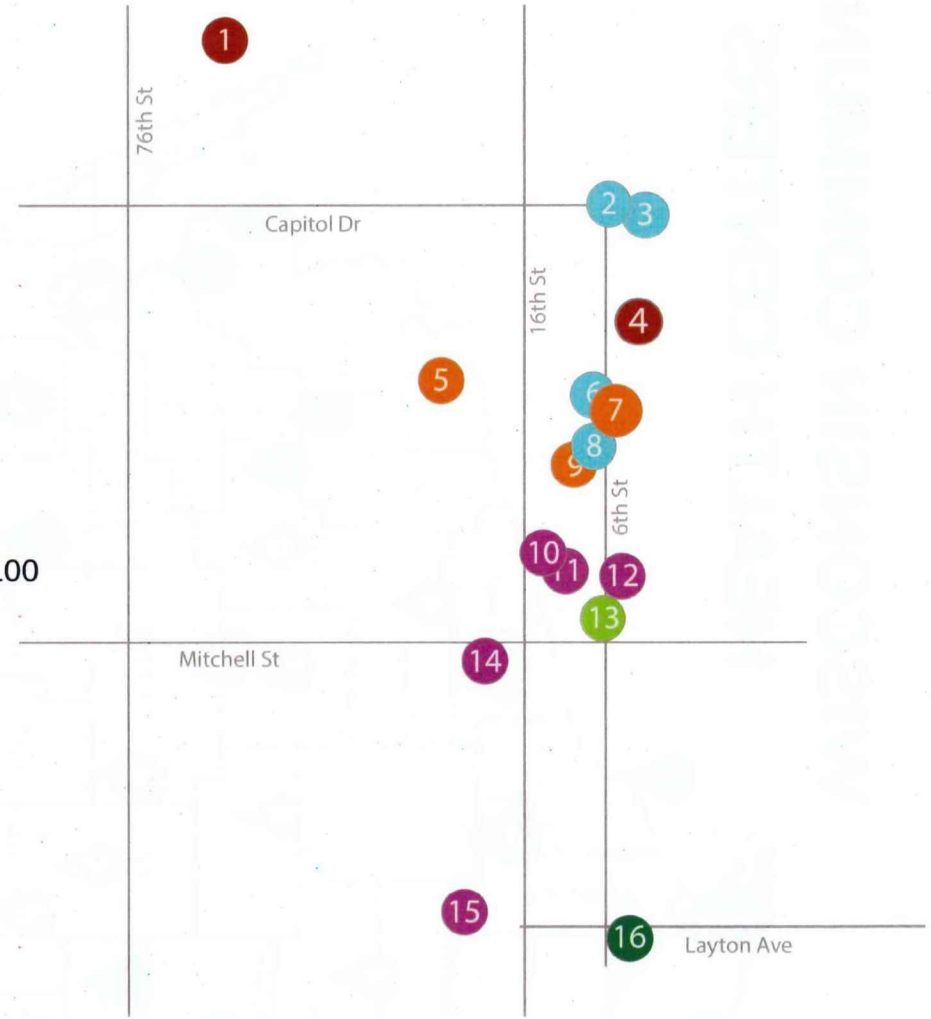
Wisconsin Primary Health Care Association

Updated January 2025

Find an interactive map at wphca.org/who-we-serve/find-a-community-health-center

MILWAUKEE COMMUNITY HEALTH CENTERS

1. Milwaukee Health Services, Inc., 8200 W. Silver Spring Dr.
2. Outreach Community Health Centers, 711 Capitol Dr. #205
3. Outreach Community Health Centers, 220 Capitol Dr.
4. Milwaukee Health Services, Inc., 2555 N. Dr. Martin Luther King Dr.
5. Progressive Community Health Centers, 3522 W. Lisbon Ave.
6. Outreach Community Health Centers - Salvation Army, 1730 N. 7th St.
7. Progressive Community Health Centers, 1452 N. 7th St., 2nd Floor
8. Outreach Community Health Centers - St. Ben's, 1004 N. 10th St., Suite 100
9. Progressive Community Health Centers, 945 N. 12th St.
10. Sixteenth Street, 1635 W. National Ave.
11. Sixteenth Street, 1032 S Cesar E. Chavez Dr.
12. Sixteenth Street, 1243 S Cesar E. Chavez Dr.
13. Gerald L. Ignace Indian Health Center, 930 W. Historic Mitchell St.
14. Sixteenth Street, 2906 S. 20th St.
15. Sixteenth Street, 4570 S. 27th St.
16. Muslim Community & Health Center, 803 W. Layton Ave.



Updated January 2025

WPHCA
Wisconsin Primary Health Care Association

*Clinics listed on these maps are brick-and-mortar clinic locations that operate more than 20 hours a week. Community Health Centers may have additional sites including mobile, part time, or school-based locations.

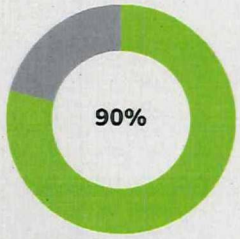
WHAT IS A COMMUNITY HEALTH CENTER?

JANUARY 2025

There are 19 federally-designated Community Health Centers in Wisconsin with more than 200 service delivery sites, serving nearly 300,000 patients.

DID YOU KNOW?

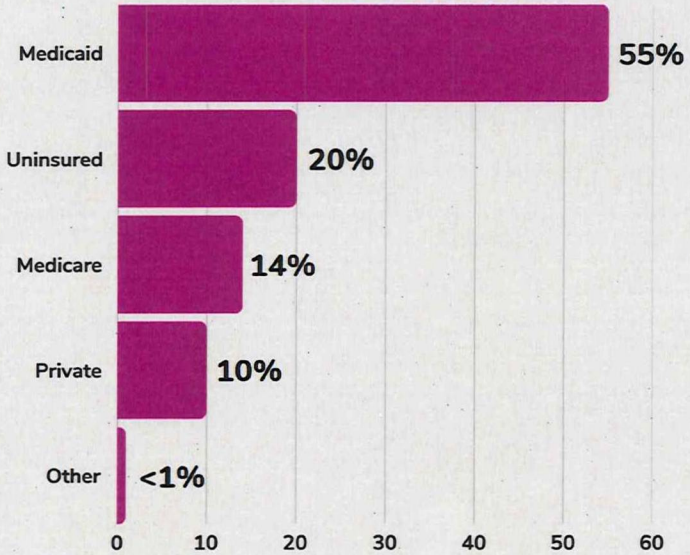
- Community Health Centers, also known as FQHCs, are clinics that provide primary care services, **including check-ups, behavioral health, dental care, mental health and substance use disorder treatment**, and supporting services like care coordination and community referrals.
- Wisconsin's 19 Community Health Centers are part of a national network of clinics that serve as the medical home for over **31 million people** of all ages in over 15,000 communities.
- Community Health Centers provide services to everyone **regardless of insurance status**, with fees adjusted based on a patient's ability to pay.
- Because of their special federal designation, Community Health Centers participate in unique programs like the National Health Service Corps, a program to incentivize practice in high-need areas.
- Community Health Centers receive **limited funding from public investments** to provide care for uninsured individuals and high-need populations (approximately one-third of revenue is state or federal grant funding).
- Every $1 in federal investments generates $7 in economic activity across Wisconsin, delivering over **$652 million in economic activity annually**.



Over 90% of Community Health Center patients live below 200% of the Federal Poverty Line.

200% of the Federal Poverty Line in 2023 was $29,160 for a family of four.

Insurance Status of Wisconsin Community Health Center Patients



WHAT MAKES COMMUNITY HEALTH CENTERS UNIQUE

Community Health Centers are:

- Dedicated to filling gaps in traditional health care systems by serving under-resourced communities
- Private or public not-for-profit organizations Located in or serving high need communities, based on federal requirements, which may be urban or rural areas
- Governed by a patient-majority Board of Directors Responsible for meeting performance and accountability requirements and publicly reporting clinical and financial data to the federal government

Community Health Centers sit at the crossroads of health care and public health. They are not:

- Hospitals or health systems
- Free and charitable clinics
- Local public health departments

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WPHCA
Serving Wisconsin Community Health Centers

PCMA

Date: May 28, 2025

To: Members of the Senate Health Committee

From: Sean Stephenson, Senior Director of State Affairs for the Pharmaceutical Care Management Association (PCMA)

RE: Testimony in opposition to Senate Bill 203

Chairwoman Cabral-Guevara, members of the committee, my name is Sean Stephenson and I am the Senior Director of State Affairs for the Pharmaceutical Care Management Association (PCMA) here to testify in opposition to Senate Bill(SB) 203. I appreciate the opportunity to be before you today.

PCMA is the national association representing America's pharmacy benefit managers also known as PBMs. PBMs administer prescription drug plans for more than 289 million Americans with health coverage through large employers, health insurers, labor unions, and federal and state-sponsored health programs.

PBMs were created to find cost savings and efficiencies in the drug supply chain to keep insurance coverage affordable. Pharmacists make more money when prices go up. Drug manufacturers make more money when costs go up. PBMs exist as a countervailing force to negotiate lower prices from both pharmacies and drug manufacturers by leveraging the size of the patient populations we serve.

PBMs focus on enabling access and lowering prescription drug costs for patients and the wide range of health plan sponsors who choose to hire them – specifically by:

- Negotiating manufacturer rebates from brand drug companies and discounts from drugstores to reduce costs for patients, their families, and health plans – saving an average of $1,154 per patient per year.[1]
- Encouraging the use of more affordable alternative drugs, such as lower-cost brands, generics, and biosimilars.
- Offering services that benefit patients, such as home delivery, adherence programs, and drug reviews.
- Managing and helping patients access high-cost specialty medications.
- Identifying and rooting out fraud, reducing waste, and preventing potentially harmful drug interactions.

These savings are fully under the control of the PBM client in every aspect. Employers and unions choose to hire PBMs to secure lower costs for prescription drugs and achieve better health outcomes for patients. While employers could negotiate directly with drug companies and pay the prices each pharmacy charges the general public, nearly all choose to work with PBMs because of the value our companies provide to them and the patients they cover. Over the next 10 years, PBMs will save employers, health plans, labor unions, state and federal governments, and patients more than $1.2 trillion[2].

