**Senate Joint Hearing on PBMs**
**October 16, 2018**

Good morning, my name is Pat Epple and I am the CEO for the Pennsylvania Pharmacists Association (PPA) and will lead off the pharmacy panel. I want to thank you for inviting us here and to express our appreciation for your interest in delving into a rather complicated but important topic, the influence, and role of PBMs in prescription management.

Lately, there been considerable national and regional press and media stories on PBMs. Many of which have shown that there are definite flaws in the current system, especially among the BIG three – CVS/Caremark, Express Scripts, and Optum Rx. But we need to continue to shine a light on these issues and work to find solutions.

In my seventeen years with PPA, PBM issues with patients and pharmacies have continued to get worse and in the last year or so have escalated to the worse levels ever. Community pharmacies are closing because of financial pressures from PBMs.

PBMs, all in the guise of saving money, have squeezed every cent they possibly can and then some from community pharmacy, at the same time that they have pocketed huge profits for themselves. One statement you will often hear from a PBM is that they save money – that may be so but most of the time it is on the back of the community pharmacy. In the overall prescription drug distribution process, the pharmacies are at the bottom, costing the system the least, yet the PBMs continue to push the reimbursements they pay to pharmacies lower and lower.

Late last fall, CVS Caremark the PBM for Gateway Health, in Medicaid Managed Care, reduced reimbursements deeply below the cost at which pharmacies could purchase the drugs. In some cases hundreds of dollars below. The outcry from our members was constant. Over a three month period, we continued to reach out and work with the Department of Human Services, Gateway, and even CVS Caremark. What we found is that neither Gateway or the Department had any control or oversight on the prices and could not review what was being done or why it was being done.

There was one scenario where a pharmacy had a patient with a very serious condition that they had been serving for years. Unfortunately, the cost for the pharmacy to purchase the medication was $600 and the pharmacy was being paid $200. That pharmacy lost $1200 on just that one patient. This example and others when brought to DHS' attention did get them looking into the situation and exploring solutions to the problem. However, they were powerless to stop it at the time. Finally, CVS/Caremark decided to slightly increase the reimbursements; however, they absolutely refused to allow pharmacies to go back and retroactively rebill claims for fair payment.

This is why our association and other pharmacy groups continued to meet with the Department, why we met with the Auditor General, and why we looked to legislators for support and action. This is part of

why we are here today! This is why some other states have returned to fee for service in their Medicaid program or launched legal and other investigations into PBM operations. Medicaid dollars are taxpayer's dollars and when PBMs are reimbursing pharmacies below cost, and charging MCOs and the state a much higher rate and pocketing the difference – this is blatantly wrong.

The Centers of Medicare and Medicaid Services (CMS) published a ruling calling for fair reimbursement for pharmacies in the Medicaid program, asking all states to move to a better model of operation providing several options. Many states including Pennsylvania moved to the NADAC (National Average Drug Acquisition Cost) model for the ingredient or drug cost and a professional dispensing fee determined by the state. Currently, Pennsylvania is using $10. However, managed care was not covered by this rule and those PBMs can reimburse however they choose.

While there is some discrepancy in viewpoints within pharmacy on this issue, generally I would say there is a feeling that PBMs can serve a role but they need to be regulated and they need to be transparent in their operations especially about the pricing they are reimbursing pharmacies and charging plans. There are ways they can help the system save money but many have gone far astray from their original purpose of claims adjudication. Because of this, we feel legislation and other action is necessary to require appropriate oversight.

PBMs cannot be allowed to arbitrarily reimburse pharmacies below the cost at which they can purchase drugs. Especially when the PBM sends letters to those pharmacies saying – business is bad – want to sell to us?

As I mentioned when I began my testimony, the issue is complex and I have only touched the tip of the iceberg with my statements. Here are a few key points I would like to leave with you:

- Patient care and their choice to use a community pharmacy is vital, especially in rural areas, and many PBMs ignore this.
- Pharmacists can play a significant role in appropriate medication use and compliance.
- Community pharmacies and community pharmacists play an important and integral role in healthcare and right now PBMs appear more interested in eliminating them.
- PBMs may also serve a real purpose but they need to be regulated and transparent in their pricing.
- I would be especially concerned with the big three (CVS/Caremark, Express Scripts, and OptumRx) and their monopolistic control over so much of the prescription drugs business and even more concerned given the recent purchase deals between Cigna and Express Scripts and Aetna and CVS.

