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No. 52685-9-II

**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

PHARMACY CORPORATION OF AMERICA, a California corporation,

Appellant,

v.

STATE OF WASHINGTON, DEPARTMENT OF REVENUE,

Respondent.

APPELLANT'S CORRECTED REPLY BRIEF

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INTRODUCTION

Appellant PharMerica Corporation (“PharMerica”) respectfully submits the following in strict reply to Respondent Department of Revenue’s (“Department”) Brief of Respondent. The dispositive issue in this case is the extent to which PharMerica is “reselling of the drugs to ... health care providers” under RCW 82.04.272(2) for purposes of the prescription drug tax classification. Under PharMerica’s interpretation of subsection (2), PharMerica is entitled to the prescription drug rate with respect to all of its sales of prescription drugs made pursuant to the Pharmacy Services Agreements between PharMerica and various long-term care providers such as nursing homes, assisted living facilities, and inpatient rehabilitation centers (collectively, “LTC Facilities”), regardless of the identity of the party who ultimately reimburses PharMerica for the cost of the drugs.

The Department, on the other hand, contends that PharMerica is eligible for the prescription drug tax rate only with respect to sales where PharMerica satisfies the Department’s so-called “buyer requirement” as set forth in Excise Tax Advisory 3180.2013 (“ETA 3180”). However, in the course of this litigation, the buyer requirement has evolved into a “monetary consideration” test under which PharMerica would be eligible for the prescription drug tax rate only on sales where it receives payment directly

from a LTC Facility and not on sales where it receives payment from the resident or a private or public third-party payor such as a health maintenance organization or a Medicare Part D prescription drug plan (collectively, “Third-Party Payors”).

For the reasons set forth in PharMerica’s opening brief and below, the Court should reject the interpretation of the statute advanced by the Department and instead conclude that, as a matter of law, PharMerica is subject to B&O tax under the prescription drug tax rate on all of its sales of prescription drugs made pursuant its Pharmacy Services Agreements with LTC Facilities, irrespective from whom PharMerica received payment.

RESTATEMENT OF THE FACTS

Although the parties agree that there is no genuine dispute of any material fact, the Department’s response brief makes several assertions of fact that are not supported by evidence in the record.

A. PharMerica does not “provide” any prescription drugs “directly” to residents of LTC Facilities.

The Department mischaracterizes PharMerica’s business activities by claiming that it “provided products and services to facilities in Washington” and “also provided products and services *directly to* residents or long term patients ... who lived or stayed in these facilities,” as if these represent two separate and distinct types of transactions or lines of business.

Resp. Brief at 3 (citing CP 20, 104, 147, 245). The Department’s characterization of PharMerica’s business activities and transactions is misleading because in reality, the only substantive difference between the transactions at issue is the identity of the party (e.g., the facility, the resident, or one or more Third-Party Payors such as Medicaid or a Medicare Part D prescription drug plan) who ultimately remits payment to PharMerica. In all other material respects, the transactions are identical – in all instances, the drugs at issue were prescribed to the residents by a licensed health care practitioner, the LTC facility ordered the drugs from PharMerica as prescribed, and the PharMerica filled the prescription and delivered the drugs directly to the LTC Facilities for administration to their residents. In no instance were any of the prescription drugs ordered by or delivered directly to the residents.

B. The LTC Facilities do not “resell” any of the prescription drugs at issue.

The Department’s claim that the LTC Facilities subsequently “re-sell” any of the prescription drugs at issue is erroneous and not supported by any evidence in the record. For example, the Department contends that in some instances, the LTC Facilities purchased drugs from PharMerica prescribed to a specific patient and would then “*resell*” the drug to the patient by seeking reimbursement from the patient or the patient’s insurance, or by

receiving a *per diem* payment covering the patient’s drug and health care costs.” Resp. Brief at 4. Although it is true that LTC Facilities are reimbursed on a *per diem* basis for prescription drugs administered to residents whose prescription drug costs are covered by Medicaid and Medicare Part A, the record is devoid of any evidence that the LTC Facilities actually resold those drugs to their residents in a separate transaction. Similarly, while the Department claims that the LTC Facilities would also order certain “commonly needed drugs to have in stock, which they later prescribed and *sold to* their patients, for example, during an emergency” (Resp. Brief at 4) again, there is no evidence that the LTC Facilities actually “resell” any of these so-called “house drugs” administered to their residents, in emergencies or otherwise. To the contrary, it is undisputed that when a resident’s prescription drug costs are covered by Medicaid or Medicare A, rather than “reselling” the drugs to the resident, the LTC Facilities simply “absorbed the drugs’ cost in the residents’ care (such as when the facility, under Medicaid or Medicare A, was paid only per diem amounts).” CP 34, 154; *see also*, CP 31 (“PharMerica bills the facility for the prescription drug and the facility recovers the cost of the medication through the per diem rate charged to the patient’s insurance provider.”).

C. PharMerica does not make any sales of prescription drugs “directly” to the resident or any other party other than the LTC Facilities.

According to the Department, “PharMerica’s sales to facilities are billed differently from PharMerica’s *sales to patients*.” Resp. Brief at 23 (citing CP 80-81). This statement, however, merely begs the question because it assumes – incorrectly – that PharMerica actually makes any sales directly to individual residents of the LTC Facilities. The Department further contends – again erroneously – that PharMerica “bills ... third party providers *in accordance with its separate agreements with them*.” Resp. Brief at 23.