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[1] Visante. 2025. The Return on Investment (ROI) on PBM Services. https://www.pcmanet.org/wpcontent/uploads/2025/02/ROI-on-PBM-Services.pdf

[2] Visante. 2025. Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers. https://www.pcmanet.org/wp-content/uploads/2025/02/PBM-Generate-Savings-for-Plan-Sponsors-andConsumers.pdf

Pharmaceutical Care Management Association
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www.pcmanet.org

designs to achieve this. This legislation amounts to a ban on the employers in your districts from purchasing plans that utilize these tools, leading to higher costs for everyone. I encourage you to oppose this legislation and PCMA stands ready to work with you on measures that will actually lower costs. Thank you to the members of the committee for the opportunity to testify today. I would be happy to answer any questions at this time.

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Advancing Free Market Healthcare

National CooperativeRx

MEMO

To: Wisconsin State Representatives and Senators
From: Advancing Free Market Healthcare and National CooperativeRx
Re: 2025 Assembly Bill 173/Senate Bill 203
Contact: mduffy@dcstrategies.org / 608-334-0624

Introduction

Advancing Free Market Healthcare advocates for common sense, free market healthcare policy solutions. Many of our employer members are part of National CooperativeRx, which is a not-for-profit cooperative headquartered in Wisconsin, consisting of 320 employers purchasing pharmacy benefit management (PBM) services together.

As employer-run organizations, we have serious concerns about proposed PBM reform legislation, particularly provisions that will increase the amounts employers and patients are paying for prescription medications. **Please understand that prescription medications are already employers' fastest growing segment of health benefit expenditures, and we need public policy that will lower prices, not increase them.** The purpose of this memo is to share the facts and numbers behind our concerns, so lawmakers can make informed policy decisions.

Advancing Free Market Healthcare

National CooperativeRx

1

Concern: Frozen Formulary

Humira serves as a perfect example of why we oppose this provision.

The Facts Using Humira as One Example

- Worldwide revenues for Humira, the world's best-selling drug at one time, more than doubled over ten years from $7.9 billion in 2011 to $20.7 billion in 2021.
- Given the amount the drug was costing U.S. taxpayers, the U.S. House Committee on Oversight and Accountability opened an investigation in 2019 into AbbVie's pricing, patent, and marketing strategies, revealing strategies AbbVie used to extend market exclusivity beyond the timeline for U.S. patent protection.[1]
- In 2023, biosimilars were finally launched. The approvals happened years before, but the market launches were delayed due to settlements, etc. Amjevita was the first Humira biosimilar to launch in 2023, but it was approved in 2016.
- The list price for the one of the biosimilars, Hyrimoz, is approximately 80% lower than the list price for Humira.
- On April 1, 2024, the PBM CVS Caremark excluded Humira from its formularies in favor of significantly lower priced biosimilar medications approved by the FDA after 20 years of exclusivity for Humira's manufacturer, Abbvie. The change took effect for all National CooperativeRx employer plans on April 1, 2024, even though employer plans have varied renewal dates.
- Patients were not aware of the lower-cost biosimilar initially and few switched from Humira to the lower priced medication until the formulary change was made. Patients on Humira were informed of the change, and once the exclusion was put in place, more than 96% of patients switched to the lower cost biosimilar with no issues report. Patients and their physicians that felt they needed to remain on Humira could pursue an exceptions process.

The Bottom Line

One year after the change, National CooperativeRx employers and patients in Wisconsin have saved an estimated **$1.7 million** on Humira costs after discounts and rebates are factored in. Each patient that made the switch on a plan with a 10% coinsurance rate would save more than $500 per year in out-of-pocket spending. Formulary flexibility allows PBMs and plans to pivot to lower cost alternatives more quickly while saving patients money and without compromising care.

Advancing Free Market Healthcare

National CooperativeRx

2 Concern: A Minimum Mandated Dispensing Fee

Higher dispensing fees will increase costs for employer health plans and insured consumers.

The Facts

- As proposed by the PBM reform bill, dispensing fees would be set at a minimum of the Medicaid rate which ranges from $10.51 to $15.69 per prescription filled, depending on volume.
- Market rates, of course, vary, but a few examples are as follows:
  - According to a 2023 study by the Pharmaceutical Care Management Association, the average dispensing fee in the commercial market is less than $2 per prescription nationally.
  - The average dispensing fee for National CooperativeRx employer plans is reported to be $4 per rx.
  - Mark Cuban Cost Plus Drugs charges a $5 dispensing fee per rx.

The Bottom Line

In 2024, National CooperativeRx plans paid for 889,935 prescription fills in Wisconsin. The proposed increase in dispensing fees would equal **$5.8 million to $10.4 million** per year in added costs for member employers.

Advancing Free Market Healthcare

National CooperativeRx

3 Concern: Drug Coupons

When financial incentives are aligned correctly in healthcare, items and services that deliver the highest value are utilized more frequently. Unfortunately, drug coupons are a good example of a misaligned incentive – one that encourages drug manufacturers to raise their list prices and encourages patients to choose the most expensive medicines even when higher value medications are available. This matter is well researched.

The Facts

- Several reliable studies have found that drug coupons increase the use of branded medications[2] over generics and increase the prices[3] for these medications.
- After a nearly three-year investigation of the pharmaceutical industry and its drug pricing practices, a Congressional report found that drug companies, "*used patient assistance programs and donations to third-party organizations—which were ostensibly intended to help patients afford expensive drugs—as tools to garner positive public relations, increase sales, and raise revenue.*"[4]
- Many of the third-party organizations that are financially supported by pharma companies, as mentioned above, are the same as those lining up to support legislation that would allow pharmaceutical manufacturers to eliminate patient cost sharing through drug coupons.
- From 2013 to 2023, the value of coupons from pharmaceutical companies increased by an estimated 188%, from $8B to $23B. Pharmaceutical manufacturers operate patient assistance programs as nonprofit, charitable organizations so they may deduct donations of inventory or cash.
- Pharmaceutical companies are in violation of the anti-kickback statute if they are found to offer coupons to induce the purchase of drugs paid for by federal health care programs such as Medicare, Medicaid, TRICARE military insurance, and Veterans Health Administration programs. Several companies have agreed to financial settlements with the U.S. Department of Justice in recent years. Pharmacies that accept manufacturer coupons for copayments owed by Federal health care program beneficiaries may also be subject to sanctions under the anti-kickback statute, the beneficiary inducement civil monetary penalty, and the False Claims Act.

The Bottom Line

In 2024, the patient coupon value for employer members of National CooperativeRx in Wisconsin was $5.4 million, for specialty drugs alone. If the drug coupon provision of the PBM reform bill had been in place last year, a significant portion of this amount would have been borne by employer plans instead of "donated" by drug manufacturers. Drug coupon regulations may undermine employer plans and the tools they use to help ensure cost-effective and clinically appropriate care.

Advancing Free Market Healthcare

National Cooperative Rx

4

Concern: Network Restrictions

National CooperativeRx offers employers the option of an exclusive specialty network for high-cost medications at a significant savings. Most employers also offer mail order medications at a more generous benefit level which is employers' way of passing along cost savings to their employees.

The Facts

- National CooperativeRx's contract with a PBM provides an additional discount value on specialty brand fills when an exclusive specialty arrangement is used.
- Many employer plans provide lower member cost shares for mail service when compared to retail pharmacy options. Participants benefit from only being charged two copays for a ninety-day supply of medications, rather than three copays, due to cost savings and improved adherence metrics when mail order is used.
- The arrangement promotes patient safety and adherence, reduces waste, and saves money on dispensing fees.
- Narrow national retail networks are extremely rare among National CooperativeRx members regardless. Employers typically opt for the broad national network of approximately 53,000 pharmacies.

The Bottom Line

The exclusive specialty pharmacy arrangement saved National CooperativeRx members in Wisconsin $2.9 million in 2024. Mail order saved an additional $2.9 million in 2024 for member plans in Wisconsin. Today, many employers deploy plan designs that provide a share in savings amongst the plan and the plan participants where lower costs incurred by the plan correlate with lower out-of-pocket costs paid by consumers. Network restrictions and/or cost share parity requirements may result in savings being realized today with costs being passed on to consumers and patients tomorrow.

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Conclusion

Employers are the largest source of prescription drug coverage for Wisconsin's working families. For National CooperativeRx employers in Wisconsin alone, the four provisions of the PBM bill that we highlighted add up to an estimated **$18.7 million to $23.3 million** cost increase annually. Our experience will largely mirror the experience for all Wisconsin employers, and would add to an already unsustainable growth in prices for pharmaceuticals, which have outpaced inflation for decades. The bill would place a significant financial burden on patients and would strain employer budgets even more than they are today.

Employers and employees that are bearing much of the burden of high health prices need flexibility and tools that enable them to control their costs. AB 173 and SB 203 as written will limit employer plan designs, hamper the free market and appear as an attempt to pre-empt ERISA protections which will likely lead to court challenges. We implore the legislature to work with employers on real solutions[5] that take costs out of health benefits instead of adding more in.

References

1. *CEO and experts on pricing. Published May 18, 2021. https://oversightdemocrats.house.gov/news/press-releases/oversight-committee-held-hearing-with-abbvie-ceo-and-experts-on-pricing*
2. *Dafny L, Ody C, Schmitt M. When discounts raise costs: The effect of copay coupons on generic utilization. Am Econ J Econ Policy. 2017;9(2):91-123. https://doi.org/10.1257/pol.20150588*
3. *Dafny L, Ho K, Kong E. How do copayment coupons affect branded drug prices and quantities purchased? Nat Bureau Econ Res. Published 2022. https://doi.org/10.3386/w29735*
4. *U.S. House Committee on Oversight and Reform. Drug pricing investigation: Majority staff report. Published 2021. https://oversightdemocrats.house.gov/sites/evo-subsites/democrats-oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf*
5. *Advancing Free Market Healthcare. Legislative agenda: Six steps to protect Wisconsin's working families. Published January 2025. https://advancingfreemarkethealthcare.com/wp-content/uploads/2025/01/Legislative-Agenda-Six-Steps-to-Protect-Wisconsins-Working-Families.pdf*

Pharmacy Society of Wisconsin

To: **Members, Senate Committee on Health**

From: **Nicole Schreiner**
President-Elect
Pharmacy Society of Wisconsin

Date: **May 28, 2025**

Subject: **Support for Senate Bill 203**

Thank you for the opportunity to provide testimony regarding Senate Bill 203. My name is Nicole Schreiner, and I am the President-Elect of the Pharmacy Society of Wisconsin (PSW), as well as the owner of Streu's Pharmacy in Green Bay. On behalf of PSW's nearly 5,000 members, I urge you to support this critical legislation.