I have attached the following as additional testimony and information and I thank you again for your time this morning.

**PBMs will state that they are "highly regulated**;**"** however, upon closer look you will find this is not really the case. There is no real federal regulation; except the recent prohibition against gag clauses signed into law last week. That language prevents gag clauses in Medicare Part D. In Pennsylvania, PBMs only have to be registered with the PA Insurance Department (PID). I have heard them say they are licensed under the PA State Board of Pharmacy, this is inaccurate. Only if they also have a mail order

pharmacy, then that mail order pharmacy is licensed with the Board and if it is out-of-state, it is a non-resident license. Important yes for this registration – but this is for compliance in pharmacy practices not in PBM activities.

**PBMs will say they save money or lower costs.** This is at least debatable and may be true. But how much and the ability to hold them to this claim is important. Unfortunately, many plan sponsors, insurers or self-funded employers never really hold the PBM to this claim and match it against actual year end results. Without transparency, it is easy to say and even "show" savings, without really seeing how much profit is actually going to the PBM. Usually if costs go up, this is blamed on the pharmaceutical company increases, which may be accurate; but those increase may also be a result of rebate demands. A more transparent system of contracting would be able to shine a light on this and allow insurers, and others to accurately see rebate dollars and other claimed savings.

**PBMs will cry that efforts to regulate them will close down operations in Pennsylvania and put people out of work.** Let's be clear that we are not calling for the elimination of PBMs; but rather requiring them to be transparent and fair in their operations. The PBM should be asked to be specific about how and why operating transparently will cause this to happen. Is the closure simply because the PBM will not be making as much profit? Look at their financials and revenues, ask how much their top executives are being compensated?

**PBMs have stated that they too support community causes**. This is great and we applaud these efforts and support. But again, let's ask and check exactly how many dollars are being used for what charities and community initiatives in Pennsylvania. Our statements are clear that community pharmacies do support their local community.

In summary, we simply urge you to be careful whenever any of these blanket statements are made to actually ask for more specifics.

**Background and History**

PBMs started as simple pharmacy plan administrators, third party claim processors, which charged a reasonable fee typically per claim for processing the claim. Originally this was done as paper claims, as the advent of electronic processing soon took over, this made additional "management" services a possibility. Over at least the last twenty to thirty years, as their control has increased, mergers have happened and what has emerged is largely a market of three major PBMs, CVS/Caremark, Express Scripts, and Optum Rx. For all three of these, it appears their focus is less - patient centric and more designed to bring in as much profit as possible and deliver higher returns to their shareholders.

Keep in mind, that while PBMs can and may serve a vital role, they are simply middlemen in the claims process. They do not deliver services directly to patients and they do not buy or directly sell medications, they manage claims. However, in doing this management they have been able to create a number of schemes which allow them to collect additional profit from the system, which we will discuss.

**Limitations of Legislation Enacted So Far**

States across the country have tried to address many of the issues with PBMs, largely with marginal results. In 2018, there have been a few more successes in a few states. In Pennsylvania we have been successful, after much effort and considerable compromise to pass two pieces of legislation that have TRIED to address some PBM issues:

Act 207 of 2012 was a huge disappointment. This was called the anti-mandatory mail order bill. Its intent was actually to simply allow patient choice. However the compromise language was carefully crafted that little was actually accomplished. This was particularly frustrating given how long and hard, pharmacists advocated for this bill. The wording in the legislation specified that community pharmacies had to accept the same terms and conditions as mail order pharmacies, and because mail order pharmacies are afforded a better rate at which to purchase prescription drugs from manufacturers through class of trade pricing.

Act 169 of 2016 which supposedly did three things.

