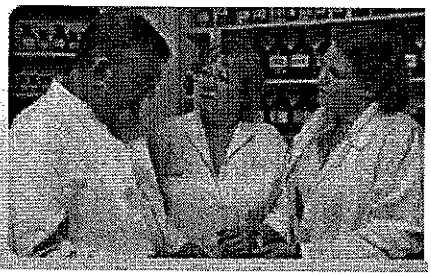
OSPA Oregon State Pharmacy Association Since 1889



OSHP Oregon Society of Health-System Pharmacists

FEBRUARY 6, 2012

TO: HOUSE COMMITTEE ON HEALTH CARE

FROM: OREGON STATE PHARMACY ASSOCIATION & OREGON SOCIETY OF HEALTH-SYSTEM PHARMACISTS

RE: STATEMENT IN SUPPORT OF HB 4122

The goal of HB 4122 is to increase Pharmacy Benefit Managers (PBMs) transparency by disclosing formulas, processes, revenue and rebate levels for various elements of their services which allow insurance companies to ensure they are not overpaying for the services provided by the PBMs and would result in decreasing the overall cost of prescription services. PBMs are entrusted with the processing of billions of dollars of prescriptions in this country and currently have absolutely no regulatory oversight on a federal level or in the state of Oregon, which is why this legislation is so very needed.

HB 4122 will require PBMs to register with the Oregon Board of Pharmacy on a regular basis if they do business in Oregon. As part of their registration, PBMs must disclose certain information including:

- formulas and processes used by the PBM to determine which drugs are placed on a payment schedule that specifies maximum allowable costs;
- the adjustment of the maximum allowable costs specified on a payment schedule;
- the reimbursement of pharmacies for prescribing a drug.

The measure also requires disclosure by the PBM of the prior year's revenues received from:

- pharmaceutical manufacturers rebates;
- the difference between the amount reimbursed by the PBM to a pharmacy for a prescribed drug and the amount reimbursed by the insurance plan for that drug to the PBM;
- the substitution of a different drug of similar therapeutic value for a prescribed drug;
- from dispensing drugs by mail.

The Board may share the information collected with the insurance companies that individually contract with the PBMs, pharmacies and pharmacists. The bill will also include a public records exemption to ensure that proprietary, sensitive information is not disclosed to competitors.

PBMs contract with public and private insurers to provide prescription drug claim coverage. Basic PBM tasks include:

- Managing which prescriptions are covered by insurance companies.
- Setting reimbursement rates with pharmacies.
- Negotiating reimbursement rates with pharmacies for certain prescriptions.
- Receiving pharmaceutical manufacturer rebates to improve a drug's formulary standing (the higher the standing, the more frequently the drug will be sold). For example, if Manufacturer A makes drug A and Manufacturer B makes drug B, both drugs do the same thing, but drug B is cheaper than drug A, drug B would ordinarily rank higher on the formulary than drug A. Manufacturer A will offer the PBM a rebate, say 10%, of the drug's wholesale price, to ensure that drug A is cheaper than B and thus appears higher on the formulary and is sold more often.
- Contracting with insurance companies to provide a wide-range of services including mail order prescriptions, claims processing, retail network management, clinical formulary development and management services, certain patient compliance, therapeutic intervention, generic substitution programs and disease management programs.

PBMs Have a Monopoly over Drug Contracts

PBMs argue that competition amongst themselves keeps drug costs down. Various sources estimate that there are roughly 50-60 PBMs operating in the United States. Of these, the FTC reports that only 12 PBMs cover at least five million or more lives. The largest of these are the three large independent, full-service PBMs with national scope: Medco, Express Scripts, and Caremark. These three PBMs have emerged from a decade of rapid growth and consolidation to cover a combined 190 million lives and manage a combined $80 billion in drug spending. Even more, Express Scripts offered to buy its mail order competitor, Medco, for $29 billion. The proposed Express Scripts-Medco merger would give one dominant PBM much greater leverage to impose one-sided deals on the government and other plan sponsors. This advantage will thwart competition, raise health care costs, restrict patient choice and end efforts to gain greater insights into PBM business practices and revenue streams.

Increasingly, PBMs have been asking pharmacies to cover drugs at a cost-ineffective rate, forcing them to choose to either forgo a certain segment of the market, or eat a loss to continue providing prescriptions to their customers insured by the plans managed by the PBMs. In fact, as of January 1, 2012, Walgreens announced that it would no longer participate in Express Scripts' pharmacy networks. Walgreens reportedly made this decision because Express Scripts reimbursements to its national chain of pharmacies are so low under the terms of the proposed new contract that the retail pharmacy giant determined it more reasonable to risk losing an **estimated $5.3 billion in annual revenue** generated from prescriptions filled by members of health plans that Express Scripts manages than accept the actual net losses from the cost-ineffective rates offered by Express Scripts. If Walgreens cannot financially afford PBM reimbursement rates, local pharmacies certainly will not have the ability to compete with these out-of-state PBMs. Experts anticipate the practice of strategic under-reimbursement to result in the theft of several million dollars from Oregon independent pharmacies each year.

