Senate Majority Policy Committee and Senate Health and Human Services Committee
Joint Hearing on Pharmacy Benefit Managers
October 16, 2018
Written Comments submitted by Patrick Lavella, RPh

Mission Statements of PBMs –

CVS/Caremark –

- Above all else ... our mission is to improve the lives of those we serve by making innovative and high-quality health and pharmacy services safe, affordable and easy to access.

Express Scripts –

- Express Scripts is a company dedicated to making the use of prescription drugs safer and more affordable for plan sponsors and over 50 million members and their families.

Optum –

- To help people live healthier lives and to help make the health system work better for everyone.

As you can see from the above statements, the 3 biggest PBM's like to use words such as safer, more affordable, work better, and easy access.

Let's talk about these individually –

Safety –

On one hand, PBM's now shout from the heavens that they no longer have a 'gag clause' in place. This is a significant step forward, a long time coming, and pharmacists can now freely discuss pricing without the fear of PBM retribution. PBM's are now telling pharmacies to not bill the patient's insurance and go ahead and use cash. On the other hand, patient safety has taken a significant step backwards. Because patients sometimes move between pharmacies, one pharmacy will no longer have an accurate record of all the possible medications a patient may be taking. This could allow the possibility of drug/drug interactions between unknown medications or the precipitation of an unwanted side effect.

Affordability –

The PBM's like to bellow that they save money for the patient and their plan sponsors. But no one has been able to statistically document these savings. As long as PBM's continue to be unregulated and lack complete transparency and fiduciary responsibilities, their 'mathematically' produced savings will never be able to be proven. They speak of rebates and discounts, but yet, no one knows what those figures are and if those 'savings' are ever turned over to their plan sponsors. How can you explain the math behind the continued use of Mandatory brand name drugs once a generic has been released in the marketplace? Examples include – Adderal XR, Concerta, and Welchol. Another example is why does one MCO (Aetna

Better Health) run by CVS/Caremark pay for Suboxone Tablets but another MCO, (Gateway) also run by CVS/Caremark, pay for Suboxone films?

The **gag clause** on affordability – All of a sudden, PBM's say they no longer have a gag clause in their contracts and are telling pharmacies to talk to their patients and fill prescriptions for cash if it is a better deal.

Is it really a better deal and for whom?

By filling a prescription for cash, the medication is not reported to the PBM and no longer shows up in the PBM's master drug database for that patient possibly leading to a serious drug interaction or adverse effect.

For some of these cash prescriptions that will now be missing in the patient's database history, the pharmacy can then be penalized by the PBM for failing to meet the PBM criteria for adherence and compliance (EQUiPP scores) with certain drug families such as diabetes, hypertension, and cholesterol. The PBM will assume the pharmacy is not meeting these PBM established goals and will use this reason to pay even lower reimbursements on claims they process and charge substantial and uncontrollable DIR fees that the pharmacy may not know of for months down the road.

In a recent 60 Minutes episode that featured a lawsuit filed by the municipal health plan of Rockford, IL against ESI, ESI denied any wrongdoing, and, in its motion to dismiss argued it was not 'contractually obligated' to contain costs.

Work Better and Easy Access –

Network access. Why would a PBM create and promote a situation that reduces the access to and the number of participating pharmacies in a network assuming the same reimbursement to all participating providers? The 'any willing provider' laws in our state only mean that a particular pharmacy will accept the reimbursement tied to a PBM schedule. These laws DO NOT mean that pharmacy is allowed to participate in that network. That ability is entirely in the hands of the PBM. It is a dark secret as to what criteria a PBM will use to include or exclude certain pharmacies for a particular network.

PBM's create unnecessary pharmacy network restrictions by building preferred pharmacy networks and mandatory mail order programs that only serve to funnel money directly back to themselves. It seems like a flawed system that a PBM can dictate to a plan sponsor how much they are going to pay themselves for filling prescriptions at their pharmacies that their members are required to use. It is arguably a complete monopoly when they can force patients into their own mail order facilities and restrict patient access even when another pharmacy (chain or independent) is willing to accept the same reimbursement rates but simply isn't allowed to participate.

