State of Kansas - House Insurance Committee  
Hearing on Continued Access to Community Pharmacy Act  
H.B. 2688  
Testimony of the National Community Pharmacists Association  
February 24, 2014

Honorable Members of the Kansas State House Insurance Committee,

My name is Matthew DiLoreto and I am the Senior Director of State Government Affairs for the National Community Pharmacists Association (NCPA). I appreciate the opportunity to provide testimony today regarding a priority issue for community pharmacists in Kansas and across our nation. NCPA would like to express strong support for H.B. 2688—legislation that would establish a fair and reasonable degree of transparency over how Pharmacy Benefit Managers (PBMs) determine reimbursement to pharmacies for generic drugs. Just as importantly, this legislation will allow those Kansas employers that pay the bills for these drugs see exactly what they are paying for. We strongly support this legislation’s intent to prevent your constituents from being prohibited from utilizing the pharmacy of their choice. H.B. 2688 reforms the current system where pharmacies are obligated to sign one-sided PBM contracts, leaving the community pharmacy blind to how the PBMs will determine the reimbursement rates for generic drugs. Similarly, patients are often forced or coerced into strictly using a PBM’s self-owned mail-order pharmacy, despite the patient’s personal preference regarding where they obtain their medications. H.B. 2688 takes fair and reasonable steps to address these clear conflicts of interest by leveling the playing field between PBMs, Kansas small business owners, and healthcare professionals by reforming these practices.

NCPA is located near our nation’s capital, in Alexandria Virginia, and represents America’s independent community pharmacists, including the owners of more than 23,000 community pharmacies, pharmacy franchises and chains. Together, these pharmacies employ over 300,000 full-time employees and dispense nearly half of the nation’s retail prescription medicines. In Kansas alone, there are nearly 300 community pharmacies that employ thousands of residents. It is estimated that Kansas independent pharmacies are responsible for over $1 billion in annual state sales. These members are a vital component of Kansas’ “Main Street Economy,” and represent America’s small business owners and healthcare providers.

The issue of generic drug pricing and the need for greater pricing transparency has never been as critical as it is today. Currently, there are more than fifteen states considering maximum allowable cost (MAC) transparency legislation similar to that which we are here to discuss. Five states have already enacted MAC transparency legislation comparable to H. B. 2688. Dramatic changes in the generic market necessitate enactment of this legislation in Kansas.

A “Maximum allowable cost” or “MAC” list refers to a payer or PBM-generated list of products that establishes the upper limit, or maximum amount, that a plan will pay a pharmacy for certain generic drugs. The PBM has free reign to create as many MAC lists as it feels would be profitable and no two of these MAC lists are alike. There is no standardization in the industry regarding the criteria for the inclusion of drugs on MAC lists or for the methodology as to how the PBM will determine the maximum price. There is also no standardization as to how or when those prices are updated or provided to the pharmacy. The pharmacy is nonetheless required to purchase the drug and ultimately dispense it to a patient without knowing if they will even recoup the drug cost. This process is further complicated by the fact that PBMs frequently maintain different MAC lists for the same health plan—higher MAC lists are used to charge health plans and aggressively low MAC lists are used to reimburse their contracted pharmacies for the same drugs. Essentially, the PBMs use MAC pricing to reimburse low and charge high, pocketing the significant “spread” between the two prices. Over the past few months numerous media outlets have published stories on this practice, including CNN Money/ Fortune.
The data compiled from an NCPA survey of more than 1,000 community pharmacists nationwide reveals a rise in pharmacy acquisition prices for generic drugs by as much as 600%, 1,000% or more. These drastic increases occur with no reporting requirement, or correction in reimbursement to pharmacies. The same survey found that patients are increasingly declining their medication due to increased co-pays (or total costs for the uninsured). This and that the trend has forced more seniors into Medicare's dreaded coverage gap (or "donut hole") where patients must pay far higher out-of-pocket costs. It should be noted that NCPA is not the only entity reporting on such extreme price increases. Attached to my written testimony you will find many independent media articles underscoring that these issues are a very real concern in the states and at the federal level. It should also be noted that the Centers for Medicare and Medicaid Services (CMS) recognizes the need for MAC transparency and proposes it within the Medicare Part D program as stated in their proposed rule “Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs.” NCPA respectfully requests that Kansas join the leaders in this endeavor.

