

June 1, 2009

The Honorable Don White
Chairman
Banking and Insurance Committee
Senate, Commonwealth of Pennsylvania

Dear Chairman White and Committee Members,

Thank you for the opportunity to offer testimony on the merits of Senate Bill 616. My name is Thomas Bowser, RPh and I am co-owner of an independent pharmacy, Shankel's Pharmacy, in DuBois, Pennsylvania. SB 616 will amend the "Unfair Insurance Practices Act" and I would like to begin by emphasizing part of the description of the act; ***"prohibiting unfair methods of competition and unfair or deceptive acts and practices"***. SB 616 addresses exactly this type of practice being perpetrated by Pharmacy Benefit Managers (PBM's) on community pharmacies, employers and other payors and most importantly on consumers, more specifically identified as "covered person" or "insured".

The most important concept today, in my opinion, is the right of an individual to exercise control in their personal healthcare. Within the scope of this hearing, it is the ability of a patient to exercise that right by having the freedom to choose the provider of their pharmaceutical services, and to prevent that freedom from being selfishly restricted by a PBM. I can understand ambivalence toward the PBM mail order practices by anyone who thinks pharmacists just "count and pour". I don't count you among those who hold such views. But those that do ignore the pharmacist-patient relationship and the direct impact on a person's health derived from that relationship. Pharmacists, in addition to our legal responsibilities, offer many value added services and are the most accessible health care professional to the public. There exists demonstrable impact pharmacists have on healthcare savings when the opportunity is provided through disease state management.

There are many reasons why a patient chooses a pharmacy. Restricting that ability to choose strikes at the very principle of free markets, a bedrock principle that resists deception, self interest and provides for true market pricing among it's benefits.

This bill, when passed, does not eliminate mail order pharmacy or restrict in any way the ability of an insured to choose mail order. It does, however, restore the ability of an insured to choose other than mail order. It prevents a PBM from coercing or mandating an insured into the mail order option. You will be asked to believe that mail order saves money, that community pharmacies charge too much, that independent pharmacies are like dinosaurs. In response to the latter comment please know that as of 2007 statistics there were 23,318 independent community pharmacies in the United States. What will be diminished is the inherent conflict of interest in the business model of a PBM operating a mail order pharmacy. If the PBM does not directly own the mail order facility it is affiliated via subsidiary. This mail order pharmacy directly competes with the community pharmacy which must operate under the terms and conditions dictated by the

very PBM that owns the mail order pharmacy. The word dictated is appropriate in my situation because, collectively, independent pharmacies do not have business negotiation rights with pharmacy benefit management companies. (We are fighting on the national level for such rights). It is important to note that the insured may not choose any mail order company. **The only choice is the one owned by the insured's PBM.** Also at issue is the lack of transparency in the PBM to Employer (Payor) relationship that fosters the absolute necessity for this legislation.

To understand the current push by PBM's to move patients into mail order it is important to understand how we got to this point. Much of the information that follows comes from a presentation of Dr. Mark Riley, Pharmacist, and Director of Arkansas Pharmacists Association. Dr Riley's credentials are bolstered by the fact that he used to work for a small, transparent PBM in the early 1990's.

PBA's (pharmacy benefit administrators) started in the late '70's and helped insurance companies and large self insured employers process pharmacy claims within their healthcare benefit. By the mid 80's PBM's were either started or evolved from PBAs, but were not yet major players in the market. In 1985 most people were insured by indemnity plans where they saved their receipts, turned them into the payor and typically got back 80% less their deductible. By the late 80's managed care became popular because, among many reasons, they provided employers with easy claims processing along with claims data and analysis. They also helped providers with an on line, real time, claim adjudication system. The PBM penetration into the market was swift. In my own experience, at our store, in 1987 35% of customers, mostly Dept. of Public Assistance recipients, had prescription cards. Today it is greater than 95% of our customers.

Increases in pharmaceutical healthcare costs directly reflect PBM market share penetration. In 1985 prescription drugs were 6% of the healthcare dollar. By the early 90's it was 10%. By 1999 it approached 18% and is currently around 15%. Again in 1985 most patients were in indemnity plans and free market principles helped control costs because patients were aware of the total medication cost. With the advent of PBM's, patients became detached from costs as they typically paid low co-pays. As a pharmacy owner I have often explained to legislators and discussed with other pharmacists this correlation to medication costs, once patients no longer paid up front. It was someone else's money. To help explain a plausible reason for this huge increase we need to examine the 3 main components of the cost of a prescription to an employer (payor):

1. **Manufacturer cost** of the drug (whose increases are well documented)
2. **Dispensing cost** (the pharmacy cost)
3. **Middlemen cost** (PBM's being the major component along with consultants, managers etc.)