In May of this year, ESI began demanding independent retail pharmacies sign a "Mail Order Attestation", limiting the pharmacy's ability to provide mail order AND DELIVERY SERVICES to ESI members to ONLY 10% of all claims submitted to ESI. Per ESI's correspondence,

a failure to return an executed "Mail Order Attestation" in a timely manner would result in the pharmacy's termination from ESI's networks.
No negotiation with a pharmacy who may be meeting or exceeding these limits – No reasoning as to why they were suddenly enforcing this – No taking into consideration that some pharmacies only do, or mostly provide, compliance packaging and delivery services to their members. Take it or leave it. How does this help patient access or benefit adherence and compliance?

Opioids –

How about the OPIOID epidemic?

One of the leading causes of the opioid epidemic in this country is the true disservice/disinterest orchestrated by the PBM industry.

In their quest for greed and to capture every dollar available – they authorized and approved hundreds of thousands of claims for opioids, cocktails, and amphetamines.
I have reviewed dispensing data from 100's of pharmacies and looked at hundreds of thousands of claims and I can tell you that there is NO JUSTIFIABLE EXPLANATION (moral or legal) that can be given for some of the prescriptions that were approved and allowed to be filled by PBM's.
In addition, the prescriptions that were questioned by pharmacists or the PBM itself (which required a Prior Authorization) were almost always approved when that PA was submitted.
The PBM industry basically created tens of 1000's of addicts by allowing people to pay for their drug habit through their insurance plans.

When they recently (most of their attempts to help regulate the problem did not take effect until this year) tried to right the ship through the use of Milligram Morphine Equivalent's (MME's), limiting initial days' supply, and other days' supply parameters, all they really did was drive people who they had already addicted to find other ways to fund their problem - or turn to alternative sources such as heroin.
They also stuck the pharmacist in the middle of their 'anti-opioid' program by forcing them to deal with the addicted patient who might be used to getting 120 pills of an opioid every 30 days and suddenly, the PBM will only pay for 90 pills. If the pharmacy only fills the prescription for the 90 pills the PBM will allow, the patient will run out of medication with one week left before they can get a refill.

If the pharmacy bills 90 pills to the PBM and then the other 30 to cash, this creates multiple unsatisfactory situations –
1. Legally, this may not be allowed under either Federal or State law or both and puts the pharmacist in the position of breaking the law in order to help the patient and prevent unwanted withdrawals
2. All the PBM has really done is allow them to say that they are helping to 'eradicate' the opioid issue by decreasing the amount of medication available to the patient. The PBM is NOT

helping the patient work through their probable withdrawal issues or offering alternative ideas or options to the patient to deal with this situation. But, they CAN and WILL say they are helping to allow a decreasing volume of opioids into the general population.
3. Patients caught in this PBM created situation will ultimately have to make one of several choses – suffer the effects of opioid withdrawal, find alternative ways to obtain additional opioid product (the street, friends, family, theft), or turn to other options to relieve their suffering (heroin).

Because the PBM's receive massive amounts of data in the processing of prescriptions, they easily could have helped to target physicians, pharmacies, and patients participating in or suffering from the opioid epidemic. They chose to ignore their ability to scrub this data to highlight and identify areas of concern and need but instead misused this information from millions of patients and millions and millions of prescriptions to structure formularies, pharmacy provider networks, and pharmacy benefit plans to achieve their goal of maximizing the profitability of their business model at the expense of group health plans, small businesses, MCO's, taxpayers, and, most of all, their patients (members).

I still cannot believe that there has not been a State, County, or municipality go after the deep pockets of the PBM's on this issue.

Action in OHIO

As a result of action in Ohio, where PBM's are going to be relegated to the role of a claims processor only position once again in 2019 (correctly in my opinion), they are going to be paid somewhere between $1-2 per claim processed.
One of the reasons that pharmacies do not like to send unnecessary claims to a PBM is the expense incurred by the pharmacy to do that – anywhere from 20 – 50 cents if the claim is clean.

How can a PBM process a claim and do everything they say they do (tout their PBM services such as pharmacy utilization reviews and Medication adherence management) for a $1.50 but still need to charge a pharmacy 20-50 cents just to submit the claim to them. Another way they profit off the backs of pharmacies.