H.B.2688 includes necessary provisions that would require the PBM to simply disclose to a contracted pharmacy the basis of the methodology and sources utilized to determine MAC pricing. Kansas was a leader among the states by requiring this stipulation be a part of the contracts of all three KanCare managed-care organizations. According to the Kansas Pharmacists Association, this requirement has been successful as it allows the Kansas Department of Health and Environment to understand fully where its KanCare drug spend dollars are going. Further, it allows for a more intensive management of Kansas taxpayer dollars. Among other provisions, this legislation would establish a reasonable appeals process under which a pharmacy could contest or appeal a listed MAC price as well as establish needed guidelines governing when and under what circumstances drugs could be placed on a MAC list.

You will probably hear from the PBMs today that the provisions of this legislation infringe on or would force them to disclose "proprietary" information. You may hear the words "damaging" or "expensive" to the overall health care system. However, I again point to the above figures. The lack of transparency has caused prices to skyrocket. Many Kansas pharmacies/small businesses report paying 1000% more for a drug and absorbing huge losses in order to continue serving their patients. This is happening to the point where pharmacists in small town Kansas pharmacies are questioning their ability to stay in business. Recently in another state considering legislation very similar to H.B.2688, a small business community pharmacist testified that she was required to take a $20,000 advance on her personal credit card just so she could pay her staff due to of the lack of adequate or timely reimbursement for dispensing generic drugs. I ask you, how can one operate a small business in this environment?

PBMs are solely in control of MAC prices. Although they may claim otherwise, I direct the committee members' attention to examples of language taken directly from PBM contracts with pharmacies:

"MAC means the maximum allowable cost for such drugs as determined by PBM. The items and their prices will be updated by PBM from time to time at its sole discretion."

And another:

"Maximum Allowable Cost’ or ‘MAC’ means the list delineating the maximum per unit reimbursement as established and solely determined by PBM for a multiple source prescription drug, medical product or device at the time a claim is processed. The MAC is subject to review and modification by PBM in its sole discretion."

The legislation before us would not require that any disclosures be shared with market competitors of the PBMs. Instead, it would simply require that the PBM "disclose" relevant and essential information to the other party in a given contract! We completely agree that confidentiality should remain intact throughout this process.
H.B.2688 also preserves a patient’s right to choose where they obtain their necessary medications. It’s as simple as that. H.B.2688 will give Kansans greater choice as they consider where to fill their prescriptions. If a patient prefers an out-of-state mail order facility, it’s their choice. If they decide that they would prefer the local community pharmacy that is so vital to the economy of Kansas, it’s their choice as well. The provisions of this bill facilitate a simple goal of allowing a patient to utilize the pharmacy of his or her choice while still requiring the retail pharmacy to offer a “comparable” price to the mail order operation.

Other states have addressed this issue head on. Anti-mandatory mail order legislation was written into law in Pennsylvania (2012), New York (2011) and Hawaii (2013). The PBM industry continuously stated that supporting such legislation would result in significant cost increases to both the state government and private plans. NCPA and state pharmacy organizations repeatedly requested evidence to back those claims, but the PBMs failed to provide a clear explanation or any supportive data. All of these bills ultimately were enacted, with the state legislatures scoring them as cost neutral ($0 impact).

In conclusion, NCPA urges the support of H.B. 2688 for the benefit of you and your citizens. This legislation would enable Kansans to obtain their healthcare services where they feel they are best served, all without increasing costs to themselves or the taxpayers of Kansas. It will also provide fair and reasonable treatment to those who foot the bills as well as the small business owners that are community pharmacies across Kansas. NCPA is confident that H.B. 2688 simply sets reasonable standards to ensure a fair pharmaceutical marketplace in Kansas.

(Additional background information is attached)
The Need for Legislation Regarding
“Maximum Allowable Cost” (MAC) Reimbursement

Background—What is MAC?
A “Maximum allowable cost” or “MAC” list refers to a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs and brand name drugs that have generic versions available (“multi-source brands”). Essentially, no two MAC lists are alike and each PBM has free reign to pick and choose products for their MAC lists.