Although the Pharmacy Services Agreement cited by the Department provides that PharMerica will, in appropriate circumstances, “directly bill the third party payor,” nothing therein indicates that sales to residents covered by a third-party prescription drug plan are made pursuant to a separate, stand-alone agreement between PharMerica and any the Third-Party Payor. Presumably, by “separate agreements,” the Department is referring to certain ancillary agreements that PharMerica enters into with Medicare Part D prescription drug plan sponsors or pharmacy benefits managers, such as the Participating Pharmacy Agreement between

PharMerica and Rx Options, Inc. *See, e.g.*, CP 115 (Rx Options Participating Pharmacy Agreement).¹

If so, the Department misunderstands the nature and purpose of these ancillary agreements, the terms of which are merely intended to supplement, not replace, the Pharmacy Services Agreements. Rather than establishing a new or separate contract for the sale of prescription drugs, ancillary agreements like the Participating Pharmacy Agreement with Rx Options simply provide special pricing and other terms and conditions required in order for PharMerica to qualify as a participating pharmacy and to receive reimbursements from the prescription drug plans administered by that pharmacy benefits manager. *See* CP 309 (Delta Rehabilitation Pharmacy Services Agreement, providing that “[n]othing in this Agreement may be interpreted as an obligation of Pharmacy to participate in any

¹ Medicare Part D generally refers to the voluntary outpatient prescription drug benefit coverage offered by a private prescription drug plan (“PDP”) sponsor, typically a health maintenance organization or health insurance company such as UnitedHealth Group, Humana, or Aetna. These PDP sponsors contract with the Centers for Medicare and Medicaid Services (“CMS”) to provide standalone supplemental prescription drug coverage or the prescription drug component of a Medicare Advantage Plan. *See* 42 C.F.R. § 423.4, submitted herewith as **App. A-1**; Kaiser Family Foundation, Fact Sheet: An Overview of the Medicare Part D Prescription Drug Benefit (Oct. 18, 2018) available at <https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/> and submitted herewith as **App. A-2**.

particular third-party Payer plan or program”); CP 115 (Rx Options, Inc. Participating Pharmacy Agreement).²

ARGUMENT

During the proceedings below, the Department took the position that the prescription drug tax rate was inapplicable to sales of prescription drug where PharMerica received payment from an individual resident or a Third-Party Payor, reasoning that whoever remits payment to PharMerica must be deemed to be the “buyer” for purposes of the requirement of “reselling of the drugs to ... a health care provider” under RCW 82.04.272(2). *See* CP 29. Although this interpretation might have some superficial merit in the case of sales of “house drugs” directly to the LTC Facilities and sales of drugs prescribed to Self-Pay residents, it breaks down when the for transactions where the cost of the drugs is paid by a Third-Party Payor like a Medicare Part D prescription drug plan. However, designating a Third-Party Payor as the buyer, even though the Third-Party Payors never obtain title, possession, or ownership of the drugs and therefore cannot reasonably be considered the “buyer” under the common and ordinary meaning of that term, much less as a matter of contract law or as defined under B&O tax law.

² A pharmacy benefits manager (“PBM”) is an intermediary entity that administers PDPs offered by Medicare Part D plan sponsors or Medicare Advantage organization. *See* Pharmaceutical Care Management Association, *What is a PBM and what do they do?*, available at <https://www.pcmantet.org/our-industry/>, submitted herewith as **App. A-3**.

Furthermore, treating a Third-Party Payor such as a Medicare Part D prescription drug plan is inconsistent with the Department's policy of not deeming the government to be the buyer of goods purchased for or on behalf of an individual or nongovernmental entity, even if the federal government is liable for or agrees to make the payment. *See Aaro Med. Supplies, Inc. v. Revenue*, 132 Wn. App. 709, 711, 132 P.3d 1143 (2006), *rev. den'd*, 159 Wn.2d 1013 (2007).

The Department's position appears to have evolved somewhat, perhaps out of recognition of the problems associated with treating Third-Party Payors as buyers for purposes of RCW 82,04.272(2). *See* CP 29. Now, rather than simply designating the party who pays for the drugs as the buyer, the Department has introduced yet another term not found in RCW 82.04.272: "monetary consideration." Resp. Brief 17. Under the Department's current interpretation of the statute, "the buyer is a person who pays the consideration for the drug *or arranges to have third party, like an insurer, pay the seller on his or her behalf.*" Resp. Brief at 17 (emphasis added). Thus, "if an otherwise eligible taxpayer, like PharMerica, directly sells the drug to a buyer who is not a pharmacy retailer or a healthcare provider, then the taxpayer is not warehousing and reselling prescription drugs." *Id.* In addition, the Department contends that the term buyer

encompasses a person “who arranges to have a third party, like an insurer, pay the seller on his or her behalf.” *Id.*

A. All of the gross proceeds from PharMerica’s sales of prescription drugs are derived from a single business activity.

In support of its interpretation, the Department correctly observes that a taxpayer engaged in business activities subject to tax under two or more B&O tax classifications is taxable under each applicable classification. *See* Resp. Brief at 13. The Department cites *Steven Klein, Inc. v. Dep’t of Revenue*, 183 Wn.2d 889, 357 P.3d 59, 59 (2015) as an example of this principle. In *Steven Klein*, the Department held that an auto dealer’s receipt of “dealer cash” incentive payments from auto manufacturers was a business activity separate and apart from its business activity of making retail sales of cars. *Id.* at 898-99. Since the activity of receiving dealer cash payments does not fall within the definition of a retail sale (or any other specific classification), the Court held that such dealer cash payments were taxable under the catch-all service and other activities B&O tax rate of 1.5% rather than the retailing B&O tax rate of 0.471%. *Id.*

Although PharMerica has no objection to the general principle that taxpayers engaged in activities subject to multiple tax classifications are separately taxable under each applicable classification, it is difficult to see how it advances the Department’s position. Similar to the auto dealer in

Steven Klein, PharMerica acknowledges that its provision of pharmacy services that are separately taxable under the service and other B&O tax classification on the compensation it receives from LTC Facilities for pharmacy services. By contrast, PharMerica's sales of prescription drugs constitute a single business activity, irrespective of the identity of the payor. Consequently, neither *Steven Klein* nor the multiple taxable principle set forth in RCW 82.04.440(1) support the Department's position.