1. Require PBMs to be registered with the state. Originally the legislation wanted this registration to include some specific documentation and information from the PBM s about their operation. They were successful in getting much of this pulled out through the compromise process. The ultimate result was a very basic registration and an annual fee of an almost laughable $50. (Keep in mind that every pharmacy location must semi-annually pay a $125 fee to be licensed with the state, and each pharmacists pays $190. In addition there are fees for many other aspects that pharmacies must pay including specific accreditations now being required by some PBMs to the tune of $5,000 to $10,000)
2. Require fair and uniform audit practices
3. Set parameters for establishing Maximum Allowable Cost (MAC) or other generic pricing. The act specifically included an appeal process be established and that the PBM had to show where the product could be purchased in Pennsylvania for at least the stated reimbursement price. This section has been completely ignored.

Neither of these two Acts has been very effective due to some key limitations and lack of enforcement where applicable. PID has not been particularly cooperative in any enforcement of these issues. This is partly because they claim they can have no jurisdiction over any federal programs such as Medicare Part D, any state programs which fall under other agencies such as Medicaid and PACE, and any self-funded employer based plans which supposedly fall under ERISA exemption. This leaves only commercial plans for which they have any enforcement rights under these acts. This means only about 20% of prescription plan coverage is even affected by passed legislation.

Unfortunately, even for this 20%, there has been limited or any enforcement. This is because there is no simple or easy way to file a complaint or have the PID investigate any issues.

**What Can Be Done?**

Now some pharmacies and pharmacists, because they have been so beaten down by various PBM actions, will say they would like PBMs to be eliminated especially in Medicaid Managed Care. But what we really need is for PBMs to be regulated and operate in an open and transparent manner. There are already some PBMs which do this. Those are the PBMs that should be utilized. Additionally, we have developed a short list of ten key reforms that we feel should be seriously considered in the regulation and oversight of PBM activities. These recommendations are spelled out in the following information, along with an attached flyer (Appendix A- PBM Reforms) which outlines each reform much more succinctly.

**1. Limit Purpose and Scope**

Because of the growing power and infiltration into managing prescribing, formulary, in addition to controlling costs, we would advocate for more specific regulation into the actual role of the PBMs or at least full transparency and disclosure in their contracts as to what they are doing, how they are doing it, and how they are making their money.

**2. Require Price Transparency**

Currently plan sponsors, insurance, MCOs, government, etc. through their contracts with PBMs do not know how much pharmacies are being paid by the PBM for dispensing medications and often there is a significant gap between the amount pharmacies are paid and what the plan sponsor or contractor is billed. This differential is called spread pricing and is a widely used practice. A simple example would be the following: a pharmacy is paid $20 for XYZ drug which cost the pharmacy $30 to purchase, but the PBM is charging the plan $40. The pharmacy loses $10, the plan was overcharged $10, and the PBM made $20! This is a very simplistic look at this practice but it shows the impact of spread pricing.

**3. Establish Fair Reimbursements**

Pharmacies are paid for prescription medications in a manner far different from a typical retail model. Understanding this system is not easy. There are a whole group of acronyms used to define the various pricing models. (Appendix B – Rx Pricing Terminology) But first and foremost it is important to understand the following points:

Pharmacies paid under insurance coverage do not set their prices. The PBMs tell them what they will be paid.

Pharmacies must have a contract with a particular PBM and for that insurance plan to be a "network" pharmacy to dispense to a patient under that coverage.

The contract offered for that plan is a take it or leave it contract – there are no negotiations. In order to serve a specific patient they must accept that contract.

Pharmacies purchase medications through wholesalers and work diligently through buying groups to purchase these medications at the best possible price possible. Pharmacies have become increasingly creative in trying to manage their purchase power as best as possible.

However, when a PBM pays a pharmacy below the price at which they can purchase medications, the pharmacy takes a loss. During the Medicaid debacle that occurred last winter, there were hundreds of claims being paid by CVS/Caremark below pharmacies' costs.

To better understand the role of the PBM, see the Drug Chanel Distribution chart. (Appendix C- Drug Channel).

**4. Set Fair Dispensing Fees**

Some PBMs in some contracts are currently paying pharmacies dispensing fees as low as ten cents per prescription. This dispensing fee is supposed to cover all the costs and professional services involved in the actual dispensing of the drug. Fee surveys typically set the average price in a $12 to $16 range, depending on whether there is any inclusion for profit. The current Pennsylvania Medicaid fee set at $10 does not include any allocation for profit. Pharmacies with higher volumes bring the cost to the lower range.