SB 203 introduces urgently needed reforms to the regulation of Pharmacy Benefit Managers (PBMs) in Wisconsin. These reforms are essential for safeguarding patient access, supporting pharmacies, enhancing market transparency, and restoring fairness to a supply chain increasingly dominated by vertically integrated corporate entities.

While opponents of this legislation are utilizing scare tactics in their protectionist stance, defending PBM market dominance and opaque business practices, I would like to provide evidence-based counterpoints demonstrating that this legislation will advance consumer interests, reduce inefficiencies, and uphold patient care without unjustifiably increasing costs.

You've heard from opponents of this legislation that the bill imposes a 'one-size-fits-all' reimbursement scheme. In reality, it requires PBMs to stop reimbursing pharmacies below acquisition cost and ensures that minimum payments cover the costs of dispensing medications.

A 2024 study by Health Affairs found that 29.4% of retail pharmacies (both chain and independent) operating between 2010 and 2020 had closed their doors by 2021, with under-reimbursement by PBMs being cited as the chief reason for closure.[1]

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[1] Guadamuz, J. S. (2021). Fewer Pharmacies in Black and Hispanic/Latino Neighborhoods Compared With White or Diverse Neighborhoods, 2007-15. *Health Affairs, 40*(5). doi:https://doi.org/10.1377/hlthaff.2020.01699

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Between 2014 and 2024, Wisconsin lost a net total of 62 outpatient pharmacies. That's 62 communities that no longer have access to their pharmacy. That's 62 businesses worth of employees out of a job. And those businesses aren't just independent pharmacies – large chains, grocery stores, and mass retailers have all closed their pharmacies because they cannot compete in this market. When no one can compete except the pharmacies OWNED by those in charge of the market, that's a problem.

Fair reimbursement is not about equal pay for unequal services—it's about ensuring no pharmacy is forced to operate at a loss due to arbitrary reimbursement that lacks transparency and consistency.

The opposition argues that limiting PBM incentives for mail-order pharmacies restricts cost-saving tools. Yet, research consistently shows that forced mail-order prescriptions are unpopular and can compromise adherence, particularly among seniors and patients with complex regimens.

Moreover, mail-order benefits often disproportionately advantage PBM-owned pharmacies, creating anti-competitive dynamics. Brick-and-mortar pharmacies, especially in rural Wisconsin, provide essential services like vaccine delivery, medication counseling, and emergency fills—services not replicated by mail-order options.

Not only that, but a 2022 report from the Purchaser Business Group on Health (PBGH) found that PBM-imposed tactics led to increased rates of medication non-adherence, worsening patient health outcomes.[2]

Under current practices, patients are steered to PBM-owned pharmacies or mail-order services, often against their will and at the expense of continuity of care. SB 203 rightfully prohibits these tactics, allowing patients to choose their pharmacy without financial penalty or coercion. This freedom is vital for patients managing complex medication regimens who depend on personalized support from pharmacists they know and trust. It doesn't ban mail order, it just requires patient consent to utilize it.

For years, PBMs have reimbursed independent pharmacies like mine at rates that do not even cover the acquisition cost of medications, let alone the overhead of dispensing. SB 203 mandates that PBMs pay at least the Medicaid dispensing fee and prohibits them from reimbursing affiliated pharmacies more for the same drugs.

What does reimbursing affiliated pharmacies more mean? The largest PBMs own their own pharmacies and often steer their patients to use those pharmacies. Investigations have

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[2] Purchaser Business Group on Health. (2022). *Pharmacy Benefit Tactics Drive Up Drug Prices, Limit Access, Contribute to Health Risks.* Retrieved from https://www.pbgh.org/wp-content/uploads/2022/12/Pharmacy-Benefit-Tactics-Drive-Up-Drug-Prices-Limit-Access-Contribute-to-Health-Risks.pdf

shown that some PBMs pay their own pharmacies up to 50% more than other in-network pharmacies (those that the PBM doesn't own).[3] Let me repeat. A PBM pays a pharmacy that it owns 50% more for the exact same prescription than it pays other pharmacies that are in its network. This is not a free market. This is a rigged system. This is an entity giving its own stores an unfair advantage in a marketplace that it controls.

A typical retail business calculates its cost of goods, necessary overhead, and a reasonable profit when setting its prices. Pharmacies cannot do that. Pharmacies do not set the price a PBM will pay them. A PBM tells the pharmacy how much they will pay them and generally requires the pharmacy to fill any prescription for a covered patient, regardless of reimbursement amount, in order to remain in the network. Of course, PBMs are going to pay the pharmacy as little as possible – even when that is less than the cost of the drug itself.

Recently, I looked at the profile of one of my patients who is on several medications. In total, it costs my pharmacy $50 per month in drug costs to fill her medications. Let me repeat that. I lose $50 per month to be this patient's pharmacist. Not to mention the pharmacist and staff salaries, equipment, rent, and keeping the lights on.

So you might ask, why do I still fill her prescriptions?

Well, first of all, I am a healthcare provider, and this patient needs care.

But also, my contract with PBMs REQUIRES me to fill her prescriptions, or I will lose that contract – which means I will not be able to fill prescriptions for ANY patients with that PBM.

How is this a fair system?

Do we ask any other business to operate at a continual loss?

Do we require any other business to accept the amount they are offered, no matter how little, in order to be able to serve their community?

Do you walk into the grocery store and tell the cashier you'll pay them 50 cents for this bushel of bananas, and tell them if they don't take the 50 cents and give you the bananas, they won't be able to sell goods to millions of other people?

What kind of system is this? And how can we expect pharmacies to survive?

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[3] Yost, D. (2018). *Ohio's Medicaid Managed Care Pharmacy Services: Auditor of State Report.* Retrieved from https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf

I've heard groups that oppose this legislation say that I, as an independent pharmacy owner, just want to make more money or that I can't compete in a changing marketplace.

This is all smoke and mirrors to deflect from the massive markups and profits being made as a result of the opaque and rigged system. But don't just take it from me:

- A 2025 Federal Trade Commission (FTC) interim staff report found that PBMs charge significant markups on cancer, HIV, and other specialty generic drugs by thousands of percent.[4]
- The House Committee on Oversight and Accountability released findings in 2024 that showed PBMs pocketed billions in profits through opaque rebate structures, driving up patient costs.[5]
- The *American Journal of Managed Care* (AJMC) reported that PBMs often exploit market power to negotiate higher rebates while maintaining formulary designs that disadvantage consumers.[6]

Senate Bill 203 is a patient-focused, transparency-driven legislative effort designed to reform a broken system. The opposition's dire predictions are rooted in fear of losing control over a non-transparent and highly consolidated segment of the healthcare market.

Dozens of states have passed the reforms included in this bill, and it hasn't led to the massive increases in cost that opponents of the legislation would like you to believe. Patients have more access, pharmacies are able to stay open, and plan sponsors and employers know more about what they are paying for – but drug prices and premium rates have increased less than in states without these reforms.[7,8] Let me repeat. In states that have passed the reforms included in this bill, drug prices and premium rates have increased less than the rate of increase in states that do not have these reforms.

We urge Wisconsin legislators to support this bill as a critical step toward fairer pharmacy practices, better drug pricing, and a more patient-centered system of care.

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[4] Federal Trade Commission (2025). *Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers.* Federal Trade Commission. Retrieved from Federal Trade Commission: https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf

[5] House Committee on Oversight and Accountability Staff. (2024). *The Role of Pharmacy Benefit Managers in Prescription Drug Markets.* Retrieved from https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf

[6] Caffrey, M. (2024, July 9). *American Journal of Managed Care*. Retrieved from FTC Finds PBMs Drive Up Drug Costs, Squeeze Out Competitors: https://www.ajmc.com/view/ftc-finds-pbms-drive-up-drug-costs-squeeze-out-competitors

[7] National Community Pharmacists Association. *PBM Reform Has Not Raised Costs for Patients and Payers.* Retrieved from https://ncpa.org/sites/default/files/2022-03/pbm-regulations-one-pager.pdf

[8] National Community Pharmacists Association. (n.d.). *Controlling PBM Conflicts of Interest Does Not Raise Healthcare Costs.* Retrieved from https://ncpa.org/sites/default/files/2021-06/ControllingPBMConflictsofInterestHealthcareCosts.pdf

By embracing these reforms, Wisconsin can join a growing number of states taking a stand against unchecked PBM practices, protecting local pharmacies, improving care continuity, and restoring balance to the prescription drug marketplace.

AHIP
Guiding Greater Health

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May 28, 2028

The Honorable Rachael Cabral-Guevara
Committee on Health, Chair
Wisconsin State Capitol
2 E Main St.
Madison, WI 53702

RE: AHIP Opposition – SB 203 / AB 173 An Act Relating to Pharmacy Benefit Managers

Dear Senator Cabral-Guevara,

On behalf of AHIP, we offer the following comments in opposition to SB 203 / AB 173 which restricts health plans' ability to hold down drug costs. This bill does nothing to control the soaring prices of prescription drugs set by pharmaceutical manufacturers, but instead rewards drug makers for steering patients towards more expensive brand-name drugs. As we will discuss below, a Wakely analysis of requirements like those in SB 203 / AB 173 demonstrates that the bill's provisions would encourage the use of more expensive drugs, increase premiums, and reduce wages for Wisconsin residents.

