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Thank you Chairman Sanfelippo and members of the Assembly Health Committee for allowing me to testify today on AB114 which pertains to licensure and regulation of PBM's or Pharmacy Benefit Managers. It's my belief that passing this bill will help to improve the health of our constituents by making the purchase of prescription drugs affordable and predictable. What AB114 accomplishes quite simply is better patient outcomes.

PBM's were created in the 1970's & 80's and began as 3rd party administrators playing an important role in the healthcare system by administering health plan prescription drug programs to health plan enrollee's. PBM's have a variety of different functions today. An important role that they play is negotiating better pricing with drug manufacturers. They become the middleman between those manufacturers and the health plans. Drug manufacturers desperately want their drugs on the PBM's formulary list, so manufacturers will offer kickbacks or rebates to the PBM's in order to be considered. The intention was that those kickbacks would be passed along to consumers to help lower prescription drug costs in the plan. What PBM's have morphed into and become in the last several years is why PBM reform is so vitally needed both here in Wisconsin and the United States.

There are 3 major PBM's that now control **80%** of the prescription drug market. That means 3 PBM's manage pharmacy benefits for 266 million Americans. The total healthcare spend in the US in 2019 was approximately **$3.8 Trillion dollars**. Of that amount, pharmaceutical spending is estimated to be about 17% of our total healthcare spend. That calculates out to roughly **$650 Billion/year** that Americans shell out for their prescription drugs.

You might be familiar with some of the names of these three larger PBM players. Express Scripts, Optum RX and CVS Caremark. So this is where things get a little cloudy and complicated. In 2018, Cigna Insurance completed their purchase of Express Scripts. Optum RX is owned by United Health Group. CVS Health owns CVS Pharmacy & the PBM CVS Caremark. Two years ago CVS Health acquired Aetna Insurance Company. As you can see, PBM's are now vertically integrated with managed healthcare companies, insurance companies, retail and mail order and specialty pharmacies. These overlapping interests within our vital healthcare

industries have led to unavoidable misalignments of their financial interests. PBM's that were once intended to process the claims between patients and the health plans that pay the bill for those medications, are now the plan designers, plan administrators and plan marketers. Most of them own pharmacies and are now either owned by insurance companies or are owned in association with health plan providers. Can you see the potential for conflicts of interest?

PBM's would have you believe that drug manufacturers are the evil culprits solely responsible for skyrocketing prescription drug costs. But that is not the reality. In 2017 the two largest PBM's had higher revenue than the largest pharmaceutical manufacturers. Looking at the top 10 companies in the Fortune 500 list, you will find the names of two of the largest PBM's I previously mentioned. Just below Walmart, Apple & Amazon, you have United Health which owns Optum RX. Just below them you have CVS Health which owns Aetna and CVS Pharmacy and CVS Caremark. As you can see these are very large publicly traded corporations with a duty first and foremost to provide shareholder value.

PBM's are **forcing** State Legislatures to get involved in reform because of some their unfair business practices. It isn't often that a bill is introduced with three quarters of the legislature signing on as cosponsors. AB114 currently has **98** cosponsors, proving that this is a non-partisan issue and an issue that is extremely important to a majority of our constituents. There are now 40 other states that have taken on some sort of PBM reform over the last 4-5 years. And if you watched President Trump last night in his SOTU Address, he specifically calls out PBM's and he told us reform is coming. It's my opinion that lack of action regarding PBM reform poses one of the foremost threats to the healthcare system and rising drug prices today.

We have drafted multiple versions of this bill after numerous meetings with all the stakeholder groups, so I'd like to run through some of the aspects still intact. AB114 requires PBM's to be licensed with the Commissioner of Insurance. Our bill also requires PBM's to submit annual transparency reports to OCI. The bill gives certainty to pharmacies participating in a PBM's preferred network, that pharmacy accreditation standards will be consistent. AB114 would also codify in WI State Statutes a federal law removing the "Gag Clause" that PBM's imposed in their contracts with pharmacies. The bill also provides clear language related to drug substitution or formulary changes. This provision was initially the sole reason why I decided to get involved in drafting this bill. After watching my wife and daughters health decline significantly, this fight became personal for me and my family. My

wife Christine along with my daughter Annalise will be testifying later specifically on this subject. I know that not everyone is as tenacious as she is, so it only stands to reason that many patients cannot or do not advocate for themselves and are not always able to obtain the medications they desperately need to remain as healthy as possible. Finally, AB114 sets fair and equitable standards related to audits that PBM's perform on pharmacies.

We have a variety of individuals & professionals here today, many of them pharmacy owners, or individuals who took the day off to come here so you can hear their concerns and horror stories firsthand. They come with examples of abuses that PBM's have inflicted on their lives & businesses. I'm confident that after hearing all of their testimonies today, you will agree that PBM reform is something that absolutely has to take place here in Wisconsin **THIS** legislative session. Thank you for listening and I'm happy to answer any questions you may have.

STATE REPRESENTATIVE
DEBRA KOLSTE
44TH DISTRICT

WISCONSIN STATE ASSEMBLY

To: Representative Sanfelippo and members of the Assembly Committee on Health

From: Representative Debra Kolste, 44th Assembly District

Date: February 5th, 2020

Re: 2019 Assembly Bill 114

Thank you, Chairman Sanfelippo, Vice-Chair Kurtz, and fellow committee members, for holding a public hearing on Assembly Bill 114.

Pharmacy benefit managers, or PBMs, play an outsize role in patient access to medications. While many are quick to blame pharmaceutical companies for high drug prices, there are more factors at play in determining the out-of-pocket costs patients face for prescriptions. Assembly Bill 114 provides some measure of PBM accountability to OCI. Many states are taking steps to reform PBM practices, and it is high time Wisconsin joins their ranks.

Assembly Bill 114 attempts to give some relief to pharmacists in their dealings with PBMs and their use of audits. This bill also removes "gag clauses" and provides patients a mechanism to ensure their medication remains on their formulary.

I thank Senator Roth, Senator Erpenbach, and Representative Schraa for their work on this legislation. Thank you for your consideration of Assembly Bill 114 and I respectfully ask for your support of this bill.

Debra Kolste

Deb Kolste
44th Assembly District

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The New York Times https://nyti.ms/2Oiw42e

How Chaos at Chain Pharmacies Is Putting Patients at Risk

Pharmacists across the U.S. warn that the push to do more with less has made medication errors more likely. "I am a danger to the public," one wrote to a regulator.

By Ellen Gabler

Jan. 31, 2020

For Alyssa Watrous, the medication mix-up meant a pounding headache, nausea and dizziness. In September, Ms. Watrous, a 17-year-old from Connecticut, was about to take another asthma pill when she realized CVS had mistakenly given her blood pressure medication intended for someone else.

Edward Walker, 38, landed in an emergency room, his eyes swollen and burning after he put drops in them for five days in November 2018 to treat a mild irritation. A Walgreens in Illinois had accidentally supplied him with ear drops — not eye drops.

For Mary Scheuerman, 85, the error was discovered only when she was dying in a Florida hospital in December 2018. A Publix pharmacy had dispensed a powerful chemotherapy drug instead of the antidepressant her doctor had prescribed. She died about two weeks later.

The people least surprised by such mistakes are pharmacists working in some of the nation's biggest retail chains.

In letters to state regulatory boards and in interviews with The New York Times, many pharmacists at companies like CVS, Rite Aid and Walgreens described understaffed and chaotic workplaces where they said it had become difficult to perform their jobs safely, putting the public at risk of medication errors.

They struggle to fill prescriptions, give flu shots, tend the drive-through, answer phones, work the register, counsel patients and call doctors and insurance companies, they said — all the while racing to meet corporate performance metrics that they characterized as *unreasonable and unsafe in an industry squeezed to do more with less.*

"I am a danger to the public working for CVS," one pharmacist wrote in an anonymous letter to the Texas State Board of Pharmacy in April.

"The amount of busywork we must do while verifying prescriptions is absolutely dangerous," another wrote to the Pennsylvania board in February. "Mistakes are going to be made and the patients are going to be the ones suffering."

[Read how you can protect yourself against medication errors.]

State boards and associations in at least two dozen states have heard from distraught pharmacists, interviews and records show, while some doctors complain that pharmacies bombard them with requests for refills that patients have not asked for and should not receive. Such refills are closely tracked by pharmacy chains and can factor into employee bonuses.

Michael Jackson, chief executive of the Florida Pharmacy Association, said the number of complaints from members related to staffing cuts and worries about patient safety had become "overwhelming" in the past year.

CVS Health ranks eighth on the Fortune 500 list and has nearly 10,000 pharmacies across the United States. Jeenah Moon for The New York Times

The American Psychiatric Association is particularly concerned about CVS, America's eighth-largest company, which it says routinely ignores doctors' explicit instructions to dispense limited amounts of medication to mental health patients. The pharmacy's practice of providing three-month supplies may inadvertently lead more patients to attempt suicide by overdosing, the association said.

"Clearly it is financially in their best interest to dispense as many pills as they can get paid for," said Dr. Bruce Schwartz, a psychiatrist in New York and the group's president.

A spokesman for CVS said it had created a system to address the issue, but Dr. Schwartz said complaints persisted.

Regulating the chains — five rank among the nation's 100 largest companies — has proved difficult for state pharmacy boards, which oversee the industry but sometimes allow company representatives to hold seats. Florida's nine-member board, for instance, includes a lawyer for CVS and a director of pharmacy affairs at Walgreens.

Aside from creating potential conflicts of interest, the industry presence can stifle complaints. "We are afraid to speak up and lose our jobs," one pharmacist wrote anonymously last year in response to a survey by the Missouri Board of Pharmacy. "PLEASE HELP."

Officials from several state boards told The Times they had limited authority to dictate how companies ran their businesses. Efforts by legislatures in California and elsewhere have been unsuccessful in substantially changing how pharmacies operate.

A majority of state boards do not require pharmacies to report errors, let alone conduct thorough investigations when they occur. Most investigations focus on pharmacists, not the conditions in their workplaces.

In public meetings, boards in at least two states have instructed pharmacists to quit or speak up if they believe conditions are unsafe. But pharmacists said they feared retaliation, knowing they could easily be replaced.

The industry has been squeezed amid declining drug reimbursement rates and cost pressures from administrators of prescription drug plans. Consolidation, meanwhile, has left only a few major players. About 70 percent of prescriptions nationwide are dispensed by chain drugstores, supermarkets or retailers like Walmart, according to a 2019 Drug Channels Institute report.

CVS garners a quarter of the country's total prescription revenue and dispenses more than a billion prescriptions a year. Walgreens captures almost 20 percent. Walmart, Kroger and Rite Aid fall next in line among brick-and-mortar stores.

In statements, the pharmacy chains said patient safety was of utmost concern, with staffing carefully set to ensure accurate dispensing. Investment in technology such as e-prescribing has increased safety and efficiency, the companies said. They denied that pharmacists were under extreme pressure or faced reprisals.

"When a pharmacist has a legitimate concern about working conditions, we make every effort to address that concern in good faith," CVS said in a statement. Walgreens cited its confidential employee hotline and said it made "clear to all pharmacists that they should never work beyond what they believe is advisable."

Errors, the companies said, were regrettable but rare; they declined to provide data about mistakes.

The National Association of Chain Drug Stores, a trade group, said that "pharmacies consider even one prescription error to be one too many" and "seek continuous improvement." The organization said it was wrong to "assume cause-effect relationships" between errors and pharmacists' workload.

The specifics and severity of errors are nearly impossible to tally. Aside from lax reporting requirements, many mistakes never become public because companies settle with victims or their families, often requiring a confidentiality agreement. A CVS form for staff members to report errors asks whether the patient is a "media threat," according to a photo provided to The Times. CVS said in a statement it would not provide details on what it called its "escalation process."

The last comprehensive study of medication errors was over a decade ago: The Institute of Medicine estimated in 2006 that such mistakes harmed at least 1.5 million Americans each year.

Jonathan Lewis said he waited on hold with CVS for 40 minutes last summer, after discovering his antidepressant prescription had been refilled with another drug.

Mr. Lewis, 47, suspected something was wrong when he felt short of breath and extremely dizzy. Looking closely at the medication — and turning to Google — he figured out it was estrogen, not an antidepressant, which patients should not abruptly quit.

"It was very apparent they were very understaffed," Mr. Lewis said, recalling long lines inside the Las Vegas store and at the drive-through when he picked up the prescription.

Pharmacists have written to state regulatory boards about their safety concerns.

"My fellow pharmacists and pharmacy technicians are at our breaking point. Chain pharmacy practices are preventing us from taking care of our patients and putting them at risk of dangerous medication errors."

New Jersey pharmacist

Too Much, Too Fast

The day before Wesley Hickman quit his job as a pharmacist at CVS, he worked a 13-hour shift with no breaks for lunch or dinner, he said.

As the only pharmacist on duty that day at the Leland, N.C., store, Dr. Hickman filled 552 prescriptions — about one every minute and 25 seconds — while counseling patients, giving shots, making calls and staffing the drive-through, he said. Partway through his shift the next day, in December 2018, he called his manager.

