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March 15, 2013

Chair Greenlick and members of the House 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 with a focus on serving the needs of individuals with HIV as part of our mission to provide services for the underserved in our community. We are the largest provider of these services in the State and are a key resource for individuals living with this condition. I am here to testify in support of HB 2123 and wish to provide context regarding the necessity for legislation related to a PBM business practice known as Maximum Allowable Cost (MAC) as well as the need for legislation regarding the behaviors exhibited by PBMs as it relates to audits.

I will start by providing insights that supports the need for legislation relating to MAC as in 2013 this business practice has resulted in an often 90% reduction in payment to Central Drugs from the PBMs. The most egregious of these examples are from behaviors being exhibited by PBMs operating on behalf of the Coordinated Care Organizations in Oregon.

The business practice known as MAC was originally introduced by PBMs to establish a standard reimbursement to pharmacies for multi-source generic medications. Because these methodologies are not transparent, this practice has been the source of much abuse. I wish to highlight, the issue at hand today is not that MAC reimbursement methodologies exist but rather that these formulas are not disclosed to business partners. In most contracts for other healthcare providers, individuals at organizations often have to sign non-disclosure agreements referencing the fact that the provider will not share the "rate" they are being paid by a payer. Pharmacies would be happy to sign such agreements. The challenge is that in the pharmacy arena, pharmacies are not only not told what they will be paid by PBMs for medications, but they are not even provided with the formula – we just have to "hope" that we get paid above cost. Lobbyists for the PBMs have noted to the house that they cannot possibly provide to pharmacies the per unit reimbursement rates for each generic medication, but the ask from us is not even to be told exactly what we will be paid, but rather to be told what formula will be used to be the basis for reimbursement. Also, PBMs do publish MAC prices for many plans (specifically many Medicaid plans) so it is not that they cannot provide these rates, but rather that they do not want to.

Relaying information related to MAC, this issue can best be conveyed by means of an example. As an example, for a prescription filled at Central Drugs, we were receiving $8.69 in total paid claim amounts, we are now receiving less than $1.80 in total reimbursement. Due to this reimbursement process called MAC, which is resulting in reimbursed rates on hundreds of prescriptions at amounts less than $2.00 in total reimbursement,

over 1,500 Oregonian's will likely experience disrupted access to pharmacy care in the probable event of a Central Drugs closure due to this issue, and over 660 of these Oregonians receive benefits from insurers that use the PBMs that exhibit the worst of these behaviors (where PBMs can change reimbursement anytime they please, without disclosing the formulas, and absent of any contract negotiations). The 2011 Cardinal Digest noted that in the Pacific Northwest, the cost to dispense a prescription is $12.39 per prescription. Due to this reimbursement strategy known as MAC, Central Drugs and pharmacies throughout the State are being paid more than $10 below the cost to dispense on generic medications that are paid at Maximum Allowable Cost. It is extremely important that MAC legislation be passed, as in Oregon over 76% of all medications dispensed are for multi-source generic medications, and thus currently eligible for PBMs to reimbursement through the methodology called MAC. I know that access to healthcare, specifically pharmacy services, is important to members of this committee, then this is a serious concern when 76% of all medications dispensed at Oregon pharmacies are subject to MAC reimbursement.

I have been hearing time and time again that MAC Transparency will lead to higher costs for insurers. However, any economist will tell you that pricing transparency builds efficiencies since businesses can better plan and adjust their operations with full knowledge. When both insurers and the pharmacies have access to the same published reimbursements for drugs, a more efficient market is established.

Let's review why the PBMs claim that MAC transparency will lead to higher costs. There is a need for MAC transparency as PBMs use MAC reimbursement methodologies to manage their Generic Effective Rates with their insurer clients, so when the PBM manages the Generic Effective Rate (GER) by decreased payment on generic medications to pharmacies, the PBM is able to keep the spread between the low MAC rate being paid by the PBM to the pharmacy and the rate they have disclosed to their insurer clients.

This is why you are seeing such an influx of lobbyists from the PBMs here today to testify that MAC will lead to higher costs. The disclosure of MAC will NOT lead to higher costs for health plans but rather may take a small bit of this "spread" that PBMs keep, which is why the PBMS have frightened all of their employers and health plan clients here in the room today. Again, as pharmacy partners we are only asking to have these MAC formulas ***disclosed,*** between contract parties not that rates for these items to change, which we should be asking but are not here today to request.

I have been asked, "even if you knew what the MAC formula would be, how would this help you make better business decisions." This is such a crazy question as in most other businesses arrangements vendors would clearly know what they will be paid before they decide to sell their product. It is quite condescending to be asked this as a business owner as I should know what I will be paid prior to agreeing to sell a product. Yet, to answer this question I can note, that with the disclosure of the MAC formula, pharmacies would have something tangible to hold on to when PBMs pay below this contracted to MAC formula.

Also, PBMs will note that based on their statistics very few pharmacies fill out the MAC complaint forms. I can note, in my 12 years at Central Drugs, I have "won" less than 2 MAC complaints. It is an arduous process to fill out MAC complaint forms, as for the specific CCO I am referencing in Oregon, it would result in disputes of over

100 claims a day. The fact of the matter is that pharmacies cannot fill out all of these forms, when the nearly always lose.