It is important to understand, with the advent of PBM's, pharmacies came under contract for dispensing costs and those costs have been driven down conversely to the increase in total costs. Discounts to Average Wholesale Price (a published list price for drugs) for brand name drugs have increased from 5% to 10% then 12%, 14% to currently 17% and greater. I wish to point out if pharmacy cost has been driven to the floor yet prescription cost continues to increase dramatically, the pharmacy cost can not possibly be the reason

for the increase! This fact alone refutes the claim that community pharmacies are responsible, in part, for the huge increases in prescription drug costs.

During the market evolution of PBM's, there has been much consolidation in the industry and hence PBM power has increased dramatically. In fact, a PBM has the capacity to audit any pharmacy testifying to this committee or speaking in public against it's interests, and the pharmacy would be virtually powerless against such retaliatory audit. I mentioned that Dr Riley worked for a small, transparent PBM that operated in a more or less fiduciary manner in the early 90's. It was bought out by what he describes as a larger Wallstreet driven PBM. He spent the first 6 months of the new ownership questioning why particular changes were being made as they were not in the best interest of the employer. He came to realize the goal was no longer to save the payor money. The priority was to make money for the PBM. He left because of what he saw as misinformation and deception.

In addition to per claim charges and management fees, PBM's make money primarily in 3 ways:

1. Spreads
2. Rebates
3. Mail Order

It is important to understand PBM's are not regulated in most states and there is usually a lack of transparency and no requirement of fiduciary responsibility. The following will define the practices.

SPREAD is the difference between what the employer pays the PBM for the prescription and what the PBM pays the pharmacy for the prescription. Because of a lack of transparency, it has been a hidden practice for years. The spread game works because the employer only knows the formula by which it agrees to pay for prescriptions and does not know the formula by which the pharmacy is paid and vice versa. The PBM keeps the spread as profit. There is nothing wrong with profit as long as a free market exists to control profit. The PBM can increase spread by increasing the amount the employer pays or decreasing the amount it pays the pharmacy or both. In Dr. Riley's experience and consultations with payors, it has become clear to him that PBM's have increased the spread on clients less savvy in the benefit arena. Payors, be they employers, governments, unions, whomever, should know the amount of the spread. This is the reason Section 5 (15) (iv) "***Reimbursing a pharmacy less than the PBM is billing the payor for covered medications***" is in the bill. It prevents the spread from being lumped in with the pharmacy reimbursement and then be reported as "drug cost". Drug cost reported in this manner is often logically misinterpreted as manufacturer drug cost plus pharmacy dispensing cost, i.e. pharmacy reimbursement. Be advised there are many ways a PBM can manipulate the spread and thus use the spread to their benefit.

REBATES: In the 1992-1993 period PBM's became formulary managers and began to provide guidance to payors on co-pay levels, to influence formulary management and the insured's portion of the benefit. With formulary management came rebates from brand name manufacturers. The amount of a manufacturers rebate depended on the amount of

shift in market share the PBM could produce, along with preferential formulary status. Realize that rebates are an expense to manufacturers and expenses affect a drug's overall price. Savvy PBM's used some of the rebates to decrease their per claim charges and gain market share. Rebates are also used to create spread in brand name drug claims. Rebates are thus a source of income for a PBM. Also realize that rebates are earned for the entirety of covered lives insured by the PBM but I contend are used in part to lower mail order costs and not community pharmacy costs. As more sophisticated payors demanded a portion of the rebate to help offset rising prescription costs it has been purported that the total reimbursement for shifting market share is being paid to PBM's in various classifications, not 100% as "rebates". This is the reason for the second part of Section 5 (15) (IV) "***and denying a verifiable transparent accounting of all rebates, incentives or other materially beneficial considerations affecting such reimbursement concerning covered medications.***" Also, I believe many formulary decisions are made for the good of the PBM because of spreads and rebates. According to Dr. Riley the FTC estimated 3 years ago that the average brand rebate was approximately \$6.50 per claim. He also notes in the same time period generic spreads of \$9 per claim per client were common.