As an additional point -- Filling a prescription and sending it in the mail to a patient has absolutely nothing to do with adherence or compliance – it only shows that the patient was sent the medication.

Comparison of PBM's vs. PSAO's fees –

PBM – charge a pharmacy 20-50 cents to process a clean claim

- At 100 claims per day (small to average pharmacy) – the cost to the pharmacy is $20 to $50 dollars/day
- $30 (average) x 26 business days per month = $780/month

PSAO – generally cost between $100 and $200 per month

- Electronic transaction reporting and automated claims reconciliation
- Direct payment reconciliation
- EFT payments – prevents lost checks and allows the pharmacy to receive payment quicker
- Credentialing, contracting, and licensing
- Support for PBM mandated policy, procedures, training such as HIPAA, OSHA, FWA, and PSE
- 835 claims processing – ability to track what is being paid, is it correct, and in what time frame even with patients with multiple insurances
- MAC appeal support
- Immediate and seamless access to thousands of regional and national plans that a pharmacy would never be able to do on their own

Stores attempting to buy better

Pharmacy owners spend countless hours and days speaking to wholesalers attempting to get a better price on the buy side of the equation. Do you know why? That is the only side of the equation they MIGHT be able to move the needle and generate some additional profit.

In reality, there is no room left on the wholesaler buy side to help anymore. In order to help keep up with the PBM squeeze on reimbursements, wholesalers have tried to facilitate support by continuing to shrink their margins just like pharmacies (becoming lean and mean).

Even if pharmacies could buy at 1% better, which would be pretty significant, the average independent pharmacy has sales of $1.5-$2 million dollars a year. This means they will have purchased approximately $1.15-1.5 million dollars of product from their wholesaler. If they bought 1% better – this would only yield a total yearly savings of between $11,500 to $15,000 dollars.

More importantly, these types of pharmacies are not of any interest to the big 3 wholesalers as the ROI on stores with this volume is negligible to them.

Will buying product from another wholesaler at a 1% better price make a difference? Probably not. Driving down the road at 60 and someone says you can get there faster by driving 61. Yes you can – but does it really make a difference?

How does this issue affect the Consumer?

By limiting and, in reality, removing all profitability from filling a prescription, independent pharmacies and not going to survive in the current PBM owned and operated business model.

The PBM's have no ability or capability (and frankly show no interest) in helping the weakest and most challenging people in our society. The poor, the mentally challenged, and the disabled. Independent pharmacy does not turn those people down or away.
On a daily basis, independent pharmacies interact with many lower income or economically disadvantaged patients.

Someone calling from a PBM on a telephone has no personal touch with that person, has no history with, cannot understand the background of that patient, how they may or may not be literate, know what that person's home life or situation is, or that patients psycho-social makeup.

Is that PBM going to supply that patient's insulin today even though that patient does not get their SS check until next Wednesday?
What happens when that patient is out of money until 'next week'?
What happens when that patients credit card is not accepted or their check bounces?
What happens when that patient has moved and their 90-day medication delivery is left at the old address? (And how is this cost effective?)
What happens when that patient changes their phone number because they had to get a new burner phone?
How do they track this patient down?
Who bails out the PBM when this happens? Who does the PBM call? The independent pharmacy. And what is there thanks? The pharmacy will get to fill a 3-5 days' supply of a medication that they will probably lose money on (or if is a generic – receive a total reimbursement of under 50 cents) – but the good news is, the patient copay is usually waived.

Who is responsible when these people end up back in the hospital for non-compliance issues? How is this a favorable use of dollars and resources?

The PBM suffers no consequences for a situation that is many times, entirely created and dependent upon their actions and inactions.

Show me a PBM that demonstrates one ounce of HANDS ON CARE?
A PBM calling a patient and saying that they are their pharmacist causes immeasurable amounts of confusion and does more harm than good (not to mention how did they get access to the patient's medication list?). Maybe a HIPAA violation here?
And with more prescriptions now being filled for cash, what is the PBM not seeing or knowing?