B. The Court should reject the Department's overly narrow interpretation of the statute because it turns entirely on the form of the transactions, rather than their substance.

The interpretation of the statute advanced by the Department appears to rest on the misconception that "the form of a business activity, rather than its substance, controls tax classifications." *Fidelity Title Co. v. State Dep't of Revenue*, 49 Wn. App. 662, 666-67, 745 P.2d 530 (1987), *rev. den'd*, 110 Wn.2d 1010 (1988). In *Fidelity*, this Court rejected the Department's assertion of form over substance where there was no functional difference between the taxpayer's title abstracting business and similarly situated title insurance business to justify the taxpayer's exclusion from the "abstract, title insurance and escrow business" tax classification. *Id.* at 666-67. In arriving at this conclusion, the Court reasoned that any difference between the business activities was entirely "in form, and form

is not to be exalted over substance in tax classifications.” *Id.*, (citing *Time Oil Co. v. State*, 79 Wn.2d 143, 146, 483 P.2d 628 (1971)).

The prohibition against exalting form over substance applies with even greater force to the instant case, because in terms of economic and functional substance, the business activities associated with all of the transactions at issue are virtually indistinguishable, except for the identity of the party from whom PharMerica receives payment. However, the Department’s interpretation places far too much significance on the significance of the source of payment or “monetary consideration” for any given transaction is simply a function of the nature and extent of the resident’s eligibility for prescription drug coverage, coupled with the claims submission and reimbursement process. Otherwise, the business activities associated with PharMerica’s sales of prescription drugs are virtually identical in all material respects – in all instances, the sales were made pursuant to the PSAs between PharMerica and the LTC Facilities; in all instances, the drugs were ordered, received, and administered by the LTC Facilities, who maintained exclusive possession, custody, and control of the drugs until they are administered to the residents as prescribed. Moreover, with the exception of drugs prescribed to Self-Pay Residents, the source of the “monetary consideration” for the vast majority of the transactions at issue is ultimately one or more government-sponsored prescription drug

plans, principally a Medicare Part D and Medicare Advantage plan. In fact, the only real difference between such transactions is whether PharMerica is reimbursed directly by a prescription drug plan on a fee-for-service basis (e.g., Medicare Part D or Medicare Advantage), or indirectly via a LTC Facility, who remits payment for the cost of the drugs to PharMerica and recovers or absorbs the cost of the same as part of the resident's *per diem* reimbursement rate (e.g., Medicare Part A or Medicaid).

In substance, all of the proceeds derived from the transactions at issue involved a single business activity – warehousing and reselling prescription drugs pursuant to the PSAs executed by PharMerica and its LTC Facility customers, which is true irrespective of the source of the so-called monetary consideration for each particular transaction. Although the source of payment and reimbursement methodology is important and varies depending upon the nature and extent of each resident's prescription drug coverage, for purposes of determining the proper classification of PharMerica's business activities, the resulting difference, if any, relate solely to the form of the transactions, which “is not to be exalted over substance in tax classifications.” *Fid. Title Co.*, 49 Wn. App. at 666-67 (citing *Time Oil Co. v. State*, 79 Wn.2d 143, 146, 483 P.2d 628 (1971)).

C. If there is any doubt as to the meaning or application of “reselling to” requirement under RCW 82.04.272(2), the Court must strictly construe the statute in favor of PharMerica and against the interpretation advanced by the Department.

In *Aventis Pharm., Inc. v. Dep't of Revenue*, 5 Wash. App. 2d 637, 639, 428 P.3d 389, 392 (2018), this Court declined the Department's invitation to “interpret the prescription drug tax strictly against the taxpayer, as a preferential rate is equivalent to an exemption or deduction. In arriving at this conclusion, the Court reasoned that “in the context of a preferential tax rate for a specific industry, ‘[i]f any doubt exists as to the meaning of a taxation statute, the statute must be construed most strongly against the taxing power and in favor of the taxpayer.’” *Aventis*, 5 Wn. App. 2d 637, 642 n.1, 428 P.3d 389 (2018) (quoting *Agrilink Foods, Inc. v. Dep't of Revenue*, 153 Wn.2d 392, 393, 103 P.3d 1226, 1227 (2005)).

Accordingly, the Court concluded that “[b]ecause the prescription drug tax statute involves a preferential rate and not an exemption or deduction, *we construe it against DOR.*” *Aventis*, 5 Wn. App. 2d at 642 n.1 (emphasis added). For the reasons explained above, PharMerica qualifies for the prescription drug tax rate under the plain language of the statute and as interpreted by the Department under ETA 3187. Furthermore, the Court should reject the interpretation of the statute advanced by the Department, adopt PharMerica's interpretation, and conclude that the prescription drug

tax rate unambiguously applies to all of PharMerica's sales of prescription drugs, irrespective of the source of payment or "monetary consideration. However, in the event that the Court concludes that the meaning of the prescription drug tax statute is ambiguous or doubtful as applied to PharMerica, then consistent with *Aventis* and *Agrilink*, the Court should strictly construe the statute and resolve any doubt or ambiguity in favor of PharMerica and against the Department. *See Aventis*, 5 Wn. App. 2d at 642 n.1.

