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03/13/13

Chair Greenlick and Committee Members:

My name is Ann Murray and I am a pharmacist from Heppner, Oregon. My husband John couldn't come today as he has to stay and work in our pharmacy. Our family business, Murray Drug Inc. has stores in Heppner, Condon and Prairie City. We have served Eastern Oregon since 1959 with 3 generations of pharmacists. 5 licensed pharmacists and a son and daughter in pharmacy school. We serve south Morrow, East Grant and all of Gilliam and Wheeler counties as the only local pharmacy provider. This equates to over 5,000 square miles of rural Eastern Oregon involving a population of about 15,000. We are passionate about quality services, know how to provide them and care about the quality of our profession. I recently spent last summer and fall serving on the work group for this legislation.

I am providing testimony in support of HB 2123 to show how certain PBM practices have put the viability of all pharmacies (both rural and urban) at risk. The emergence of PBMs a couple of decades ago has added a very expensive layer of bureaucracy which is only found in the United States. In 2002, an article called "Evolution of a Hurricane" predicted what would happen if PBM's became more powerful and how this "middle man" layer would increase the cost of health care.(I will submit this article to the committee.) This prediction has come true. Instead of lowering premiums and reducing costs, PBM's have continually reduced payments to the providers actually providing the service, while not showing insurers what the pharmacies are being paid, effectively and profitably keeping the difference. This lack of transparency is an issue that needs to be addressed in Oregon, as several states already have done. According to Forbes.com on their list of 2012 highest paid CEO's Express Scripts CEO was at # 6 (of top 100) taking in $51.5 million last year.

The issue I am addressing today is why HB 2123 is needed is protect access to local pharmaceutical care, the importance of preserving Oregon jobs and Oregon pharmacists helping Oregon patients. The playing field is not level right now. Oregon pharmacies are squeezed to the breaking point by the PBM's. The contracting process involves "take it or leave it" contracts where dispensing fees are way below actual costs of dispensing (nationally $10-12/ RX in rural areas more like $14-15) then with MAC's we don't know what we will be paid on generic's which amount to about approx. 87% of all RX's we dispense in our stores. The PBM can set, and then change the MAC rate paid on generics at any time. When signing contracts we don't know what we will be paid as the formula will typically read for generics: MAC + a dispensing fee and we don't know what the MAC is!

When an Rx is being filled and AFTER we see the adjudication on a claim then we know on that particular drug how much money we just lost. We try to call the PBM to see if a MAC can be adjusted. We tell them that is the only product available to us, or that a market shortage has changed the price. I have an entire book documenting these RX's that happen all day long. I can spend 25 minutes on hold for each RX only to be told by a customer service person, we don't know what a MAC is. I ask for a supervisor, then wait again. Usually there is only an email to a department within the PBM, no phone number to talk to anyone. They say they don't know how long it will take to review, meanwhile I am told I MUST dispense the medication or be in violation of my contract. I wait a few weeks, then have to email back again when I haven't heard anything. Sometimes 3 weeks later I get a response that "no adjustment will be made at this time" Here are a couple of examples:

Clarithromycin 500 mg (antibiotic)cost $100.19, we were paid a total of 26.15 which included the pt. co pay. -example of a MAC not responding to market shortage issue.
Phenergan suppositories (nausea) cost $32.48 paid. 14.20

Meanwhile we have paid our wholesaler for the medication for the drug dispensed, provided professional pharmacy services to their clients for which the PBM is being paid an undisclosed amount per Rx from the insurer.

Besides the MAC issue, other PBM tactics include unfair Audit practices, which can involve "fishing expeditions" where thousands of dollars can be recouped for such things as clerical errors where the PBM is allowed to take back not just the dispensing fee but also the entire cost of the medication that was already safely and effectively provided to the patients. Being allowed to "extrapolate" to claims that have nothing wrong in order for the PBM to take back large amounts of money is unfair(and intended to put pharmacies out of business). HB 2123 doesn't do anything to prevent auditors from tracking fraud, or reasonable exemptions.

Another issue affecting our rural pharmacies is the practice of PBM's forcing clients into mandatory mail order service in which the PBM owns the pharmacy that they directing the patients to. This issue is addressed by SB 363 but is important as it shows how PBM's are affecting rural pharmacies. By financially incentivizing them to use mail order - offering them 3 months for same co pay as 30 days at a retail store, patients are effectively denied using the pharmacy of their choice. PBM's say they have "studies" showing mail order saves money. We would beg to disagree and show they are self-funded studies. A large California insurer recently dropped their mandatory mail order program. The lack of transparency to insurers shows itself again here when insurers may not know what the PBM owned pharmacy actually paid itself vs. what a community pharmacy was paid.. Is the MAC rate paid to its own pharmacy different than the retail pharmacy? It should be important for insurers to see.