"I said, 'I am not going to work in a situation that is unsafe.' I shut the door and left," said Dr. Hickman, who now runs an independent pharmacy.

Dr. Hickman felt that the multitude of required tasks distracted from his most important jobs: filling prescriptions accurately and counseling patients. He had begged his district manager to schedule more pharmacists, but the request was denied, he said.

CVS said it could not comment on the "individual concerns" of a former employee.

With nearly 10,000 pharmacies across the country, CVS is the largest chain and among the most aggressive in imposing performance metrics, pharmacists said. Both CVS and Walgreens tie bonuses to achieving them, according to company documents.

Nearly everything is tracked and scrutinized: phone calls to patients, the time it takes to fill a prescription, the number of immunizations given, the number of customers signing up for 90-day supplies of medication, to name a few.

The fact that tasks are being tracked is not the problem, pharmacists say, as customers can benefit from services like reminders for flu shots and refills. The issue is that employees are heavily evaluated on hitting targets, they say, including in areas they cannot control.

In Missouri, dozens of pharmacists said in a recent survey by the state board that the focus on metrics was a threat to patient safety and their own job security.

"Metrics put unnecessary pressure on pharmacy staff to fill prescriptions as fast as possible, resulting in errors," one pharmacist wrote.

Of the nearly 1,000 pharmacists who took the survey, 60 percent said they "agree" or "strongly agree" that they "feel pressured or intimidated to meet standards or metrics that may interfere with safe patient care." About 60 percent of respondents worked for retail chains, as opposed to hospitals or independent pharmacies.

Surveys in Maryland and Tennessee revealed similar concerns.

The specific goals are not made public, and can vary by store, but internal CVS documents reviewed by The Times show what was expected in some locations last year.

Staff members were supposed to persuade 65 percent of patients picking up prescriptions to sign up for automatic refills, 55 percent to switch to 90-day supplies from 30-day, and 75 percent to have the pharmacy contact their doctor with a "proactive refill request" if a prescription was expiring or had no refills, the documents show.

Pharmacy staff members are also expected to call dozens of patients each day, based on a computer-generated list. They are assessed on the number of patients they reach, and the number who agree to their requests.

Representatives from CVS and Walgreens said metrics were meant to provide better patient care, not penalize pharmacists. Some are related to reimbursements to pharmacies by insurance companies and the government. CVS said it had halved its number of metrics over the past 18 months.

But dozens of pharmacists described the emphasis on metrics as burdensome, and said they faced backlash for failing to meet the goals or suggesting they were unrealistic or unsafe.

"Any dissent perceived by corporate is met with a target placed on one's back," an unnamed pharmacist wrote to the South Carolina board last year.

In comments to state boards and interviews with The Times, pharmacists explained how staffing cuts had led to longer shifts, often with no break to use the restroom or eat.

"I certainly make more mistakes," another South Carolina pharmacist wrote to the board. "I had two misfills in three years with the previous staffing and now I make 10-12 per year (that are caught)."

Much of the blame for understaffing has been directed at pressure from companies that manage drug plans for health insurers and Medicare.

Acting as middlemen between drug manufacturers, insurers and pharmacies, the companies — known as pharmacy benefit managers, or P.B.M.s — negotiate prices and channel to pharmacies the more than $300 billion spent on outpatient prescription drugs in the United States annually.

The benefit managers charge fees to pharmacies, and have been widely criticized for a lack of transparency and applying fees inconsistently. In a letter to the Department of Health and Human Services in September, a bipartisan group of senators noted an "extraordinary 45,000 percent increase" in fees paid by pharmacies from 2010 to 2017.

While benefit managers have caused economic upheaval in the industry, some pharmacy chains are players in that market too: CVS Health owns CVS Caremark, the largest benefit manager; Walgreens Boots Alliance has a partnership with Prime Therapeutics; Rite Aid owns a P.B.M., too.

The Pharmaceutical Care Management Association, the trade group representing benefit managers, contends that they make prescriptions more affordable, and pushes back against the notion that P.B.M.s are responsible for pressures on pharmacies, instead of a competitive market.

Pharmacists have written to state regulatory boards about their safety concerns.

"I am expected to make 50-100 phone calls in addition to answering phone calls, consultations, vaccinations and prescription verification. This has resulted in dispensing errors. A member of our staff misfilled a narcotic prescription for immediate release rather than extended release which resulted luckily in only patient fatigue, but it could have easily been deadly."

South Carolina pharmacist

Falling Through the Cracks

Dr. Mark Lopatin, a rheumatologist in Pennsylvania, says he is inundated with refill requests for almost every prescription he writes. At times Dr. Lopatin prescribes drugs intended only for a brief treatment — a steroid to treat a flare-up of arthritis, for instance.

But within days or weeks, he said, the pharmacy sends a refill request even though the prescription did not call for one. Each time, his office looks at the patient's chart to confirm the request is warranted. About half are not, he said.

Aside from creating unnecessary work, Dr. Lopatin believes, the flood of requests poses a safety issue. "When you are bombarded with refill after refill, it's easy for things to fall through the cracks, despite your best efforts," he said.

Pharmacists told The Times that many unwanted refill requests were generated by automated systems designed in part to increase sales. Others were the result of phone calls from pharmacists, who said they faced pressure to reach quotas.

In February, a CVS pharmacist wrote to the South Carolina board that cold calls to doctors should stop, explaining that a call was considered "successful" only if the doctor agreed to the refill.

"What this means is that we are overwhelming doctor's office staff with constant calls, and patients are often kept on medication that is unneeded for extended periods of time," the pharmacist wrote.

CVS says outreach to patients and doctors can help patients stay up-to-date on their medications, and lead to lower costs and better health.

Dr. Rachel Poliquin, a psychiatrist in North Carolina who says she constantly gets refill requests, estimates that about 90 percent of her patients say they never asked their pharmacy to contact her.

While Dr. Poliquin has a policy that patients must contact her directly for more medication, she worries about clinics where prescriptions may get rubber-stamped in a flurry of requests. Then patients — especially those who are elderly or mentally ill — may continue taking medication unnecessarily, she said.

The American Psychiatric Association has been trying to tackle a related problem after hearing from members that CVS was giving patients larger supplies of medication than doctors had directed.

While it is common for pharmacies to dispense 90 days' worth of maintenance medications — to treat chronic conditions like high blood pressure or diabetes — doctors say it is inappropriate for other drugs.

For example, patients with bipolar disorder are often prescribed lithium, a potentially lethal drug if taken in excess. It is common for psychiatrists to start a patient on a low dose or to limit the number of pills dispensed at once, especially if the person is considered a suicide risk.

But increasingly, the psychiatric association has heard from members that smaller quantities specified on prescriptions are being ignored, particularly by CVS, according to Dr. Schwartz, the group's president.

CVS has created a system where doctors can register and request that 90-day supplies not be dispensed to their patients. But doctors report that the registry has not solved the problem, Dr. Schwartz said. In a statement, CVS said it continued to "refine and enhance" the program.

Dr. Charles Denby, a psychiatrist in Rhode Island, became so concerned by the practice that he started stamping prescriptions, "AT MONTHLY INTERVALS ONLY." Despite those explicit instructions, Dr. Denby said, he received faxes from CVS saying his patients had asked for — and been given — 90-day supplies.

Dr. Denby, who retired in December, said it was a "baldfaced lie" that the patients had asked for the medication, providing statements from patients saying as much.

"I am disgusted with this," said Dr. Denby, who worries that patients may attempt suicide with excess medication. "There are going to be people dead only because they have enough medication to do the deed with."

'We Already Have Systems in Place'

Alton James never learned how the mistake came about that he says killed his 85-year-old mother, Mary Scheuerman, in 2018.

He knows he picked up her prescription at the pharmacy in a Publix supermarket in Lakeland, Fla. He knows he gave her a pill each morning. He knows that after six days, she turned pale, her blood pressure dropped and she was rushed to the hospital.

Mary Scheuerman died in December 2018 after taking a powerful chemotherapy drug mistakenly dispensed by a Publix pharmacy. Her son said she was supposed to have received an antidepressant.

Mr. James remembers a doctor telling him his mother's blood had a toxic level of methotrexate, a drug often used to treat cancer. But Mrs. Scheuerman didn't have cancer. She was supposed to be taking an antidepressant. Mr. James said a pharmacy employee later confirmed that someone had mistakenly dispensed methotrexate.

Five days after entering the hospital, Mrs. Scheuerman died, with organ failure listed as the lead cause, according to medical records cited by Mr. James.

The Institute for Safe Medication Practices has warned about methotrexate, listing it as a "high-alert medication" that can be deadly when taken incorrectly. Mr. James reported the pharmacy's error to the group, writing that he wanted to raise awareness about the drug and push Publix, one of the country's largest supermarket chains, to "clean up" its pharmacy division, according to a copy of his report provided to The Times.

Trexall, a brand name for the drug methotrexate, can be used to treat cancer.

The company acknowledged the mistake and offered a settlement, Mr. James wrote, but would not discuss how to avoid future errors, saying, "We already have systems in place."

Last September, Mr. James told The Times that Publix wanted him to sign a settlement agreement that would prevent him from speaking further about his mother's death. Mr. James has since declined to comment, saying that the matter was "amicably resolved."

A spokeswoman for Publix said privacy laws prevented the company from commenting on specific patients.

It can be difficult for patients and their families to decide whether to accept a settlement.

Last summer, CVS offered to compensate Kelsey and Donavan Sullivan after a pediatrician discovered the reflux medication they had been giving their 4-month-old for two months was actually a steroid. To be safely weaned, the baby had to keep taking it for two weeks after the error was discovered.

"It was like he was coming out of a fog," Mrs. Sullivan recalled.

The couple, from Minnesota, are still considering a settlement but haven't agreed to anything because they don't know what long-term consequences their son might face.

The kinds of errors and how they occur vary considerably.

The paper stapled to a CVS bag containing medication for Ms. Watrous, the Connecticut teenager with asthma, listed her correct name and medication, but the bottle inside had someone else's name.

Directions on the prescription for Mr. Walker, the Illinois man who got ear drops instead of eye drops from Walgreens, were clear: "Instill 1 drop in both eyes every 6 hours." He later saw the box: "For use in ears only."

In September, Stefanie Davis, 31, got the right medicine, Adderall, but the wrong dose. She pulled over on the interstate after feeling short of breath and dizzy with blurred vision. The pills, dispensed by a Walgreens in Sun City Center, Fla., were each 30 milligrams instead of her usual 20. She is fighting with Walgreens to cover a $900 bill for her visit to an emergency room.

Fixes That Fall Short

State boards and legislatures have wrestled with how to regulate the industry. Some states have adopted laws, for instance introducing mandatory lunch breaks or limiting the number of technicians a pharmacist can supervise.

But the laws aren't always followed, can be difficult to enforce or can fail to address broader problems.

The National Association of Chain Drug Stores says some state boards are blocking meaningful change. The group, for instance, wants to free up pharmacists from some tasks by allowing technicians, who have less training, to do more.

It also supports efforts to change the insurance reimbursement model for pharmacies. Health care services provided by pharmacists to patients, such as prescribing birth control, are not consistently covered by insurers or allowed in all states. But it has been difficult to find consensus to change federal and state regulations.

While those debates continue, some state boards are trying to hold companies more accountable.

Often when an error is reported to a board, action is taken against the pharmacist, an obvious target. It is less common for a company to be scrutinized.

The South Carolina board discussed in November how to more thoroughly investigate conditions after a mistake. It also published a statement discouraging quotas and encouraging "employers to value patient safety over operational efficiency and financial targets."

California passed a law saying no pharmacist could be required to work alone, but it has been largely ignored since taking effect last year, according to leaders of a pharmacists' union. The state board is trying to clarify the law's requirements.

In Illinois, a new law requires breaks for pharmacists and potential penalties for companies that do not provide a safe working environment. The law was in response to a 2016 Chicago Tribune investigation revealing that pharmacies failed to warn patients about dangerous drug combinations.

Some states are trying to make changes behind closed doors. After seeing results of its survey last year, the Missouri board invited companies to private meetings early this year to answer questions about errors, staffing and patient safety.

CVS and Walgreens said they would attend.

Research was contributed by Susan C. Beachy, Jack Begg, Alain Delaquérière and Sheelagh McNeill.

Good Afternoon Everyone,

My name is Christine Schraa and this is my daughter Annalise. Thank you so much for allowing us to be here today to tell a little bit of our story and why we feel AB 114 is critical for the state of Wisconsin.

Annie and I both suffer from autoimmune disorders, along with thousands of others within the state of Wisconsin and millions nationwide. Proper medical attention, exercise, healthy diet and appropriate medications are keys to managing autoimmune disorders. The key word is managing, as autoimmune disorders are not curable. Autoimmune disorders are the 10th leading cause of mortality in developing countries. I continue to thank God that we live in the United States so I and my daughter Annie, along with millions of others, have greater access to healthcare.