CONCLUSION

For the reasons discussed above, PharMerica respectfully requests that the Court of Appeals reverse the trial court's order granting summary judgment in favor of the Department and order the entry of summary judgment in favor of PharMerica, granting its claim for the refund of the B&O tax paid at the higher retailing B&O tax rate on gross income derived from warehousing and reselling prescription drugs, in the amount of \$167,908, plus refund interest calculated in the manner prescribed by RCW 82.32.060.

DATED: March 12, 2019.

STOLL PETTEYS PLLC

A handwritten signature in blue ink, consisting of several loops and a horizontal stroke at the end.

By: _____
David A. Petteys, WSBA No. 33157

*Attorneys for Appellant Pharmacy
Corporation of America*

APPENDIX A-1

1860D-11. PDP regions; submission of bids; plan approval.

1860D-12. Requirements for and contracts with prescription drug plan (PDP) sponsors.

1860D-13. Premiums; late enrollment penalty.

1860D-14. Premium and cost-sharing subsidies for low-income individuals.

1860D-15. Subsidies for Part D eligible individuals for qualified prescription drug coverage.

1860D-16. Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

1860D-21. Application to Medicare Advantage program and related managed care programs.

1860D-22. Special rules for Employer-Sponsored Programs

1860D-23. State pharmaceutical assistance programs.

1860D-24. Coordination requirements for plans providing prescription drug coverage.

1860D-31. Medicare prescription drug discount card and transitional assistance program.

1860D-41. Definitions; treatment of references to provisions in Part C.

1860D-42. Miscellaneous provisions.

(2) The following specific sections of the Medicare Modernization Act also address the prescription drug benefit program:

Sec. 102 Medicare Advantage conforming amendments.

Sec. 103 Medicaid amendments.

Sec. 104 Medigap.

Sec. 109 Expanding the work of Medicare Quality Improvement Organizations to include Parts C and D.

(b) *Scope.* This part establishes standards for beneficiary eligibility, access, benefits, protections, and low-income subsidies in Part D, as well as establishes standards and sets forth requirements, limitations, procedures and payments for organizations participating in the Voluntary Medicare Prescription Drug Program.

§ 423.4 Definitions.

The following definitions apply to this part, unless the context indicates otherwise:

Actuarial equivalence means a state of equivalent value demonstrated through the use of generally accepted actuarial

principles and in accordance with section 1860D-11(c) of the Act and with CMS actuarial guidelines.

Brand name drug means a drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(c)), including an application referred to in section 505(b)(2) of the Federal Food, Drug and Cosmetic Act (21 USC 355(b)(2)).

Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursement contract under section 1876(h) of the Act.

Eligible fallback entity or fallback entity is defined at § 423.855.

Fallback prescription drug plan is defined at § 423.855.

Formulary means the entire list of Part D drugs covered by a Part D plan.

Full-benefit dual eligible individual has the meaning given the term at § 423.772, except where otherwise provided.

Generic drug means a drug for which an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(j)) is approved.

Group health plan is defined at § 423.882.

Insurance risk means, for a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitutions, nor does it include elements potentially in the control of the pharmacy (for example, labor costs or productivity).

MA stands for Medicare Advantage, which refers to the program authorized under Part C of title XVIII of the Act.

MA plan has the meaning given the term in § 422.2 of this chapter.

MA-PD plan means an MA plan that provides qualified prescription drug coverage.

Medicare prescription drug account means the account created within the Federal Supplementary Medical Insurance Trust Fund for purposes of Medicare Part D.

Monthly beneficiary premium means the amount calculated under § 423.286

§ 423.6

for Part D plans other than fallback prescription drug plans, and § 423.867(a) for fallback prescription drug plans.

PACE Plan means a plan offered by a PACE organization.

PACE organization is defined in § 460.6 of this chapter.

Part D eligible individual means an individual who meets the requirements at § 423.30(a).

Part D plan (or Medicare Part D plan) means a prescription drug plan, an MA-PD plan, a PACE Plan offering qualified prescription drug coverage, or a cost plan offering qualified prescription drug coverage.

Part D plan sponsor or Part D sponsor refers to a PDP sponsor, MA organization offering a MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage.

PDP region means a prescription drug plan region as determined by CMS under § 423.112.

PDP sponsor means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part that apply to entities that offer prescription drug plans. This includes fallback entities.

Prescription drug plan or PDP means prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in § 423.272 and that is offered by a PDP sponsor that has a contract with CMS that meets the contract requirements under subpart K of this part. This includes fallback prescription drug plans.

Service area (Service area does not include facilities in which individuals are incarcerated.) means for—

(1) A prescription drug plan, an area established in § 423.112(a) within which access standards under § 423.120(a) are met;

(2) An MA-PD plan, an area that meets the definition of MA service area as described in § 422.2 of this chapter, and within which access standards under § 423.120(a) are met;

(3) A fallback prescription drug plan, the service area described in § 423.859(b);

(4) A PACE plan offering qualified prescription drug coverage, the service

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area described in § 460.22 of this chapter; and

(5) A cost plan offering qualified prescription drug coverage, the service area defined in § 417.1 of this chapter.

Subsidy-eligible individual means a full subsidy eligible individual (as defined at § 423.772) or other subsidy eligible individual (as defined at § 423.772).

