

**TESTIMONY SUBMITTED REGARDING PENNSYLVANIA SENATE BILL 616**

**BANKING and INSURANCE COMMITTEE**

**Submitted by:**

**Andrew Friedell  
Director, Government Affairs  
Medco Health Solutions, Inc.**

**June 9, 2009**

Mister Chairman, and members of the Committee, my name is Andrew Friedell and I am Director of Government Affairs for Medco Health Solutions, Inc., which is a pharmacy benefits management company, or “PBM.” I would like to thank you for this opportunity to testify today regarding our opposition to Senate Bill 616. This bill will prohibit a health plan in Pennsylvania from encouraging its members to choose a lower cost pharmacy and will thus significantly increase the cost of prescription drug care for patients and payors in the state.

As a PBM, Medco is hired by large employers, unions, health plans and public sector entities to help manage the quality and affordability of the drug benefit these plans offer to their members or employees. Medco provides drug benefits to roughly 60 million people nationwide and about 35 percent of the Pennsylvania population. In 2008, we mailed approximately 6.7 million prescriptions to state residents. We operate seven pharmacies in the state located in North Versailles, Bensalem, Warrendale, Harrisburg, Linwood, Pittsburgh and State College, we also have offices in Bluebell and Mechanicsburg and we employ almost 1500 Pennsylvania residents. Of that number, 232 are pharmacists and 613 are union jobs (members of the United Steel Workers union).

As you can imagine, many of our clients are struggling to stretch limited resources into a meaningful drug benefit for the members or employees. Therefore, they look to Medco for solutions to help maintain the affordability of their prescription drug costs. Mail service pharmacy is one of the most valuable cost-saving tools available to a plan. Because the drug benefit is often something that our clients voluntarily provide, their ability to take advantage of cost-saving strategies like mail service pharmacy can frequently be the difference in determining whether they can continue to offer these benefits to their members or employees.

## **Evidence on the Value of Mail Service Pharmacy:**

There is a growing body of evidence that mail service pharmacy is a more efficient and cost effective alternative for patients on maintenance medications.

- In a study that explored mail service pharmacies and PBM ownership, the Federal Trade Commission (FTC) found that retail prices were higher than mail prices for a common basket of drugs; that “Plan sponsors often secured more favorable pricing for mail dispensing than for retail;” and that most plans paid no dispensing or shipping fees to the PBM-owned mail service pharmacy.
- This same FTC study also determined that generic drug prices for 30-day scripts were 23.9% higher at retail than at the PBM-owned mail pharmacy and single-source brand prices were 13.9% higher.<sup>1</sup>
- A study commissioned by the U.S. Department of Health and Human Services found that prescriptions dispensed from a mail service pharmacy “cost six to eight percent less than if the prescriptions are filled through retail pharmacies.”<sup>2</sup>
- A study conducted by the Maryland Health Care Commission found that if all 90-day scripts dispensed to state residents were filled at mail, consumers would save about \$16 million annually and that it would reduce total Maryland consumer spending on prescription drugs by about 2 to 6 percent.<sup>3</sup>
- A study conducted by the U.S. General Accounting Office (GAO) found that at mail, PBMs provide plans with savings of about 27% and 53% for brand and generic drugs, respectively over the retail prices paid by patients without third-party coverage.
- This same GAO study also found that while mail service typically lowers an enrollee’s out-of-pocket costs, in their analysis mail also generated cost savings that reduced the plans’ costs and helped to lessen rising premiums.<sup>4</sup>

There is also evidence suggesting that mail service pharmacies can offer significantly higher quality care to the patients:

- A study conducted by researchers at Auburn University and published in 2003 in the *Journal of the American Pharmaceutical Association* (generally considered to be the benchmark study on retail dispensing accuracy), found an error rate of roughly 1.72% -- or approximately one error for every 58 scripts.<sup>5</sup> In this study, the authors

---

<sup>1</sup> Federal Trade Commission Report: Pharmacy Benefit Managers: Ownership of Mail Order Pharmacies; (August 2005). <http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf> (last accessed 10/3/2007)