For transparency's sake I wanted to share with you that I am diagnosed with Mast Cell Activation Disorder. A quick definition of MCAD is a condition in which the patient experiences repeated episodes of anaphylaxis-allergic symptoms such as hives, swelling, low blood pressure, difficulty breathing and severe diarrhea. High levels of mast cell mediators are released during episodes. In simpler terms, I need to stay away from things I am allergic to and carry epi-pens at all times. Needless to say, when my exposure to potential life threatening allergens occur I can become a frequent flyer at the ER. I am incredibly regimented with foods, colorants and medications, and have found that offers me the most successful quality of life possible.

One medication I am prescribed is Dexilant. Dexilant is a medication for GERD, which can be common with people that have MCAD as inflammation is our biggest enemy. I had been on Dexilant successfully for many years. I had tried other meds, but eventually their effectiveness dwindled and I would need a med change. Dexilant contains properties that do not cause issues with my Mast Cell Disorder. I would pay $35 per month for my script a couple years ago. 2 years ago Navitus, our PBM, changed the formulary and Dexilant was no longer available to us. My doctor filed an exception form, which was denied. The claim would be considered only if I tried at least 3 different medications from their formulary list of meds. I explained my issues, stating that I had tried one of the meds unsuccessfully and was allergic to either binding agents or colorants in the other medications. I was told I was denied an exception review until I tried the PBM's listed alternatives. That's right, I was forced to try medications that I was documented allergic to or pay the cash cost of $1000 every three months. So I tried some of the medications until I was so sick I had to stop. I was sick from not having the medication I needed and sick from the medications I was forced to try. I was spending money on doctor appointments and other medications to offset the side effects of the medications I was forced to try before even being considered for a Tier 3 medication approval. Everything Mast Cell Disorder side effect happened. I wasn't sick for a few days, I suffered for weeks, almost 2 months, before I finally talked with a pharmacist from our PBM and she said I had suffered enough, she was approving the medication. It took a few weeks before I finally felt better. At the end of the day, I still need to fight each year to take this medication. One approval is just for one year, so I continue the fight. I am currently in the process of renewing my annual medication approval through my PBM. As I stated previously, 2 years ago I was paying $35 per month. That changed to

$185 every three months. That is a 90.4857% increase. This year my cost is $59 for 3 months!! I was so excited that my PBM put my medication back on the formulary, but they didn't. I am available for a coupon for one year which is why my cost went down. Without the coupon my cost would have risen to $303, which is a 51.4924 percent price increase from the previous year. In total that is a 1,022.222% price increase in 13 months.

Annie was diagnosed with Post Concussive Disorder at 15 ½ after 2 life changing concussions in 8th grade. This diagnosis also came with a host of medications. Trial and error again, but after time her doctors came up with a medication regime that was life changing. Annie will never fully recover from those injuries, but she has developed techniques to learn and communicate at the same capacity or above compared to kids her own age. She rocked her ACT test. At 16 Annie had surgery to straighten her deviated septum. Her recovery was exceptionally slow with complications. We also noticed she had lost a significant amount of hair and almost all her eyebrows, her skin was a mess. Make up for teenagers can hide many things, so these became very apparent during recovery. Assuming it was a vitamin deficiency we saw a skin doctor and our regular GP. After a battery of tests Annie came back positive for Lupus. I had the tests rerun, because I didn't believe it. It was positive again. So off to more specialists to see what we could do for our girl again.

Lupus, SLE specifically or Systemic Lupus Erythematosis, had a mortality rate of over 50% at the end of 5 years only 20 years ago. Annie has SLE. Currently SLE has a 90% survival rate beyond 5 years as long as symptoms can be controlled. The goal for anyone with Lupus or an

autoimmune disorder is to reach remission, but in reality there is no remission available, only management of symptoms. The goal is to prevent or at least delay organ damage, organs such as skin, kidneys, lungs, heart and/or brain are all potential targets of Lupus.

A couple years prior Annie was placed on birth control pills to help control her periods. She tried a host of different types, but Annie and her specialist settled on Yaz as that was the medication that controlled most of her problems successfully. She truly tried over 6 different types in a span of 2 years. We were so thankful for that medication. A little over a year ago Navitus denied Yaz and said we needed to start Annie on the generic form of the medication. Med change again. Within 6 weeks Annie started losing the eyebrows that had grown back, her hair was falling out and her skin was erupting. The most disturbing thing were her blood test results, every number was off, not by a little bit, but a lot. Enough that her specialist at UW-Madison started talking about Annie beginning immunosuppressant therapy if things didn't turn around. Some of you may know, immunosuppressants are prescribed for individuals with significant Autoimmune Disorders or Cancer. Those drugs also come with a host of side effects. As a parent this was not a conversation I wanted to be having. I can't even describe the look on Annie's face that day. So, back to the drawing board. What had changed in her life that could have caused such a radical change in her blood tests and skin. My only thought was Yaz. When I brought this up to her specialist she stated there is a .04% variation on either end of the generic formula of the medication. It could be enough to destabilize Annie's hormone levels and place her in a perpetual level of instability with her Lupus. Both specialists agreed Annie needed to resume the Yaz, not in its generic form, and take an active pill daily to maintain consistent hormone levels. After innumerable calls to our PBM and

enough documentation to write a book from multiple doctors, Annie was approved to return to Yaz as a Tier 3 medication. Prior to the change 14 months ago I was paying $5 every 3 months for her medication. Our new cost came to $161 every 3 months. That is a 3,220% increase to what we were paying 3 months prior. 3,220% increase!! How is that even possible!! My medications suffered a significant increase with the formulary change, but 3,220%?? So I paid the $161 dollars and thank God I did. Within 4 months her hair started growing back, her skin began to clear up and her eyebrows starting filling in. It has been a year since the forced generic disaster and I am happy to say Annie's numbers are now the best they have ever been since her diagnosis. The cost for her med had now gone up to $168.01 for this year, a 3,360.2% increase from our cost only a year and 2 months ago. I pay it, what are my choices? Her health would continue to decline, effect significant organs and potentially jeopardize her life, so I pay it. I am lucky I can pay it, but what if I couldn't? What if she can't afford her own meds when she becomes financially independent? What would her future look like then?

This is why AB114 is so important to us, and thousands of other people and their doctors in the state of Wisconsin. We deserve to receive the medications we need, most of which many of us have been on successfully for years. We shouldn't have to worry about a 3,220% increase in our medications. We shouldn't have to be denied 3-4 times before there is finally an approval, or another denial. I know I spent over 30 hours between doctors and PBM calls to beg to get things approved for Annie or myself. At Annie's third denial of Yaz I asked for a Navitus representative to tell her face to face she was denied, because I refused to tell her again. Some people just get tired of the rejections and stop advocating for themselves. It becomes

disheartening and defeating. Or clients accept the decision of a non-medical professional with a formulary guide sitting in front of them, being told what they can and can't take regardless of their prescribing physicians orders. I spent over 20 years working in a not for profit company advocating for people that weren't able to do it for themselves. Now I am advocating for my family and all the other families that have suffered in the state of Wisconsin.

It is said it takes a village to raise a child. I am asking all of you to be part of Annie's village. I am asking you to be part of every village for every Annie out there. We aren't alone, we aren't the exception to the rule as people may want you to believe. We have taken healthcare out of our doctors hands and placed them in the hands of drug companies. Doctors are being made to jump through hoops to provide care for their patients. I think AB 114 is a starting block to provide greater transparency for providers and consumers. I understand, we too own our own business, there are price increases and desired profit margins, but a 3,360.2% increase in less than 2 years is incomprehensible to me. I hope it is to you too.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, Governor
Mark V. Afable, Commissioner

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Date: February 5, 2020

To: Representative Joe Sanfelippo, Chair
Representative Tony Kurtz, Vice Chair
Members of the Assembly Committee on Health

From: Nathan Houdek, Deputy Commissioner
Office of the Commissioner of Insurance

Subject: OCI Fiscal Estimate on Assembly Bill 114, relating to registration and regulation of pharmacy benefit managers, drug pricing transparency, granting rule-making authority, and providing a penalty.

The Office of the Commissioner of Insurance (OCI) submitted a fiscal note for Assembly Bill 114 (AB 114) indicating a resource need of 7.5 additional positions at an ongoing annual cost of $546,706 and a one-time Information Technology (IT) expense of $204,000. OCI appreciates the opportunity to emphasize the need for these resources in order to effectively administer the new regulations established by this legislation.

Currently, OCI regulates the Wisconsin insurance industry; including insurers and agents engaging in the sale of property and casualty, health, and life insurance products. Listed below are major functions OCI performs in protecting insurance consumers and ensuring a competitive insurance market.

- Reviewing insurance policies that are sold in Wisconsin to make sure they meet the requirements set forth in Wisconsin law;
- Conducting examinations of domestic and foreign insurers to ensure compliance with Wisconsin laws and rules;
- Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;
- Issuing licenses to the various parties involved in selling and marketing insurance products;
- Assisting insurance consumers with their insurance problems;
- Researching special insurance issues to understand and assess their impact on Wisconsin;
- Providing technical assistance on legislation and promulgating administrative rules to interpret insurance laws;
- Creating and distributing public information and consumer education pieces to educate people about insurance; and
- Operating a state life insurance fund and an injured patient's compensation fund insuring health care providers for medical malpractice.

- Over -

Currently, OCI does not directly regulate Pharmacy Benefit Managers (PBMs) and does not have the necessary staff or expertise to ensure PBM compliance with the requirements AB 114 places on those entities. Under the bill, PBMs are required to register with OCI and adhere to certain price transparency requirements, as well as requirements with respect to their contracts with pharmacies, pharmacists, and health insurers. The additional resources outlined in the OCI fiscal note are necessary to enable OCI to carry out its obligations under the bill as the new regulatory entity over PBMs. As the regulator, OCI will need to review PBM compliance with contracting, network adequacy and auditing requirements, as well as collect and review PBM data, and ensure there is a means for complaints handling.

There has been a fair amount of reference to the fact that PBMs are currently licensed with OCI. OCI does regulate third party administrators collecting premium or charges for insurers. Chapter 633, Wis. Stats. refers to these entities as Employee Benefit Plan Administrators (EBPAs). Most PBMs engage in collecting enrollee premium from insurers to pay for enrollee prescription drug claims. As such, PBMs contracting with licensed health insurers offering comprehensive coverage in Wisconsin are licensed EBPAs. This licensure requirement entails the entity submitting a surety bond to OCI along with a $100 annual fee and a financial statement that includes assets, liabilities, and net worth. **This licensure process does not include a review of PBM business practices, or the requirements newly imposed on PBMs in AB 114.**

The new PBM requirements detailed in AB 114, along with the new responsibility for OCI to regulate PBM compliance with those requirements, expands OCI's regulatory oversight beyond its current scope of the insurance industry. Additionally, the resources needed to effectively carry out the compliance responsibilities in AB 114 cannot be adequately funded with the current $100 annual fee associated with EBPA licensure.

As noted in the fiscal note, "AB 114 creates Wis. Stat § 649.05(2), which requires a PBM to 'pay any registration fee set by the commissioner.' OCI would anticipate pursuing the establishment and assessment of that fee to support operationalizing AB 114."

Assessing a fee on PBMs in order to cover costs associated with the regulation of PBMs is consistent with OCI's current practices. As a program revenue-funded agency, OCI currently derives its funding from a mixture of assessments on insurance companies and fees paid by insurance agents.

OCI appreciates the Legislature's support for providing a mechanism to adequately fund the resources necessary to ensure compliance with the new PBM regulatory requirements included in AB 114.