Drug manufacturers intentionally use copay coupons to keep drug prices high. Everyone should be able to get the medications they need at a cost they can afford. But drug prices are out of control, and Wisconsin families feel the consequences every day. Pharmacy costs now represent over 24 cents out of every dollar of premium spent on health care.[1]

Drug manufacturers acknowledge their drugs are unaffordable for patients, but rather than addressing this by lowering their prices, they instead offer copay coupons[2] to hide the actual cost of those drugs. Coupons intentionally offset short term cost sharing for a few patients, while increasing the cost of pharmacy care for everyone and benefiting drug manufacturers.

Copay coupons encourage the use of high-priced branded prescription drugs when more affordable generic alternatives are available. The federal government considers copay coupons to be an illegal kickback if used by an enrollee in Medicare or Medicaid because they induce a patient to use a specific drug.[3] In the commercial market, coupons are often offered by the drugmaker only for a limited time – once the patient hits their deductible, the drugmaker discontinues the patient's assistance.

The Centers for Medicare and Medicaid Services (CMS) has concluded that coupons can distort the market and hide the true cost of drugs. "Such coupons can add significant long-term costs to the health care system that may outweigh the short-term benefits of allowing the coupons, and counter-balance issuers' efforts to point enrollees to more cost-effective drugs.[4]"

Studies prove drug promotions are used to increase sales, fueling increased spending overall. Repeated studies have shown coupons benefit only drug manufacturers and have much larger, negative consequences for patients throughout the entire market:

- The U.S. House Oversight Committee's report on drug pricing found that drug companies use patient assistance programs as a sales tool – focusing on their rates of return, encouraging patients to stay on high-priced branded drugs after a generic is introduced, and subsidizing third-party foundations to drive sales and attract patients who otherwise might not have used the drug.[5] The Committee stressed that these programs **"do not provide sustainable support for**

patients and do not address the burden that the company's pricing practices have placed on the U.S. health care system."

- The Oversight Committee found one manufacturer projected a potential rate of return of $8.90 for every $1 spent on their copay assistance program for a cancer treatment "because oncologic drugs are a necessity for patients, there is less sensitivity to price increases."[6]
- A study by Harvard, Kellogg, and UCLA economists found couponed drugs had a higher annual price growth (12-13%) than non-couponed drugs (7-8%). After a generic alternative was introduced, coupons increased spending on brand drugs by $30-$120 million per drug over 5 years.[7]
- A National Bureau of Economic Research (NBER) working paper estimated "copayment coupons increase spending on couponed drugs without bioequivalent generics by up to 30 percent."[8]
- A Congressional Research Service report found "manufacturers may use coupons as part of a marketing strategy to keep prices for brand-name drugs higher than they otherwise would be after a lower-cost generic substitute comes to market."[9]

Studies estimate that eliminating coupons would save at least $1 billion per year.[10] Reporting on one such study, Axios noted, "The study adds further evidence to the idea that drug copay cards are a great short-term deal for patients – and especially the pharmaceutical companies that promote them – but a bad long-term deal for society."[11]

Health plans use guardrails to hold drug manufacturers accountable for pricing schemes such as copay coupons. It is critical to have guardrails in place against this kickback system to ensure transparency and affordability in drug pricing. Employers and health plans have worked hard to develop guardrails that reflect patients' actual out-of-pocket spending on drugs and shed light on drug manufacturer pricing schemes.[12] These employer and health plan guardrails do not result in higher costs for patients. Instead, they maximize the value of coupons to benefit the patient, taxpayers, and plan sponsors, and reduce the ability of drug manufacturers to avoid fair negotiation on prices.

CMS has explicitly allowed health plans to adopt programs that allow patients to use manufacturer coupons at the pharmacy counter but exclude some such coupons from counting towards annual cost sharing limitations to "lower the cost of coverage and generate cost savings while also ensuring efficient use of federal funds and sufficient coverage for people with diverse health needs."[13] This balanced approach allows patients to use coupons to reduce their cost sharing without subjecting consumers to higher premiums resulting from increased total plan spending – a more generous treatment than in the Medicare or Medicaid programs, which prohibit patients from using these coupons at all.

This bill will have negative consequences for all patients. This bill would significantly hamper health plans' ability to develop programs to hold manufacturers accountable for problematic pricing schemes. To assist policymakers considering whether to require health plans to accrue third-party payments towards patient cost-sharing, AHIP commissioned the actuarial firm Wakely to analyze the impact of such policy. Wakley found that legislation like SB 203 / AB 173 would:

- **Increase premiums**, with the largest increases in the individual marketplace
- **Result in adverse selection** into lower premium plans, such as Bronze plans, resulting in **higher premiums and consumers dropping their coverage.**
- **Reduce wages** for workers who receive coverage at work, due to **higher employer costs.**
- **Encourage use of more expensive drugs** over cheaper alternatives.[14]

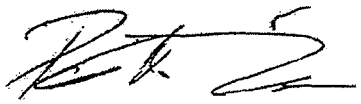
Restricting the use of health plans' guardrails will reduce incentives for drug companies to offer lower prices because those drug companies can continue to replace real price reductions with coupons. As a result, drug companies will make more money, while consumers and businesses continue to foot the bill through lower wages and higher premiums and out-of-pocket expenses.

The legislature should focus on solutions that forbid market manipulation. Instead of taking away the few tools that health plans and employers use to address ever increasing drug prices, the legislature should focus on fixing the market distortion caused by drug manufacturer pricing schemes, including copay coupons. We support a ban on copay coupons, especially in cases where less expensive generic alternatives are available, as California and Massachusetts have done.[15] This has been proposed by a group of prestigious health care scholars looking at ways to offer evidence-based steps for reforming health care spending in the US.[16]

If you wish to allow the use of drug manufacturer coupons to continue, we urge you to consider reforms that require a fair and equitable distribution of such coupons with sufficient oversight and transparency. This includes requiring that coupons be given to all patients prescribed a drug, assistance be provided for the entire plan year, and manufacturers inform health plans when they are providing a coupon or other type of financial assistance to an enrollee of that health plan.

AHIP stands ready to work together with state policymakers to ensure every patient has access to the high quality, affordable drugs that they need.

Sincerely,



Patrick Lobejko
Regional Director, AHIP State Affairs
Plobejko@ahip.org / Mobile (202) 748-2733

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.

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[1] *Where Does Your Health Care Dollar Go?* AHIP. October 2024.

[2] Here, the term "copay coupons" is used to represent all payments provided by a third party towards a patient's cost sharing (copay, coinsurance, deductible). This includes coupons directly from drug manufacturers, but also third-party payments and discount programs from patient assistance programs.

[3] *See 42* U.S.C § 1320a-7b; *Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons*. Department of Health and Human Services, Office of the Inspector General. September 2014.

[4] *Notice of Benefit and Payment Parameters for 2020*. Final Rule. April 25, 2019.

[5] *Drug Pricing Investigation, Majority Staff Report*. U.S. House Committee on Oversight and Reform. December 10, 2021.

[6] *Drug Pricing Investigation: Novartis-Gleevec, Staff Report*. U.S. House Committee on Oversight and Reform. October 2020.

[7] Dafny, Ody & Schmitt. *When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization*. October 2016.

[8] Dafny, Ho & Kong. *How Do Copayment Coupons Affect Branded Drug Prices and Quantities Purchased*? NBER Working Paper Series. February 2022.

[9] *Prescription Drug Discount Coupons and Patient Assistance Programs*. Congressional Research Service. June 15, 2017.

[10] *Id.*, Dafney, Ody & Schmitt. *Eliminating Prescription Drug Copay Coupons*. 1% Steps for Health Care Reform.

[11] Herman, Bob. *The growing evidence against drug copay cards*. Axios. February 15, 2022.

[12] Humer, Caroline and Michael Erman. *Walmart, Home Depot adopt health insurer tactic in drug copay battle*. Reuters. November 13, 2018.

[13] *Notice of Benefit and Payment Parameters for 2020*.

[14] *Implications of Third-Party Payments on Commercial Market*. Wakely. July 15, 2024.

[15] *CA Health and Safety Code § 132000- 132008.; Mass. Gen. Laws Ann. ch. 175H, § 3.*

[16] *Eliminating Prescription Drug Copay Coupons*.

To: Wisconsin Senate Committee on Health

From: Ann Lewandowski
1657 Percheron Trl.
Sun Prairie, WI 53590
RE: Cole's Act SB 203

Dear Senators,

Thank you for your time. I am writing to you as a patient asking you to support Cole's Act, SB 203. As a patient with two chronic illnesses, my family spends thousands on medical bills every year. We rely on a copay card to provide us with affordable solutions. As you know, pharmacy benefit managers (PBMs), hospitals, and insurance plans often receive significant medication discounts, often between 30% and 50% of the drug cost.[1][2][3][4]However, patients are usually charged the full price of the medication, increasing their copay by thousands, resulting in plans making money from their sickest patients.[5] This likely contradicts their testimony today, which highlights that they lose money on expensive drugs. The data from 26brooklyn Research is not isolated; we see similar trends in Minnesota's rebate pricing data, including plans making millions from their sickest patients.[6]

Money from Sick People Model					
	Deductible Phase		Coinsurance Phase		
Months	Patient Cost	Health Plan Cost (POS)	Rebate	Net Health Plan Cost	Overall Net Drug Cost
January	$ 408.00	$ -	$ 339.00	$ (339.00)	$ 69.00
February	$ 408.00	$ -	$ 339.00	$ (339.00)	$ 69.00
March	$ 408.00	$ -	$ 339.00	$ (339.00)	$ 69.00
April	$ 408.00	$ -	$ 339.00	$ (339.00)	$ 69.00
May	$ 34.34	$ 373.66	$ 339.00	$ 34.66	$ 69.00
June	$ 34.34	$ 373.66	$ 339.00	$ 34.66	$ 69.00
July	$ 34.34	$ 373.66	$ 339.00	$ 34.66	$ 69.00
August	$ 34.34	$ 373.66	$ 339.00	$ 34.66	$ 69.00
September	$ 34.34	$ 373.66	$ 339.00	$ 34.66	$ 69.00
October	$ 34.34	$ 373.66	$ 339.00	$ 34.66	$ 69.00
November	$ 34.34	$ 373.66	$ 339.00	$ 34.66	$ 69.00
December	$ 34.34	$ 373.66	$ 339.00	$ 34.66	$ 69.00
Total	**$ 1,906.72**	**$ 2,989.28**	**$ 4,068.00**	**$ (1,078.72)**	**$ 828.00**