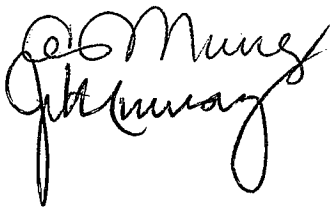
Being on the "front line" of pharmacy service here in Eastern Oregon I can say the bottom line will come down to access. If PBM's put local community pharmacies out of business due to lack of transparency, below cost MAC reimbursement, audit abuses and forced mail order to their out of state PBM owned

pharmacies, you will have vast areas of Eastern Oregon patients without access to time sensitive medications. Waiting for mail order for antibiotics, nausea meds or critical maintenance meds that "didn't come in time" will cause patient harm and increase hospitalizations, thus increasing health care costs.

PBM's hope not to have light shined on their highly profitable business practices that come at the expense of health care purchasers in our state. Other states and other insurers have gone away from the PBM model and realized huge savings in their pharmaceutical services budget. It is time for Oregon to catch up and do the same. Please support HB 2123 to address these issues.

$51 Million dollars gained back from just one PBM executive would provide pharmaceutical care for a lot of Oregonians, people that Oregon pharmacists care about and care for every day.

Sincerely,



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Submitted By
Ann Murray
Heppner, OR

PBMs: The Evolution Of A Hurricane

by H. Edward Heckman, R.Ph.

Pharmacy benefit managers (PBMs) are sweeping through the pharmacy industry with gale force winds. They grew over the years from providing beneficial information services to pharmacies and drug plan sponsors into oligopsonistic market-controlling colossuses. They are also creating a whirlwind for the drug manufacturers as the PBM demands for lower prices and larger rebates grow recklessly out of control. These are major reasons for the runaway inflation that our society experiences with drug expenditures. As costs continue to skyrocket, the PBMs line their pockets with lavish profits by controlling drug expenditures for the majority of Americans—nearly 90 percent of all prescriptions are covered by a third-party payor. The PBM model is unique to the United States. There is really nothing quite like it anywhere else in the world.

The Beginning—How It Started

Let's go back to the beginning when PBMs served a beneficial purpose. The original operating plan posed by Pharmaceutical Card System, Inc. (PCS) to the Antitrust Division of the Department of Justice in 1969 was to serve as an information clearinghouse for health plan payors and pharmacy providers. They legitimately initiated operation as an organized method to efficiently pass information about a plan sponsor's drug benefits to pharmacies across the country. And indeed that is how they operated for better than a decade.

Many pharmacists can recall receiving the plan specifications sheets sent to their pharmacy from PCS, PAID, and other third parties back in the 1970s. Pharmacists received three-hole punched information pages that listed a plan number in the upper corner with the details of the drugs covered, permitted days supply, allowable quantities, and payment information. We filed these informative plan profiles away in our three-ring PCS and PAID binders for future reference.

When a patient appeared in the pharmacy with a drug card listing a particular plan number that was unfamiliar, the pharmacist would look up the plan parameters and then make a decision to provide services under those terms or not. The PBMs provided a beneficial service that saved pharmacists and patients frustrations in attempting to verify eligibility and coverage.

Eventually, the PBMs agreed, along with pharmacies and plan sponsors, on

a standardized format to submit claims for services, the universal claim form. The universal claim was a great time saver. And, PBMs began administering drug plans by reviewing drug claims on behalf of plan sponsors. At the time, this was an excellent benefit helping pharmacists cut through the increasing mire of where and how to submit claims for payments.

The PBM was more like a breath of fresh air in those days—providing a beneficial service to pharmacists. Life was simple. Business was good. These were elementary statements of fact during an era when the average prescription price was less than $5. At that time, third parties were a small part of a pharmacy's business with minimal impact on the bottom line. Pharmacists didn't pay a lot of attention to PBMs back in those days.

Where It Went Wrong

Over time, the PBMs became more and more aware that pharmacists really didn't closely watch how much or how little a particular plan reimbursed. Pharmacists would fill anything for any plan for any price because after all, "it didn't cost any more to fill another prescription." The PBMs learned that they could do more than just act as an information pass-through from plan sponsor to provider pharmacy. The PBMs turned the corner from bona fide ancillary service organizations to become opportunistic.