Submitted by
Rep. Sanfelippo

Summary of ASA 1 to AB 114

- Consumer Transparency (§§7-9)
  - Drug substitution notice signage: Requiring pharmacies to post notices about current law, which says that they may substitute the prescribed drug for an equivalent generic or biosimilar drug
    - NB: This is not the formulary substitution section!
  - Generic equivalents signage: Requiring pharmacies to make available a list of top-100 drugs and their generics, including prices. Prices updated monthly
  - FDA generic book link signage: Requiring pharmacies to post instructions on how to find the FDA's master list of drug / generic equivalents
- Gag Clauses (§15.2)
  - Prohibits both PBMs and health plans from imposing gag clauses on pharmacies
    - This is the federal language: Pharmacist can tell patient about cheaper cash price
- Clawbacks (§15.3)
  - Prohibits PBM from making a consumer pay a higher cost sharing than the cash price
- Drug Substitution (§15.4)
  - Requires 30 days' notice for formulary removal or tier elevation, **UNLESS**
    - An approved alternative generic or brand is offered at same or lower tier
      - Pharmacist gives notice instead
    - FDA pulls the drug's approval or issues safety warning
    - FDA allows the drug to be sold over-the-counter
  - Notice must include information on how to get an exception
  - 30-day exception
    - Pharmacist can give patient a 30-day supply (potentially at higher cost sharing) if the drug was removed from formulary AND the patient has had a previous adverse reaction to the generic
- Accreditation (§21.4)
  - PBM must provide pharmacy with certification and accreditation standards within 30 days, upon request
  - PBM may can only change accreditation requirements once every 2 years
- Retroactive Claim Reduction (§21.5)
  - PBM may not retroactively deny or reduce a claim after adjudication, UNLESS
    - There was fraud, an error, or federal law requires them to change it
  - PBM can only recoup amount paid in excess of the otherwise allowable claim amount
- Audits (§21.6)
  - Provides for various procedures and safeguards against abusive PBM practices for routine audits
  - These provisions don't apply if there was fraud, willful misrepresentation, or criminality
- Transparency Reports (§21.7)
  - PBMs must report to OCI, for its WI pharmacy contracts:
    - The aggregate amount of rebates received that were not passed on
    - The percentage of rebates received that were not passed on
  - These reports are considered trade secrets and will be confidential

- Licensure (§§21.3, 23-45)
    - Adds PBMs to licensure requirements under ch. 633 as Employee Benefit Plan Administrators
        - Any PBM already licensed under ch. 633 does not need to get a second license, but they will be bound by any PBM-specific items in ch. 633
    - Unless specified otherwise, all general authority that OCI has under the insurance statutes applies to its oversight of PBMs
        - This includes
            - Rulemaking authority
            - Investigatory authority
            - Ability to issue and enforce orders
            - Ability to suspend or revoke a PBM's license
            - Prohibiting deceptive marketing or other unfair business practices
- Miscellaneous: Clarifies that cooperative formed to negotiate with PBMs on behalf of plans is not a PBM (§§18-19)

ATAP
ALLIANCE *for* TRANSPARENT & AFFORDABLE PRESCRIPTIONS

Alliance for Transparent and Affordable Prescriptions
Proponent Testimony to the Wisconsin Assembly Committee on Health
Assembly Bill 114
Presented by: Taraneh Mehrani, MD
February 5, 2020

Chair Sanfelippo, Vice Chair Kurtz, and members of the Wisconsin Assembly Committee on Health, my name is Dr. Taraneh Mehrani and upon my graduation from medical school and the completion of my residency and fellowship, I became a practicing rheumatologist in 2010, and currently treat patients in the Milwaukee area. I serve as a Director and the Chair of Local Chapters for the Association of Women in Rheumatology (AWIR), a provider organization dedicated to advocating for access to the highest quality of care and management of patients with rheumatic diseases.

Today, I am here testifying as a representative member of the Alliance for Transparent and Affordable Prescriptions. ATAP is an organization comprised of twenty-seven (27) patient and provider non-profit organizations. Our overarching goals include increasing transparency and appropriate oversight of how manufacturers, pharmacy benefit managers (PBMs) and insurers determine the price and cost of drugs; reducing prescription drug costs for patients and improving access to treatments; and increasing regulations on PBMs to combat their unfair and deceptive practices. Thank you for the opportunity to provide testimony today.

As you are likely aware, PBMs essentially act as middlemen between insurers, drug manufacturers, and pharmacies and thus have a uniquely central role in the drug market, handling everything from setting patient copayment amounts to determining which drugs are covered by which health plans. PBMs claim to pass a portion of the rebates and discounts they get from manufacturers back to the insurers to help drive down costs for patients, but due to the opaque nature of their contracts, most of these funds appear to go to their bottom line.

Transparency surrounding PBM formularies and patient cost-sharing obligations is critical to improving a patient's ability to obtain their medication in a timely and predictable manner. Provisions in AB114 require PBMs to register or obtain a license with the Commissioner in order to conduct business in the state. ATAP implores you to enact a licensing provision that increases oversight to better ensure PBMs act in the best interest of patients.

Further, PBM insurer mergers and consolidations should be subject to review to further explore the impact those arrangements have on prescription drug costs. To that end, ATAP opposes practices PBMs use that require or incentivize customers to use a pharmacy with which the PBM has an ownership or financial interest. ATAP suggests that the legislature adopt a policy that would provide for studying the impact PBMs actions have on drug costs.

PBMs often put in their contracts with pharmacies a "gag clause" that prevents pharmacists from discussing all prescription drug costs with their customer which results in consumers paying more. If enacted, the provisions in AB114 would no longer allow for PBMs to mandate to pharmacies that they not tell a patient when a lower cost medication is available to them that is therapeutically equivalent. The legislation also provides some protections to ensure patients are not paying more at the counter than they should be under the terms of their plan.

Similarly, ATAP suggests language be put back into the bill that would require PBMs to disclose, to the Commissioner, the aggregated dollar amount of rebates the PBMs receive that are not passed on to plans; making this information publically available would further strengthen transparency. In addition, ATAP suggests language be put back into the bill that would require PBMs to report the amount of administrative fees PBMs collect and retain.

Decisions about which medications are chosen for formulary inclusion should be based upon effectiveness and safety rather than kickbacks. However, PBMs construct their formularies based on rebate amounts, not patient care and this leads to practices referred to as utilization management protocols: step therapy, prior authorization, and non-medical switching.

ATAP holds that medically stable patients should not be forced off of their medications. Abrupt disturbances in treatment can result in irreversible disease progression, loss of function, loss of effectiveness of the original therapy and even hospitalizations – all of which drive up health care costs. At the very least, proper notification should be given to patients and providers when formularies are changing or medications are being discontinued.

Recent changes proposed to be made to this bill do not go far enough for patients and providers in regard to addressing medication formulary removals. In particular, the language provides for a 30-day notice to patients and providers, and in some cases no notice at all. Neither provision allows for enough time to handle medication formulary changes that result in medication switches; instead, ATAP advises the legislature to adopt policy requiring *a minimum of 60 days notice for all changes.* Also, it is imperative that a clear and transparent process be outlined to guide providers when submitting a request for continuation of coverage or appealing a denial from an insurer. ATAP supports language which would require a policy, plan, or PBM to use an existing medical exceptions procedure, including an internal grievance procedure, as provided for in WI Statute, when making decisions regarding exceptions; however, none of which are included in this legislation at this time.

In sum, ATAP holds that increased transparency and appropriate oversight of the prescription drug supply chain is necessary in order to be able to reduce costs for patients and improve access to treatments. For these reasons, the Alliance for Transparent and Affordable Prescriptions respectfully asks the Committee on Health to support the reforms in Assembly Bill 114 that improve PBM transparency and patient access to timely treatments.

Thank you once again for the opportunity to testify today. I would be happy to answer any questions the committee may have.

February 5, 2019

The Honorable Joe Sanfelippo
Chair, Assembly Committee on Health
Wisconsin State Capitol
2 East Main St.
Madison, WI 53703

RE: NATIONAL COMMUNITY PHARMACISTS ASSOCIATION SUPPORT OF AB 114

Dear Chair Sanfelippo, Vice-Chair Kurtz, and members of the Assembly Committee on Health,

Thank you for giving me the opportunity to testify in support of Assembly Bill 114, which would control drug costs in Wisconsin, provide greater protections for patients regarding their prescription drug benefits programs, and establish greater oversight of the pharmacy benefit managers that administer those benefits.

My name is Matt Magner, and I am here on behalf of the National Community Pharmacists Association. NCPA represents the interest of America's community pharmacists, including the owners of more than 21,700 independent community pharmacies across the United States and 272 independent community pharmacies in Wisconsin. These Wisconsin pharmacies filled almost 16 million prescriptions last year, impacting the lives of thousands of patients in your state.

Patient access to community pharmacy services has taken a significant hit recently in Wisconsin. Since 2012, the number of independent community pharmacies has decreased by almost 36%.[1] When community pharmacies close, patient health suffers. Research published in a publication of the Journal of the American Medical Association has shown that pharmacy closures "are associated with nonadherence to prescription medications, and declines in adherence are worse in patients using independent pharmacies that subsequently closed."[2]

Community pharmacists have long known that the culprits responsible for the loss of community pharmacies are opaque PBM practices.[3] Government officials across the nation who have examined PBM practices share those same concerns. For example, the New York Senate Committee on Investigations & Government Operations found that "PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies."[4]

Assembly Bill 114 would put a stop some of those opaque practices that are threating patient access to community pharmacy services and raising patients' out-of-pocket costs. Gag clauses and

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[1] *See NCPA Annual Digest*, 2013.

[2] Jenny S. Guadamuz, G. Caleb Alexander, Shannon N. Zenk & Dima M. Qato, *Assessment of Pharmacy Closures in the United States From 2009 Through 2015*, JAMA Internal Medicine, Oct. 21, 2019, www.jamainternalmedicine.com.

[3] *See* Abiodun Salako, Fred Ullrich & Keith Mueller, *Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018*, RUPRI Center for Rural Health Policy Analysis, July 2018, Rural Policy Brief No. 2018-2, *available at* https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf.

[4] New York Senate Committee on Investigations and Government Operations, *Final Investigative Report: Pharmacy Benefit Managers in New York*, (May 31, 2019), *available at* https://www.nysenate.gov/sites/default/files/article/attachment/final_investigatory_report_pharmacy_benefit_managers_in_new_york.pdf.

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copay clawbacks have prevented pharmacists from informing patients about lower cost alternatives at the pharmacy counter. By passing AB 114, Wisconsin would join 36 other states that have prevented gag clauses and copay clawbacks, thereby allowing pharmacists to work with patients to make the best, most cost-efficient healthcare decisions for that patient.

AB 114 would also prohibit retroactive clawbacks that end up increasing out-of-pocket costs for patients. When a PBM has reimbursed a pharmacy for filling a prescription, it is not uncommon for the PBM to claw back a portion of the reimbursement days, weeks, or even months later. However, a patient's cost share amount is tied to the initial reimbursement. Therefore, when there is a retroactive clawback, the true reimbursement amount is lower than the initial reimbursement. This means that a patient's cost share is based on an arbitrarily inflated figure. By prohibiting retroactive active claim reductions, AB 114 will ensure patients' cost shares reflect the true cost of their health care services.

AB 114 also brings much needed reform to pharmacy audits. Pharmacists understand that audits are a necessary practice to identify fraud, abuse, and wasteful spending, and they are not opposed to appropriate audits to identify such issues. Current PBM audits of pharmacies, however, are often used as an additional revenue source for the PBM. PBMs routinely target community pharmacies and recoup vast sums of money for nothing more than harmless clerical errors where the correct medication was properly dispensed and no financial harm was incurred.

Wisconsin is not the only state to recognize that reform is necessary. The Centers for Medicare and Medicaid Services has found that pharmacy audits were not focused on identifying fraud and financial harm but on targeting clerical errors that "may be related to the incentives in contingency reimbursement arrangements with claim audit vendors." CMS concluded that "full claim recoupment should only take place if the plan learns that a claim should not have been paid. . . at all; for example, because it is fraudulent."[5] Forty-two states have already passed legislation similar to AB 114 that ensure pharmacy audits are used properly to identify fraud, waste, and abuse.

AB 114 would protect patients and pharmacies by putting an end to abusive, opaque PBM practices. To protect patient access to vital pharmacy services, we respectfully ask you to support AB 114. Thank you, again, for your time, and I'd be happy to answer any questions you may have.

Sincerely,

Matthew Magner

Matthew Magner
Director, State Government Affairs

[5] Centers for Medicare and Medicaid Services, *Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* (April 1, 2013), *available at* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2014.pdf.

Pharmacy Society of Wisconsin

TO: Assembly Committee on Health

FROM: Matthew Mabie, RPh
Owner, Forward Pharmacy
Chairman of the Board, Pharmacy Society of Wisconsin

DATE: February 5, 2020

SUBJECT: **Testimony in Favor of Assembly Bill 114**

Thank you, members of the Assembly Committee on Health, for the opportunity to provide testimony in support of Assembly Bill 114. This bill takes a number of much-needed steps toward increasing transparency and accountability for Pharmacy Benefit Managers (PBMs).

Pharmacy benefit managers, or PBMs, play a crucial role in prescription drug benefits. In fact, PBMs manage plans for nearly 95% of Americans with prescription drug coverage[1]. PBMs serve as an intermediary between health plans and pharmacies to create formularies of preferred medication lists, negotiate with drug manufacturers for discounts and rebates, negotiate with pharmacies to establish networks for dispensing drugs, and process prescription claims at the point of sale for more than 200 million Americans. In addition, many PBMs own and operate mail order pharmacies.

Even though PBMs manage numerous prescription plans funded by taxpayer dollars and despite the fact that all other aspects of health care are closely regulated, there are almost no regulations at the state level in Wisconsin specific to pharmacy benefit managers. Over the past decade, more than thirty states have passed legislation to regulate specific PBM practices.

PBMs were created to bring savings to health plans and their members by reducing administrative costs, validating patient eligibility, and negotiating costs between pharmacies and health plans; however recent studies have demonstrated that many PBMs operate with a lack of transparency and have taken advantage of their middleman position between the health plan and pharmacy provider; additionally, some PBMs have implemented business practices that are unfair to pharmacies and patients.

This bill seeks to address a number of problems that pharmacies experience due to this lack of transparency and accountability.

[1] AIS Market Data, Pharmacy Benefit Management, PBM Market Share, Top 25 Pharmacy Benefit Management Companies and Market Share by Membership. 2000-2011 Survey Results: Pharmacy Benefits Trends & Data.

