To whom it may concern:

Please consider my suggestions in the following to help strengthen the enforcement of our state laws and give the residence of our state relief from the predatory business practices of the pharmacy benefit managers.

I am a pharmacist and independent pharmacy owner. I have navigated the current OIC appeals process since it was instated in 2017. The following are my comments on the first prepublication draft for R 2024-02 Health care benefit managers.

**WAC 284-180-130 (15) And (26)**: This definition still has "Generic" in it, I move to strike the word generic. Brand name medications as of now are not put on "lists" but that doesn't mean that the PBMs won't figure out a way to use this terminology in the future to circumvent the intentions of our law.

**WAC 284-180-130 (29)**: this definition of "retaliate" only includes protections for a pharmacy that has filed an appeal. I would like it to include terminology to offer pharmacies the same protections if they submit complaints as well.

- I hope the OIC is taking this piece very seriously, the fear of retaliation by PBMs is a big reason many independent pharmacies are not using the current system. We do not have the capital to hire lawyers and fight the behemoth PBMs in a legal battle but with one flip of the switch by any of the 3 big PBMs they could terminate a contract, or initiate undue audits and it could put a pharmacy out of business. I would like to see some stronger language added to protect pharmacies from retaliation.

**WAC 284-180-210(1)**: *Each health care benefit manager must contribute a sufficient amount to the commissioner's regulatory account to pay for the reasonable costs, including overhead, of regulating health care benefit managers.*

The OIC should define "reasonable costs". Currently in the appeals section WAC 284-180-505(9) the term "reasonable adjustments" is used and in WAC 284-180-520(3) the term "fair and equitable" is used and to date the OIC/OAH hearings officers have only awarded pharmacies break even reimbursements up to our invoice cost when we win appeals. I argue that this is not reasonable or fair and equitable to expect a business to operate at break even reimbursements. So, to this point, it seems the hearings officers need more definition of what "reasonable" is in the rule.

**WAC 284-180-500(1)**: current OIC proposal is in Blue.

Specifically, this subchapter applies to the actions of pharmacy benefit managers regarding contracts with pharmacies on behalf ~~of an insurer, a third-party payor, or the prescription drug purchasing consortium established under RCW 70.14.060~~ a carrier, employee benefits program, or Medicaid managed care program in regard to: (a) Fully insured health plans; and (b) Medicaid managed care plans. However, the appeal requirements of RCW 19.340.100 do not apply to medicaid managed care plans.

My suggestion of how it should read;

Specifically, this subchapter applies to the actions of pharmacy benefit managers regarding contracts with pharmacies ~~on behalf of an insurer, a third-party payor, or the prescription drug purchasing consortium established under RCW 70.14.060 a carrier, employee benefits program, or Medicaid managed care program in regard to: (a) Fully insured health plans; and (b) Medicaid managed care plans. However, the appeal requirements of RCW 19.340.100 do not apply to medicaid managed care plans~~

With many of the sections of WAC 284-180-500 the OIC is putting all these various stipulations on what types of business can be regulated. In the original legislation I see no mention of these stipulations so why is the OIC taking it upon themselves to add these things into the rule? If I am missing something here, please educate me.

**WAC 284-180-505(1)**: current OIC proposal in blue:

A network pharmacy, or its representative, may appeal the ~~a~~ reimbursement amount for a drug to a health care benefit manager providing pharmacy benefit management services (first tier appeal) if the reimbursement amount for the drug is less than the net amount the network pharmacy paid to the supplier of the drug……

My proposed changes in black;

A network pharmacy, or its representative, may appeal ~~the~~ a reimbursement ~~amount for a drug~~ to a health care benefit manager providing pharmacy benefit management services (first tier appeal) if the reimbursement amount for the drug and pharmaceutical service is less than the net amount the network pharmacy paid to the supplier of the drug……

> Again the original intent of the legislation was not limited to the reimbursement of just the drug cost, but rather the reimbursement of the entire pharmaceutical service which includes the cost of the drug its self, the expertise of the doctorate trained pharmacy professionals, extensively trained and state licensed support staff, and overhead of vials, labels, computer systems, facilities ect.

**WAC 284-180-505(1)**: the following wording in blue was added to this section.

…… and the claim was paid during the term of the current or immediate past contract between the network pharmacy and the pharmacy benefits manager.