Tiered cost-sharing means a process of grouping Part D drugs into different cost sharing levels within a Part D sponsor's formulary.

§ 423.6 Cost-sharing in beneficiary education and enrollment-related costs.

The requirements of section 1857(e)(2) of the Act and § 422.6 of this chapter with regard to the payment of fees established by CMS for cost sharing of enrollment related costs apply to PDP sponsors under Part D.

Subpart B—Eligibility and Enrollment.

§ 423.30 Eligibility and enrollment.

(a) *General rule.* (1) An individual is eligible for Part D if he or she:

(i) Is entitled to Medicare benefits under Part A or enrolled in Medicare Part B; and

(ii) Lives in the service area of a Part D plan, as defined under § 423.4.

(2) Except as provided in paragraphs (b), (c), and (d) of this section, an individual is eligible to enroll in a PDP if:

(i) The individual is eligible for Part D in accordance with paragraph (a)(1) of this section;

(ii) The individual resides in the PDP's service area; and

(iii) The individual is not enrolled in another Part D plan.

(3) Retroactive Part A or Part B determinations. Individuals who become entitled to Medicare Part A or enrolled in Medicare Part B for a retroactive effective date are Part D eligible as of the month in which a notice of entitlement Part A or enrollment in Part B is provided.

(b) *Coordination with MA plans.* A Part D eligible individual enrolled in a MA-PD plan must obtain qualified prescription drug coverage through that plan. MA enrollees are not eligible to enroll in a PDP, except as follows:

APPENDIX A-2

An Overview of the Medicare Part D Prescription Drug Benefit

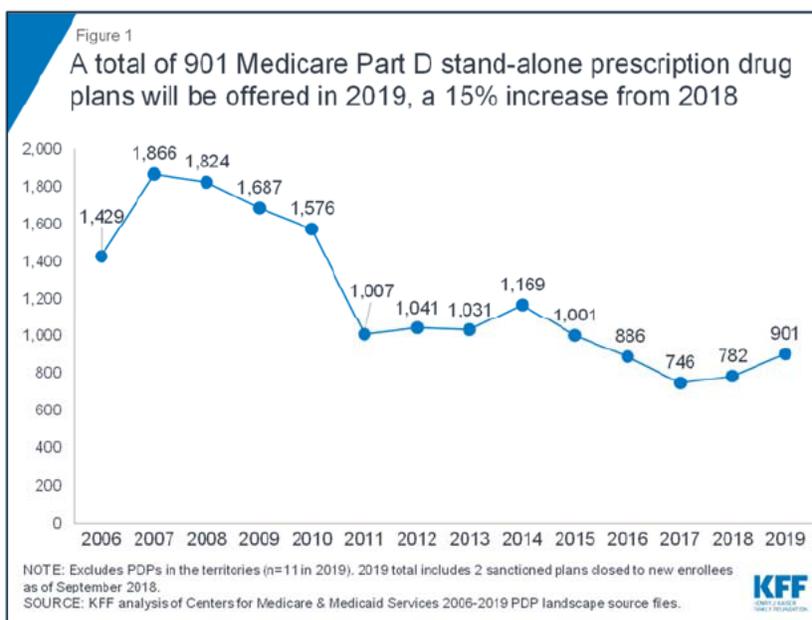
Medicare Part D is a voluntary outpatient prescription drug benefit for people with Medicare, provided through private plans approved by the federal government. Beneficiaries can choose to enroll in either a stand-alone prescription drug plan (PDP) to supplement traditional Medicare or a [Medicare Advantage](#) prescription drug plan (MA-PD), mainly HMOs and PPOs, that cover all Medicare benefits including drugs. In 2018, [more than 43 million](#) of the 60 million people with Medicare are enrolled in Part D plans. Of this total, nearly 6 in 10 (58%) are enrolled in stand-alone PDPs and just over 4 in 10 (42%) are enrolled in Medicare Advantage drug plans. The Congressional Budget Office (CBO) estimates that spending on Part D benefits will total [\\$99 billion in 2019](#), representing 15% of net Medicare outlays

This fact sheet provides an overview of the Medicare Part D program, plan availability, enrollment, and spending and financing, based on data from the Centers for Medicare & Medicaid Services (CMS), CBO, and other sources.

Medicare Prescription Drug Plan Availability

In 2019, 901 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories). This represents an increase of 119 PDPs from 2018 and the second year in a row with an increase, after three years of plan reductions (Figure 1).

The relatively large increase in the number of PDPs is likely due to the recent [elimination by CMS of the “meaningful difference” requirement](#) for enhanced benefit PDPs offered by the same organization in the same region. Plans with enhanced benefits can offer a lower deductible, reduced cost sharing, and/or a higher initial coverage limit. Previously, PDP sponsors were required to demonstrate that their enhanced PDPs were meaningfully different in terms of enrollee out-of-pocket costs in order to ensure that plan



premium. Some enrollees have fewer benchmark plan options than others, since benchmark plan availability varies at the Part D region level. The number of premium-free PDPs in 2019 ranging from a low of 2 plans in Florida to 10 plans in Arizona (see map).