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1. **MAC Pricing**: Due to the secretive nature of PBM MAC pricing list, the pharmacy often is unaware what the reimbursement of a drug will be until time of claim adjudication. Often, if there has been an increase in the drug cost and a reimbursement rate that does not catch up to the increased cost to the pharmacy, the pharmacy will lose money on the claim. Despite existing state laws relating to MAC transparency, efforts to ask PBM for reconsideration of MAC pricing have been returned with a statement from PBM of "Pricing per contract." While Wisconsin has a MAC transparency law on the books, it is not currently being enforced. **This bill would give OCI greater authority to enforce the existing MAC transparency law.**

2. **Audits**: When a PBM audits the pharmacy and asks to see a prescription, they often recoup for a clerical error (missing date, DEA number, etc.) Often, the PBM recoups all money for the prescription. **This bill prohibits recoupments for clerical errors when the service was lawfully and correctly provided and limits recoupments in other circumstances when the prescription was lawfully dispensed.**

3. **Transparency**: PBMs often negotiate rebates for every prescription that is dispensed. **This bill requires PBMs to report rebates it receives and does not pass along to consumers to OCI to provide more transparency to this process.**

4. **Any Willing Provider**: Wisconsin is an any willing pharmacy state. If a pharmacist is willing, then they should be allowed into a PBM contract. Recently I have called several PBMs to ask to join a certain network or enter the mail order contract only to be told "that network is closed," or "apply next year." **This bill would give OCI greater authority to enforce the existing any willing pharmacy law if a pharmacist feels they are being excluded from a network for which they meet the contractual requirements.**

5. **Gag Clauses & Clawbacks:** When PBMs charge patients co-pays that are more expensive than the pharmacy's price for the same medication, pharmacists have been banned by contract from informing the patient of the lower cost option. Practice such as these force patients to spend more money out-of-pocket when using insurance than they would spend without using insurance. **This bill prohibits PBMs from banning or penalizing pharmacists from informing patients of a lower-cost option to purchase medications - for example, if paying with cash is less expensive than the patient's copay. Additionally, PBMs cannot require a patient to pay an amount that is greater than the cost of the drug or the amount the patient would pay if using cash.**

While the bill the committee is hearing today is narrower in scope than the original bill that was introduced earlier in the session, the Pharmacy Society of Wisconsin is appreciative of the efforts that the bill's authors and other legislators have made to find common ground that provides greater transparency and accountability of pharmacy benefit managers for pharmacies, patients, and policymakers.

Thank you for the opportunity to provide testimony on AB 114. I am happy to answer any questions you may have.

Quartz

To: Members, Assembly Committee on Health
From: Pat Cory, PharmD, Director of Pharmacy for Quartz Health Solutions
Date: February 5, 2020

RE: Assembly Bill 114 relating to: registration and regulation of pharmacy benefit managers, drug pricing transparency, granting rule-making authority, and providing a penalty.

Representative Sanfelippo and members of the Assembly Committee on Health:

Thank you for this opportunity to testify on AB 114. My name is Pat Cory and I am the Pharmacy Director for Quartz Health Solutions ("Quartz").

Quartz is jointly owned by three provider systems – UW Health, Gundersen Health System and Unity Point Health. We have office locations in Onalaska, Madison and Sauk City, Wisconsin, and provide community-based plans and services to more than 300,000 members across the State of Wisconsin. Quartz is also a member of the Wisconsin Association of Health Plans (WAHP).

I provide my testimony to the Assembly Committee on Health on AB114 today as a graduate of the UW School of Pharmacy, former clinical pharmacist in cardiology and critical care at UW Hospitals, former President and Board Chair of the Pharmacy Society of Wisconsin (PSW), former officer of the Wisconsin Pharmacy Foundation Board, former member of the Wisconsin Medicaid Drug Utilization Review (DUR) Board and former member of the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP) Board. I am currently a Clinical Instructor and guest lecturer for the UW School of Pharmacy and a member of the executive committee of the Sonderegger Research Center at the University of Wisconsin and, as mentioned, Pharmacy Director at Quartz.

I have and continue to work passionately to maximize the value of medications as a tool to improve the health and quality of life of individuals while balancing the costs of the services that provide this valuable benefit. I am intimate with and empathetic to the challenges faced by patients, pharmacy providers, payers and employers in today's healthcare system.

I think it is important to emphasize the range of my experiences as part of my testimony today because it is with these experiences and perspectives that I am able to speak to the impact of AB114 as introduced.

While I agree that Wisconsin needs a regulatory framework to oversee certain aspects of Pharmacy Benefit Managers (PBMs), AB114 contains several provisions that, while well-intentioned, will decrease quality of care and increase costs for Wisconsin residents and employers. For these reasons, Quartz is opposed to AB 114 as introduced. A subset of the provisions opposed by Quartz is discussed below.

Drug Substitution and Formulary Changes

AB114 would prohibit PBMs and health plans from making changes to a member's formulary in the middle of a benefit plan year. Formulary management is an effective tool for health plans to provide safe, medically appropriate care at the lowest cost. Formulary changes are usually prompted by market events (new drug released with superior clinical profile, existing drug taking significant price increase, new generic on the market creating savings opportunities, etc). Hampering a health plan's ability to adjust to these changes will result in greater utilization of lower value products (same outcomes, higher cost) and a pharmaceutical market that is less sensitive to price. The direct impact of this will be higher costs to health plan members in the form of increased premiums and member cost share.

"Freezing" a formulary for a patient's benefit year will cause health plans to maintain 12 versions of the formulary (we have benefit plans renewing every month of the year). Maintaining 12 versions of the formulary will be necessary to respond to the market conditions discussed and capture and pass available savings to our members. Maintaining this many formularies will create significant confusion for members and providers and will place a significant administrative burden on health plans. The resulting administrative costs will reduce the value gained in actively managing formularies and will ultimately increase claims cost for the pharmacy benefit, increase administrative costs and increased patient out of pocket costs.

In response to increasing costs, employer groups are often faced with three options: 1) offer insurance benefits that are less comprehensive, 2) buy down the cost of premium increase by moving to plan designs with higher member cost share or 3) move to high-deductible health plans.

Pharmacy Accreditation and Credentialing Requirement's

Several provisions in AB114 prohibit activities that are designed to structure a pharmacy provider network that produces the lowest costs while delivering the highest possible care to members.

Some pharmacies contend PBM's and Health Plans use arbitrary or unreasonable credentialing standards that exceed those established by the Pharmacy Examining Board to unfairly deny access to a health plan's pharmacy network, sometimes as part of an effort to benefit a pharmacy that is affiliated with a PBM. Quartz does not engage in this activity and only utilizes credentialing standards that are directly related to the quality of service and care received from the pharmacy by our members. To pass legislation that removes accreditation or credentialing standards from a PBM or Health Plan's efforts to contract with pharmacies that can meet the highest quality standards is contrary to the direction the healthcare industry is moving with regards to value -based purchasing and high-performance networks.

To maximize value and quality of our pharmacy network, Quartz requires pharmacies that dispense specialty drugs to be accredited as a specialty pharmacy by a national accrediting organization, the pharmacists dispensing specialty drugs to be board certified in pharmacotherapy, and the pharmacy must implement a variety of clinical outcomes management programs to optimize the medical outcomes of patients taking the medications in the program.

Pharmacies that are able to meet these quality requirements are better qualified and structured to provide comprehensive longitudinal pharmacy care to our members on these rare and costly medications. Health plans that have high standards for network participation benefit patient care and elevate pharmacy practice. In fact, Wisconsin's Department of Health Services (DHS) adopted such an approach in implementing the Wisconsin Pharmacy Quality Collaborative (WPQC) program for Wisconsin ForwardHealth. In order to be reimbursed for Comprehensive Medication Review and Assessment services for ForwardHealth a pharmacy needs to be accredited and the pharmacist certified by the PSW. This was put in place to make sure that the clinical services provided are done so by a pharmacy and pharmacist with appropriate training and expertise to provide a high value service.

In addition to the concern with network requirements, the proposed legislation eliminates a health plan's ability to have a member's cost share reflect the relative economics of the pharmacy they choose relative to the rest of the network. Removing price competition from the community pharmacy marketplace would result in increased drug costs and member out of pocket.

Thank you for this opportunity to share my concerns about AB114. I am happy to speak in greater detail about Quartz's formulary development process, how we communicate changes to our members, the process that allows members to remain on a drug when medically appropriate, or the value of our credentialing requirements.

I welcome any questions you may have.

DeanHealthPlan
A member of SSM Health

1277 Deming Way
Madison, WI 53717
phone: 800-279-1301
Medicare: 888-422-3326
TTY: 711
deancare.com

TO: Members of the Assembly Committee on Health

FROM: Amanda Borleske, PharmD, Manager of Pharmacy Operations, Dean Health Plan

DATE: February 5, 2020

RE: 2019 Assembly Bill 114, relating to: registration and regulation of pharmacy benefit managers, drug pricing transparency, granting rule-making authority, and providing a penalty

Thank you Chairman Sanfelippo and members of the Assembly Committee on Health for the opportunity to testify before you today on Assembly Bill 114. My name is Amanda Borleske. I am a pharmacist and the Manager of Pharmacy Operations at Dean Health Plan. For more than 35 years, Dean Health Plan has had the privilege of providing health insurance to Wisconsinites. Our Mission and Values center on the sacredness and dignity of each person we serve. Currently we insure more than 400,000 members through our individual, small-group, large-group, Medicare, Medicaid, and administrative only plans.

I would like to start by thanking the members of the Assembly Committee on Health for your willingness to work collaboratively on Assembly Bill 114. When the bill was first introduced, we raised several concerns and the Committee responded by working with us to amend the bill. We appreciate your efforts in addressing and removing the most problematic provisions of the bill.

Dean Health Plan is a patient-focused organization, dedicated to serving our members and providing access to quality and affordable health care. As a pharmacist, I have a unique opportunity to engage with patients directly on their health care needs. While I acknowledge changes to areas such as formulary coverage may at times appear perplexing, our decisions focus on what is best for our overall membership based on clinical evidence. Dean Health Plan's Pharmacy and Therapeutics Committee makes formulary management decisions and is composed of practicing pharmacists and physicians from a variety of specialties. This Committee abides by a formulary development and management process that promotes clinically appropriate, safe, and cost-effective drug therapy. Our Committee reviews data which includes, but is not limited to: the Academy of Managed Care Pharmacy (AMCP) dossier; peer-reviewed journals, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, and outcomes research data; relevant findings of government agencies, medical associations and national commissions, including published practice guidelines; authoritative compendia; opinions of local experts of the appropriate specialty; clinical recommendations from our Pharmacy Benefits Manager, Navitus; and recommendations from IPD Analytics.

Given the highly variable cost for medications and the potential drug shortages for individual drugs, we cannot ignore cost in decision-making when alternatives with clinically equivalent or better outcomes are available at lower costs. Changes to formularies allow health plans to provide patients with the most effective and up-to-date treatments that are available to improve their health. This gives patients the chance to use new and better clinical solutions, while also reducing drug prices for both the member and the health plan. We applaud this Committee's dedication to removing restrictions that prevent health plans from providing the best possible care to our members.

As health care costs increase, it becomes more challenging for people to afford the health care they need and deserve. Our focus is on making sure health care is affordable and providing our members with high quality care. For example, in 2019 Dean Health Plan was rated 4.5 out of 5 for our Commercial HMO plans by the National Committee for Quality Assurance (NCQA), an independent, not for profit organization that evaluates health plans based on over 50 care and service standards. Our 4.5 rating is in the top 17% of Commercial plans in Wisconsin and the top 8% in the nation. Providing our members with access to high quality products and services is why we only contract with those providers willing to adhere to high quality standards, protecting the wellbeing and health of our members.

Prescription drug costs are one of the leading drivers of soaring health care costs in the United States. As you did with the previous versions of this bill, we urge members of this Committee, as well as all those focused on reducing health care costs, to take a holistic view of prescription drug cost rather than to place your focus on only one sliver of the industry. Meaningful solutions come when all stakeholders are involved and committed to finding cost saving solutions that benefit and improve the health of patients.

Dean Health Plan and its parent company, SSM Health, are committed to finding cost saving solutions that benefit and improve the health of our patients and have taken actionable steps to demonstrate this commitment. Over the past two decades, shortages of generic, injectable drugs critical to lifesaving work of hospitals in the U.S. have become commonplace. In 2018, SSM Health, along with six other health systems and three philanthropies, came together and formed Civica Rx. Its mission, to make quality generic medicines accessible and affordable for everyone. Civica Rx is a nonprofit, non-stock corporation that focuses on reducing drug shortages, ensuring a stable and predictable supply of lifesaving generic drugs. Today over 45 health systems, representing more than 1,200 hospitals across the U.S., have joined Civica Rx in its mission of bringing competition to certain market segments through focus on value, which includes price and quality. Civica Rx acts as the conscience of the generic drug market, serving as a check against monopolistic behavior in the generic drug manufacturing industry.

We look forward to continuing to work collaboratively with the Committee on Assembly Bill 114 to best serve the residents of Wisconsin and achieve affordable health care, addressing concerns as they arise.

Thank you for your time and consideration of my testimony.

Alan Lukazewski, Director of Pharmacy of two health plans, WEA Trust and Health Tradition the last 5 years. WEA Trust was the founding company in 1970 by teachers, for teachers, to deliver a sustainable health care benefit.