I suggest that we strike this from the rule. The PBMs hold so much monopolistic power that they have the freedom to change contracts at will. A current common practice of the PBMs is to make changes to our contracts and fax it to the general pharmacy fax number saying it is a "opt out" change. So if we do not opt out within 7 days the changes are deemed excepted, we get no chance for negotiation. Furthermore, they hold such a monopoly that we, as small pharmacies, must keep the contracts even if they have terrible terms because we would lose 33% or more of our business overnight if we rejected one of the PBM contracts. So, with this proposed added language, I foresee that the PBMs will manipulate it so contracts change readily so they can say that the laws do not apply to the "current"

contract. To date, since the legislation was put in place originally in 2017, there has been no such time limits and certainly there were no time limits such as this in the legislation old or new. OIC adding this verbiage into rule goes against the intent of the legislation and will give the PBMs a loophole to circumvent our laws.

**WAC 284-180-505(2)**: Before a pharmacy files an appeal pursuant to this section, upon request by a pharmacy or pharmacist, a pharmacy benefit manager must provide a current and accurate list of bank identification numbers, processor control numbers, and pharmacy group identifiers for health plans and for self-funded group health plans that have elected to participate in sections 5, 7, and 8 of this act through WAC 284-180-465 with which the pharmacy benefit manager either has a current contract or had a contract that has been terminated within the past 12 months to provide pharmacy benefit management services.

In this section I appreciate that the OIC is trying to make it possible for pharmacies to identify plans including self-funded plans to determine if the state laws apply to the claim in question, but I see the wording of this proposed addition as another roadblock for pharmacies. This is basically saying I would have to request the information from the PBM, they could take however long they like getting back to me using whatever convoluted system they come up with (very similar to what they do with the MAC lists now). I would somehow have to keep track of this for possibly multiple claims at a time while waiting on the PBM. This is asking too much of the pharmacies, the onus of this legislation needs to be on the PBMs and OIC not the pharmacies. On average in my pharmacy, we are underpaid by PBMs on about 1500 claims per month. I would say this is very similar in every small pharmacy in the state, but as you know very few pharmacies are using the current OIC/OAH appeals system. One of the main reasons for this lack of use of the system is the complexity of the process as well as the time commitment the current system takes. We are small business operators and healthcare providers we do not have spare time to navigate and track just a few appeal a month, let alone 1500 per month and adding this terminology to the rule further complicates the process as well as adding longer time commitments.

I suggest terminology that would require the PBMs to keep a searchable list or database available to pharmacies at all times, where all the plans are identified by the demographics that are available on a patients prescription insurance cards. This should definitely include the information about self-funded plans that have opted into the laws.

Furthermore, the terminology does not specify that the self-funded plan information must be identified as separate from the other plans. With this terminology I foresee the PBMs listing a bunch of numbers with no identifying characteristics, hindering us from determining which plan is or is not self-funded. In the past, with my appeal cases PBMs have been caught lying to the OIC saying that a claim was protected by ERISA, but I was able to prove that it was not ERISA, see OIC order # 18-0159 as it pertains to appeal # 1557232 and the subsequent appeal of the initial decision for proof of this. Due to the history of the blatant untrustworthiness of the PBMs the OIC needs to require more of the PBMs to meet this burden of the legislation. Meaning the PBMs need to present proof that they notified and offered self-funded plans the opportunity to opt into the protections of this legislation.

Also, the language at the end of this section puts a time limit on our laws. I again assert that there were no time limits referenced in the legislation or related law and it is improper to add it in rule.

**WAC 284-180-505(3)(i)(A)** A telephone number by which the pharmacy may contact the pharmacy benefit manager during normal business hours and speak with an individual responsible for processing appeals.

We need to define "normal business hours" I would recommend; normal business hours, being 9am-5pm in the time zone the network pharmacy is located. Again the onus of this legislation needs to be on the PBMs, they should have to be available at reasonable times for the pharmacy. We have very little time to commit to issuing these appeals so the information needs to be readily available to us when we have the time to work on them.

**WAC 284-180-505(3)(i)(B)** A summary of the specific times when the pharmacy benefit manager will answer calls from network pharmacies at that telephone number.

I move to completely strike this form the rule, WAC 284-180-505(3)(i)(A) with my proposed addition form above would meet the intent of the legislation. If this language is allowed to stand in the rule it gives the PBMs the freedom to limit their availability to what ever they want. We take care of patients and give them quick service at all times, the PBMs, which are multibillion dollar companies should be available during normal business hours.