There is no standardization in the industry as to the criteria for the inclusion of drugs on MAC lists or for the methodology as to how the PBM will determine the maximum price or how it’s changed or updated. PBMs have free reign on developing these methodologies and in turn, the ultimate price. The PBM’s client is left entirely in the dark.

PBM Use of MAC as Revenue Stream:
Because of this lack of clarity, many PBMs use their MAC lists to generate significant revenue. Typically, they utilize an aggressively low MAC price list to reimburse their contracted pharmacies and a different, higher list of prices when they sell to their clients or plan sponsors. Essentially, the PBMs reimburse low and charge high with their MAC price lists, pocketing the significant spread between the two prices. Most plan sponsors are unaware that multiple MAC lists are being used and have no real concept of how much revenue the PBM retains.

Most PBMs try to incentivize the use of their own in-house mail order pharmacies and do not apply MAC pricing to mail order drugs. Instead these PBMs offer a discount off Average Wholesale Price (AWP) — another industry pricing standard — for mail order generic drugs at a rate agreed upon by the PBM and plan sponsor. In this way, the PBM is motivated to utilize the product with the highest AWP relative to the actual drug acquisition cost for their in-house mail order operations, not the product with the lowest net cost. Thus, plan sponsors could pay significantly more for generic drugs via the PBM-owned mail order pharmacy than through a community retail pharmacy.

MAC legislation is designed to reasonably address the above concerns by:
• Providing clarity to plan sponsors and pharmacies w/regard to how MAC pricing is determined and updated and establishing an appeals process in which a dispensing provider can contest a listed MAC price.
• Providing standardization for how products are selected for inclusion on a MAC list.
• Compelling PBM disclosures to plan sponsors about the use of multiple MAC lists and whether or not MAC pricing is utilized for mail order products.

In summary, neither plan sponsors nor contracted retail network pharmacies have any transparency into the MAC process. They are required to blindly agree to contracts. Retail pharmacies are not informed how products are added or removed from a MAC list or the methodology that determines how reimbursement is ultimately calculated. However, pharmacies must contract with PBMs to provide services and participate in plans without having this critical information. In other words, pharmacies are required to sign contacts not knowing how they will be paid. It is equivalent to agreeing to the services of a home builder, not knowing how you will be paid or what materials will be utilized in the homes construction.

For more information please visit our website at www.ncpanet.org.
Background—What are Mail Order Pharmacies? Pharmacy Benefit Managers (PBMs) own automated dispensing facilities that fill and ship prescriptions requiring 90-day supplies. The PBMs refer to them as “mail order pharmacies,” however, these closed-environment, robotics-driven assembly lines don’t deliver the patient benefits of a traditional pharmacy. Face-to-face consultation between a pharmacist and patient, the most effective type of intervention to ensure that patients adhere to their prescribed medication regime and are counseled about possible negative side effects, is replaced with patient email and calls to 1-800 numbers to seek assistance from out-of-state corporate pharmacists. PBMs “hard sell” health plans on implementing complex schemes to require a “mandate” that all patients on maintenance medications exclusively use PBM-owned dispensing facilities. They promise outrageous savings – and since these promised savings are never backed up with a dollar-for-dollar guarantee – the health plans discover that the PBMs have over-promised and under-delivered on savings - and in many cases, on patient service and care. A closer look at the mail order equation demonstrates that the numbers don’t add up.