Background: Pharmacist by 36 years with experience in clinical consulting in LTC, retail pharmacy with ShopKo Stores, and managing the P&L for a LTC pharmacy with PharMerica for 6 plus years and just over 13 years managing a pharmacy at Oakwood Village Retirement Communities here in Madison where I had the responsibility of negotiating contracts with wholesalers to manage to lowest cost, negotiated PBM contracts, worked with our buying group to negotiate contracts for the entire pharmacy group including rates for Part D contracts and generic effective rates.

My responsibility is to deliver a pharmacy benefit that supports safe and effective medications and services at a price that is affordable in order for our members to not be burdened with high out of pocket costs. Some examples of this are:

High-cost generic program in which we watch generic prices for inflation and move them to a higher copay tier when they hit an upper threshold in order to incent members to use the lower cost options. We communicate these changes, along with equivalent lower cost options, to both members and prescribers well in advance of any changes. This ensures members have access to equally effective medications at the lowest cost and keep the cost trend at the lowest possible rate. This program has saved over $5.3 million since inception that positively impacts premium.

We also manage our preferred drug list to incent members and prescribers to use the lowest cost, equally safe and effective options, again to manage total spend to the group. One method is to manage to lowest net cost with rebates, which leads to some products being excluded. The formulary does change quarterly, and notification does occur giving ample time for members and prescribers to select from the preferred drugs on the PDL. We have a process available to review requested exceptions and have done so on a routine basis, such as if there was a previous trial and failure or intolerance, even if it occurred at another plan. We work with members and providers to ensure the member receives a safe, effective and affordable medication. One example where exclusions are critical is when the drug Zegerid came out, a combination of Prilosec and sodium bicarbonate at a cost

over $1200! Without the ability to exclude a useless drug combination at an abuse price, we'd end up paying for this drug combination that can otherwise be purchased over the counter at WalMart for $23.97.

We have a Value Choice Drug List of no-cost medications for use in chronic conditions to incent members to use well established safe and effective medications to manage their chronic conditions.

We also manage opiate use, especially in those who are opiate naïve, new to opiates, to minimize the risk of them becoming dependent on opiates or end up misusing them. Our day's supply and total daily dose limitations may flag at the pharmacy and limit the total quantity dispensed, but we also work with members, prescribers and pharmacies to review exceptions where the prescribed amount may be justified, where in some instances it is not.

We do have an open network of pharmacies, yet have available a limited network option or narrow network. This could be used to incent members to use a lower-cost group of pharmacies, yet not totally exclude other pharmacies. Higher copays would be used to incent members to use the lower cost participating pharmacies. I am also working with the Pharmacy Society to reimburse pharmacies for clinical interventions, performing MTM and also chronic disease assessments and motivational interviewing to help members become more aware of their capabilities to manage their chronic conditions, and this program has met with much success, both for members and participating pharmacies. We welcome all pharmacies to participate and join in the effort to deliver more affordable and effective health care to the public.

We do use a specialty hub model in order to have participating specialty pharmacies meet specific criteria that minimizes waste and also affords our members access to those pharmacies that are expert in their specialty disease management. One such pharmacy is expert in supporting members and families with cystic fibrosis. Their efforts have helped members gain financial assistance, community support, and ensured medication wasn't sent if it wasn't needed, as people with CF can frequently visit the hospital for serious infections, hence not use medication from home for a period of time. That effort to talk with members and inventory on-hand supplies of medications has saved over $250,000 in one year. Otherwise, allowing the stockpiling of medications is not delivering value.

Testimony on PBM Reform

My name is Nicole Sandberg and I can say that I have been extremely privileged to be a staff pharmacist for Ballweg Family Pharmacy, a small independent pharmacy in Prairie du Sac, WI. Dennis and Sharr Ballweg, a husband and wife, pharmacist and nurse team, own and operate this pharmacy. They live and breathe by their work there. Sinking in unimaginable hours, not taking one vacation that didn't include days of continuing educatuion and business building in the 14 years they have been open. I can tell you that I never thought that I would be lucky enough to work for a pharmacy like theirs. In fact, my first job was at a CVS/pharmacy at the age of 16. I worked through high school, college, pharmacy school and my first couple years as a pharmacist for them. I grew up in central Illinois, where I spent summers and breaks helping with the buyouts and conversions of independent pharmacies to CVS stores.
After marrying a Wisconsin boy and then moving to Prairie du Sac, I was amazed at the number of independent pharmacies. In 2007, there were 4 of them in our small town of eight thousand residents. As of this fall, there are only 2 remaining and now a Walgreens. There have been a number of reasons for this decline, but one of them has been extremely low reimbursements and huge fees from PBMs. Chain pharmacies have been combating this hardship by cutting back drastically on staffing, and buying their own PBMs and paying themselves nicer margins.

At our pharmacy we have been fighting in all the ways that we know how, while making sure that it doesn't negatively impact the community that we take care of. We have invested in new software this year that makes the workflow faster, bought two robots in the last three years to improve efficiency, safety and provide a valuable packaging service that prevents patient errors in taking their medications. We have been a part of a number of initiatives to improve quality of care, and continuity of care with other healthcare providers. We are working to always be the best we can for our community. And, when you talk to our patients or other healthcare providers in our area, the difference is immensely clear. We are saving lives, reducing errors, keeping healthcare costs down by addressing diseases, limiting unnecessary medications and helping people get medicines that they can afford. All of this and our costs are almost always lower. Ballweg Family Pharmacy is what is going right in healthcare, but if we don't address PBM reform, the option to have the care that we offer is going to slip away.

Payment to our pharmacy continues to decline. Every year it is a new trick, and even mid year, things change that seem completely insane. Last year, one PBM sent me a fax with a change in how they were going to rate our pharmacy. If a patient was put onto a statin at your pharmacy, then left because they moved, or they finally relented to all the phone calls saying that they needed to go to a network owned pharmacy, we were still going to get dinged for any non-adherence they had at that new pharmacy. My rating and my payment across all claims was still going to be impacted by this patient that was no longer my patient, who I could no longer help.

Last year, I spoke to a patient that was on a Humana plan. She had $0 copays on all her medications with us, but she was told she had to go to Walmart now or pay more. She was

elderly, and needed all kinds of extra help, and certainly was easily confused and concerned by the phone call that she got from a call center pushing her to change pharmacies. Going to Walmart did not save her money. It was the same for her at either place. Except now she had to travel and possibly get a lower level of care. She couldn't be convinced that it was going to be okay for her to ignore that call and stay with us.

PBMs should be helping patients save money, help employers and state payers save money and ensure that quality care is provided that actually reduces further healthcare spending at hospitals or on worsening disease. They have implemented programs that were mandated by CMS that were meant to help tie together better health outcomes and payment, but have just led to further fees to pharmacies despite stellar star rating and positive measurements of these outcomes. This year we have a mandated 5% fee back at the end of each quarter even if I am making perfect scores or 7% back if I am not with WellCare, a CVS owned PBM.

In order to stop the bleeding, we have had to stop our prefered status with the CVS owned plans. This has left patients in the Sauk Prairie area only an option of mail order or leaving town to go to another pharmacy. These pharmacies are known to be understaffed to the point that I hear from my peers about not getting to go to the rest room or eat lunch through their entire shifts. The recent New York Times article "How Chaos at Chain Pharmacies is Putting Patients at Risk" has brought some of that practice to public light.

What I know about the current process of payment in the relationships between patients to insurers to PBMs to pharmacies is that they are incredibly complex. So much so that the contracts leave everyone guessing how much they are actually going to get paid for a product and then afraid of what the clawback fees will be after the fact. All this is happening when my friends, family and community members still are struggling to pay for their life saving medicines. Where are they saving from all this reduced payment? What is the effect on all of our health when patients are sent to corporate pharmacies or mail order to only to be pushed through as fast as possible without the pharmacy and pharmacist meeting their professional obligations to review, intervene and educate that patient on their medication and health? What happens when small hometown pharmacies are no longer there doing all they know if best for their community?

Nicole Sandberg, PharmD
Staff Pharmacist
Ballweg Family Pharmacy
Prairie du Sac, WI

Some of the stories from our patients and providers in the area given to me in just the last 12 hours:

Hi Nicole,

Here's my story for you to share. After my 2nd miscarriage I had extensive testing which discovered I had a clotting disorder as well as a luteal phase defect. My doctor told me that it was very important for me to start progesterone while trying to conceive or immediately after discovering I was pregnant to be able to carry full term.

I got pregnant without trying and knew it was imperative to get progesterone ASAP! My doctor called in the prescription to Ballwegs. Unfortunately, my insurance deemed it a prescription they would only cover via mail order. When I contacted the company they said it could take up to 4 weeks. My doctor informed me it was highly likely I would miscarry before I got the meds. As a result I had to pay out of pocket for it until I could get it via mail. It was hundreds of dollars but definitely worth my child's life.

The staff at Ballwegs was amazing. It's too bad my insurance company thought they knew what was best for me an my baby. Thankfully I had funds to pay for it, but not all may be so fortunate.

When insurance companies take lives in their hands, none of us benefit.

Laurie Killam

Tue, Feb 4,
8:31 PM (15
hours ago)

Inhalers and insulin, have been out forever, but are some of the most expensive medications despite their importance. I have to entertain reps just so that we have something to give patients.

Leah E. (Family Physician)

As a case manager for the past 5 years, serving individuals with AODA and mental health challenges, I have experienced many issues with insurance companied, that have limited, delayed or prohibited medical treatment and medication.

1. Requiring individuals to obtain their medication from UW Specialty Pharmacies and Dean approved pharmacies, has delayed patients getting their medications due to the closest pharmacy being over an hour away and not having transportation.
2. Blue Cross Blue Shield has been very challenging to work with, getting patients Vivitrol approved and not able to send to their local pharmacy, instead requiring it be sent to the patients home. Pharmacists have made many phone calls to BCBS attempting to fill clients vivitrol, and have gotten very little assistance and support
3. Getting injectable suboxone, Sublicade, approved by insurance companied, has been virtually impossible.
4. Group Health insurance has mandated that certain clients use generic brand suboxone, even though their physicians have requested brand name due to the patients not doing as well on generic brand. Side effects have been documented and sent to insurance companies, with no support or avail.
5. Medicare does not cover vivitrol to the best of my knowledge
6. The BIGGEST issue that I have seen and most detrimental to patients physical and mental health, is Medicaid cutting individuals off with no warning, due to making over the allotted income level. There are a lot of clients that go without insurance all together and cant afford their medications, because they have had to make the choice to pay rent and food, and cannot afford market place insurance or pay out of pocket for medications. Medicaid only allows a single individual to make $1000/month before no longer qualifying for Medicaid. The average market place monthly premium is $300 for an individual.

Kelly Zuelke
MAT Case Manager
Madison Trauma Therapy
4785 Hayes Rd. Suite 201, Madison, WI
608-733-0791

Hi:

I saw your FB post asking for drug stories for your visit to the capital tomorrow. My husband is prescribed Humira for Crohns Disease. Our insurance requires us to get it from their mail order pharmacy partner. The cost of the drug is ~ $3500 for 2 doses a month. Our copay is $1900 for a month until we hit our overall insurance deductible of $4000 (our employer health insurance is a high deductible plan). Once we meet our deductible we will pay a 10% copay for the drug. Once we meet our out of pocket maximum of $6000 for in network providers/pharmacies then it will be covered 100%.

Each month our health insurance premium is deducted from my husband's paycheck. On top of that we have ~$400 a month deducted for our HSA account which helps us cover our $4000 deductible we have to meet. We are fortunate that we have found a way to make this work, but the price for this much need medication
and our deductibles are ridiculous. I don't know how most people could do this.

Thanks for going to the capital tomorrow to share stories like ours.

Jennifer

P.S. A bonus frustration is that Humira has to be refrigerated and because our insurance requires us to get it mail order we have piles of styrofoam coolers that cannot be recycled.

Nicole Sandberg Tue, Feb 4, 2020 at 9:04 PM

To: Jennifer M

Thank you so much for sharing your story. It is truly so ridiculous! Do you ever feel that that your medication is exposed to dangerous temps during shipping or feel disconnected from the pharmacist that should be counseling him on how to use a medication like Humira safely?
Thanks again!
Nicole

Jennifer Moore Tue, Feb 4, 2020 at 9:13 PM

To: Nicole Sandberg

You're welcome!

The summer heat worries us, so we make sure that we are home when it gets delivered to help avoid it being left on the porch in the heat. Of course that assumes that it's hasn't been left in high heat environments en route.

The insurance company's pharmacy require a multiple call process each month when he needs to get his refills, so he does have options to talk to them. If anything he hates having to go through so many steps just to get the refill now that he's been on the medication for the last 18 months.

Good luck!

February 5, 2020

To: Wisconsin Legislative Session

Re: Pharmacy Benefit Managers

Good Morning,

My name is Gary Boehler; I live in the Twin Cities of Minnesota. I have been a pharmacist for 50 years, the last 35 of which I have focused on pharmacy store operations and third party contracting. I work now as an independent consultant for approximately 600 stores in 10 of the Upper Midwest states.

We have the most expensive drug delivery system in the world and it continues to grow each year; it is one of the most discussed topics by patients, plan sponsors who pay the bills, and is in the news almost daily.