PBM's don't deliver that patient's medication TODAY or drop it off on the way home.
PBM's don't blister that patient's medications or fill compliance packaging.
PBM's don't ask "How are things going today?" or "Having any issues with your medication or side effects we should be worried about?"
PBM's don't call that patient's son or daughter to say, "Something doesn't seem right, you might want to check in with Mom or Dad."
PBM's don't support Little League, soccer programs, beauty pageants, all kinds of various programs and teams in schools, and local communities.
PBM's don't funnel their money back into the local economies.
PBM's don't stay late or come in after hours to deal with emergency prescriptions and questions.

How does this affect the Taxpayer?

As all these people begin to fall through the cracks, where do they always end up?
Using valuable and expensive resources such as ambulances, hospitals, and nursing facilities.
Because a PBM has no skin in the game when it comes to the well-being and quality of life of these people -- Who ends up ultimately paying for these resources? – The Taxpayer

Better yet, the PBM stands to additionally benefit as eventually these people will be put on additional medications or discharged with additional medication needs.

Additional comments and thoughts --

Banking Comparison –
Have we forgotten the 2008 Global Financial Crisis?
This crisis was primarily caused by deregulation in the financial industry that permitted banks to engage in hedge fund trading with derivatives.
There is now a Health Crisis in this country that has been created by the PBM industry. This epidemic affects every single person in this country (as everyone will receive a prescription sometime in their life) by removing valuable dollars from their pockets and prevents them from receiving the best medication choice for their condition but instead, forces them to take the best money-making choice for the PBM.

Shark Tank – How long would this business model last with the Sharks?
How can you explain a business where I am forced to sign a contract with my competitor and that competitor tells me what I am going to be paid, what prescriptions I can fill and for how long I am allowed to fill them?

In addition, wouldn't you love to hear the Sharks responses to this statement? I will lose money on an ever-growing number of prescriptions but 'hope' to make it up with volume.

PBM's – It is only to their advantage to fill more and more prescriptions. The more prescriptions they fill, the more profit they can generate for themselves. The more expensive the product, the bigger the discount or rebate they will request from the manufacturer and, again, the bigger dollar volume they can 'hide and keep'.

Brand Pricing

Definitions --	WAC	Wholesale Acquisition Cost (Cost)	Determined by the Manufacturer
	AWP	Average Wholesale Price	AWP = WAC x 20% (1.2)
	NADAC	National Average Drug Acquisition Cost	WAC – 3% (?)

So if WAC = $100 to get AWP, take WAC x 20% AWP = $100 x 1.20 = $120 This formula applies to ALL brand name drugs

Therefore, WAC/AWP = % ($100/$120 = 83.3%) or WAC = AWP - 16.7%

Most pharmacies currently purchase brand name drugs between WAC minus 4 or 5%

Assuming ---- WAC – 4.5% = $95.50 is net cost of the item So $95.50 / $120 = 79.58% or **AWP – 20.42% true net cost**

Below is a copy of the last 2 ESI basic contracts rates to independent pharmacies –
Top is for years 2018 (year 1), 2019, and 2020
Bottom is for previous years 2015 (year 1), 2016, and 2017

2.4.a Schedule A Contract Rates: ESI's broadest, open access national commercial network of pharmacy providers.

	BRANDS Up to an Average Discount Single-Source & Multi-Source[3.1] Brands not paid on ESI MAC + Not less than an Average Dispense Fee:	**GENERICS - A** Up to an Average Discount Generic Drugs not paid on ESI MAC + Not less than an Average Dispense Fee:	**GENERICS - B** Generic Drugs and Multi-Source Brands paid on ESI MAC + Not less than an Average Dispense Fee:
30 Day Network Participation			
Year 1	**AWP - 19.75% + $0.10**	**AWP - 50.50% + $0.10**	**ESI MAC + $0.10**
Year 2	**AWP - 20.10% + $0.05**	**AWP - 51.00% + $0.05**	**ESI MAC + $0.05**
Year 3	**AWP - 20.45% + $0.00**	**AWP - 51.50% + $0.00**	**ESI MAC + $0.00**
90 Day Network Participation[3.3]			
Year 1	**AWP - 23.55% + $0.00**	**AWP - 50.50% + $0.00**	**ESI MAC + $0.00**
Year 2	**AWP - 23.80% + $0.00**	**AWP - 51.00% + $0.00**	**ESI MAC + $0.00**
Year 3	**AWP - 24.05% + $0.00**	**AWP - 51.50% + $0.00**	**ESI MAC + $0.00**