**WAC 284-180-505(3)(ii) and (iii)** (EMPHASIS ADDED to this section, please, please strongly consider changing this)

(ii) A detailed description of the actions that a network pharmacy must take to file an appeal; and

(iii) A detailed summary of each step in the pharmacy benefit manager's appeals process.

This wording does and has allowed the PBMs too much freedom within the law. They basically make up whatever rules they like, in a way that benefits them and puts undue hassle on the appealing pharmacy just to start the 1st tier appeal process. Have those of you responsible for this rule making ever tried to navigate all the different PBMs 1st tier appeal process? If not, I strongly suggest that you do. I would invite you to my pharmacy, or I will take my time and come to you and we can sit down and try to navigate the big 3 PBMs appeal process together to give you insight into how frustrating and time consuming the PBMs have made this process. If we want to start from scratch and get 1 appeal submitted for each of the big 3 PBMs, please block out at least 4-5 hours of your day for this meeting. This just cannot continue to be allowed. We as pharmacists just do not have the time it takes to do this especially when the PBMs are allowed to make the process as difficult, convoluted, and time consuming as they like. OptumRx probably has the most user friendly process because they at least allow you to submit multiple appeals at once in an excel format. But the excel form has all kinds of limitations and things must be formatted in certain ways and they limit the information we can submit and the form rejects if we don't follow their rules and format to a T. They also use this method to control how and what type of information we can submit in our appeal. They all have different rules for every state based on what they have found they can get away with in each state. Like they will not accept or process appeals for Washington State pharmacies if we do not give them our invoice up front in the 1st tier, I

refuse to do this, so I have to wait the 30 day time period before I can move my appeal on to the OIC 2nd tier appeal. Until recently the OIC had not weighed in on whether we were required to include our invoice in the 1st tier. Please see my previous statements submitted to the OIC on the rule re-write for information as to why we cannot be forced to give our invoice during the 1st tier appeal. Just recently this month, July of 2024, OAH Administrative Law Judge, Laura Bradley finally made a ruling that sets the precedent that pharmacies do not have to give the PBMs our invoice cost during the 1st tier appeal. See Docket No. 06-2024-INS-00458, 00459, 0060, and 0061. Please see my explanation in these appeal cases of how I met the pharmacies burden of the law to "demonstrate that I was unable to purchase a therapeutically equivalent interchangeable product from a supplier doing business in Washington at the pharmacy benefit manager's list price," while still protecting my proprietary information which is my invoice cost. I understand this is a very difficult part of the law to form rule around, because invoice cost must be protected during the 1st tier appeal for the integrity of the small pharmacy's business but is necessary for proof of purchase price. This is why I purpose that the invoice information be protected during the 1st tier appeal but is necessary during the 2nd tier appeal with in the OIC. Fortunately, we now have precedence set by the OIC/OAH Judge that this meets the requirements of the law.

With this recent ruling, I intend on submitting complaints to the OIC on each of the PBMs because they all are requiring our invoice to start the 1st tier appeal when it obviously is not a requirement of the law. This is a prime example of how the PBMs are using this language to try and circumvent the intent of the legislation. The OIC really needs to take more control of the 1st tier appeal process to curb these predatory business practices by the PBMs. I outlined in my suggestions of how this could be accomplished with my previous letters to the OIC on this rule re-write, but will summarize here. The OIC should make a 1st tier appeal form and require all state registered PBMs use this form to process 1st tier appeals. The OIC can use the law to guide what information the PBMs need to process appeals and require pharmacies produce this information for the PBMs and also give the PBMs only the options of the law on how they must respond to those appeals. The PBMs either need to approve the appeal, or defend their reimbursement rate by giving proof that the medication was available for purchase to small pharmacies in Washington State. This should include NDC of the medication, proof of purchase by Washington State small pharmacy, and proof of place of purchase. This form could always be readily available to all pharmacies to work on at their convenience. This could simplify and narrow the time constraints of the whole process so so so so much, and alleviate much of the need for the 2nd tier process.

**WAC 284-180-505(4)**

Please add sub (c);

WAC 284-180-505(4)(c) In the 1st tier appeal a pharmacy may meet their burden of the law with a statement showing they have done their due diligence to procure the medication at the best rate available to their small pharmacy at the time of purchase. This shall include an attestation that the received reimbursement is less than the price the pharmacy paid to procure the medication from the supplier and that the small pharmacy will be able to present proof of this during the 2nd tier appeal if needed.