The drug delivery system, up until the last 35 years or so consisted primarily of the drug manufacturer, drug wholesalers, the pharmacy provider network, and ultimate delivery to the patient/plan sponsor. Suddenly, middlemen came into the picture, also known as pharmacy benefit managers, or more simply, PBMs. From that point forward the entire model has changed from being simply a claims processor for a fee to "middlemen that now impact every step of the drug delivery system, either directly or indirectly." Please allow me to explain in brevity how each step in this convoluted drug delivery system is costing everyone more money.

1. **Drug manufacturers**: are impacted directly by PBMs' relentless demands for increasingly higher rebates. In a recent article Eli Lilly disclosed that its list prices for insulin are being discounted by 53% worth of rebates that are paid out to PBMs and to a smaller degree for 340B programs and state Medicaid programs. Lilly's actual net prices are some 3% lower than in the past. The other two insulin manufacturers (Novo Nordisk and Sanofi-Aventis) also report very similar results. Of particular interest to everyone in this room is the fact these manufacturers currently have on the market lower cost equivalent products that are 50% of the original cost of the insulin products, BUT NONE OF THE BIG FIVE PBMs WILL ALLOW THESE LESS COSTLY ALTERNATIVES TO BE ON THEIR FORMULARIES. Eli Lilly has stated their less costly version (50% less) accounts to 3% to 4% of their total insulin sales. This speaks volumes about PBMs and their greed for maximizing rebates. It is the

same with many other brand name products; one only needs to look at their annual list of drugs not covered by their formularies. There are many other examples.

This is not to say the drug manufacturers are not complicit in their own ways as well, especially with how patents are manipulated and extended, thus deferring the time for an equivalent generic to enter the market. But to me the far overreaching reason for increased costs of drugs is PBMs' insatiable greed for rebates.

2. **Drug Wholesalers:** drug wholesalers are indirectly impacted by rising costs of pharmaceuticals. As PBMs consolidate, continue their vertical integration, and border on monopolistic activities, they also continue to wreak havoc with pharmacy reimbursements. As reimbursements continue to decline, pressure is then placed on the wholesaler to provide better costs to these pharmacies who are in many, many instances, forced to dispense below their actual acquisition cost.
3. **Pharmacy Provider:** is directly feeling the brunt of egregious and heinous activities by PBMs. Among the things I see destroying pharmacy today are pricing below actual acquisition cost, contracts of adhesion, increasingly more preferred networks, DIR fees (either at the point of sale or months after a claim has been filled), effective rate contracts which only serve to take more money from a pharmacy, extremely aggressive audits of up to $250,000 and then looking for technicalities (scrivener's errors) to recoup earlier payments, negative response rates on generic pricing appeals (MACs) of 95% or higher, moving pharmacies from one network to another with more aggressive rates, disallowing 90 day refills for patients on maintenance medications, and forcing that business to their self-owned pharmacies (steering).
4. **Patients:** continue to see higher cost deductibles for their medications, are constantly being steered to either self-owned pharmacies or to "big box" pharmacies (Express Scripts and Prime Therapeutics are masters at this game), higher copays, lack of counseling and consulting through mail order – the patient is to be the one to call the pharmacy, and not the other way around as it should be. I have examples by Optum of patient clawbacks at the point of sale (artificially high copays which are taken back from the

pharmacy by remittance advice sheets later – this serves as a way for the PBM to add to their own coffers at the expense of the patient. Patients are very directly being impacted by PBM actions.

5. **Plan Sponsor:** the plan sponsor is ultimately responsible for paying the drug claims after the patient copay has been satisfied and once again is very directly impacted by how PBMs take advantage of their opaque contracting techniques. Spread pricing rises to the top as a way PBMs enrich themselves, and is running rampant. There are not clear definitions of what constitutes a rebate v. an administrative charge, how and when rebates are paid, and how these plan sponsors are paid compared to what a provider pharmacy has been paid. There is an example in Texas (very recent) of where county commissioners learned one of the big three had an average spread price of $29.09 per script on what the county was charged vs. what the local pharmacy was being paid. There is a specific example in North Dakota for a Medicaid patient who, for nine months, received a cancer drug through Optum's managed care Medicaid (MCO) program. When the administrator of ND Human Services did an analysis the difference between the Optum billing and what fee for service Medicaid would have been billed was in excess of $100,000 – just for nine months. Effective, January 1, 2020, North Dakota moved all Medicaid recipients over to a fee-for-service model and for this small state of 675,000 residents, the taxpayer/state/federal savings will be in the millions of dollars.

The bottom line to all of these issues is how to resolve them in a fair way that benefits patients and plan sponsors – the solutions are simple and need to be tackled on a state by state level – far too many politics and lobbyists in Washington, D.C. Besides, why not battle close to where the action is and it can be seen very visibly? Here are my recommendations:

1. Require complete fiduciary responsibility by any PBM doing business in Wisconsin. If they don't agree to those terms, they simply do not do business in Wisconsin! It is that simple, and I know there are PBMs that will abide by those requirements. I have in my possession a Caremark contract where language says if there are fiduciary requirements they (Caremark) will not participate. To that I say FINE! DON'T PARTICIPATE.

2. Require radical transparency for all plans that a PBM administers in the state of Wisconsin. That means transparency for the plan sponsor/patients, pharmacy provider networks, and the state insurance or commerce commissioner riding shotgun and requiring transparent reporting on a regular basis by all PBMs.
3. Eliminate MCO Medicaid networks completely; state after state is showing hundreds of millions of dollars of savings by going back to the fee-for-service model. It all started out in Ohio two plus years ago where savings were $224 million; it just happened in North Dakota and is being looked at in many other states, among them New York, Arkansas, and others. There is simply no justification for these kinds of insane profits being made by the PBMs because of their opaque and one-sided tactics.
4. CMS has developed its own MAC pricing for all drugs, not just generics. It is called NADAC pricing, is updated weekly by Myers and Stauffer, the national accounting firm contracted with CMS to provide more accurate costs. The NADAC pricing plus a reasonable dispensing fee would absolutely be a model to pursue for fair pricing for patients, plan sponsors, and pharmacy providers. No more retaliatory and predatory pricing by PBMs, all for their own gain.

Wisconsin is predominantly a rural state; with what has happened and continues to happen patients are running into and will increasingly find it more difficult to find local access to prescription drug services. It is not too late and all of you serving in the Wisconsin legislature have the power to make positive change for the entire state.

Thank you.

Gary W. Boehler

Gary W. Boehler, R.Ph.

Gary Boehler

From: Joyce, Brendan <bjoyce@nd.gov>
Sent: Monday, February 3, 2020 11:18 AM
To: Gary Boehler
Subject: Voice mail

Simpler in e-mail. 2019 fills

BEXAROTENE 75 MG CAPSULE (Generic for Targretin)

#120 1 fill reimbursed at $27,693.42 $55,386.84
#120 6 fills reimbursed at $26,724.15 $160,344.90
#180 2 fills reimbursed at $40,086.23 $80,172.46
#T $301,904.20 Billed by Optum to NDAK.

1200 capsules total.

I'll let you pull what the pharmacy costs were in 2019.

Brendan Joyce, PharmD
Administrator, Pharmacy Services

701.328.4023 • 701.328.1544 (fax) • 711 (TTY) • bjoyce@nd.gov • DHS Home Page

NORTH Dakota | Human Services
Be Legendary.

- Costs shown on attachment range $61.69 to $189.00 per dose.
- Cost for 1,200 doses range from $74,028 to $226,800 (before any rebates to the state or pharmacy).
- Therefore, Optum's spread price ranges from a minimum o- $75,104.20 to $227876.20 - likely on the higher side since the state reported spread price well in excess of $150,00
- These were filled at Optum's own pharmacy, so their costs were very likely less than the attachment.

ADVANCED FILTER

	NDC/ PROD ID	STRENGTH	PACK SIZE	DOSAGE FORM	EXP DATE	MFR	SUPPLIER	UNIT PRICE	PRICE	WAC/AWP SPREAD	QTY AVL	NOTICE	PURCHASE QTY
Bezafibrate 75mg Capsule (Targretin) | AB Generic													
	68682000310	75mg	100 ea	Cap		Bausch	Top Rx (VA...	$61.692	$6,169.19	AWP±: $21,783.64	1		QTY ADD
	68682000310	75mg	100 ea	Cap		Bausch	IPC (VAWD)	$61.150	$7,450.00	AWP±: $20,502.83	999+		QTY ADD
	43975031510	75mg	100 ea	Cap		Amerigen	IPC (VAWD)	$61.231	$7,459.00	AWP±: ($102.75)	999+		QTY ADD
	68682000310	75mg	100 ea	Cap		Bausch	Hercules (V...	$189.000	$18,900.00	AWP±: $9,052.83	23		QTY ADD

February 3, 2020

To Whom It May Concern,

I am writing this letter to express my frustration concerning my inability to use the pharmacy of my choice. I have a Medicare drug supplement plan that because of certain drug/insurance contracts, and the cost of my prescriptions, causes me to use a pharmacy that is NOT my choice. Yes, I can use other local pharmacies, but I would have to pay approximately an additional $600-$700 out of pocket per year. That is not an option on a fixed income.

My question is why? Why can't I use the pharmacy of my choice and receive the same uniform copay? Why is there such a difference between drug costs and insurance plans for the same drug? My ~~current~~ new pharmacy makes mistakes every time I need a prescription. I have to drive further to get my prescriptions and I have no confidence that I am getting the correct drug or dosage.

Waunakee Hometown Pharmacy is the pharmacy of choice and I support their effort in making my voice heard to the state legislature concerning this issue.

Sincerely,

Jean A. Schuster

Jean Schuster

PAAS National, Inc.
Expert Third-Party Contract and Audit Advice
160 Business Park Circle • Stoughton, WI 53589 • 608-873-1342 • Fax: 608-873-4009

5 February 2020

Dear Wisconsin State Assembly Committee on Health,

My name is Trent Thiede and I am a pharmacist and the Chief Operating Officer at PAAS National®. I live in Oregon, WI, and our business is based in Stoughton, WI. Since 1993 PAAS National® has been helping community pharmacies navigate their Pharmacy Benefit Manager (PBM) and insurance audits. Over the 27 years in business, we've analyzed 80,000 audits and have more than 20% of all independent community pharmacies in the nation as members of our services.

Today you will hear/have heard the impact and control PBMs have over community pharmacies. I'd like to share with you some statistical comparisons that PAAS has access to being nationwide.

Since 2015, PAAS has seen a 78% increase in the number of audits pharmacies are subjected to.

2019 PAAS Audit Statistics

	Wisconsin	Minnesota	WI versus MN	Iowa	WI versus IA
Number of Audits (per Pharmacy)*	**5.25**	2.13	2.5x increase	3.07	1.7x increase
Initial Audit Findings (per Audit)*	**$17,181**	$6,520	2.6x increase	$5,248	3.3x increase

*Based on audits reported to PAAS by members

The main difference between Wisconsin and Iowa/Minnesota is both Iowa (59:191-59.4(510B)) and Minnesota (62W.09) have PBM Audit Integrity statutes. Wisconsin pharmacies are being targeted for easier audit recoupments from community pharmacies due to the lack of regulation. I urge you to move the PBM Reform Bill forward for the sake of community pharmacies and small business in Wisconsin.

Respectfully submitted,

Trenton Thiede PharmD, MBA
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www.paasnational.com

Coalition of Wisconsin Aging & Health Groups

Financial Empowerment – Personal Advocacy – Victim Rights

"Advocating for all Generations"

The Coalition of Wisconsin Aging and Health Groups is a nonprofit, nonpartisan, statewide membership organization that was founded in 1977.

2/5/2020

Coalition of Wisconsin Aging and Health Groups AB 114 Testimony

Chair Sanfelippo, Vice Chair Kurtz, and members of the Committee, good afternoon and thank you for the opportunity to speak today. I'm Rob Gundermann, CEO of the Coalition of Wisconsin Aging and Health Groups and Chair of the Wisconsin Pharmacy Patient Protection Coalition. I will be speaking to two provisions in this legislation that are important to our coalition, the removal of the gag clause and drug substitution or non-medical switching.

Gag clauses have been used to bar pharmacists from telling consumers when it would cost less to pay cash for a prescription than paying the copayment on their insurance. People deserve to know the lowest price they can pay for their medications at their pharmacy and gag clauses imposed by PBMs have prevented this. The provision in this bill that prevents the use of gag clauses in Wisconsin corrects this problem and will enable people to pay less for their prescription medications.

Another issue in this legislation that is of great importance to us is that of drug substitution or non-medical switching. When a patient is taking multiple medications, their doctor has to find the right combination that works for them and that can be daunting. Finding drugs that will work together without causing negative side effects becomes more and more difficult as you add additional drugs in to what essentially becomes a drug cocktail. A formulary change that requires the patient to change medications can seriously impact people in these circumstances.

The substitute amendment requires a patient to have previously failed on the medication being substituted in order to receive a 30-day supply of their current medication. We are not clear on what the patient does after their 30-day prescription runs out or why the 30-day figure was used.