Part D Plan Premiums and Benefits

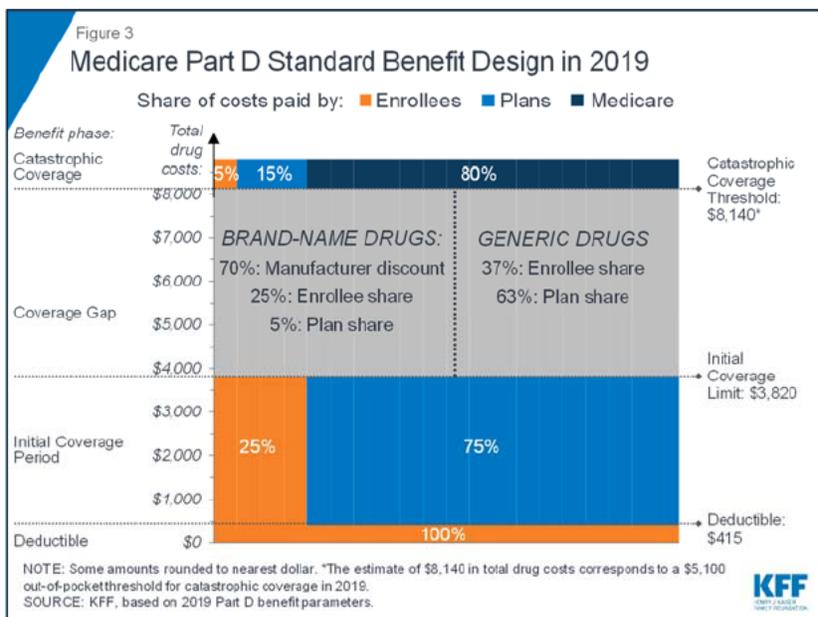
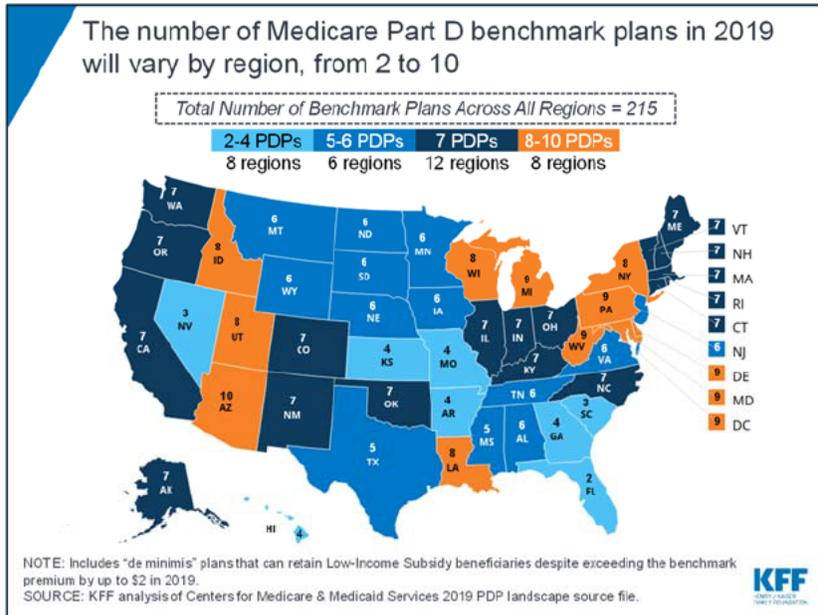
Premiums

The 2019 Part D base beneficiary premium—which is based on bids submitted by both PDPs and MA-PDs—is [\\$33.19](#), a 5% reduction from 2018. But actual premiums paid by Part D enrollees vary considerably from this amount.

For 2019, PDP monthly premiums vary by plan across the country (and even within regions), ranging from a low of \$10.40 for a PDP available in Texas to a high of \$156 for a PDP in the Pennsylvania/West Virginia PDP region. In addition to the monthly premium, Part D enrollees with higher incomes (\$85,000/individual; \$170,000/couple) pay an income-related premium surcharge, ranging from \$12.40 to \$77.40 per month in 2019 (depending on income).

Benefits

Part D plans must offer either the defined standard benefit or an alternative equal in value (“actuarially equivalent”), and can also provide enhanced benefits. The 2019 Part D defined standard benefit has a \$415 deductible and 25% coinsurance up to an initial coverage limit of \$3,820 in total drug costs (Figure 3). For total drug costs above that amount, under [changes made by the Bipartisan Budget Act of 2018](#) (BBA), Part D enrollees’ out-of-



pocket costs for brands will be 25% in 2019 (down from 35% in 2018)—rather than in 2020—while plans’ share of costs for brands will be 5% and the manufacturer discount will be 70% (an increase from 50% prior to 2019). For generic drugs, enrollees will pay 37% coinsurance and plans will pay 63%. This allocation of costs for brands and generics in the coverage gap applies until an enrollee’s total out-of-pocket spending reaches \$5,100, the out-of-pocket threshold for catastrophic coverage in 2019. For total drug costs above the catastrophic threshold, Medicare pays 80%, plans pay 15%, and enrollees pay either 5% of total drug costs or \$3.40/\$8.50 for each generic and brand-name drug, respectively.

The standard benefit amounts are indexed to change annually based on the rate of Part D per capita spending growth, and, with the exception of 2014, have increased each year since 2006 (Figure 4).