Remember that RCW 48.200.280(3) already has the stipulation on the pharmacy that to even submit the 1st appeal the reimbursement must be less than the net amount the pharmacy paid the supplier. So, the pharmacy would be violating this law if they submit appeals without proof of such.

*RCW 48.200.280(3) …….A network pharmacy may appeal a predetermined reimbursement cost for a multisource generic drug if the reimbursement for the drug is less than the net amount* (emphasis added for future point) *that the network pharmacy paid to the supplier of the drug.*

Again, the onus of this legislation was intended to be on the PBMs to defend the reimbursements they are paying because they have been proven to be the bad actors. This legislation was deemed necessary by the law makers of our state due to all the evidence of the predatory business practices of the PBMs. So we must put the burden of the law on the PBMs not the pharmacies that are seeking relief. So, it is the PBMs that should have to defend the rates they are reimbursing. I do understand that the pharmacy has a responsibility to purchase at the lowest rate possible, and that they should be able to defend that, which is not a problem, but it should not be by showing their invoice rate or wholesaler price during the 1st tier. We can very easily give this proof during the 2nd tier appeal where the PBMs are subject to the terms of these laws and the OIC has the jurisdiction to issue orders and civil penalties. Remember that pharmacies also have the responsibility of taking care of patients and getting them the needed medication when needed. The following is the explanation I gave in OAH Docket No. 06-2024-INS-00458 OIC Agency No. 24-0145, OAH Docket No. 06-2024-INS-00459 OIC Agency No. 24-0146, OAH Docket No. 06-2024-INS-0060 OIC Agency No. 24-0147, and OAH Docket No. 06-2024-INS-0061 OIC Agency No. 24-0148. This argument was accepted by the Judge to have satisfied the law.

*RCW 48.200.280(3) The pharmacy benefit manager* ***shall uphold the appeal*** *of a pharmacy with fewer than fifteen retail outlets, within the state of Washington, under its corporate umbrella if the* ***pharmacy or pharmacist can demonstrate that it is unable to purchase a therapeutically equivalent interchangeable product from a supplier doing business in Washington at the pharmacy benefit manager's list price.***

Our OIC has not given any guidance as to how a pharmacy must fulfill this requirement of demonstrating our inability to procure the medication at a lesser price. Due to the fact that my invoice costs are proprietary trade secret, confidential, and subject to non-disclosure agreements I cannot present them in the 1st tier appeal. So, to satisfy this requirement, in the following I outline that I have done my due diligence to procure the medications at the best rates available to my small pharmacy. My pharmacy holds an account with AmerisourceBergen, one of the three primary medication wholesalers in the country, this ensures a reliable supply of all the available medications patients may need. To obtain the best prices from a primary wholesaler a pharmacy must only hold a contract with one primary, because the wholesaler requires certain volume purchases to obtain the pricing we get. If we tried to spread our bulk purchases over all three of the primaries, we would not meet criteria and prices would be higher. Let me point out that our invoice price is the price we pay already taking this into account, meaning the wholesaler does not give an additional NDC specific discount after invoice. It is industry standard that pharmacies must only do business with one of the primary wholesalers. Secondary Wholesalers do bring cheaper prices to the market at times, but they are not a reliable source that always has access to certain medication. Furthermore, the secondary market is a place with higher risk of bringing counterfeit medications into the supply. A pharmacy must be cognizant of this and ensure they are doing business with quality accredited suppliers. My pharmacy holds accounts with multiple accredited secondary

wholesalers throughout our country, we have done extensive market analysis to narrow down our secondary wholesalers to about 10 trustworthy secondaries who consistently offer competitive prices to the market. My pharmacy software system automatically interfaces with all our wholesalers, making their medication price files electronically available to me in real time. My pharmacy software uses set electronic smart parameters to take all things into account such as minimum order requirement and shipping cost to selectively order medications from the wholesaler that can provide it to me at the lowest cost at the time of order. Therefore, by default, every day when we place our medication order, an algorithm that identifies the best market pricing throughout our country is leveraged to ensure my pharmacy gets the best price available to a pharmacy of my size and scope.