Schedule A Contract Rates:

ESI's broadest, open access national commercial network of pharmacy providers

	Brands Up to an Average Discount Single-Source & Multi-Source(3.1) Brands not paid on ESI MAC + Not less than an Average Dispense Fee:	**Generics** Up to an Average Discount Generic Drugs not paid on ESI MAC + Not less than an Average Dispense Fee:	**Generics-B** Multi-Source Brands paid on ESI MAC and Generic Drugs paid on ESI MAC + Not less than an Average Dispense Fee:
30 Day Network Participation			
Year 1	AWP - 17.75% + $0.30	AWP - 38.00% + $0.30	ESI MAC + $0.30
Year 2	AWP - 18.00% + $0.25	AWP - 38.00% + $0.25	ESI MAC + $0.25
Year 3	WP - 18.25% + $0.20	AWP - 40.00% + $0.20	ESI MAC + $0.20
90 Day Network Participation			
Year 1	AWP - 20.50% + $0.00	AWP - 38.00% + $0.00	ESI MAC + $0.00
Year 2	AWP - 20.75% + $0.00	AWP - 38.00% + $0.00	ESI MAC + $0.00
Year 3	AWP - 21.00% + $0.00	AWP - 40.00% + $0.00	ESI MAC + $0.00

Example of pharmacy pricing – using **Lantus Solostar (insulin)**

Description	Alert		Therapeutic	Prod Class	Selling Price	PC	Pkg Size	SWP	AD Spc	Restricted Item	Invoice Cost	CC	Unit Cost	WAC Cost
LANTUS SOLOSTAR PREFILLED PEN 3ML 5CT	N			H			15	$485.14		Yes	$400.25		26.6833	$404.29

WAC = $404.29 AWP = $404.29 x 1.2 = $485.14 at WAC – 4.5% = $386.10 true net cost

At current contract rates (2018- year 1):

30 day AWP – 19.75% + $.10 ($485.14 – 19.75%) = $389.32 + .10 = $389.42 total reimbursement
$389.42 - $386.10 = $3.32 gross profit or less than 0.67% of the cost of the product

90 day AWP – 23.55% + $.00 ($485.14 x 3 boxes) = $1455.42 – 23.55% = $1112.66 + .00 = $1112.66
$1112.66 – ($386.10 x 3 = $1158.30) = **-$45.64 gross profit loss**

In 2020 (Year 3) at contract rates:

30 day AWP – 20.45% + $.00 $485.14 – 20.45% = $385.92 + .00 = $385.92 total reimbursement
$385.92 - $386.10 = **-$0.18 gross profit loss**

90 day AWP – 24.05% + $.00 $485.14 X 3 boxes = $1455.42 – 24.05% = $1105.39 + .00 = $1105.39
$1105.39 – $1158.30 = **-$52.91 gross profit loss**

Another Example – Ventolin Inhaler (Rescue Inhaler to stop / prevent an Asthma attack)

Description	Alert		Therapeutic	Prod Class	Selling Price	PC	Pkg Size	SWP	AD Spc	Restricted Item	Invoice Cost	CC	Unit Cost	WAC Cost
VENTOLIN HFA INH 90MCG 200 MDI	N			H			18	$64.50			$53.21		2.9561	$53.75

WAC = $53.75 AWP = $64.50 at WAC – 4.5% = $51.33 true net cost

At current contract rates:

30 day AWP – 19.75% + $.10 $64.50 – 19.75% = $51.76 + .10 = $51.86 total reimbursement $.53 profit

90 day AWP – 23.55% + $.00 $64.50 x 3 boxes = $193.50 – 23.55% = $147.93 + $.00 = $147.93
$147.93 – ($53.75 x 3 = $161.25) = **-$13.32 gross profit loss**