<sup>2</sup> U.S. HHS Report: “Identification and Description of Industry Best Practices to Manage the Costs of Prescription Drugs.” (11/11/2005) (p. 47 and 58) <http://aspe.hhs.gov/sp/cost/cost.pdf> (Last accessed on 10/3/2007)

<sup>3</sup> Maryland Healthcare Commission Report: Mail-Order Purchase of Maintenance Drugs: Impact on Consumers, Payers, and Retail Pharmacies, (12/23/2005)

<sup>4</sup> GAO Report: Federal Employees’ Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies (1/2003). <http://www.gao.gov/new.items/d03196.pdf> (last accessed 10/3/2007)

<sup>5</sup> Flynn EA et al. National Observational Study of Prescription Dispensing Accuracy and Safety in 50 Pharmacies. *JAPhA* Volume 43, No. 2, pp 191-200, at 196, March/April 2003.

concluded that "dispensing errors are a problem on a national level" in the retail setting.

- The 11/2005 issue of *Pharmacotherapy* published a study that looked at dispensing accuracy at mail -- based on the same research design that the Auburn researchers used to measure the retail setting. This study found that a highly automated mail service pharmacy achieved dispensing accuracy rates of less than one in every 1,000 prescriptions (0.075%). This equates to **an error rate that is roughly 23 times better** than those seen in the benchmark study of retail pharmacy dispensing error rates.<sup>6</sup>

In addition, prescription drug spending has been the one bright spot among health care cost trends over the past few years and there is considerable evidence that increased use of lower cost mail service pharmacy is contributing to that positive trend. For example, the Centers for Medicare and Medicaid Services (CMS), which publishes its National Health Spending estimates each year in *Health Affairs*, began commenting several years ago on the deceleration in the rate of growth for prescription drug costs. This year, growth in prescription drug spending hit a 45-year low of 4.9% (well below hospital spending which increased 7.3% and physician office and clinic visit spending which increased 6.5%).<sup>7</sup> As recently as 2006, CMS attributed this encouraging pattern to "a shift toward greater mail-order dispensing," among other factors.<sup>8</sup>

Those numbers from CMS confirm what we see in the data from our own clients. The drug trend or year-over-year rate of increase for Medco clients in 2008 was 3.3 percent. To underscore the important role that mail plays in this equation, we looked at the experience of those clients with higher utilization of mail service pharmacy. Those clients where 40 percent or more of all prescriptions (based on the total days supply) were dispensed at mail had an average drug trend of -0.7 percent (in other words, their total per member prescription costs actually decreased from one year to the next!). In contrast, clients with less than 40 percent use of mail had an average drug trend of 5.8 percent.<sup>9</sup>

### **Potential Impact of Senate Bill 616:**

SB 616 would impose new restrictions on health plans in the state of Pennsylvania to prohibit their ability to offer incentives that encourage the use of more cost effective mail service pharmacies. The bill would also prohibit a health plan from contracting for a guaranteed rate for retail prescriptions through their PBM (as is the case when borrowers contemplate fixed versus adjustable rate loans, some payors also see

---

<sup>6</sup> Teagarden et al; "Dispensing Error Rate in a Highly Automated Mail-Service Pharmacy Practice." *Pharmacotherapy*; 2005;25(11):1629-1635), 11/2005 edition. This study reviewed prescriptions dispensed through Medco's mail service pharmacies.

<sup>7</sup> CMS report by Micah Hartman, Anne Martin, Patricia McDonnell, Aaron Catlin, and the National Health Expenditure Accounts Team. National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998. (*Health Affairs*, January/February, 2009, p.246).

<sup>8</sup> CMS report by Cynthia Smith, Cathy Cowan, Stephen Heffler, Aaron Catlin the National Health Accounts Team. National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending Drug Spending. (*Health Affairs*, January/February, 2006, p.186)

<sup>9</sup> Medco 2009 Drug Trend Report.

value in the certainty of contracting for a fixed rate for their prescription drug benefit -- rather than simply accepting the risk of whether their members will utilize lower or higher cost retail services). And finally, the bill also appears to require pharmacy benefit managers to reveal confidential elements of their cost structure to their subcontractors (the network pharmacies) when reimbursing pharmacy claims.