Furthermore, as most Americans are aware we are seeing shortages of all kinds of things in our country and medication is no exception to this. So, if my primary wholesaler does not have the medication a patient needs at the time they need it, that medication may be available from a creditable secondary wholesaler. To procure that medication from that wholesaler the pharmacy may have to pay shipping charges to order that one medication. For example, patient needs 30 tablets of medication, that medication is available for purchase at multiple secondary wholesalers. The invoice price for that 30 count bottle of medication is $20 but the wholesaler has a $200 minimum purchase to get free shipping, so to get the medication the pharmacy has to pay $20 for the medication and $25 for shipping so the NET AMOUNT to procure this medication is $45 but the invoice cost is $20. Or consider this further, the above example but the medication is also available at the primary wholesaler for $35 with free shipping. If the pharmacy purchases the product with the lower "invoice" price it is actually costing more to get the medication to the patient because the NET AMOUNT is more. Should the burden of that cost lie on the pharmacy or the insurance carrier/ PBM? With the system the way it is now that burden falls on the pharmacy, and we have to make the decision to either reject the patient or take the loss and risk going out of business. If we reject the patient then we have uncared for people that could lead to higher and higher healthcare costs.

**WAC 284-180-505(6)** Current verbiage in blue, my suggestion in black;

> The pharmacy benefit manager must complete the appeal within ~~thirty~~ SEVEN calendar days from the time the network pharmacy submits the appeal. If the network pharmacy does not receive the pharmacy benefit manager's decision within that time frame, then the appeal is deemed denied.

With the current process the PBM gets 30 days to process 1st tier appeals, then it takes multiple days once the pharmacy submits appeal to the OIC for it to be converted over to the OAH then the OIC/OAH has 30 days to process the 2nd tier appeal. For a pharmacy to get properly reimbursed through this system it could take upwards of 65-70 days. Many pharmacies are on bi-weekly or shorter payment schedules with wholesalers. With all the underpayments by PBMs pharmacies run on very narrow margins and cashflow can be very challenging. These PBMs are multibillion-dollar top fortune 20 companies, they should have processes in place to process these appeals at a reasonable rate so as not to hold our money hostage. Our state does have prompt pay laws which speaks to the fact that in healthcare cashflow can be a challenge. Furthermore, these longer waiting periods make it harder to manage multiple appeals at a time. Also I must say, that in general most the PBMs currently do process appeals fairly quickly so this adjustment to the rule would not be a heavy lift for them. It would speed up

the process for ones where the PBM does not intend to respond to an appeal, which happens often, so with this adjustment in time limit the pharmacy would only have to wait 7 days to move on to the 2nd tier rather than waiting 30 days.

**WAC 284-180-505 (4 7)** The pharmacy benefit manager must uphold the appeal of a network pharmacy with fewer than fifteen retail outlets within the state of Washington, under its corporate umbrella, if the pharmacy demonstrates that they are unable to purchase therapeutically equivalent interchangeable product from a supplier doing business in the state of Washington at the pharmacy benefit manager's list price. "Therapeutically equivalent" is defined in RCW 69.41.110(7).

With this current wording of the rule it is putting the burden of the law on the pharmacy in the 1st tier. I argue that this is not the intent of the law. I do agree that the pharmacy has a responsibility to ensure they are purchasing at the best rate available to their small pharmacy, but it is not necessary in the first tier appeal where the OIC does not have jurisdiction or oversight of the PBM. This burden of proof should be moved to the second tier. My suggestion is as follows;

> WAC 284-180-505 (4 7) The pharmacy benefit manager must uphold the appeal of a network pharmacy with fewer than fifteen retail outlets within the state of Washington, under its corporate umbrella, if the pharmacy has met the requirements of WAC 284-180-505(4).
>
> WAC 284-180-505(4) should have sub (c) added as mentioned above.
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> WAC 284-180-505(4)(c) In the 1st tier appeal a pharmacy may meet their burden of the law with a statement showing they have done their due diligence to procure the medication at the best rate available to their small pharmacy at the time of purchase. This shall include an attestation that the received reimbursement is less than the price the pharmacy paid to procure the medication from the supplier and that the small pharmacy will be able to present proof of this during the 2nd tier appeal if needed.

**WAC 284-180-505(8 ~~5)~~(a)** : current OIC proposed language in blue, my suggested changes in Black

If the pharmacy benefit manager denies the network pharmacy's appeal, the pharmacy benefit manager must provide the network pharmacy with a reason for the denial, ~~and~~ the national drug code and price of a drug that has been purchased by other network small pharmacies pharmacies located in the state of Washington at a price less than or equal to the ~~predetermined~~ reimbursement cost for the ~~multisource generic drug~~ drug and the name of the wholesaler or supplier from which the drug was available for purchase at that price on the date of the claim or claims that are subject of the appeal.