Figure 1 - Money from Sick People Table
Source: 46brooklyn Research

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[1] https://www.commonwealthfund.org/publications/explainer/2022/sep/federal-340b-drug-pricing-program-what-it-is-why-its-facing-legal-challenges
[2] https://www.340bhealth.org/members/340b-program/overview/
[3] https://www.pcmanet.org/pcma-blog/big-pharma-highlights-how-pbms-secure-significant-savings-on-prescription-drugs/08/12/2024/#:~:text=David%20Joyner%2C%20Executive%20Vice%20President,pocket%20costs%20and%20expanded%20coverage.%E2%80%9D
[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs/PartD_Rebates
[5] https://www.46brooklyn.com/news/111121-money-from-sick-people
[6] https://mn.gov/commerce/insurance/health/policy-data-reports/pharmacy-benefit-manager-transparency.jsp

Copay accumulators, maximizers, and other alternative funding tactics compound the injustice associated with the current drug pricing policy. The AIDs Institute gives Wisconsin an F because nearly all plans in Wisconsin use some copay accumulator program.[7] I will need to transition to a marketplace plan in August, and I need your help to make my healthcare affordable so I can keep working and being a mom.

It means requiring the value of coupons to count. Unlike Medicare beneficiaries who can seek a supplemental plan or Medicare Advantage plan to limit my liability, I will be responsible for thousands of dollars *every year* to meet my plan responsibility meaning somewhere between $3,000 and $10,000 will not be available for my family to plan for retirement, save for college, reduce debt, address increasing inflation, or enjoy leisure time activities such as visiting the Dells or Door County. I agree that we need more rational drug pricing in this country. Still, right now, you must address this issue as an issue of fairness, stating that we patients deserve to receive our discount to make our copays reflect the discounts and money available to health plans and other payers; otherwise, you allow plans to continue stealing from patients.

Do not trust today's testimony that people like me will drive up costs or ignore cheaper solutions when the time comes; the data above speaks for itself. Patients need affordability. They are willing to spend money on affordability. But the prescription drug market is an inflated balloon with billions to make off the sickest patients, so the money is talking in this case, health plans, PBMs, and even some hospitals are simply looking to protect a profit center.

I thank you for doing your job to protect the people of Wisconsin.

Thank you,

Ann Lewandowski

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[7] https://www.theaidsinstitute.org/copays

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

NACDS Testimony to the Wisconsin State Legislature, Senate Committee on Health
Wednesday, May 28, 2025

Support for 2025 Senate Bill 203

Chair Cabral-Guevera, Vice-Chair Testin, and Honorable Members of the Senate Committee on Health, the National Association of Chain Drug Stores (NACDS) would like to offer our sincere thanks for the opportunity to provide written testimony regarding Senate Bill 203. Senate Bill 203 is paramount to continued neighborhood pharmacy access for patients across Wisconsin and the improved healthcare outcomes that are consistently derived therefrom.

As an industry, Pharmacy Benefit Managers (PBMs) have been highly unregulated. PBMs claim to reduce prescription drug costs, but their practices are key components of skyrocketing healthcare spending. PBM activities include unfair and opaque dealings with pharmacies with respect to reimbursement, network design, audit practices, constructing artificial barriers that limit patient choice and competition, steering patients to their own mail-order operations, switching patients to more expensive medications to benefit the PBM, and questionable use and disclosure of sensitive patient information. PBMs claim that their ability to negotiate with drug manufacturers and pharmacies reduces overall prescription drug costs. However, despite their claims PBMs regularly inflate the prices patients pay for medications and frequently force pharmacies to operate at a loss. States across the country, including Wisconsin, have recognized the acute need to enact PBM reform and to press forward with implementation, enforcement, and oversight despite PBMs' efforts to oppose or roll back such reforms. While more than 155 new PBM reform laws were enacted nationwide from 2021 to 2024, additional reforms and enforcement of existing laws remain urgently needed.

Provide Fair and Adequate Payment for Pharmacy Patient Care Services Across Wisconsin

Pharmacies provide comprehensive and reliable care access points and patient-centered services, in addition to traditional dispensing roles, to advance the health and wellness of communities across Wisconsin. Pharmacy access is especially critical for vulnerable and underserved populations. Despite this value added to the health care system, this access is at risk when PBMs reimburse pharmacies below the cost to buy and dispense prescription drugs. Pharmacy reimbursement below pharmacy costs threatens future sustainability for pharmacies to continue providing medication and pharmacy care services to patients across Wisconsin.

Pharmacy reimbursement should be comprised of two parts: 1) the product cost; and 2) a professional dispensing fee across payer markets to help ensure reasonable reimbursement and sustainable pharmacy services for beneficiaries. The dispensing fee is typically calculated to incorporate the costs of a pharmacist's time reviewing the patient's medication history/coverage, filling the container, performing a drug utilization review, overhead expenses (rent, heat, etc.), labor expenses, patient counseling, and more to provide quality patient care.[1] In order to maintain availability and access to certain prescription drugs for Patients across Wisconsin, it is imperative that these cost considerations include *both* the product costs of the drug and a professional dispensing fee – a core component of pharmacy reimbursement.

[1]CMS defines the professional dispensing fee at 42 CFR § 447.502 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-I/section-447.502

Without necessary guardrails to ensure reasonable and sufficient reimbursement for community pharmacies across Wisconsin, inadequate or below-cost reimbursements could force pharmacies to either operate at a loss, be unable to stock certain medications, or worse, potentially close their doors permanently – negatively impacting patients by ultimately worsening patient outcomes, reducing medication adherence, and increasing prescription abandonment and hospitalizations. Careful consideration of the impact on community pharmacies and the patients they serve is both necessary and invaluable to help avoid preventable adverse downstream consequences on patient access to essential medications and overall health outcomes.

Senate Bill 2023 takes the invaluable step of requiring PBMs' pharmacy reimbursements to include a dispensing fee at a rate not less than is paid by the state under the medical assistance program. Such a requirement would help maintain robust access to pharmacies for essential medications and health services across Wisconsin.

Help Preserve Access to Pharmacies by Addressing PBM's Retroactive Pharmacy Fees

Local community pharmacies provide increased options for safe, affordable, and convenient patient care. Yet, this access can be undermined when health plans and their PBMs "claw back" fees retroactively from pharmacies weeks or months after a claim has been adjudicated or processed. These "claw backs" can diminish access to care and can result in a pharmacy reimbursement that falls below a pharmacy's costs (e.g., cost to buy the drug based on ingredients and to dispense the drug). "[P]ost-sale adjustments can require a pharmacy to, often blindly, make payments of hundreds of thousands of dollars back to the PBM months after the relevant prescriptions are dispensed."[2] The financial pressures that retroactive pharmacy fees place on pharmacies have contributed to some pharmacies choosing to close their doors, while others have chosen to pare back hours and health care services.

The United States House of Representatives, Committee on Oversight and Accountability's 2024 report found "retroactive fees are often arbitrary and can be levied weeks to months after a prescription is processed. Even though a pharmacy may be in-network, extraneous PBM fees add up, often costing a pharmacy more to fill a prescription than it is reimbursed. Due to the market share of the three largest PBMs, pharmacies are often faced with choosing between accepting fees or not serving patients."[3] Similarly, the United States Federal Trade Commission, Office of Policy Planning's recent report confirmed that "another key factor adding to pharmacies' difficulties in understanding and predicting reimbursement is the financial adjustments PBMs make many weeks and months after the point of sale. These adjustments exacerbate information asymmetries that disadvantage unaffiliated pharmacies...Through these adjustments, PBMs often extract significant fees and claw back payments from pharmacies."[4]

Community pharmacies need predictability and transparency in their pharmacy reimbursement to continue to be viable and reliable access points of care for much needed patient services. **Senate Bill 203 prohibits a pharmacy benefit manager from directly or indirectly reducing the amount of a claim payment to a pharmacist or pharmacy or any form of renumeration, including through the use of claim-processing frees, performance-based fees, network-participation fees, or accreditation fees.** PBMs should be not only obligated, but legally compelled, to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points of care for patient services across Wisconsin.

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[2] Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[3] The Role of Pharmacy Benefit Managers in Prescription Drug Markets. https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf

4 Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

PBMs, on behalf of health plans, routinely conduct audits to monitor pharmacies' performance and reverse or claw back pharmacy payments when there are issues with a particular pharmacy claim. However, audit processes can be inefficient and vary across PBMs, creating unstandardized processes and unforeseen administrative challenges that can delay and disrupt patient care delivery in pharmacies—particularly in vulnerable communities. Audits interrupt the pharmacy workflow, can extend wait times, and detract attention from quality delivery of pharmacy patient care services. In an effort to minimize disruption to patient care and apply fair audit practices, **Senate Bill 203 ensures all audits are conducted under the same standards and parameters, that the same number of randomized prescriptions are audited in each benefit tier, that audits of prescriptions under Medicare Part D are audited separately from other payers, and that the pharmacy or pharmacist is provided with the final audit report within 90 days. Importantly, Senate Bill 203 probits a PBM from retaliating against a pharmacy or pharmacist for reported reporting allegations of violations of applicable laws.**

Protect and Preserve Choice of Pharmacies Across Wisconsin

Patients across Wisconsin rely on their neighborhood pharmacy for dispensing of needed medications and essential healthcare services like health screenings, disease state management, vaccinations, testing, and treatment services (e.g., patient counseling, medication adherence). However, this access to care can be undermined when health plan coverage *requires* patients to use specific pharmacies, including mail-order pharmacies.