Specifically, language beginning on line five of page four of the bill would deem it an unfair or deceptive practice or method of competition if a health plan were to require patients to obtain certain medications from a mail service pharmacy in order to receive payment, or to structure their benefit in any way to encourage patients to choose the lower cost mail service pharmacy. Furthermore, language beginning on line 13 of this same page would also deem it an unfair or deceptive practice or method of competition if a health plan were to reimburse “a pharmacy less than the pharmacy benefits manager is billing the payor for covered medications and denying a verifiable transparent accounting of all rebates, incentives or other materially beneficial considerations affecting such reimbursement concerning the covered medications.”

As to the prohibition on any incentives that encourage the use of a lower cost mail service pharmacy (p. 4, line 9), considering the fiscal challenges faced by employers who offer prescription drug coverage, it makes sense that plans should be able to reward those patients who make better economic decisions by offering them more attractive co-payment or coinsurance options. Yet SB 616 prohibits plans from sharing with their members any of the savings generated through the use of mail service pharmacies. This simply makes no sense. Why would the state prohibit health plans from giving the consumer a break if they are willing to choose a lower cost pharmacy?

Supporters of SB 616 have argued that legislation of this sort is needed to create a “level playing field.” This argument assumes that prices must be equal among competitors in order for the playing field to be level. Every healthy marketplace has a range of competitors who compete with one another at different prices. That range of prices is the playing field. Legislating price equality among competitors would distort or eliminate, not level the playing field.

With regard to the provisions that would prohibit a plan from requiring patients to obtain certain drugs at mail in order to obtain payment (p.4, line 6), we know of many instances where a plan’s ability to promote mail service is the difference in whether or not they are able to maintain their overall drug benefit offering. Employers and health insurers want their employees and retirees to use mail service for maintenance medicines because it saves money. For example, in a *Wall Street Journal* story from 2/15/2005, General Motors indicated that their use of mail service pharmacy helped them to save about \$80 million overall across an annual drug benefit of about \$1.3 billion.

As to the language in the bill that prohibits a plan from contracting for a guaranteed rate for retail transactions (p.4, line 14), we think it is counterproductive (particularly in these turbulent times) to take away a popular tool that plans are adopting in order to help them mitigate uncertainty. It is true that such policies can result in the

PBM reimbursing the pharmacy at a rate that is different than the amount billed to the plan. But that difference can occur on the upside as well as the downside (meaning pharmacies can end up being paid both more or less than the amount billed to the plan in different instances). It is interesting that the bill takes issue only with those occurrences where the pharmacy could be getting paid less but is silent on those instances where the pharmacy may be paid more.

Finally, the provision relating to the verification of reimbursement accounting (p.3 line 16) is unclear and unnecessary (presuming this provision relates to some accounting that must be provided by the PBM to the pharmacy). The network agreements that establish the relationship between a PBM and a retail pharmacy are typically based on a discounted rate that the pharmacy will be paid on each prescription, plus a dispensing fee. When the pharmacy submits a claim to Medco, we adjudicate that claim and submit payment to the pharmacy at the agreed upon rate in the next bi-weekly payment cycle. The amount owed is straightforward and there is no need to provide a separate accounting beyond the statement the pharmacy already receives with its bi-weekly payment from Medco.

It is also important to point out that because state laws of this sort apply only to fully-insured plans in the state and not to those self-insured plans that are subject to federal rules, SB 616 will disproportionately affect those smaller employers who typically do not have the resources to self-insure. These are the same employers who not only drive job creation but who are also most vulnerable to added health care costs of the sort that would be levied by this bill. At the same time, numerous studies, including a 2003 Kaiser Family Foundation study, have found that employer-based health plans in general are increasingly shifting costs to their members. Notably, deductibles and co-payments are on the rise. SB 616 will accelerate this problem by adding costs for plans and by removing a lower cost alternative for patients.

In summary, we believe that every benefit provider should be able to create health benefits based on their own needs and values. At a time when coverage is eroding, when overall healthcare costs are going up and when employees and retirees' out-of-pocket costs are on the rise, employers need support, not shackles, in designing their drug benefits.

I appreciate the opportunity to submit our concerns with this legislation. I look forward to answering any questions you may have on my testimony.