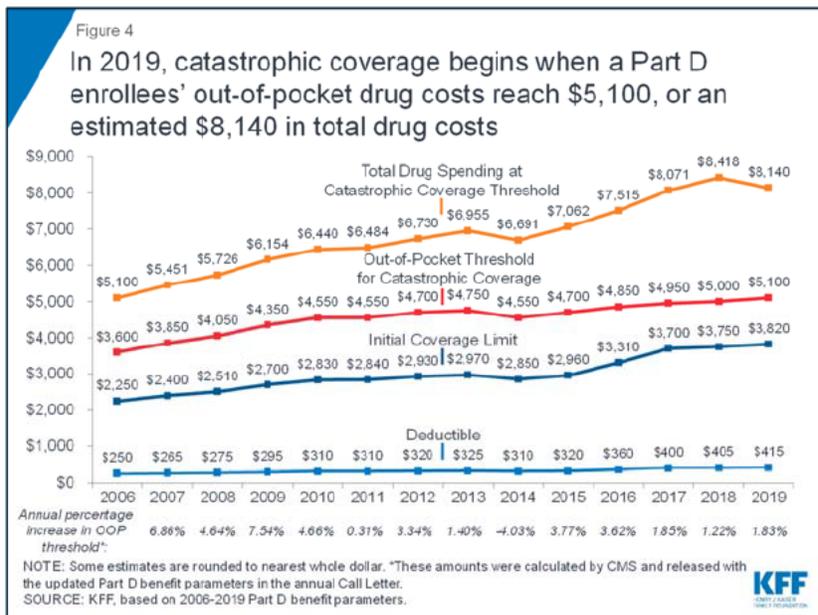
Both basic and enhanced plans vary in terms of their specific benefit design, coverage, and costs, including deductibles, cost-sharing amounts, utilization management tools (i.e., prior authorization, quantity limits, and step therapy), and formularies

(i.e., covered drugs). Plan formularies must include drug classes covering all disease states, and a minimum of two chemically distinct drugs in each class. Part D plans are required to cover all drugs in six so-called “protected” classes: immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.

In 2019, most PDPs (71%) will charge a deductible, but only half (52%) of PDPs will charge the full amount (\$415). Over time, Part D plans have shifted to charging tiered copayments or coinsurance amounts for covered drugs rather than a uniform 25% coinsurance rate, and nearly all plans use specialty tiers for high-cost medications.

Part D and Low-Income Subsidy Enrollment

Enrollment in Medicare Part D plans is voluntary, with the exception of beneficiaries who are eligible for both Medicare and Medicaid and certain other low-income beneficiaries who are automatically enrolled in a PDP if they do not choose a plan on their own. Unless beneficiaries have drug coverage from another source that is at least as good as standard Part D coverage (“creditable coverage”), they face a penalty equal to 1% of the national average premium for each month they delay enrollment.



In 2018, 43 million Medicare beneficiaries are enrolled in Medicare Part D plans, including employer-only group plans. Another [1.5 million beneficiaries](#) are estimated to have drug coverage through employer-sponsored retiree plans where the employer receives subsidies equal to 28% of drug expenses between \$415 and \$8,500 per retiree (in 2019). Several million beneficiaries are estimated to have other sources of drug coverage, including employer plans for active workers, FEHBP, TRICARE, and Veterans Affairs (VA). Yet [12% of people with Medicare](#) are estimated to lack creditable drug coverage.

An estimated 13 million Part D enrollees receive the Low-Income Subsidy in 2018. Beneficiaries who are dually eligible, QMBs, SLMBs, QIs, and SSI-onlys automatically qualify for the additional assistance, and Medicare automatically enrolls them into PDPs with premiums at or below the regional average (the Low-Income Subsidy benchmark) if they do not choose a plan on their own. Other beneficiaries are subject to both an income and asset test and need to apply for the Low-Income Subsidy through either the Social Security Administration or Medicaid.

Part D Spending and Financing

The Congressional Budget Office (CBO) estimates that spending on Part D benefits will total [\\$99 billion in 2019](#), representing 15% of net Medicare outlays (net of offsetting receipts from premiums and state transfers). Part D spending depends on several factors, including the number of Part D enrollees, their health status and drug use, the number of enrollees receiving the Low-Income Subsidy, and plans' ability to negotiate discounts (rebates) with drug companies and preferred pricing arrangements with pharmacies, and manage use (e.g., promoting use of generic drugs, prior authorization, step therapy, quantity limits, and mail order). Federal law prohibits the Secretary of Health and Human Services from interfering in [drug price negotiations](#) between Part D plan sponsors and drug manufacturers.

[Financing for Part D](#) comes from general revenues (73%), beneficiary premiums (15%), and state contributions (11%). The monthly premium paid by enrollees is set to cover 25.5% of the cost of standard drug coverage. Medicare subsidizes the remaining 74.5%, based on bids submitted by plans for their expected benefit payments. Higher-income Part D enrollees pay a larger share of standard Part D costs, ranging from 35% to 85%, depending on income.

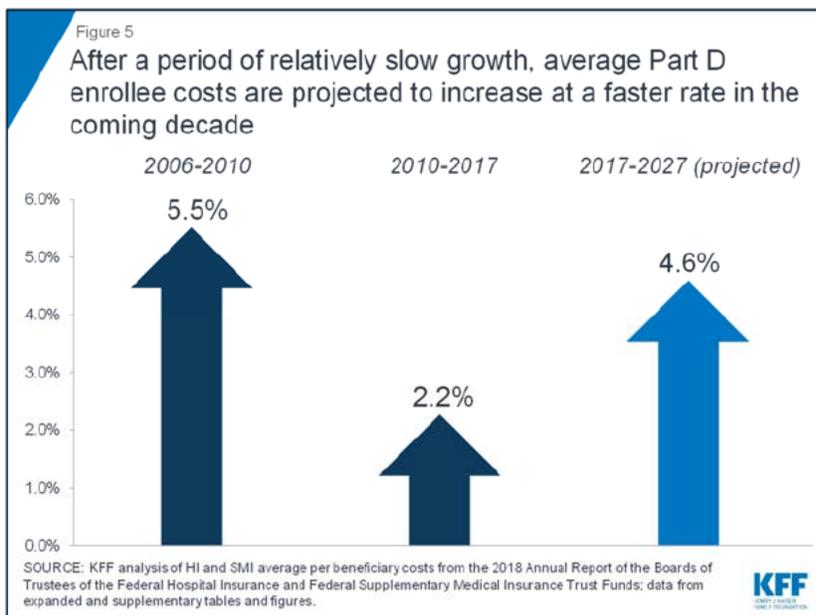
For 2019, [Medicare's actuaries estimate](#) that Part D plans will receive direct subsidy payments averaging \$296 per enrollee overall and \$2,337 for enrollees receiving the LIS; employers are expected to receive, on average, \$553 for retirees in employer-subsidy plans. Part D plans' potential total losses or gains are limited by risk-sharing arrangements with the federal government ("risk corridors"). Plans also receive additional risk-adjusted payments based on the health status of their enrollees and reinsurance payments for very high-cost enrollees.