I now wish to provide some testimony regarding a few points in the attached document relating to MAC …

- 4(a) currently there are no requirements for PBMs to disclose the methodology for determining the MAC rate, and these rates can float throughout the day, month, or year. Meaning, pharmacies have absolutely no idea what they will be paid to dispense a medication until the time they go to dispense it. There is no transparency for pharmacies regarding reimbursement on generic medications even at the contracting stages with PBMs as MAC reimbursement rates are typically representative of "business agreements" between PBMs and insurers. I have heard it mentioned many times by OHA staff that "pharmacies can negotiate" with the PBMs. Regarding MAC reimbursement, this is not true. How can pharmacies negotiate rates for medications paid at a reimbursement methodology that is not transparent whereas the "formula" is not disclosed?

- 4(d) as a taxpayer in the State of Oregon, both I and everyone on the committee and in the audience today should be interested in this section. This section requires that PBMs must disclose to the insurer the difference between the lists used for billing and the MAC rates paid to pharmacies. It is the practice of many PBMs to keep the difference between the rates being disclosed to the insurer and the MAC rate paid to the pharmacy. Personally in dialogues that I have had with insurer clients, informing insurers of the aggressive MAC rates being paid by the PBMs, most of the time, the insurer was not aware of the MAC rates being paid to pharmacies as these specific reimbursed amounts were not being disclosed to the insurer.

An final point regarding MAC, even if a pharmacy realized that it was being reimbursed below acquisition cost and/or below cost to dispense, pharmacies cannot refuse to provide the medications to the individual as the refusal directly due to reimbursement rates is not allowed in most contracts. In the case of Central Drugs, for many of the generic medications we are currently dispensing, the dispensing of these medications to the members to CCOs is akin to us filling the prescription for free then handing the PBM $10.00 for each medication we dispense for a member, as this is the amount below cost to dispense we are being paid due to MAC reimbursement.

I know that others will speak to why legislation regarding audits is necessary, but in closing, I wanted to provide examples from Central Drugs as they relate to the behaviors being exhibited by PBMs relating to audits.

I wish to note that I am certainly not against being audited by the PBMs. What I am thoroughly against is how the PBMs manage their audits. I wish to relay to the committee two experiences that have occurred at Central Drugs over the last year relating to audits. The most egregious of the behaviors exhibited that I have personally been involved with involves a PBM currently in the room. After completing the audit (of which it takes me approximately 40+ hours to prepare for) the auditor left and did not provide to me a summary of her audit findings. What I did receive in the mail a few weeks later was a letter referencing the fact that the PBM would be deducting $48,000 from my next payment due to findings from the audit. What were these

findings you might ask? The auditor referenced the fact that our "our pharmacist did not initial the prescriptions" so they were considered invalid so not only was the PBM going to take away the entire amount paid to our pharmacy for the medication, but the PBM extrapolated forward and was suggesting that they would be debiting the amount that they paid for all subsequent refills as well. This is theft. It was not the amount of "profit" that our pharmacy might have made that the PBM was trying to recoup but the entire amount paid to our pharmacy. Given that Central Drugs serves individuals on very expensive antiretroviral therapies, this audit risk with PBMs is immense. Our pharmacy had filled the right drug for the right patient for the right frequency and billed the PBM correctly. In addition, our pharmacist had in-fact initialed the prescriptions that were in reference. We spent months fighting this, which pulled me away from running our small business, and ultimately won. But, it should not have to be this way. Under the audit arrangements that PBMs currently deploy through their contractors, pharmacies are guilty until proven innocent. Often when a pharmacy provides documentation to note that they are indeed innocent, they are still denied. It is no wonder that 23 states have now passed laws to manage this behavior.

The second example I wish to highlight relates to an audit that was conducted at Central Drugs in December and we are still currently fighting the PBM (who is also in attendance today) regarding the outcome. In this case, the staff at Central Drugs inadvertently used the wrong provider on the prescription. Even after providing supplemental information referencing that this was a technical error that resulted in no hardship to the patient or to the plan, the PBM is still "taking back" the entire amount of payment on this claim (which represents $1,800). In this case, there is no remediation process as the PBM notes that the insurer does not allow for any post-audit follow –up documentation. Akin to our challenges with MAC, I am told by the PBM that the health plan does not allow for modification of the audit (and that I cannot even contact the health plan) and the health plan says that it is the PBMs issue not theirs.

Lastly, I also wish to note that these audits (absent of Medicare Part D ones as Medicare Part D requires random samples of claims), audits are solely "fishing expeditions" where Central Drugs is only audited on the most expensive of claims (which for us is the majority of our business).

I appreciate the opportunity to provide this testimony today as I am hopeful that these additional insights help to convey why it is so necessary to pass HB 2123. As the MAC and audit behaviors exhibited by the PBMs are 1) not transparent 2) have a devastating impact on pharmacies and 3) most importantly, are negatively impactful to the community at large when local pharmacies close and are not able to provide critical care to individuals in need.

Respectfully:

Shelley J. Bailey