The above examples show the consistently decreasing reimbursement to pharmacies that has been systematically put in place by the PBM industry.
A wholesaler distributor buys a brand product from a manufacturer at WAC ($100). The wholesaler generally receives a 2% discount from the manufacturer if they pay their bill on time and may also receive an Inventory Management Agreement discount from the manufacturer of an additional 1.5%. Therefore, the wholesalers true net cost to purchase the product would be approximately $96.50. ($100 – (2% + 1.5%) = $96.50).
Because the PBM's have continued to decrease the reimbursements to pharmacies, wholesalers have attempted to try to offset these decreases by continuing to lower the cost of the product to the pharmacy – in this case by selling brand name drugs to their pharmacies at WAC – 4.5% (or $95.50 in this case). This amount is now below the cost of the product to the wholesaler.

At this figure (WAC – 4.5%), on an AWP minus basis, this would represent AWP – 20.42% as the true net cost of a brand name product to the pharmacy.

In the Lantus example from above, a pharmacy dispensing 1 box of Lantus for a 30 day supply would receive $389.32 plus a 10 cent dispensing fee (total of $389.42) for filling that prescription. This would mean that the pharmacy would a make a gross profit of $3.32 for that prescription.

In the 90 day Lantus example, a pharmacy dispensing 3 boxes of Lantus would receive $1112.60 plus a dispensing fee of ZERO ($0) for filling that prescription. Or in reality, a LOSS of almost $46 on that prescription.

In the example of the Ventolin Inhaler – the pharmacy would receive a gross profit of 53 cents for the 30 day prescription and LOSE over $13 when filling it for 90 days.

In year 3 (2020) of this contract, because the pharmacy will be buying brand name drugs at AWP – 20.42% and be reimbursed at AWP – 20.45%, that pharmacy will not only continue to LOSE money on every 90 day prescription, but will also LOSE money on every 30 day brand prescription that they fill.
In order words,

IT WILL BE IMPOSSIBLE FOR THEM TO MAKE ANY PROFIT ON EVERY BRAND NAME PRESCRIPTION THAT THEY FILL!!

The above shown Contract Rates demonstrate that in the **last 3 years (2015 to 2018),** ESI has **decreased brand drug reimbursements to pharmacies by 2% points and their dispensing fees by 20 cents on 30 day prescriptions and over 3% points on 90 days prescriptions (no change in the dispensing fee here as it was already ZERO).**

Speaking of **Dispensing Fees** –

When a patient visits a physician's office – that physician is generally paid a specific rate for that appointment or office visit. That rate is supposed to cover the physician's knowledge and salary, the office overhead, and allow them to make a profit.
A PBM pharmacy reimbursement schedule pays us for the cost of the product (sometimes) and either 10 cents or nothing for our knowledge and salary, pharmacy overhead and forget about a profit.
The national average for a pharmacy to cover their expenses or overhead (dispensing fee) when filling a prescription is somewhere in the $11-$13.50 range.

What does that pharmacy do to deserve their, if lucky, $0.10 dispensing fee?

- Receive the prescription from the patient
- Verify who it is for by getting the patient address, phone number, insurance and allergies
- Enter the prescription into their pharmacy system
- Check for possible drug interactions
- Check the PDMP program if it is for a Controlled Substance
- When everything looks good, they submit it to their pharmacy switch which forwards the required information to the patient's PBM
- If they receive a clean claim (no issues) on the first transaction, the pharmacy computer system will print a label, receipt, and possibly a medication guide for the patient
- If the claim rejects, the pharmacist may need to speak to the patient, call the physician, call the PBM, or any combination of those 3 in order to obtain the correct information needed to fill the prescription
    - They then make the correction and transmit the prescription again in order to try to get a clean claim
- Once they receive a clean claim, they choose the correct product, fill and dispense the prescription to the patient
- They then will ask if the patient has any questions or would like to be counseled on their medication
- The pharmacy also involuntarily serves as the PBM's insurance coordinator
- In addition, the charge to the pharmacy from the PBM and the switch to process a single claim is somewhere in the range of 20-50 cents / prescription. And this is only if the claim is clean. If the claim rejects, the pharmacist is charged additional fees every time the claim has to be resubmitted. The current dispensing fee being paid does **NOT cover the cost** of sending the claim to the PBM. Another way PBM's profit off the backs of pharmacies.