Dispensing fees include salaries and benefits for pharmacy staff, overhead costs such as rent, light, and heating, supplies, medications, packaging, software fees, and more. It is challenging to imagine a 10 cent fee covering this.

**5. Equal Treatment for All**

There has been some question whether certain PBMs have reimbursed their own pharmacies at a higher rate than other pharmacies. In Arkansas, they specifically saw this in their Medicaid program. While we do not have any concrete proof that happened here, the very fact that neither the Department of Human Services or the Auditor General can look at these figures is problematic. Also most other plans are not privy to know this information either. It would be different if there was something different done to earn the differential but that is not the case.

**6. Restrict Use of Rebates**

Rebates were designed to reduce patient out of pocket costs. This is rarely occurring. Rebates have become a vicious cycle in which PBMs demand more rebates from pharmaceutical companies, causing the pharmaceutical companies to only increase their prices to offset these increased rebates. Additionally one has to examine how rebates are earned. Rebates are paid based on the number of prescriptions being dispensed on a particularly branded drug when their actually might be a less expensive equally effective alternative. There is nothing inherently wrong with rebates, it is more what they have become, how they are managed, and where they are going.

**7. Better Formulary Management**

This recommendation relates to the aforementioned rebate issue. If insurers through their PBMs focused first and foremost on least expensive treatments, often generics, this would be fiscally responsible. This would not restrict brand names drugs but would require possible exploration of least expensive treatments first and not medications selected for formulary use based on highest rebates or outside pressures. Emphasize patient care and outcomes.

**8. Allow Patients Choice of Pharmacy**

Many patients really like and trust their community pharmacies. Many of our community pharmacies in Pennsylvania are located in rural areas and are the only easily accessible and convenient healthcare professional. Our pharmacists have many, many stories about how they have had a meaningful impact on many of their patients care. Instances such as when a pharmacist drove a snowmobile through a snowstorm to go and open their pharmacy to get a medication and deliver it to a woman who desperately needed it. Talk to any independent owner and they will have many of these patient care scenarios. These are things that the PBM, the mail order pharmacy, or maybe even the big chain pharmacy can't or does not do.

Patients who believe in, trust, and confide in their community pharmacist, should be permitted to go to that pharmacy. Pushing them to a chain or mail order pharmacy, does not help them. Today's health industry spends plenty of time talking about medication compliance but underutilizes the community pharmacy which can really have a meaningful impact on adherence.

There are so many ways that the community pharmacy is part and parcel of their local community including supporting local charities and participating in other community efforts, employing individuals, and paying taxes. (Appendix E – Information on Community Pharmacy in PA)

**9. Eliminate or Regulate the Sale of Date or Misuse**

We do not know nor do most insurers or plans what data is being sold or utilized by PBMs but we know that some happens. While patient data might be scrubbed to ensure HIPAA compliance, PBMs are able to pocket additional money by selling this data. For example, they may sell data to a pharmaceutical company which shows that their Drug XYZ is being heavily prescribed by physicians in this county but not in another. This provides an opportunity for the pharmaceutical company to send out their drug reps to prescriber offices armed with this information to further educate them on using XYZ drug.

We also know that the PBMs use this data internally to send letters to patients encouraging them to change pharmacies. The way many letters are worded individuals feel they have no choice.

In either case, we are fairly sure the plan does not know this is happening. Any use of data should be approved and known by the plan.

**10. Prohibit Gag Clauses**

Success! At this point, this legislation introduced by Rep Judy Ward is scheduled to be voted on and this is great. Her legislation will affect commercial business in Pennsylvania only. But think how ridiculous this requirement really was. The PBMs until this became a big issue would not allow a pharmacist to tell patients that they could pay less money by using another drug or by paying cash! It is amazing that we needed legislation to address this – but it goes to show how crazy and out of control this whole PBM business has become!

At the same time, Congress has recently passed legislation prohibiting gag clauses:

S.2553 – Prohibited in Medicare Part D Only and effective January 1, 2020

S.2554 – Has to do with Gag clauses in ACA exchange and private plans immediately.

The Gag Clauses, while important and we were glad to see some focus on questionable practices, really are only the tip of the iceberg.