For consumers, this means decreased access to service if their pharmacy stops covering their prescription at the insured rate and individuals will either pay more for the prescription or be

forced to find a new pharmacy (which may not be an option late at night or in smaller, rural communities).

HB 4122 Protects Small Businesses and Independent Pharmacies from Out-of-State Corporations

PBMs use confidential medical data to market their services to patients. This strategy is used to force patients out of independent pharmacies and into proprietary programs owned by PBMs. Currently, little transparency exists to ensure that PBMs report their rebate levels, pricing deals and other information necessary for insurers to make informed decisions. Therefore, regardless of what insurers pay, they do not know how much their PBM pays the pharmacy. The lack of information creates an incentive for PBMs to overcharge insurance providers and underpay pharmacies to gain the greatest profit.

PBM Controversies

After years of being relied upon to reduce prescription drug costs, PBMs have come under scrutiny by the federal government and consumers who question if PBMs are actually saving their clients' money.

Health plan representatives have filed numerous lawsuits over the past years. The lawsuits generally alleged that the PBMs:

- Forced health plans and health care consumers to pay inflated prescription drug prices through patterns of illegal, secret dealings with drug companies;
- Reaped billions of dollars in profits by steering health insurers and health care consumers into reliance on more expensive prescription drugs;
- Negotiated rebates and discounts from drug manufacturers and discounts from retail pharmacies that were not passed onto health plans and consumers, but were used instead to increase their own profits; and
- Used anti-competitive practices against small independent pharmacies.

Some of the lawsuits involving PBMs over the years include:

- October 2006: Medco Health Solutions agreed to a $155 million, plus interest, fraud settlement with the Justice Department. The charges included inappropriately canceling government employees' prescriptions, falsely claiming it had called physicians to warn them of potential bad-drug interactions, changing prescriptions without a doctor's consent, taking longer to fill prescriptions than it claimed, and under-filling pill bottles.
- December 2005: An Ohio court in a jury trial ordered Medco Health Solutions to pay $7.8 million for defrauding the State Teachers Retirement System of Ohio ("STRS Ohio"). The jury found that Medco owed a fiduciary duty to STRS Ohio and breached that duty. The court is still hearing arguments on punitive damages in the case.
- September 2005: Caremark/AdvancePCS agreed with the U.S. Attorney's Office in Philadelphia to pay $137.5 million to resolve civil fraud and kickback allegations involving the Federal Employee Health Benefits Program and Medicare+Choice program. The company also signed an extensive consent order as part of the agreement.

- May 2004: Medco Health Solutions agreed to a $42.5 million settlement in a class action suit that alleged Medco violated its fiduciary duty by promoting more expensive drugs made by Merck and other manufacturers over less costly alternatives.

Transparency Saves Money for Consumers and Plans

- TRICARE anticipates savings of $1.67 billion by negotiating its own drug prices and rebates for its 9 million beneficiaries rather than going through a PBM.
- Texas estimates savings of $265 million by switching to a transparent PBM contract.
- New Jersey projects savings of $558.9 million over six years from a new transparent PBM contract it just signed with Medco for its 600,000 covered employees, dependents and retirees.
- Wisconsin saved over $30 million by switching to a transparent PBM.

New York's Anti-Mandatory Mail Order Victory

PBMs have the power to force patients to participate in mail order pharmacies without giving patients an opportunity to visit a retail pharmacy. As a result, in 2011, New York passed a bill that gives consumers a choice to go to a retail pharmacy if they desires, but does not ban anyone from using mail order to fill prescriptions if that is his or her desire. Although mail pharmacy dispensing of generic drugs accounts for a minority of a PBMs' prescriptions, it still accounts for more than half of per-prescription profits. HB 4122 will include mail order prescriptions in its definition of "Pharmacy Benefit Manager" to assure PBMs must disclose their mail order practices and revenues.

Oregon Health Care Transformation

As Oregon's Health Care Transformation evolves, access, quality of care and health care costs are critical issues. Prescription drugs and related services represent a major component in health care delivery and cost. Passage of **HB 4122** will help provide Oregon with the information and the opportunity to ensure that prescription benefit plans are designed to address access and quality of care in a cost effective manner.

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