If the prescription is for a 90 day supply – in addition to all of the above, that pharmacy is going to have the pleasure of not only being guaranteed to lose money on the cost of the medication but they are going to have their dispensing fee reduced to ZERO.

	Cmp	Ext. Hist	90 Hist	PO Qty	On Open PO	DOE #	Fav	Description	Alert		Therapeutic	Prod Class	Selling Price	PC	Pkg Size	SWP	AD Spc	Restricted Item	Invoice Cost	CC	Unit Cost	WAC Cost
Add	Cmp	Hist				139261	☆	TYLENOL TAB 100	N			S	$8.75		100	$7.65			$6.54		0.0654	$6.38

A pharmacy can order in the 100ct bottle of Tylenol tablets shown above from a wholesaler.
When that order comes in, the pharmacy staff will open the tote, place the sales sticker on the item and then place the item for sale in the pharmacy's OTC section.
A patient can come into the pharmacy, pick the Tylenol off the shelf, take it to the register where a clerk will ring it up and place it in a bag.
After collecting $8.75 for that Tylenol, the pharmacy will have made a profit of $2.21. Selling price ($8.75) minus Cost ($6.54) equals profit of $2.21.
The pharmacy was not required to complete any of the steps listed above when filling a prescription (except the pharmacy will provide counseling on the product if the patient would ask) to make a profit of over 22 times (2200%) what they are paid for filling a prescription.
Another example of how PBM's devalue not only the services that a pharmacist can provide in bettering the health of a patient but shows what they feel the health of a patient is worth.

In my opinion –

There should **NEVER** be a brand drug prescription filled for a **90-day supply**.
When you want to talk about the waste and unwise use of employer and/or taxpayer dollars being spent, here is your perfect example.
This filling of 90-day brand name prescriptions makes absolutely no economic sense to anyone except the PBM.
Every pharmacy can tell you horror stories and show pictures of the waste involving non-compliance or excess and leftover medications when a patient is hospitalized, a medication is changed or a dosage is adjusted.
The patient comes in to the pharmacy and says "What am I supposed to do with this? This is a lot of money being wasted here."

When discussing Fraud, Waste, and Abuse –

- Do PBM's look internally at their mail order programs?
- Do they audit themselves and hold themselves to the same ridiculous standards they impose on retail pharmacies?
- Do they recoup money from themselves? (Where is the proof?)
- What happens to this money?

Generic Pricing

2.4.a Schedule A Contract Rates: ESI's broadest, open access national commercial network of pharmacy providers.

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Almost always uses a MAC (Maximum Allowable Cost) MAC x (# pills) + Disp Fee = Total Reimbursement

- Usually means there are 2 or more approved generics in the marketplace

	Ext. Hist	90 Hist	PO Qty	DOE #	Description	Image	Therapeutic	Prod Class	Selling Price	PC	Pkg Size	SWP	AD Spc	Restricted Item	Invoice Cost	CC	Unit Cost	WAC Cost
Add				454165	XANAX TAB 1MG 100			J			100	$798.08			$658.42		6.5842	$665.07
Add				792747	ALPRAZOLAM TAB 1MG 500 MYL		AB	M			500	$628.59			$29.26	C	0.0585	$30.52
Add	Hist	7		781310	ALPRAZOLAM TAB 1MG 1000 GREENS		AB	M			1000	$887.64			$26.93	C	0.0269	$39.02
Add				892265	ALPRAZOLAM TAB 1MG 1000 PAR		AB	M			1000	$1,097.25			$15.83	C	0.0158	$63.94

PA STATE MAC LIST OFFICE OF MEDICAL ASSISTANCE PROGRAMS – effective 9/7/2018

ALPRAZOLAM	1 mg	TAB	TABLET	$0.0258

Using the Par brand cost = $15.83 / 1000 or $0.01583 cents / tab Profit = $0.00997 / tab
Reimbursement for 90 tabs = 90 x $0.0258 = $2.32 + $.10 = $2.42 cost for 90 = $1.42 Rx Profit = $1.00