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<th>The Mandated Mail Service Equation</th>
<th>How It Adds Up For Patients &amp; Health Plans</th>
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<td><strong>PBM + Mandated Mail = No Accountability to the Patient</strong></td>
<td>No patient can “fire” their PBM-owned mail service. Once you’re in – you are locked in. The patient is “captive” to a single PBM-owned mail service – no matter how poorly it performs. Patients have reported numerous delivery issues that have caused patients to be unable to take medications that are vital to their health and well-being including delays in receiving medications, temperature-sensitive drugs being left outside or on delivery trucks, drugs lost in transit, medication switching and even the wrong drugs being shipped.</td>
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<td><strong>PBM +Profit = Less Patient Interest</strong></td>
<td>When given a choice, 83% of customers prefer to fill their prescription at a community pharmacy rather than at a so called mail order pharmacy. Clearly, mail order is not for everyone. This is why PBMs support “mandates,” complex cost-shifting schemes to promote the use of PBM-owned dispensing facilities and even disincentives that penalize patients for using community pharmacies.</td>
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<td><strong>More Brands + More Rebates = Less Generics Savings</strong></td>
<td>In 2009, retail pharmacies drove a 69% generic dispensing rate while Medco Health Solutions, Inc., Express Scripts, Inc. and CVS Caremark dispensing facilities had GDRs under 58%. Coincidentally, PBMs receive billions from drug manufacturers each year to increase brand name drug market share.</td>
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<td>• Increasing Generic Dispensing Rates (GDR) is the most effective method to drive and guarantee savings for both the members and the plans without mandating or restricting patient access to care through negative incentives and cost-sharing</td>
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<td>• For every $1 plan invests in generics, the plan receives $2 in savings</td>
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<td>• According to a new AARP report, the average retail price of the most popular brand-name drugs increased by 8.3 percent in 2009 and by 41.5 percent over the past five years</td>
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<td>• In 2009 alone, the use of FDA-approved generics saved $139.6 billion—a 15% growth over the prior year's savings—or about $382 million every day.</td>
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What Solutions Can Address the Most Egregious PBM Mail Order Practices?
Enactment of legislation requiring PBMs to:
- Fully disclose to plan sponsors potential conflicts of interest in PBM service contracts
- Promote lower cost through increased competition by establishing an “any willing provider provision” in all PBM mail service contracts

For more information please visit our website at [www.ncpanet.org](http://www.ncpanet.org).
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION
2012–2013 NCPA State Legislative Update

MAC Transparency
Kentucky (2013) S.B. 107
Kentucky Pharmacists successfully passed S.B.107 through both chambers of the legislature by unanimous votes before being signed by Governor Steve Beshear (D).

Arkansas (2013) S.B. 1138
Arkansas’ bill passed the Senate unanimously with one vote against in the House.

North Dakota (2013) H.B. 1363
North Dakota’s legislation passed both chambers unanimously. Upon its final days within the legislative process Express Scripts supported the legislations movement.

Texas (2013) S.B. 1106
Texas’ bill provides for MAC Transparency under the Medicaid managed care program. This bill passed both chambers by unanimous votes.

Oregon (2013) H.B. 2123 (MAC, Audit and PBM registration)
Oregon’s legislation passed both chambers by a unanimous vote. Governor John Kitzhaber (D) signed the bill July 1. PBMs went neutral on the bill.

Registration/Licensure
Oregon (2013) H.B. 2123 (MAC, Audit and PBM registration)
Oregon’s H.B. 2123 will require PBMs to register with the Oregon Insurance Division in order to operate in the state. Governor John Kitzhaber (D) signed the legislation July 1.

Anti-Mandatory Mail Order “AMMO”
Pennsylvania (2012) S.B. 201 / Act 207
Act 207 prohibits a copayment, deductible, fee, limitation on benefits or other condition or requirement for the coverage of prescription drugs when not imposed on the covered individual with a mail order pharmacy. Pennsylvania became the second state in the nation to enact anti-mandatory mail order legislation following New York in 2011.

Hawaii H.B. 65 (2013)
H.B. 65 allows a qualified retail community pharmacy to enter into a contractual retail pharmacy network. This bill grants a patient the right to purchase their prescriptions at a contracted pharmacy instead of being required to purchase their medications through a mail order pharmacy owned by the PBM.