This appeals section of the law pertains to small pharmacies, so the wording "small pharmacies" should be added here, to prevent the PBMs from using the pricing information form their own mail order pharmacies who hold monopolistic market power and use that power to force manufacturers and wholesalers to give them pricing that would not be available to small pharmacies of our state.

**WAC 284-180-505(9 ~~6~~)** current oic proposed language in blue

If the pharmacy benefit manager upholds the network pharmacy's appeal, the pharmacy benefit manager must make a reasonable adjustment no later than one day after the date of the determination. The reasonable adjustment must include, at a minimum, payment of the claim or claims at issue at the net amount paid by the pharmacy to the supplier of the drug. The reasonable adjustment must also apply prospectively for a period of 90 days from the date of the upheld appeal.

I take some offense to the OIC's definition of "reasonable adjustment" here. With this language it is saying that "reasonable adjustment" is to pay the pharmacy at breakeven price just for the cost of the drug alone, I strongly argue that this is not reasonable at all. No business can function at breakeven reimbursements. Every business has some sort of overhead. Pharmacies have special packaging requirements including vials, labels, blister packs ect., facility requirements including security, technology, storage, environment control and more. Furthermore, Pharmacists are doctorate trained health care professionals, Pharmacy technicians and pharmacy assistants are highly trained state licensed health care support staff. The current payment model is set up to compensate these health care professionals for their services through the profits on the medication they provide. A government entity allowing these wealthy PBM, multibillion dollar, fortune 20 companies to take advantage of our states healthcare providers by only awarding them breakeven prices is appalling.

RCW 48.200.280(5)(a) states that PBM must make "reasonable adjustments" and RCW 48.200.280(6)(a) states that the OIC shall direct PBMs to make adjustments that are "fair and equitable. Break even reimbursement are neither reasonable nor fair and equitable. Yearly the NCPA publishes the national average of the "cost to dispense" a prescription, this usually falls in the $13 to $18 range. So, I would argue the OIC should order the PBM to make an adjustment to include the drug invoice price + cost to dispense + dispensing fee. The invoice price and cost to dispense are just covering the pharmacy's cost and the dispensing fee is the profit or the payment for the pharmacy's services. Many other states in our country have implemented various methods of determining a cost to dispense, if you do not like the NCPA studies I would suggest looking to fellow states for guidance on this.

I do appreciate the OIC's added protection of the prospective period. I ask that you consider ordering the PBMs to make the same reasonable adjustments for all pharmacies in the state in the network. The big 3 PBMs control over 80% of all pharmacy claims in the country, so the pharmacy networks are huge. It makes no sense to catch the PBM violating one pharmacy in the network and order them to correct that behavior but allow it to continue to all other pharmacies in the network.

Another thing to consider while determining what is reasonable and fair and equitable is RCW 48.200.280(2)(k) "*A pharmacy benefit manager may not reimburse a pharmacy in the state an amount less than the amount the pharmacy benefit manager reimburses an affiliate for providing the same pharmacy services.*"

My basis for this request stems from the recent study performed in Washington State, "*Understanding Drug Pricing from Divergent Perspectives, State of Washington Prescription Drug Pricing Analysis*" This study was performed by 3 Axis Advisors and funded by The Washington State Pharmacy Association and the Washington Health Alliance. This study looked at claims data from Washington State Pharmacies and compared them to remittance data that was charged to

employers and payors for claims. This study was just reported In the Wall Street Journal with the article "*Mail-Order Drugs Were Supposed to Keep Costs Down. It's Doing the Opposite."* The study found on multiple occasions that PBMs are directly violating our state law RCW 48.200.280(2)(k) and they are reimbursing their own affiliate pharmacies more than other pharmacies. The recent study found, "Generic prescriptions dispensed by mail pharmacies were marked up on average more than three times higher than prescriptions filled by bricks-and-mortar pharmacies, according to a recent analysis by 3 Axis Advisors, a healthcare research firm. Branded drugs filled by mail were marked up on average three to six times higher than the cost of medicines dispensed by chain and grocery-store pharmacies, and roughly 35 times higher than those filled by independent pharmacies, according to the analysis, which looked at 2.4 million claims."