Using the Greenstone brand cost = $26.93 / 1000 or $0.02693 cents / tab Profit = -$0.00113 / tab
Reimbursement for 90 tabs = 90 x $0.0258 = $2.32 + $.10 = $2.42 cost for 90 = $2.42 Rx Profit = $0.00

Using the Mylan brand cost = $29.26 / 500 or $0.0582 cents / tab Profit = -$0.0324 / tab
Reimbursement for 90 tabs = 90 x $0.0258 = $2.32 + $.10 = $2.42 cost for 90 = $5.24 Rx Profit = -$2.82 loss

For NON-MAC generic drugs --- will use AWP minus (but uses the Generic pricing Schedule - A)

Suboxone 8/2 Film 30ct (Brand) AWP = $293.32 WAC – 4.5% = $233.44 pharmacy cost
Buprenorphine/Naloxone 8/2 Film 30ct (generic) AWP = $264.00 WAC – 4.5% = $176.68 pharmacy cost

Filling the Brand at AWP – 19.75%
$293.32 – 19.75% = $235.39 + $0.10 = $235.49
Gross Profit = $1.95

Filling the Generic at AWP – 50.5%
$264.00 x 49.5% = $130.68 + $0.10 = $131.78
Gross Profit = -$44.90

For Generic Drug Pricing –

Generally, 85 to 90 % of all prescriptions are now filled with a generic medication. Of these generic prescriptions, 90% or more are filled using a MAC reimbursement method. A MAC is usually applied to "AB" rated generic drugs that have more than one generic manufacturer.

In the above example for Alprazolam 1mg, I have used the MAC price established by the PA DHS on their State MAC List as of 9/7/2018. They have set the MAC at a price of $0.0258 per tablet. I then gave 3 examples of Alprazolam 1mg tablets that can be purchased from Value Drug. The Invoice Cost is what one of our pharmacies would be billed when purchasing that product from us based upon our contractual pricing established by our purchasing group – Opti Source. The manufacturers used were Par, Greenstone, and Mylan. As you can see, the price varies greatly from manufacturer to manufacturer with Par having the least expensive unit cost per tablet, followed by Greenstone and then Mylan

If a pharmacy purchases the Par brand, they will be able to generate an additional profit for themselves of one penny ($.01) per tablet dispensed. The Greenstone brand will basically be a break-even proposition and if they were to purchase the Mylan brand, they would be losing about 3.2cents per tablet dispensed.

In general, pharmacies will almost always purchase the least expensive AB rated generic available to them.

Reasons they would purchase a more expensive product –

1. Someone may be allergic to one of the ingredients in the lease expensive brand – i.e., the color (dye), a filler used in the making of the product, or the product may be too big to swallow or cannot be broken
2. Someone only likes the 'blue' tabs or thinks they work best for them. The pharmacy will attempt to please the patient even at the expense of losing some money
3. The less expensive product is currently unavailable in the marketplace and the pharmacy has to buy a more expensive product even though the PBM has not updated their MAC list to accommodate the market shortage

For NON-MAC generic drug pricing – this pricing formula is almost exclusively used when there is only 1 generic in the market – a brand drug has recently gone off patent and the first generic is being introduced. Normally when this happens, the new generic drug is priced very near the brand name drug.

In the example above with Suboxone Films, when the generic medication first came to market, you can see that the AWP's are priced relatively close and the actual cost to the pharmacy is still close but there is a somewhat bigger difference. Since there is not 2 or more competitors in the generic marketplace at this time, the PBM's will price this new generic using their AWP minus formula. This formula penalizes pharmacies because the AWP minus is such a big percentage that there is no way the pharmacy can be expected to take that kind of loss when filling the prescription.

As you can see, if the pharmacy filled the brand name drug (Suboxone), they would generate a gross profit of under $2. If the pharmacy substituted the generic for the brand (which they can do by law), they would be accepting a loss of almost $45 to fill that prescription. In the vast majority of cases, the pharmacy will not substitute the generic at this time. However, some PBM's will mandate them to do the substitution as the generic is now available. Again, the pharmacy is put in a bad position.