Fair and Uniform Pharmacy Audits
New Fair and Uniform Audit Laws
South Dakota: S.B. 133 signed by Governor Dennis Daugaard (R) March 8, 2013
Montana: S.B. 235 signed by Governor Steve Bullock (D) March 28, 2013
Colorado: H.B. 13-1221 signed by Governor John Hickenlooper (D) April 8, 2013
Alabama: S.B. 283 (2012); effective August 1, 2012
California: S.B. 1195 (2012); effective January 1, 2013
Indiana: S.B. 407 (2012); effective July 1, 2012
Louisiana: S.B. 756 (2012); effective August 1, 2012
Minnesota: H.F. 1235 / S.F. 973 (2012); effective August 1, 2012
South Carolina: S.B. 1269 (2012); effective January 1, 2013
Utah: H.B. 76 (2012); effective May 8, 2012
Vermont: S.B. 200 (2012); effective July 1, 2012
Texas: H.B. 1358 (2013); effective September 1, 2013
Oregon: H.B. 2123 (2013); effective January 1, 2014
New Hampshire: S.B. 38 (2013); effective January 1, 2014

Strengthened Pharmacy Audit Laws
Utah: S.B. 194 signed by Governor Gary Herbert (R) March 26
Mississippi: H.B. 1490 (2012); effective July 1, 2012
Maryland: S.B. 903 (2012); effective October 1, 2012
Maine: L.D. 44 (2013); effective September, 2013; signed by Governor Paul LePage (R) May 7
Tennessee: S.B. 63 signed by Governor Bill Haslam (R) May 14
Georgia: H.B. 179 signed by Governor Nathan Deal (R) May 6

(See back for complete summary of all)
## All Current Pharmacy Benefits Manager Reform Laws

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<tr>
<td>Fair and Uniform Pharmacy Audits</td>
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<tr>
<td>Anti-Mandatory Mail Order</td>
<td>4 (PA, NY, HI, and TX—Medicaid and state employees only)</td>
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<tr>
<td>Registration/Licensure/Reporting</td>
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## Contact

If you wish to discuss community pharmacies legislative efforts in a particular state, please contact NCPA State Government Affairs at Matt.Deloseto@ncpnet.org or 703.600.1223.
In late 2008, Meridian Health Systems, a nonprofit that owns and operates six hospitals in southern New Jersey, hired a new pharmacy benefits management (PBM) company to help reduce the surging medication costs for its 12,000 employees and their families. Express Scripts, which has since become the largest PBM in the country, projected that it would slice at least $763,000 from Meridian’s $12 million in annual drug spending.

But just three months into the contract, Meridian discovered that its bills were soaring, on pace to balloon by $1.3 million in 2009. Express Scripts insisted that, in reality, Meridian was saving money.

Robert Schenk didn’t buy it. He oversees Meridian’s spending on medications for employees and its in-house pharmacy. Schenk, 57, had once owned two small-town drugstores but sold them in part because of relentless price-lowering pressure from PBMs. He knew firsthand how little pharmacies were paid relative to what customers were charged.

Schenk decided to figure out where Meridian’s money was going and why its drug costs were escalating. That was no easy task because, like most PBM customers, Meridian received data only on what it was being charged for each employee prescription. Meridian didn’t know what it cost the PBM to fill that order.

Then Schenk had a stroke of inspiration. He realized that Meridian had a second stream of data that almost no other PBM customers had: Its in-house pharmacy was paid by Express Scripts for many prescriptions. That meant Meridian could see both what the PBM was paying to buy drugs and what it was selling them for.

When he compared the two lists, the mild-mannered pharmacist was shocked: Express Scripts was making huge gross profits (known as “spreads” in the PBM world) ranging from $5 per order to many multiples of that. In one particularly extreme example, Meridian was billed $92.53 for a prescription for generic amoxicillin filled at an outside pharmacy. Meanwhile, Express Scripts paid $26.91 to Meridian’s own pharmacy to fill the same prescription. That meant a spread of $65.62 on one bottle of a generic antibiotic.

Express Scripts vehemently insists it saves money for clients and that the vast majority are satisfied with its service. And like any company — to state the obvious — it’s entitled to a profit. The question is, Who is making out better — the PBM or its...
customers? Many experts say the former. They argue that many companies stick with traditional PBMs because drug pricing is so impossible to untangle that customers have no way to verify how much they’re saving, if anything.
Independent Pharmacies Struggle With Increasing Generic Drug Costs


Posted: Jan 27, 2014 6:55 PM EST

By: Ted Hart

At Uptown Pharmacy in Westerville the list of generic medications available for $4 a month keeps getting shorter because the wholesale cost of generics keeps going up.