Further deteriorating patients' rights to access pharmacy services from the pharmacy provider of their choice, PBMs often put in place networks and contract barriers which render community pharmacies willing to serve patients ineligible to provide important pharmacy services and patients may experience reduced access to certain pharmacies – impeding not only patient choice and influencing health outcomes, but possibly causing unnecessary delays and interruptions in patient care. About 90% of Americans live within 5 miles of a community pharmacy[5] and 85% of adults report that pharmacies are easy to access.[6] "PBMs may also use network design, such as narrow networks, to steer patients to their own vertically integrated affiliated pharmacies—even if a rival unaffiliated pharmacy may provide the same or better pricing and terms to the PBM for its pharmacy services."[7] **Senate Bill 203 protects patients' choice of pharmacy by allowing a beneficiary to use any pharmacy or pharmacist licensed in the state so long as the pharmacy or pharmacist accepts the same terms and conditions that the PBM established for at least *one* of their established networks, and prohibits excluding a pharmacy or pharmacist because they serve less than a designated portion of the population of the state.**

Senate Bill 203 further provides for robust reimbursement protections for 340B entities and, in a crucial step, establishes that a PBM owes a fiduciary duty to a health plan sponsor – a fiduciary duty we encourage be extended to pharmacies and pharmacists as well. NACDS appreciates the sponsors of this important piece of legislation and the Senate Committee on Health's sincere efforts to reduce prescription drug costs and enhance affordability for patients across Wisconsin and welcomes the opportunity to further collaborate to address these serious concerns. Patients and consumers across Wisconsin rely on neighborhood pharmacies for access to important healthcare services like health screenings, disease management, vaccinations, testing services, and patient counseling, as well as essential medication access. Senate Bill 203 is absolutely critical to ensuring patient access and protecting neighborhood pharmacies. **For all of these reasons, NACDS and their members strongly support Senate Bill 203 and encourage its expedient passage.**

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5 https://www.japha.org/article/S1544-3191(22)00233-3/fulltext
6 https://accessagenda.nacds.org/dashboard/
7 Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

Pharmacy Society of Wisconsin

To: **Members, Senate Committee on Health**

From: **Danielle Womack**
Vice President, Public Policy & Advocacy
Pharmacy Society of Wisconsin

Date: **May 28, 2025**

Subject: **Support for Senate Bill 203**

Thank you for the opportunity to submit testimony in support of Senate Bill 203. My name is Danielle Womack, and I am the Vice President of Public Policy & Advocacy at the Pharmacy Society of Wisconsin. Our nearly 5,000 members are proud to serve patients with the knowledge, care, and commitment that defines the profession of pharmacy.

Senate Bill 203 is a long-overdue and critically necessary reform to the way pharmacy benefit managers (PBMs) operate in our state. We see firsthand the detrimental effects of opaque PBM practices on patient care, pharmacy sustainability, and healthcare costs.

PBM Transparency and Accountability Are Long Overdue

The PBM industry has operated with minimal regulation for decades despite growing concerns about its impact on drug pricing. Opponents of SB 203 state that PBMs effectively control costs; however, studies indicate that PBMs frequently contribute to inflated drug prices through opaque pricing schemes and retained manufacturer rebates.

- A 2025 report from the Federal Trade Commission (FTC) found that PBM-affiliated pharmacies marked up 63% of specialty generic drugs by more than 100% and 22% by more than 1000%.[1]
- In fact, the FTC filed a complaint against several PBMs in 2024, arguing that they often prioritize higher-rebate drugs over lower-cost generics, leading to increased overall drug spending.[2]

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[1] Federal Trade Commission (2025). *Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers.* Federal Trade Commission. Retrieved from Federal Trade Commission: https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf

[2] Administrative Complaint, Caremark Rx LLC, et al, FTC Docket No. 9437 (November 11, 2024): https://www.ftc.gov/system/files/ftc_gov/pdf/612314.2024.11.26_part_3_administrative_complaint_-_revised_public_redacted_version.pdf

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- In-depth reporting by the *Wall Street Journal* and the *New York Times* found that mail-order pharmacies raise costs to employers and patients, while PBMs pocket billions in profit each year. [3,4]
- The Kaiser Family Foundation reported that PBM-imposed "spread pricing," where PBMs charge insurers more than they reimburse pharmacies, results in unnecessary cost hikes for Medicaid and commercial insurance.[5] That means unnecessary cost hikes to employers and taxpayers.
- A study in the *Journal of the American Medical Association* (JAMA) highlighted that patients often face higher out-of-pocket costs due to PBM formularies that favor expensive brand-name drugs over generics.[6]

PBMs like to say that they're 'the only entity within the drug supply chain that is incentivized to lower drug prices.' Why, then, does study after study show that they are increasing costs to patients, increasing costs to employers, increasing costs to taxpayers, lowering payments to pharmacies, and pocketing billions in profit?

Three PBMs control approximately 89% of the covered lives in this country. That level of consolidation has created a breeding ground for decreased competition, making it nearly impossible for pharmacies of all sizes to compete.

- The RAND Corporation testified before Congress that their studies have found that PBM consolidation has led to decreased competition, resulting in less market pressure to keep drug prices affordable.[7]

This bill establishes a mechanism for pharmacies to appeal low ingredient cost reimbursements to a PBM, sets a minimum dispensing fee reimbursement (i.e., overhead), and allows pharmacies to refuse to fill a prescription if they will not be paid the actual cost of purchasing the drug.

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[3] Hopkins, J. S. (2024, June 25). Mail-Order Drugs Were Supposed to Keep Costs Down. It's Doing the Opposite. *The Wall Street Journal*. Retrieved from https://www.wsj.com/health/pharma/higher-drug-costs-mail-order-prescription-bf37886f

[4] Robbins, R., & Abelson, R. (2024, June 21). The Opaque Industry Secretly Inflating Prices for Prescription Drugs. *The New York Times*. Retrieved from https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html

[5] Dolan, R., & Tran, M. (2019, December 6). Management and Delivery of the Medicaid Pharmacy Benefit. *Kaiser Family Foundation*. Retrieved from https://www.kff.org/medicaid/issue-brief/management-and-delivery-of-the-medicaid-pharmacy-benefit

[6] Yeung, K., Dusetzina, S. B., & Basu, A. (2021). Association of Branded Prescription Drug Rebate Size and Patient Out-of-Pocket Costs in a Nationally Representative Sample, 2007-2018. *Journal of the American Medical Association*. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780950

[7] Damberg, C. L. (2023). *Health Care Consolidation: The Changing Landscape of the U.S. Health Care System.* Testimony submitted to the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health. Retrieved from https://www.rand.org/content/dam/rand/pubs/testimonies/CTA2700/CTA2770-1/RAND_CTA2770-1.pdf

You've heard today that pharmacies are just looking to make more money through this bill. Yet, a 2024 3 Axis Advisors study found that mail-order drugs had a markup of more than three times that of the average markup of brick-and-mortar pharmacies.[8]

Pharmacists are critical healthcare providers who help patients optimize the use of their prescription medications. Forcing patients into situations where they must use mail-order services, must rely on a pharmacist they do not trust, or are penalized with higher out-of-pocket expenses is detrimental to their care.

Studies have shown that investing in pharmacist-provided care improves patient outcomes, with pharmacist-delivered patient counseling saving the healthcare system $164 per patient in the 6 months following the start of a new prescription medication.[9] Moreover, studies have shown that patients are three times less likely to be readmitted after a hospital visit when community pharmacists provide post-discharge care.[10]

That care just doesn't happen when a patient doesn't have a pharmacy to go to because their PBM has forced them to use a mail-order pharmacy.

What does that all mean? Patient care is suffering, pharmacies are closing, and PBMs are pocketing the difference. Three times the average markup by mail-order pharmacies – that doesn't sound like a cost savings to me. And who is suffering? Taxpayers and employers.

- A study by 3 Axis Advisors found that the average employer was charged approximately $8 more per prescription than the pharmacy was reimbursed for the same prescription and that between 2020 and 2023, employer costs increased by 30%, while pharmacy reimbursement decreased by 3%.[11]
- The Centers for Medicare & Medicaid Services (CMS) issued a warning letter in 2023 to plans and PBMs after concerns that PBM pricing models contributed to excessive Medicaid spending, necessitating policy changes to curb abuses were raised.[12]

Any Willing Pharmacy (AWP) Enhances Access and Competition

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[8] Three Axis Advisors. (2024). *Understanding Drug Pricing from Divergent Perspectives.* Retrieved from https://cdn.ymaws.com/www.wsparx.org/resource/resmgr/pbm/3aa_washington_report_202406.pdf

[9] Walgreens Study Shows Pharmacy Interventions Significantly Reduce Health Care Costs and Improve Outcomes. November 2, 2015. Business Wire. Available at: http://www.businesswire.com/news/home/20151102005173/en

[10] Luder, H. R. (2015, May-June). TransitionRx: Impact of community pharmacy postdischarge medication therapy management on hospital readmission rate. *Journal of the American Pharmacists Association,* 55(3), 246-254. Retrieved from https://www.japha.org/article/S1544-3191(15)30055-8/abstract

[11] Three Axis Advisors. (2024). *Understanding Drug Pricing from Divergent Perspectives.* Retrieved from https://cdn.ymaws.com/www.wsparx.org/resource/resmgr/pbm/3aa_washington_report_202406.pdf

[12] *CMS Letter to Plans and Pharmacy Benefit Managers.* (2023, December 14). Retrieved from Centers for Medicare and Medicaid: https://www.cms.gov/newsroom/fact-sheets/cms-letter-plans-and-pharmacy-benefit-managers

Opponents of this legislation talk a lot about how it interferes with the free market. But what's so free about restricting access only to pharmacies owned by a PBM? What about the true free market, where anyone can join a market if they can figure out how to compete? That's what Any Willing Pharmacy (AWP) provisions do – ensure that pharmacies meeting contract terms can join networks, promoting patient access and preventing monopolistic practices.

Contrary to the opposition's claim, AWP does not prohibit network design—it simply ensures fair access to participation. This promotes competitive pricing and broader patient access.

Wisconsin Is Behind in Addressing Pharmacy Benefit Manager Abuses

Dozens of other states have adopted the reforms included in this legislation. Red states, blue states, purple states – this is not a political or partisan issue.