Since PBMs are reimbursing their own pharmacies 35 times higher than small pharmacies of our state, the OIC needs to take a serious look at what they are deeming reasonable and fair and equitable.

**WAC 284-180-505(9 ~~6~~)** current oic proposed language in blue

If the pharmacy benefit manager upholds the network pharmacy's appeal, the pharmacy benefit manager must make a reasonable adjustment no later than one day after the date of the determination. The reasonable adjustment must include, at a minimum, payment of the claim or claims at issue at the net amount paid by the pharmacy to the supplier of the drug. The reasonable adjustment must also apply prospectively for a period of 90 days from the date of the upheld appeal.

In this section, we are still talking about the 1st tier appeal, so this new proposed language would mean that the pharmacy has to give the PBM our invoice or wholesale cost. In previous communications to the OIC I have belabored the point that pharmacies cannot give their wholesale price upfront during the 1st tier appeal due to the secret proprietary nature of the business, as well as non-disclosure agreements the pharmacies must enter into.

My proposed language for this rule;

WAC 284-180-505(9 ~~6~~) If the pharmacy benefit manager upholds the network pharmacy's appeal, the pharmacy benefit manager must make a reasonable adjustment no later than one day after the date of the determination. The reasonable adjustment must include, at a minimum, the pharmacies requested reimbursement plus $12 cost to dispense fee and must meet the requirements of RCW 48.200.280(2)(k). The reasonable adjustment must also apply prospectively for a period of 90 days from the date of the upheld appeal for all network pharmacies.

I understand that this "requested reimbursement" may be controversial but remember the PBM can always deny the appeal if it follows RCW 48.200.280(4)(b). So this would basically make the PBMs follow the law that they have skirted since its inception in 2017. It really is simple, the PBM either upholds our appeal and pays our requested reimbursement or simply be able to defend the reimbursement rate they are paying within the confines of the law. Right now the PBM reimbursement rate is an arbitrary number that they have not been forced to defend, I

understand that using the terminology requested reimbursement makes that a arbitrary number, but the party responsible for the ambiguity is being shifted from the PBM to the pharmacist. Allow me to point out that pharmacist are the number 1 trusted healthcare professionals in the country and PBMs have been proven to be bad actors over and over again and are under constant scrutiny through out our country including our Federal Trade Commission due to their unfair predatory business practices.

**WAC 284-180-520 (3)** This section states "issuing civil penalties pursuant to RCW 48.200.290." this law reads as follows "*(2) Any person, corporation, third-party administrator of prescription drug benefits, pharmacy benefit manager, or business entity which violates any provision of this chapter shall be subject to a civil penalty in the amount of one thousand dollars for each act in violation of this chapter or, if the violation was knowing and willful, a civil penalty of five thousand dollars for each violation of this chapter.*"

I have won over 200 appeal cases against the same PBM for their violation of the same RCW and WAC. The OIC/OAH has issued the civil penalty of $1000 but to date has never issued the $5000 penalty. I do not know how this could not be deemed knowing and willful being fined repeatedly for the same violation but still committing the same violation. Please add some verbiage to this section that will give some clarity to the Judges of what constitutes knowing and willful violations.

Also please add some language in this section that will entitle pharmacies to recoup lawyer fees if they win these appeals and can provide invoices from lawyers for their work on the case. This process of appealing reimbursements takes an inordinate amount of my valuable time, that I would rather be spending caring for my patients. I am a healthcare professional not a lawyer. Again, the reason we have these laws are because the PBMs have been proven to be bad actors and continue to be. The PBMs should be the ones responsible for this undue burden they are putting on our healthcare system. So they should be subject to pay lawyer fees. See OIC Docket No. 05-2021-INS-00156, in this appeal I did consult a lawyer and was charged a fee. The OIC did not grant the lawyer fees. The hearings officer said the lawyer did not have enough involvement. What is enough involvement? Our law does not specify for lawyer fees, nor does it specify against lawyer fees. Other administrative hearing proceedings in our state do award lawyer fees so there is no reason we should not be awarded these lawyer fees. I am a healthcare professional and should be spending my time taking care of patients, not fighting with PBMs for what is rightfully owed to me. Awarding lawyer fees would take the burden off of pharmacies and place it back on the PBMs where the legislators and law intended it.

Thank you for your time and consideration, please reach out to me if more explanation or clarification is needed.

Clinton Knight PharmD.

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