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March 4, 2013

Chair Monnes-Anderson, Vice-Chair Kruse and members of the Senate Health Committee:

My name is Shelley Bailey and my partner and I own Central Drugs pharmacy, a 110 year old independent pharmacy in downtown Portland. Over the last ten years, the focus of Central Drugs has been to serve the needs of individuals living with HIV as part of our mission of providing pharmacy services the underserved of our community. We are the largest provider of HIV pharmacy services in the State and are a key resource for individuals living with this condition.

I am here to today to testify in support of legislation that addresses the business practice of PBMs called Maximum Allowable Cost (MAC) reimbursement. This practice was originally introduced by PBMS to establish a standard reimbursement to pharmacies for generic medications, which are manufactured by different companies and may be available for purchase at different prices. However, because the practice of PBMs in establishing MAC prices is not transparent and prices are known only to PBMs, the practice has been the source of much abuse and is a principal reason that many independent pharmacies may be forced to close their doors.

For Central Drugs, in 2013 MAC-based pricing used by PBMs has resulted in a reduction of as much as 90% in the payment we receive for providing services to patients enrolled in Coordinated Care Organizations in Oregon. Absent any correction to this practice, Central Drugs pharmacy will likely have to cease operating and close its doors.

By way of example, for prescriptions we filled in 2012 where we received $8.69 in total reimbursement per prescriptions from a PBM, we now receive less than $1.80. Oftentimes, this reimbursement is below what it costs Central Drugs to purchase the medication, let alone compensate our staff for the dispensing and counseling services we are required by law and by contract to provide.

Because of the large numbers of generic medications now available in the market, MAC reimbursement has resulted in a large percentage of the prescriptions we dispense to be reimbursed by PBMs at less than $1.80 per prescription in total payment. Should indiscriminant and non-transparent MAC pricing by PBMs be allowed to continue forcing Central Drugs to close its doors, over 1,500 Oregonian's will experience disrupted access to our pharmacy care. This is not a minor issue. Over 660 patients that Central Drugs serves day in and day out receive prescription coverage from insurers that use the PBMs that exhibit the worst MAC management behavior.

What is this behavior? Under the current practices by PBMs relating to MAC, PBMs can change how they calculate a MAC reimbursement anytime, without disclosing the basis of the change, the formula used to derive the new MAC price, and absent any disclosure or contract negotiation with pharmacies. Pharmacies must simply take it.

The 2011 Cardinal Digest noted that in the Pacific Northwest, the cost to dispense a prescription is $12.39 per prescription. Because of the way MAC pricing is used by PBMs, Central Drugs and pharmacies throughout the State are being paid as much as $10 below the cost to dispense on generic medications that have a MAC price (which can be 75% or more of all prescriptions dispensed).

The most egregious examples of the current MAC practices paid to pharmacies today are those of PBMS operating on behalf of the Oregon CCOs. It is extremely important that MAC legislation be passed as in Oregon over 76% of all prescriptions dispensed are for multi-source generic medications, and thus currently eligible for PBMs to reimburse pharmacies by using MAC pricing. If access to healthcare, specifically pharmacy services, is important to members of this committee, and when over 75% of all medications dispensed at Oregon pharmacies is subject to a unpublished MAC that can be secretly manipulated, good public policy and fair business practices demands that prices be known to payors and pharmacies alike and be publicly available.

PBMs will argue that MAC transparency will lead to increased cost to insurers. This is not true. Any economist will tell you that pricing transparency builds efficiency since businesses can better plan and adjust their operations with full knowledge. When both insurers and the pharmacies that serve their patients can have access to the same published prices for drugs, a more efficient market is established.

MAC reimbursement is inherently inefficient. PBMs use MAC reimbursement to triage the Generic Effective Rate they are contracted with their insurer clients to deliver. When a PBM manages its Generic Effective Rate by decreasing payment using MAC reimbursement on generic medications to pharmacies, it oftentimes keeps the "spread" between the low MAC rate paid to the pharmacy and the Generic Effective Rate it has disclosed to its insurer client. MAC rates can be adjusted hourly, daily, weekly or monthly and can be used to maximize the spread opportunity to PBMs. This adds huge inefficiency and cost to the market.

I will now provide some specific insights concerning a couple portions of the proposed regulation to further clarify the need for this proposed MAC legislation.

- Section 1 – 2a. Currently there are no requirements for PBMs to disclose the methodology for determining the MAC rate they pay to pharmacies, and these rates can float throughout the day, month, or year. This means that pharmacies have absolutely no idea what they will be paid to dispense a medication until the time they dispense it to the patient.

  There is no transparency provided to pharmacies or insurers regarding reimbursement on generic medications even at the contracting stage with PBMs as MAC reimbursement rates are typically confidential to the PBM and undisclosed. I have heard it mentioned many times by OHA staff that "pharmacies can negotiate" with the PBMs concerning reimbursement. This is not true for MAC rates. How can pharmacies negotiate rates for medications paid at a reimbursement methodology that is not transparent and the "formula" is not disclosed?

- Section 4F – As a taxpayer in the State of Oregon, I and everyone on the committee and in the audience today should be interested in this section. This section requires that PBMs disclose to the insurer the difference between the list used for billing insurers and the MAC rates paid to pharmacies. This is not common practice today. And as discussed earlier, it is the practice of many PBMs to keep the difference (i.e., "spread") between the rate it discloses to the insurer and the MAC rate it pays to the pharmacy. Personally, in conversations that I have had with insurers concerning the aggressive MAC rates being paid by PBMs, most of the time, these insurers were unaware of the MAC rates being paid to pharmacies, as these specific reimbursed amounts are not disclosed to the insurer.

As a final point regarding MAC, even if a pharmacy realizes that it is being reimbursed below its acquisition cost and/or below its cost to dispense, a pharmacy typically cannot refuse to provide medications to an individual, since pharmacies are contractually prohibited by PBMs to refuse service because of reimbursement rates. In the case of Central Drugs, for many of the generic medications we currently dispense, the dispensing of these medications to

members of CCOs is akin to us filling the prescription for free then handing the PBM a $10, as this is the amount below cost to dispense that we are being paid because of MAC reimbursements.

I appreciate the opportunity to provide this testimony today as the MAC reimbursement policies of PBMS are: 1) not transparent to insurer clients; 2) devastating impact on the ability of pharmacies to continue to operate; and 3) negatively impactful to the community at large if local pharmacies are forced to close and are no longer available to provide critical care to individuals in need.

We can all agree that the dispensing of generic medications saves money. But due to the lack of clarity in how MAC prices are established and the ways in which they can be manipulated to achieve outcomes known only to PBMs, Central Drugs and other providers must now consider influencing patients and providers to try more expensive brand-name medications within the same therapeutic class as a direct result of the invisible and secretive practices used in deploying MAC reimbursement.

Shelley Bailey