So far this year, for example, Indiana, Montana, and Georgia have all enacted new laws with reimbursement floors for pharmacies, prohibiting affiliated pharmacy reimbursement from being greater than that of non-affiliated pharmacies, and requiring a minimum dispensing fee.

Texas, meanwhile, just passed a PBM reform bill out of both of its chambers unanimously that enforces an Any Willing Pharmacy model.

Florida just banned mandatory mail order and required Any Willing Pharmacy.

And those are just a few examples from 2025, not even mentioning the countless laws passed in previous years. The last page of my printed testimony includes maps of the major provisions of this bill and all of the states where those laws are in effect.

As you can see, Wisconsin is BEHIND other states.

The nice thing about being behind, though, is that we can learn from other states. And do you know what the data shows? In states that have implemented these reforms, patient access increases, pharmacies are able to remain open, and plan sponsors and employers have a better understanding of what they are paying for – but drug prices and premium rates have increased less than in states without these reforms.[13,14]

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[13] National Community Pharmacists Association. *PBM Reform Has Not Raised Costs for Patients and Payers.* Retrieved from https://ncpa.org/sites/default/files/2022-03/pbm-regulations-one-pager.pdf

[14] National Community Pharmacists Association. (n.d.). *Controlling PBM Conflicts of Interest Does Not Raise Healthcare Costs.* Retrieved from https://ncpa.org/sites/default/files/2021-06/ControllingPBMConflictsofInterestHealthcareCosts.pdf

I am going to say that again because it's the opposite of what you've heard today – in states that have passed the reforms included in this bill, drug prices and premium rates have increased less than the rate of increase in states that do not have these reforms. We have the data to back that assertion up. The second-to-last page of my written testimony displays the data, and it's clear – PBM reform does not raise costs.

Conclusion

Senate Bill 203 restores balance to a broken system by holding PBMs accountable, supporting pharmacies that provide frontline care, and putting patients first. As a pharmacist, I strongly urge you to support this legislation and to protect the integrity of pharmacy practice and patient access to essential medications in Wisconsin.

SUPPORT PBM REFORM IN WISCONSIN

PSW
Pharmacy Society of Wisconsin

Pharmacy benefit managers, or PBMs, manage plans for nearly 95% of Americans with prescription drug coverage by serving as a "middle-man" between health plans and pharmacies. Operating with limited government oversight, some PBMs have utilized tactics such as "gag clauses" and "copay clawbacks" to drive up costs for customers. Tactics such as "pharmacy steering," deceptive advertising, and mandatory mail-order have reduced patient access to pharmacy and complementary health care services at the pharmacies of their choice.

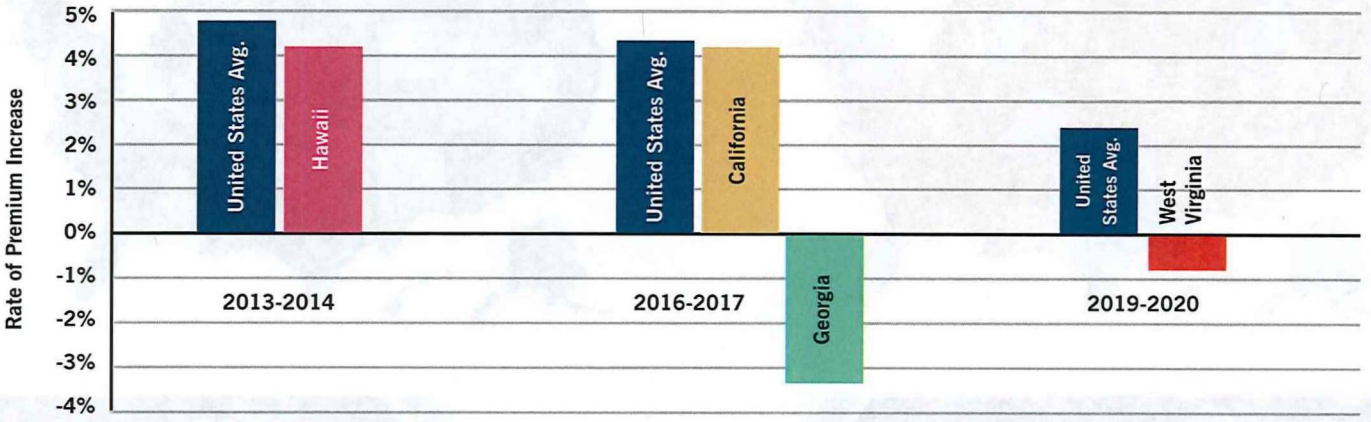
$633.5 Billion
amount the U.S. spent on prescription drugs in 2022[1]

89%
of the market is controlled by only 3 PBMs[2]

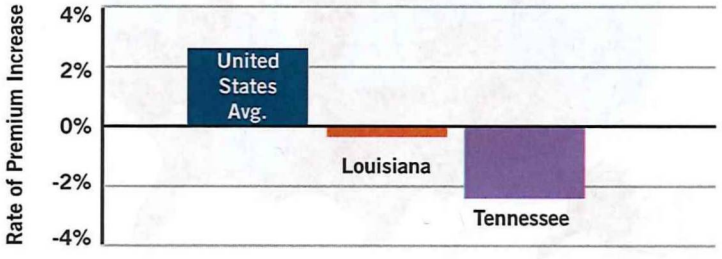
PBM REFORM HAS NOT RAISED COSTS FOR PATIENTS AND PAYERS

Rates of Premium Increases are LOWER in States with PBM Reforms

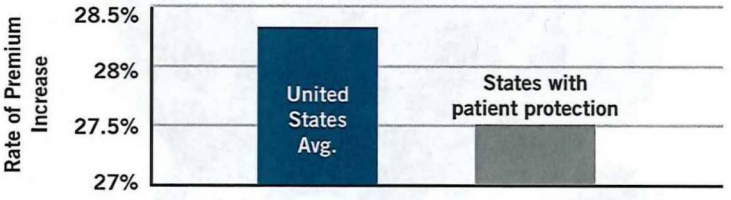
States that Protect Patients from Mandated Use of a Mail-Order Pharmacy[3]



States that Prohibit PBMs from Reimbursing PBM-Owned Pharmacies at Higher Rates than Non-Affiliated Pharmacies (2019-2020)



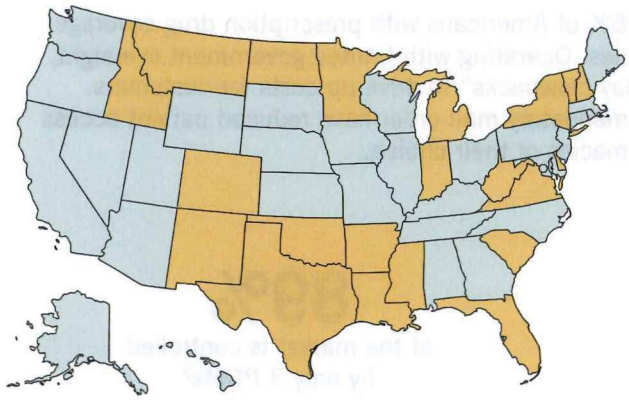
States that Protect Patients from PBM Penalties (e.g., Higher Copays) for Utilizing the In-Network Pharmacy of their Choice (2013-2020)



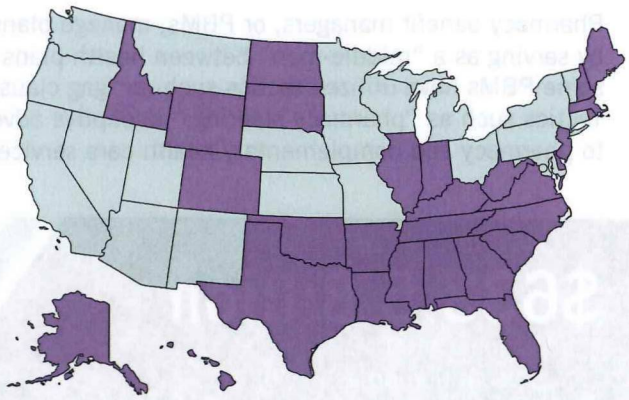
States include Delaware, Mississippi, North Carolina, and South Dakota.

STATES THAT HAVE PASSED PBM REFORM

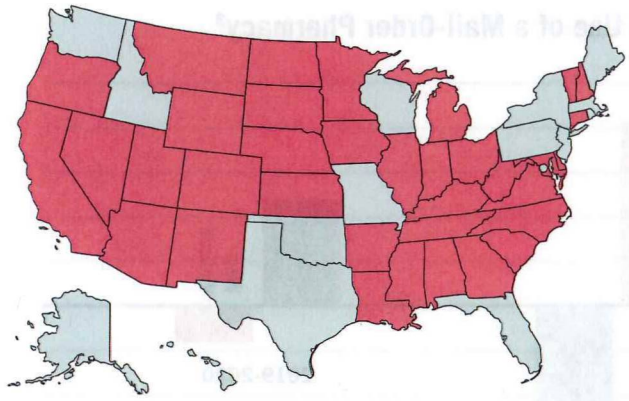
Accreditation Requirement Transparency



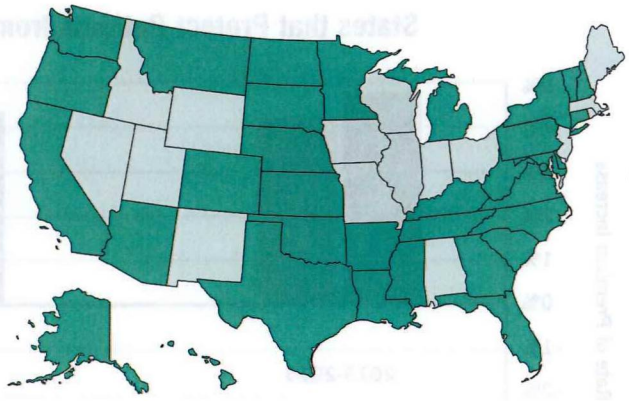
Any Willing Pharmacy (AWP)