They began coaching their plan sponsors on pharmacy reimbursement offers to help them "control their expenditures" for drug benefits. Their advice of "offer the pharmacies less, they'll take anything!" became the operating standard and indeed for a number of years pharmacists accepted anything offered. The PBMs took it a step further by creating their own networks with reimbursements so they could potentially sell services to plan sponsors at one price and then reimburse pharmacies at another.

And so, what once seemed a gentle breeze, the PBM, matured into the hurricane of the drug industry whose behavior careened out of control. The plan sponsors didn't attempt to control them because after all, the PBM controlled a huge network of pharmacies and could obtain services on their behalf at rates lower than they believed could be obtained on their own. And pharmacists weren't about to take restrictive measures against PBMs, else a customer might go down the street to another pharmacy. And pharmacists could never let that happen. The PBMs grew from minor tropical depressions to the devastating hurricanes they are today.

Pharmacists Fight Back

It has only been in the past few years that pharmacists have become more aggressive in taking steps to stem these storms and make amends. Pharmacists are now drawing profit lines and turning down programs and networks that fall below them. In fact, the 2001 edition of the *Takeda and Lilly Prescription Drug Benefit Cost and Plan Design Survey Report* focuses on just that stating,

> "The PBMs negotiate (sic) with the pharmacies for discounts to AWP... Although we expect respondents (PBMs) to continuously negotiate for greater discounts, there are limits as to how far they can go. Many retail pharmacies, particularly large national chains, have drawn the line in the sand at AWP-13%."

This annual study is sponsored by Takeda Pharmaceuticals and Eli Lilly and Company for the Pharmacy Benefit Management Institute, Inc. in Tempe, Arizona. Many independent pharmacists have also drawn their own line in the sand. More and more pharmacists are individually turning down subpar, often predatory, plan offerings.

In addition, community pharmacists have initiated attempts to negotiate more favorable terms. Even the smallest pharmacies are charting strategies and approaching PBMs to negotiate more favorable terms. If you have not attempted to improve contract terms you should start. You may be pleasantly surprised.

PBMs hate to admit it but they need community pharmacies. Yes, PBMs push their very profitable unregulated mail order operations as the pancea to high drug costs, but this mode of prescription delivery is not well accepted by patients. The Takeda/Lilly study states that 87 percent of employers offer mail order to their employees but only 14.2 percent of prescriptions are dispensed through it.

If a community pharmacy is in an underserved location, performs services not readily available elsewhere, or has developed a niche, they may have an opportunity to improve reimbursement with third party payors.

PBM Legislation And Regulation

PBMs have evolved in an unregulated environment. The lack of regulation allowed PBMs to become bolder in their actions. PBMs claim that they are not insurance companies and therefore do not fall under state insurance laws, although some argue they should as they act as an agent of the insurance companies. The real question is whether or not it is too late to make amends for the devastation and destruction PBMs have wreaked upon unsuspecting patients, our economy, and community pharmacies. One thing is certain; left unchecked PBMs will continue gain strength and control in the pharmacy market.

Pharmacists in every state must step to the forefront to push state legislatures to place PBMs under some form of

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NCPA assists states by providing
PBM Regulation Legislation to be
to initiate such legislation. Georgia
ently was the first state to enact legis-
to regulate PBMs. Many other
are beginning to address this issue,
some members of Congress are be-
ing to scrutinize the unwieldy and
nsive control of PBMs on the drug
ustry.

nough For The Manufacturers
armacists were the first to learn these
ons. Now the manufacturers are
ng tossed about by the PBMs. What
originally a low-stakes game for a
nufacturer to pay a PBM for the pre-
ential treatment of their products has
come a PBM entitlement of gigantic
portion. While it is unclear the exact
gnitude of these arrangements, the
ent lawsuit between AARP and Ad-
ncePCS might provide a clue.

AARP is suing AdvancePCS because
claims that AdvancePCS illegitimately
pt their Cash Discount Card (100
rcent copay) business after AARP
oved to Express Scripts as their claims
ocessor. AARP is asking for damages
$18 per prescription in this suit. Keep
mind that the patient pays the entire
st of the prescription (100 percent co-
y card) so the $18 claimed in damages
ust come from somewhere. The likely
ource is from the sale of the data to the
anufacturers and by dipping into their
ebate pockets.

So huge is the PBM influence that a manufacturer may employ a marketing representative whose sole job is to service one customer, a single PBM, and to stay on top of what they are doing. Their jobs are to promote positive relationships with the PBMs lest some other manufacturer capture a more favored position. They bend over backwards to do whatever it takes to please the PBM and maintain or increase their share of the market.