Pharmacy manager Jarrett Bauder says the increases have become more frequent.

"It seems like in the last six to nine months we've seen a big increase in the number of products that are being impacted by this and how often we're seeing those jumps," Bauder said.

Bauder pointed to a bottle of Divalproex, a generic for the seizure medication Depakote, as an example. The bottle on the shelf at Uptown Pharmacy was purchased in October for $132. Bauder said a replacement bottle today would cost $1,299.

But as those acquisition costs for pharmacies skyrocket, their reimbursement rates from pharmacy benefit managers (PBM's) like Express Scripts and CVS Caremark, lag behind by weeks — sometimes months. The result for pharmacists is filling prescriptions at a loss.

At County Line Pharmacy, John Komara said he's losing money on prescriptions every day. For example, Komara was recently reimbursed a total of $6.20 for a 30 day supply of Digoxin, a generic drug used by heart patients. Komara’s cost for the drug was $29.69. He filled prescriptions for Digoxin three times in a two-week period losing $23.49 each time.

Komara said those losses add up, "In the two week period my total losses on situations just like that were $523."

When generic drugs first become available, the prices tend to drop with multiple manufacturers competing for business. Now, pharmacists say, there are fewer manufacturers and the prices are going back up.

Pharmacy benefit managers make money by reimbursing pharmacies at one rate while charging the health plan a higher rate.

The Ohio Pharmacists Association is drafting legislation that would require more transparency from PBM’s and allow the state insurance commissioner to see those numbers.

Komara said, as it stands, pharmacists are in a difficult position.

"Am I willing to sell a product that I'm losing money on? I'm not going to deny somebody their heart medication because I'm losing $25, I couldn't sleep at night if I did that," Komara said.
Exposing PBMs' spread pricing game


By Jason Wallace

October 17, 2013

Groups advocating for increased transparency in the world of pharmacy benefits managers often cite “spread pricing” as one way PBMs drive up the cost of prescription drugs for employers and consumers. While the practice is often hard to expose, the upcoming issue of Fortune Magazine includes an in-depth piece, called "Painful prescription," which does just that.

Reporter Katherine Eban uses the story of Meridian Health Systems — a former customer of the nation's largest PBM, Express Scripts — to show the sometimes drastic difference in what PBMs charge patients to fill prescriptions and what they in turn pay pharmacies to dispense those prescriptions. This difference often leads to greater profits for the PBM and increased costs for the employer.

Robert Schenk, who oversees Meridian's spending on employee medications, dug through the employer's bills to discover just how rampant the practice was. One such example he found were charges for generic amoxicillin — Meridian was billed $92.53 when an employee filled the prescription, but Express Scripts paid only $26.91 to the pharmacy to fill the same prescription.

That amounts to a “spread” of $65.62 for only one prescription. In another instance, Meridian was billed $26.87 for a prescription of the antibiotic azithromycin. Express Scripts paid the pharmacy $5.19 to dispense the prescription, creating a spread of $21.68.

As this practice persisted, Meridian's health benefits costs skyrocketed, all while Express Scripts continually promised savings. In the first year alone, Meridian's prescription benefits costs increased by $1.3 million. It wasn't long before Meridian switched to a more transparent PBM to handle their prescription benefits.

So how do PBMs get away with this practice, without most employers ever knowing?

The contracts that employers sign with PBMs are often confusing, full of industry jargon, and provide ample opportunities for the PBM to hide their costs. Employers may assume they're paying pharmacy costs and administrative fees, but are unaware of the mark up that happens in the middle — the spread. As Schenk found, Meridian's contract with Express Scripts contained no restrictions on PBM spreads.

As this article demonstrates, it's more important than ever that those making benefits decisions are aware of these practices so they can ensure that they're not being manipulated by the PBMs that are supposedly helping them. As PBMs continue to produce record profits, employers and patients suffer.

You can learn more about “spread pricing” and access resources on navigating PBM contracts at Pharmacists United for Truth and Transparency's website, www.truthrx.org.