MAIL ORDER:

Mail order is promoted for maintenance medications, medications used on a daily basis. Mail order operations are also a profit center for PBM's. In the late 80's and early 90's PBA's and PBM's advised payors to limit the days supply of medications to 30 days to avoid waste and to control the outlay of benefit dollars. However, around 1996 PBM's who started mail order operations reversed themselves 180 degrees, purporting money could be saved via mail order operations. And they had the ability to make mail order appear less expensive to the health care system and to the payor because of spreads and rebates. By paying a community pharmacy a low amount for a drug and charging a payor a much higher amount, you can create enough spread to make the formula for payors at the mail order level less than what they paid with the formula at the community pharmacy level. Many people, however, chose providers other than mail order despite modest incentives. The penetration rate of mail order has been around 8 to 9% when current tactics are not employed. Dr Riley points out that the current tactics are being used by PBM's to increase mail order participation in anticipation of transparency, either demanded by payors or perhaps regulation.

Consumer choice is being restricted or denied by primarily two methods, coercion or mandate. They work in this manner. Typically, community pharmacies are contractually restricted by PBM's owning mail order operations to providing a one month supply of medication. You will be correctly told that 90 day contract terms are offered to community pharmacies. Realistically, most of the contracts can not be accepted because the terms are at or below drug acquisition costs, let alone providing for overhead or profit. Community pharmacies are effectively shutout of competition with the mail order pharmacy on a days supply basis. The patient, if not coerced, would then have the choice of having the prescription filled at a community pharmacy for a 30 day supply or via mail order for a 90 day supply of medication. The coercion comes in the form of monetary penalty. The insured is typically charged co-pay for a 90 day supply of medication from mail order equal to a 60 day supply if filled at a community pharmacy. Typical co-pay for

a 30 day supply of brand medication filled at a community pharmacy is \$30.00. To stay with the community pharmacy of their choice, it effectively costs the insured \$90 for a 90 day supply that must be purchased in 3 monthly \$30 purchases. The mail order pharmacy can supply 90 days of medication in one purchase for \$60. Remember **the mail order pharmacy is owned by the PBM who sets these terms**. The same applies to generic drugs except the monthly co-pay is typically \$10 yielding \$30 at community pharmacy vs. \$20 via mail order. The monetary penalties are particularly significant if the insured is on multiple drug therapy. Another coercive tactic recently employed by CVS/Caremark is contained in one of multiple letters, each for different medications filled at my pharmacy, received by one of my customers. For one particular medication her co-pay was increased from \$20 to \$61 to stay with my pharmacy. Her other option is to use Caremark mail order or go to the CVS store across town for much lower co-pays.

Mandatory mail order benefit is precisely that. If you do not use the mail order option you have no coverage for the medication period. Typically, the insured is allowed to fill the initial prescription plus one or two refills at the community pharmacy then further coverage is denied and is available only at the mail order level. This scenario allows the community pharmacy to “iron out” any dosage issues, adverse reactions, drug interactions etc. before the mail order pharmacy takes over dispensing of the medication.

Remember PBM's used to counsel against 90 day supplies of medications. Waste is a huge reason to avoid large supplies of expensive medications. The PACE program in Pennsylvania does not allow more than a 30 day supply for this very reason. But waste is ignored by PBM's, as I contend profit is the motive for mail order operations to be owned by the PBM. Why don't large non-PBM owned mail order pharmacies exist? I contend the reimbursement formulas and the rules and restrictions would be drastically different if the mail order operation was not owned by the PBM. The purported savings are the result of the preferential application of rebates, discounts, incentives and spread games that are to the advantage of the PBM. In my opinion, mail order pharmacy is an inferior form of pharmacy for a myriad of reasons perhaps others will expound upon. The reasons are also legitimate grounds to resist the coercion to mail order. My testimony centers on your constituents right to manage their healthcare and the conflict of interest inherent in a PBM owning a mail order operation.

In conclusion, I ask for your support of Senate Bill 616 without amendments. People have a right to choose their pharmacy just as much as they do to choose their doctor. It's their health and their rights should not be restricted by a PBM to bolster its profits. Will you next allow Auto Insurers to own body shops and coerce or mandate that collision repairs be made in company owned shops? Would you allow life insurance benefits to only be paid if the insured's family used a company owned funeral home for burial? This bill amends the “Unfair Insurance Practices Act” to prevent those scenarios within the pharmacy benefit portion of healthcare. It stops the coercion and mandating to mail order pharmacy and restores the insured's choice of pharmacy provider, including mail order if they so desire. It moves PBM's toward transparency and hopefully payors will demand fiduciary responsibility which will trend to lower medication costs for payors. It moves healthcare in the pharmacy benefit segment toward free market principles. PBM's do

have a place in this healthcare market. I look forward to the day independent community pharmacy has business negotiation rights and we work together for the insured's benefit in a better healthcare system. Please restore and protect your constituents' rights.

Respectfully,

Thomas E Bowser RPh