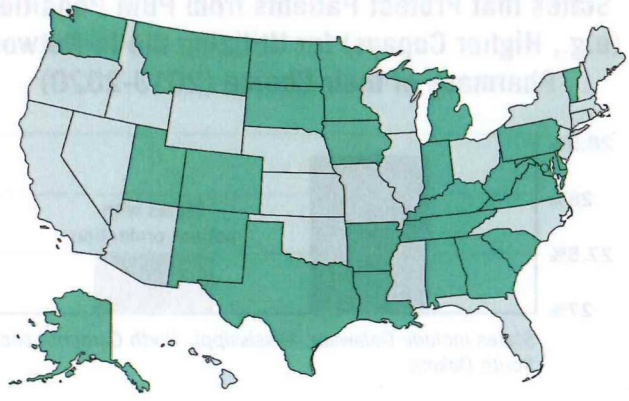
340b Non-Discrimination



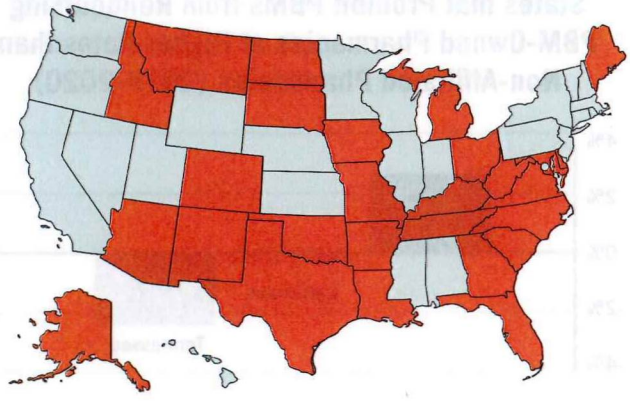
No Mandatory Mail Order



No Unequal Affiliated Reimbursement



No Adjudication Fees



1. https://www.pharmacist.com/Publications/Pharmacy-Today/Article/drug-expenditures-expected-to-increase-in-2023
2. https://content.naic.org/cipr-topics/pharmacy-benefit-managers
3. https://ncpa.org/sites/default/files/2022-03/pbm-regulations-one-pager.pdf

Pharmacy Society of Wisconsin

CYSTIC FIBROSIS FOUNDATION®

May 28, 2025

The Honorable Rachael Cabral-Guervara
Chair, Senate Committee on Health
2 E Main Steet
Madison, WI 53702

Dear Chair Cabral-Guervara, Vice-Chair Testin, and Honorable Members of the Committee on Health:

On behalf of the more than 700 people with cystic fibrosis (CF) in Wisconsin, we write to express our support for SB 203 (Felzkowski), which provides a number of accountability measures to protect patients' access to medication, including requiring insurers to apply third-party assistance to out-of-pocket maximums and other patient cost-sharing requirements as well as requiring covered benefits to be considered essential health benefits (EHBs). While copay assistance is not a silver bullet for systemic issues that face our health care system, solutions to address affordability and sustainability cannot come at the expense of patients' health and financial wellbeing. We ask for your support and co-sponsorship of SB 203.

About Cystic Fibrosis

Cystic fibrosis is a progressive, genetic disease that affects the lungs, pancreas, and other organs. There are close to 40,000 children and adults living with cystic fibrosis in the United States, and CF can affect people of every racial and ethnic group. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. Cystic fibrosis is both serious and progressive; lung damage caused by infection is irreversible and can have a lasting impact on length and quality of life. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. While advances in CF care are helping people live longer, healthier lives, we also know that the cost of care is a barrier to care for many people with the disease.

Accumulator Programs Jeopardize Access to Care

Accumulator programs prevent third-party payments from counting towards deductibles and out-of-pocket limits and therefore increase out-of-pocket costs for patients—which can cause people with CF to forgo needed care and lead to adverse health outcomes. According to a 2024 study conducted by the Cystic Fibrosis Foundation and Dartmouth College, over a third of people with CF delayed or went without at least one aspect of their CF care in the last year—including but not limited to skipping medication doses, taking less medicine than prescribed, delaying filling a prescription, or skipping a treatment altogether—due to cost concerns.[1] Because CF is a progressive disease, patients who delay or forgo treatment—even for as little as a few days—face increased risk of lung exacerbations, costly hospitalizations, and potentially irreversible lung damage.[2]

Accumulator programs also place additional financial strain on people with CF who are already struggling to afford their care. While over 80 percent of people with CF received some form of assistance to help pay for their health care, nearly 70 percent of respondents to the aforementioned study indicated that paying for health care has caused financial problems such as being contacted by a collection agency, filing for bankruptcy, experiencing difficulty paying for basic living expenses like rent and utilities, or taking a second job to make ends meet. One mother of an eight-year-old child

[1] Cystic Fibrosis Foundation (2024). Cystic fibrosis Outcomes, Social factors, Tradeoffs due to Cost and Financial Burden Survey
[2] Trimble AT, Donaldson SH. Ivacaftor withdrawal syndrome in cystic fibrosis patients with the G551D mutation. J Cyst Fibros. 2018 Mar;17(2): e13-e16. doi: 10.1016/j.jcf.2017.09.006. Epub 2017 Oct 24. PMID: 29079142.

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living with CF who, like many families in Wisconsin, depends on financial assistance to access life-changing medications, shares that they "would have to consider the cost of such medications, our ability to pay for them, and our family's financial stability" if it weren't for copay assistance programs.

We understand the challenge insurers face in managing the rising cost of drugs. However, cost containment strategies that further burden patients are unacceptable. Accumulators are especially challenging for a disease like CF, which has no generic options for many of the condition's vital therapies. The situation has become even more dire as a company that manufactures CF therapies recently reduced the amount of copay assistance available for people enrolled in accumulator programs.

Maximizer Programs Place Administrative and Financial Burdens on Peoples with CF
SB 203 would also require covered benefits to be considered essential health benefits (EHBs). Currently, private health plans are allowed to deem certain categories of prescription drugs as "non-essential." This determination allows plans to substantially adjust their cost-sharing for a particular drug or eliminate coverage for certain specialty medications altogether. In doing so, plans can require enrollees to seek free drugs from manufacturers or collect the maximum amount of copay assistance available through manufacturers and other third-party programs. These strategies include an accumulator component, which adds to the considerable costs and administrative burdens for people with CF. Cystic fibrosis treatments rarely have generic alternatives so when private plans exclude specialty CF medications or cover them while placing significant administrative and financial burden on the enrollee, people with CF face the difficult choice of foregoing these necessary treatments, changing to an often more costly insurance plan from the ACA marketplace, or in some cases seeking alternate employment.

Ensure Access to Care for People with CF Living in Wisconsin
This issue has unfortunately impacted many Wisconsin families and caused them financial hardship, significant administrative burden, and unnecessary barriers to accessing care. The mother of an 11-year-old living with CF reported facing a $24,000 monthly copay for one of her son's vital medications unless she was able to shuttle between a copay assistance program and a pharmacy benefit manager to negotiate additional assistance. She shared that "this resulted in a year where we had to use six different pharmacies to get my son's medications. It was a total nightmare. Hours on the phone, filling out paperwork and trying to navigate why the insurance we were paying for wasn't seeming to fill their end of the deal. We enlisted the assistance of the Cystic Fibrosis Foundation Compass program right away, and this still took months to navigate."

By passing SB 203, you will help ensure continued access to quality, specialty care for people with CF. The Cystic Fibrosis Foundation appreciates the Committee's attention to this important issue for the CF community in Wisconsin and urges you to support SB 203.

Sincerely,

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President, Policy & Advocacy
Cystic Fibrosis Foundation

American Cancer Society Cancer Action Network
Sara Sahli, Wisconsin Government Relations Director
608.215.7535
sara.sahli@cancer.org
fightcancer.org/wisconsin

May 28, 2025

To: Wisconsin Senate Committee on Health
From: The American Cancer Society Cancer Action Network
Re: Testimony in Favor of Senate Bill 203

Good morning, Chairwoman Cabral-Guevara and members of the Committee,

My name is Sara Sahli - I am the Government Relations Director for the American Cancer Society Cancer Action Network in Wisconsin. ACS CAN is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society advocating for evidence-based public policies to reduce the cancer burden for everyone.

I appreciate the opportunity to provide testimony in support of Senate Bill 203 the Pharmacy Benefit Manager (PBM) Accountability bill that incorporates all provisions included in the All Copays Count legislation.

Like those that have shared their stories today, many cancer patients and individuals living with chronic medical conditions have difficulty affording the cost of their prescription drugs. This is especially true for newer drugs – including cancer drugs – that do not yet have a generic equivalent. To help temper high prescription costs, many individuals living with cancer and other chronic medical conditions receive copay assistance offered through manufacturer programs and charitable patient assistance programs. Unfortunately for many, this copay assistance is increasingly not treated the same as copays that are paid with cash and therefore not applied to the patient's deductible and out of pocket financial responsibilities. This means patients using these copay assistance programs are still responsible for the entire deductible and out of pocket maximums as the assistance is not benefitting them in the intended way.

This legislation would remove these barriers to prescription drug access and allow patients to utilize the full benefit of copay assistance programs by ensuring all payments made by the patients - directly or on their behalf - be counted toward their overall out of pocket maximum payment or deductible.

I also want to make clear - this bill is not a coverage mandate and does not require that insurance companies cover any particular drug or class of drugs. Nothing in this bill prevents insurers from using their existing utilization management tools such as step therapy and prior authorization. We are addressing copay assistance that is being used by patients for drugs that their insurance company has already made the decision to cover, and their doctor has determined they need. Patients still have plenty of skin in the game when it comes to making and paying for their healthcare decisions, as they are still paying their insurance premiums and patients living with chronic illnesses don't have the luxury of forgoing certain health care treatments and services until they can more easily afford them.

The American Cancer Society Cancer Action Network is urging members of the Senate Committee on Health to stand with patients and help those with chronic and complex conditions like cancer access the treatments they need to live a healthy and productive life by voting yes on Senate Bill 203.

Thank you for your time.

Sara Sahli