Unregulated Mail Order Pharmacies And Pharmacists
After opening the money tap with preferred products in formularies, the PBMs realized that they could exert more control and extract deeper discounts from manufacturers on brand name drugs if the PBM owned the pharmacy. Thus the introduction and evolution of mail order pharmacies owned by the PBMs.

Apparently, the Federal Trade Commission (FTC) viewed these new PBM business ventures into mail order pharmacies with blinders. How could they sit in ambivalence with such a huge conflict of interest looking them straight between the eyes? The PBM that was once limited to being an information conduit now created the opportunity to vertically integrate the marketplace at the demise of others.

Once in operation, the mail order Goliaths honed their operations over time. Today, for those manufacturers who ante the most, personnel at mail pharmacies will contact doctor after doctor to make therapeutic switches to

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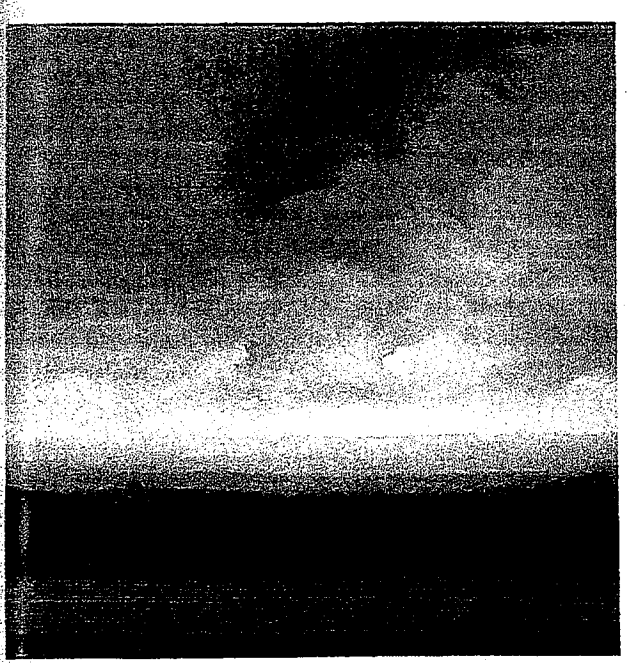
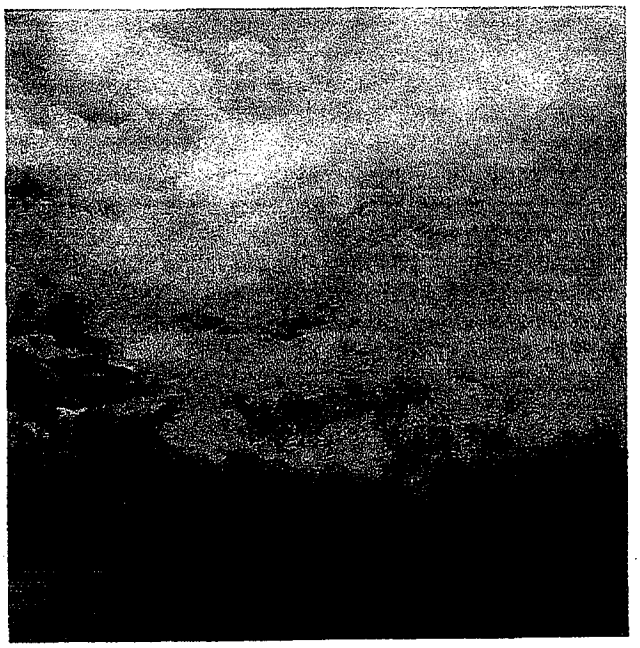
the profitable formulary product. PBM spin doctors state these switches are for better medication therapy for the patient or to benefit cost containment for the plan sponsor. But indeed, the Takeda/Lilly study alludes to the fact that mail order for sponsors is more expensive unless plan sponsors shift enough of the cost sharing to the patient.

The study states that mail order copayments must be at least two times the retail copayment before the sponsor can expect any savings. And when it comes to mail order the PBMs appear to have conveniently forgotten MAC prices on generic drugs. The study states,

> "Most PBMs no longer offer maximum allowable cost (MAC) pricing for mail service prescriptions. This is important as deep discounts offered in mail for generic drugs are not as deep as MAC prices in the retail environment."

The PBMs know that the real money is in brand name drug rebates and that is





the likely reason that mail operations only dispense generics 28 percent of the time versus independent community pharmacies at a nearly 50 percent rate.