Under reinsurance, Medicare subsidizes 80% of total drug spending incurred by Part D enrollees above the catastrophic coverage threshold (Figure 3). For 2019, average reinsurance payments per enrollee are estimated to be \$936, a 6% increase from the 2018 estimate. In the aggregate, Medicare's reinsurance payments to plans have grown from \$6 billion in 2006 to an estimated \$43 billion in 2019, accounting for a

larger share of total Part D spending over time (from 14% in 2006 to an estimated 42% in 2019¹). This increase is due in part to a growing number of Part D enrollees with spending above the catastrophic threshold, which is a result of several factors, including the introduction of high-cost specialty drugs, increases in the cost of prescriptions, and a change made by the ACA to count a manufacturer discount on the price of brand-name drugs in the coverage gap towards the out-of-pocket threshold for catastrophic coverage. Analysis from MedPAC also suggests that in recent years, plans have [underestimated their enrollees' expected costs](#) above the catastrophic coverage threshold, resulting in higher reinsurance payments from Medicare to plans over time.

Issues for the Future

In the face of ongoing concern among consumers and policymakers about rising prescription drug costs, the Trump Administration has issued proposals that would [change some features](#) of the Part D benefit and other proposals related to [Medicare drug coverage and reimbursement](#) in an effort to contain rising drug costs. The average annual growth rate in per beneficiary costs for Part D is projected to be higher in the coming decade (4.6%) than between 2010 and 2017 (2.2%) (Figure 5). This is due in part to higher Part D program costs associated with expensive specialty drugs, which are expected to be reflected in higher reinsurance payments from Medicare to plans. Part D benefits spending is projected to increase from 15% of total (net) Medicare spending in 2018 to 17% in 2028.²



The Medicare drug benefit helps to reduce out-of-pocket drug spending for enrollees, which is especially important to those with modest incomes or very high drug costs. [Closing the coverage gap](#) will bring additional relief to millions of enrollees with high costs. But with drug prices on the rise and more plans charging coinsurance rather than flat copayments for covered brand-name drugs, Part D enrollees could face higher out-of-pocket costs for their medications. These trends highlight the importance of comparing plans during the annual open enrollment period. [Research shows](#), however, that relatively few people on Medicare have used the annual opportunity to switch Part D plans voluntarily—even though those who do switch often lower their out-of-pocket costs as a result of changing plans.

Understanding how well Part D is meeting the needs of people on Medicare will be informed by ongoing monitoring of the Part D plan marketplace, assessing coverage and costs for high-cost biologics and

other specialty drugs, and evaluating the impact of the drug benefit on Medicare beneficiaries' out-of-pocket spending and health outcomes.

Endnotes

¹ KFF analysis of aggregate Part D reimbursement amounts from Table IV.B10, [*2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*](#).

² KFF analysis of Part D benefits spending as a share of net Medicare outlays (total mandatory and discretionary outlays minus offsetting receipts) from CBO, [*Medicare-Congressional Budget Office's April 2018 Baseline*](#).

APPENDIX A-3



Our Industry

Our Mission

Pharmacy Benefit Managers (PBMs) reduce prescription drug costs and improve convenience and safety for consumers, employers, unions, and government programs. PCMA's mission is to lead the effort in promoting PBMs and the proven tools they utilize, which are recognized by consumers, employers, policymakers, and others as key drivers in lowering prescription drug costs and increasing access. PCMA monitors and advocates on a range of important health care issues that allow PBMs to continue:

- Lowering pharmacy costs for America's employers and consumers.
- Protecting affordability and choice in Medicare Part D.
- Lowering pharmacy costs for Medicare seniors.
- Improving safety with specialty pharmacies.

M?

Pharmacy Benefit Managers (PBMs) administer prescription drug plans for more than 266 million Americans who have health insurance from a variety of sponsors including: commercial plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program (FEHBP), state government employee plans, managed Medicaid plans, and Veterans Affairs. PBMs are expected to save employers, unions, government programs, and consumers \$654 billion or up to 30 percent on drug benefit costs over the next decade.

Key strategies include:

- Streamlining the home delivery of medications and creating select networks of more affordable pharmacies;
- The use of generics and more affordable brand medications;
- Negotiating rebates from drug manufacturers and discounts from drugstores;
- Utilizing cost specialty medications; and
- Educating patients and improving adherence.

Learn How PBMs Reduce Costs and Improve Quality

Learn how PBMs reduce prescription drug costs and improve quality for consumers, employers, unions, and government programs at [drugbenefitsolutions.com](https://www.pcmnet.org/our-industry/).



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