Additional attention and focus is now needed on the many other areas.

**The Pennsylvania Medicaid (Debacle) Story**

This past winter things became extremely difficult for community pharmacies, particularly those in western Pennsylvania, where Gateway is a big player. Gateway uses CVS/Caremark as their PBM. All of a sudden on October 26, 2017, CVS/Caremark ratcheted down the reimbursement prices of drugs to unheard of low levels. Community pharmacies that were used to low payments saw INCREDIBLY low payments and in some cases had to turn patients away because they could not afford to provide the drug. One pharmacy had an example where they were being paid $200 for a drug that cost $600. There were many large differences like that but there were also hundreds in any given pharmacy where they lost smaller amounts but still lost and others where they were only being paid $1, including the dispensing fee, over their cost. NO pharmacy can stay open on $1/claim.

PPA on behalf of our pharmacies tried to intervene. We immediately contacted the Department of Human Services (DHS) and Gateway. We also sent letters to all MCOs thinking this was going to be a larger issue. We did also see similar effect in Aetna where CVS/Caremark is also the PBM. When we

finally spoke to Gateway, they seemed surprised and did indicate they really wanted to look into this. Likewise in meetings with DHS, they were concerned and wanted time to investigate. Numerous meetings, calls, and emails ensued. We continued to share specific examples.

We also tried to contact and work with CVS/Caremark. When we finally were able to get on a call with their Government Relations team the last week in December, the call was very awkward and no answer or explanation was provided. Even when we asked when we might expect more information – there was dead silence. As you can imagine this was very frustrating. Later meetings with the Department resulted in a commitment to address this and they have been helpful in trying to find solutions. They have indicated to us that they do not want to eliminate PBMs but rather would prefer to have more oversight.

Eventually in late January, CVS/Caremark returned pharmacy reimbursement to a slightly better level. But they refused to allow pharmacies to reverse and rebill the three months' worth of claims that were paid at below cost. This meant that many pharmacies lost thousands and thousands of dollars but the PBM still made money. How much – we don't know because this information is proprietary! We cannot begin to state how blatantly unfair this is.

The real kick was that at the same time – they were pushing down reimbursements, they were sending letters and emails to pharmacies, basically stating…"We know business is bad, its hard to survive – why not sell your pharmacy to us?" (See Appendix D – CVS Purchase Solicitation)

The sad part is that there have been some sales and closures since that time. In the immediate central Pennsylvania area, Hinkle's a long-time fixture in Columbia closed the pharmacy portion and transferred prescription files to CVS, laying off 71 employees. In Hummelstown, Rhodes Pharmacy also dropped its pharmacy portion and transferred files to CVS. Just outside Harrisburg, in Susquehanna Township, Value Health Mart opened earlier this year and has already closed due to not being able to get into many PBM networks.

**Community Pharmacies are a Valuable Partner**

Community pharmacies are the most accessible source of healthcare. Most people live within five miles of a community pharmacy, so they are very convenient. They are accessible sometimes for long hours into the evening and on weekends. They also provide valuable medication counseling, adherence packaging, and often offer delivery services. They serve as an integral partner in the healthcare team. All the medicines in the world can be prescribed but if they are not the right ones to work together and if they are not taken appropriately, they just cost the system money. Pharmacists are there to provide medication management. (Appendix F – PA Impact Fact Sheet)

Our Association has put together a community pharmacy enhanced services network or CPESN which is part of a national movement. Our network is called the Pennsylvania Pharmacists Care Network and it includes about 120 pharmacies committed to a high level of patient care. The network engages with various payers such as Medicaid MCOs to provide service above normal prescription dispensing. Encounters are opportunities for the pharmacist to meet face-to-face and dedicate time to engage a patient in a discussion around their medications and ensure that not only are they prescribed the right medications but helping them understand them and take them appropriately.

Community pharmacists are all about keeping prescription drug prices affordable! They care about the patients they serve and are very aware that the current pricing system is broken and something must be done and done soon. We pledge our assistance to finding solutions that are fair for all. But we urge legislators to act now, before it is too late. Community pharmacies cannot last much longer and once they are gone, any semblance of competition will also be gone.