The manufacturer-PBM scenario was complicated by drug companies who purchased PBMs. It is unclear how the FTC could be convinced that firewalls would prevent conflicts of interest between the manufacturer and the PBM they owned. This is worse than the case of the fox in the hen house. Given the fact that the entire existence of PBMs focuses upon the passing of transactions between pharmacies and payors for prescription drugs, firewalls are not realistic possibilities. The only firewalls set up by manufacturer-owned PBMs were those against other manufacturer's competitive products. Indeed, Merck has increased the percentage of its products moved through Medco-PAID by nearly 50 percent over the past few years.

The Manufacturers Fight Back

Yes, PBMs—the growing hurricane of the drug industry—have exploited the manufacturers to the maximum. Evidence is surfacing that the stakes have grown out of proportion and manufacturers are fighting back. Their direct-to-consumer marketing campaigns reach potential patients by television, radio, the Internet, and printed media. These manufacturer advertisements project desirable outcomes and positive lifestyle changes, thereby motivating and empowering a potential patient to vigorously advocate for a particular prescription drug. If patients scream long enough and relentlessly push enough buttons, they can usually gain approval for drugs that otherwise wouldn't be covered.

Manufacturers are lamenting off-the-record of their "Catch-22" situations with the PBMs. While they won't say it in public, they really wish the PBM would become someone else's problem, or better yet, drift out to sea.

The Senior Discount Strategy

The most interesting twist focuses on senior citizens and the political initiative to provide a Medicare prescription drug benefit. The Bush administration substituted for a real Medicare prescription drug benefit their cash discount cards, to which the manufacturers initiated an unique strategy after the Bush card was stopped by a federal court. They created their own discount programs for low-income seniors covering select products. There is no question that the manufacturers were using this opportunity to bolster their images with some positive public relations. But that may not have been their only motivation.

There is no question that the manufacturers were using this opportunity to bolster their images with some positive public relations. But that may not have been their only motivation.

The Bush Medicare-Endorsed Discount Card for seniors exposed the PBMs greed as they hungrily attended the July 2001 unveiling of the program in the White House Rose Garden. The manufacturers envisioned even greater financial doom and demands from the large PBMs to keep their products on the favored side of the senior discount program. Rather than sitting still for the onslaught, they had finally learned their PBM lesson.

Drug companies created their own programs. This may well have been a planned effort to avoid the high stakes required by the big three PBMs-AdvancePCS, PAID, and Express Scripts. By selecting much smaller pharmacy benefit companies, Argus and McKesson Health Systems, to administer their programs, the manufacturers side-stepped biting the bullet with the big three. To encourage participation in their programs instead of a Medicare-endorsed plan administered by the big three, they are offering pharmacists comparably high rates of reimbursement and at the same time large discounts to low-income seniors.

It is likely that the manufacturers feel they are less encumbered and further ahead selling a month's supply of medication for $12 or $15 and reimbursing pharmacists the difference. From a manufacturer's perspective, this really works out to be inexpensive advertising. The return on investment under this scenario has to be more appealing than dealing with the big three PBMs.

The Future

While PBMs will certainly disagree, their usefulness and future may be in question. In other words, this storm may be losing its steam. PBMs may have outlived their benefit and purpose.

Pharmacists do not really need the PBMs as much as the PBMs need pharmacists. That's right, the PBMs need pharmacists. Pharmacists can certainly live without their predatory audit tactics or unilateral contracts. The chains woke up in the mid-1990s and independent pharmacies are starting to do the same. The technologies now at our disposal and the Internet place direct dealings with plan sponsors for even the smallest pharmacies within the range of possibilities. Computer software can be aimed to send a claim in any electronic direction we choose. There is no question that a pharmacy or group of pharmacies administering a drug program for a local employer could with close personal involvement produce substantial savings, especially if the pharmacies share some of the risk and assume a degree of responsibility for outcomes management. These scenarios are evolving on a limited basis at this time, but are picking up more speed and interest. As these opportunities evolve for community pharmacies, the drug companies won't shed tears.

As concerns for spiraling drug costs heighten, expect more and more of the tactics of PBMs to be revealed and questioned by the public. Expect representatives and senators in Congress to embark upon fact-finding missions to help all Americans understand the expensive economics of PBM-controlled drug benefits. Keep in mind that the rest of the world functions without pharmacy benefit managers, so why do American pharmacists need them? Maybe pharmacists don't! ▣

H. Edward Heckman, regular contributing writer to America's Pharmacist, *is president of PAAS National®, the Pharmacy Audit Assistance Service. For further information, Heckman can be reached at 888-870-7227.*