Lastly, we would prefer a clear process be outlined in the bill for submitting a request for continuation of coverage or appealing a denial from an insurer as was included in the previous substitute amendment.

Thank you and I'm happy to try and answer any questions.

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NATIONAL INFUSION CENTER ASSOCIATION

February 5, 2020

Chair Sanfelippo, Vice Chair Kurtz, and the members of the Wisconsin Assembly Committee on Health, I would like to thank you for the opportunity testify on AB 114 today. My name is Kaska Watson, and I am the Education & Policy Coordinator at the National Infusion Center Association (NICA).

NICA is a 501(c)(3) nonprofit patient advocacy organization formed to represent patients requiring provider-administered medications and the providers that treat them. NICA works to ensure that our nation's sickest and most vulnerable patients can access the outpatient infusion and injectable medications they rely upon to manage their complex, chronic condition(s) through advocacy, education, and resource development. NICA represents hundreds of thousands of patients managing complex, chronic, rare, life-threatening and/or difficult-to-manage diseases (e.g., autoimmune diseases) with medical benefit drugs (e.g., biologics) in one of several thousand outpatient infusion facilities across the country, including several NICA member offices here in Wisconsin. We work to ensure that patients can access these medications in non-hospital care settings to improve affordability and access.

Pharmacy Benefit Managers (PBMs) act as middlemen between pharmacies, payers, and drug manufacturers. With PBMs playing such a critical role in formulary development and determining a patient's cost share obligation, transparency is paramount in ensuring that savings from rebates or manufacturer coupons are passed down to the patient. AB 114 requires PBMs to obtain a license with the Insurance Commissioner in order to practice in Wisconsin. The bill also requires PBMs to report, to the Commissioner, the dollar amounts of rebates and administrative fees they receive. NICA supports this provision that increases oversight and ensures that PBMs are acting in the best interest of the patients they serve.

Under current regulation, patients purchasing prescription medications through an insurance plan are not protected from inflated copayment costs, which are often higher than the true cost of the drug. In many cases, health plans that utilize a Pharmacy Benefit Manager (PBM), charge a higher copayment at the pharmacy and profit from a percentage of the medication sale. PBM. This increases the cost of care for patients. Furthermore, a PBM, pharmacy, or insurer can contractually prevent pharmacists from informing patients of opportunities for costs savings, such as paying a cash price or paying less for a different brand. In situations where patients could save money by paying out of pocket for their medication, rather than using their insurance, they are often unaware and end up overpaying. NICA supports the intent of AB 114 to prohibit PBMs from charging more than the cash price for a prescription, essentially keeping patients' hard-earned dollars in their pockets, and permit pharmacists to inform patients of all opportunities for potential savings.

Non-medical switching occurs when an insurer requires a stable patient on their health plan, or "enrollee," to switch from their current effective medication to a less costly alternative one, irrespective of efficacy. Insurers and PBMs achieve this outcome in several ways — typically, they remove coverage for the medication, or they make the medication too expensive for the patient to afford. Non-medical switching can negatively impact a patient's health. Health care providers often work with their patients

for months, or even years, to find a therapy that manages the progression of a disease or helps stabilize a complex or chronic condition. Oftentimes, people with mental illnesses, immunodeficiency disorders, epilepsy, cancer, and autoimmune diseases such as rheumatoid arthritis, inflammatory bowel disease, lupus, multiple sclerosis, and psoriasis, must try multiple medications before finding the one that works.

The original version of AB 114 included mid-year non-medical switching protections for patients, allowing patients the security of knowing their treatment plans would not be changed mid-year for reasons unrelated to health or safety. The new substitution strips patients of those protections, and waters down the statute to simply provide notification of formulary changes at least 30 days in advance. In some cases, 30 days is not enough time to safely transfer a stable patient from one medication to another. The amendment offers a route to request an exemption, but the process is not clearly outlined and does not stipulate a timeframe in which PBMs or insurers must respond. NICA recommends using the same timeline currently in statute for step therapy exemptions: 3 business days or by the end of the next business day in exigent circumstances.

In summary, NICA supports AB 114 and respectfully request the House Committee on Health vote in support of this legislation. In addition, we urge the Committee to reconsider the original language regarding non-medical switching and midyear formulary changes to better protect patients that are stable on their treatment plans.

Thank you for your time and consideration,

Kaska Watson

Kaska Watson, MPH
Education & Policy Coordinator, National Infusion Center Association

TO: Assembly Committee on Health

FROM: Thad Schumacher, PharmD
Owner, Fitchburg Family Pharmacy
Former Chair - Wisconsin Pharmacy Examining Board

DATE: February 5, 2020

SUBJECT: **Testimony in Favor of Assembly Bill 114**

Thank you, members of the Assembly Committee on Health, for the opportunity to provide testimony in support of Assembly Bill 114. This bill requires Pharmacy Benefit Managers (PBMs) to register with the Office of the Commissioner of Insurance (OCI) and allows the commissioner of insurance to regulate PBMs. This bill would allow OCI to revoke a PBM's registration if the PBM commits "fraudulent, coercive, or dishonest practices."

A pharmacy benefit manager, or PBM, plays a significant role in prescription drug benefits. In fact, PBMs manage plans for nearly 95% of Americans with prescription drug coverage. PBMs serve as an intermediary between health plans and pharmacies to create formularies of preferred medication lists, negotiate with drug manufacturers for discounts and rebates, negotiate with pharmacies to establish networks for dispensing drugs, and process prescription claims at the point of sale for more than 200 million Americans. In addition, many PBMs are part of large vertically integrated corporations which own retail pharmacies and operate mail order pharmacies.

When Pharmacy Benefit Managers were created, the intentions were noble. Help employers, insurance, and pharmacies navigate the electronic payment model of pharmaceuticals. Even though PBMs manage numerous prescription plans funded by taxpayer dollars, they are virtually unregulated at the state or federal level. This lack of regulation hurts patients. In response, over thirty states have passed legislation to regulate specific PBM practices.

I wanted to share four ways that PBMs negatively impact my patients and my business.

Making patients pay more at the pharmacy counter. To start, you should know that pharmacies communicate with the PBMs to verify coverage in real time. When this occurs the PBM communicates the amount that they will pay the pharmacy and the amount that the patient should pay, the Copay. These two amounts make up the total that the pharmacy is paid for a prescription. One example is the young lady that was at our pharmacy the other day for her prenatal vitamin. She had been getting the same prescription for months with an $8 copay. This week when we filled it, the copay was $50. Through the process of generic substitution we found that we could fill another version of the drug for an $8 copay. Further analysis revealed that this version of the drug, the PBM was incentivising her to choose was 100% more expensive. In addition to being more expensive, the pharmacy was reimbursed at a loss. This is costing our healthcare system more money either way you look at it. Either the employer who sponsors the insurance plan is paying more for the expensive drug that the patient is being incentivized to choose or the patient is paying more for choosing the version that she used to take. Secondly, as a pharmacist under contract with the PBM, I am gagged from telling the patient or the employer about this situation. I can tell you from personal experience that they are serious about enforcing this gag clause. I have received more than one admonishment from the PBM's for giving my patient, their doctor, or their employer more information about what is going on with the cost of medication than the PBM thought I should. It is quite intimidating.

A second example: At our pharmacy we provide the administration of injectable medication to patients suffering from alcohol/opioid addiction, as well as schizophrenia. These medications are given by injection and supply the patient with a steady dose for 28 days. This is a great way for providers to help their patients become compliant with their medication. We provide these medications as a service to our community and we have providers from all over the state referring patients to us, because of our availability with scheduling. We often get referrals for patients, who's PBM will not pay for their medication at the retail pharmacy. This often results in a break in therapy, which places the schizophrenic or addicted patients at risk.

The take or leave it contracting with PBMs. Just this week I was sent a contract from a major PBM via fax. It was another take it or leave it contract with a pricing structure that I could see with a glance would be a losing proposition for almost all the Brand name drugs I dispense. There was an opt out clause, with a 20 day window. There was no information as to who this contract would cover. I was left to wonder what portion of my customer base, if any, would be affected by this pricing structure. I would be left to make a yes/no decision with little or no information about the most vital part of my business. This is normal practice with the PBM's low reimbursement rates and no negotiating.

I have owned and operated my family run business in Fitchburg for 6 years. As we have spent most of this time building the business and establishing our client base, the PBM's have been ever present to hamper our success. In the past 3 years my pharmacy has been assessed over $90,000 in DIR fees. Mind you, this was money that the PBM's paid to me for claims that I had submitted. Then through their non-transparent system they assessed these deductions and automatically subtracted them from future payments that I was due.
That $90,000 could have been used to hire an additional delivery driver to reach more people with transportation needs. I could have hired a community health worker to help some of our most vulnerable patients coordinate the care that they need. It could have gone to service our pharmacy's debt, allowing us to meet our financial obligations earlier, which could lead to expansion of our many services. All these would benefit the taxpayers of Wisconsin, but instead the money went into the pockets of the PBMs. Don't think for a minute that my store was singled out for these DIR fees, I assure you that every community pharmacy in the State of Wisconsin is having more money taken from them than what I had taken from me.

Again, please vote to support AB114 and hold PBMs accountable. This bill requires Pharmacy Benefit Managers (PBMs) to register with the Office of the Commissioner of Insurance (OCI) and allows the commissioner of insurance to regulate PBMs.

Thank you for your time, I would be happy to answer any questions.

Thad Schumacher, PharmD
Owner of Fitchburg Family Pharmacy

PBM's

The Need for Regulation

1. Mr./Madam Chairman, committee members, I'm Doug Schultz, president and co-owner of Tobin's, a family owned Pharmacy in Oconomowoc, Wisconsin. Tobin's was started in Burlington and has been serving patients for over 106 years.

   I urge the assembly to pass bill 114 pertaining to regulation of activities of Pharmacy Benefit Managers, also referred to as PBMs, in the state of Wisconsin.

2. PBM's compel patients through manipulative pricing into a mindset that they **MUST** have their prescriptions filled at pharmacies chosen by their health plan rather than at the pharmacy of their choice. On Monday, I spoke to one of our patients who was using the OptumRx PBM's mail order pharmacy to fill his prescriptions. He told me that his cost for a month's supply of brand name Lyrica is $50.00 from OptumRx, but if he has Tobin's fill his prescription, the cost is $450.00. What is most disturbing is that if his insurance plan allowed the use of the generic, pregabalin, he could have received a 90 day supply for under $50.00. In both cases, OptumRx controls the price this patient is paying, <u>NOT</u> Tobin's! In fact, Tobin's is only able to set a price on 4.7% of all prescriptions that are filled at our pharmacy.

Over 95% of all prescription prices are set by the PBM's and insurers. If you could save $400.00 per month, where would you have your prescription filled? The patient is also taking Eliquis of which he pays $8.00 per month from Optum's mail order pharmacy and from Tobin's he pays $16.00. Again, OptumRx sets Tobin's price and their mail order pharmacy's price for the sole purpose of driving patients away from their local pharmacist caregiver. He also told me that sometimes he runs short of his medications and has to call Optum and in his words, "scream at them," in order to get a few more pills.

3. PBMs coerce their business clients into paying lower premiums if they accept a health insurance plan that requires employees to have their prescriptions filled at mail order pharmacies owned by or affiliated with the insurance companies. These mail order pharmacies are not abiding by the regulations that community pharmacies in Wisconsin must adhere to. The patient who I spoke to Monday told me that he receives no consultation from OptumRx's mail order pharmacy other than product information printouts. Wisconsin Pharmacists, by law, are required to consult with the patient. People receive a much **lower level of service** at mail order pharmacies

compared to community pharmacies. Just last week one of Tobin's pharmacists was consulting with a patient in the drive-thru who had been prescribed Lexapro which is used to treat depression and anxiety. Our pharmacist asked the patient if she had any heart rhythm issues. The patient said she was currently in atrial fibrillation. Lexapro can exacerbate this condition. Our pharmacist explained that to the patient and followed up with a phone call to the physician who personally called back and changed the medication. She also thanked our pharmacist for catching this potentially fatal error. These types of interactions **DO NOT** occur at mail order pharmacies!

4. PBM's work deals with big pharma in order to receive kickbacks which they call "rebates" for placing the manufacturer's medications on the health insurer's formularies. It's called "Pay to Play". This money is supposed to help insurance companies lower co-pays, but the drug manufacturers just build the bribes they pay the PBM's into the price of their drugs. Most of these kickbacks are used to increase the profits of the PBMs and insurers at the expense of patient's and pharmacy caregivers. Furthermore, the drug formularies created by the PBMs lead to **delayed care to the patient** and create

more work for physicians and pharmacists. If a drug prescribed by a physician is not listed in the insurer's formulary, the pharmacist has to spend valuable time contacting the physician. The busy doctor has to stop what he or she is doing and prescribe another drug that is covered by the insurer. In some cases patients have to wait a day or two before they can pick up their prescriptions thus delaying medical care. Even worse, the medication may not be the best one for the patient, instead, it's one that has been placed on the insurer's formulary by the PBM because the kickback paid by the drug manufacturer was higher. **Profit overrides the quality of care!**

5. Pharmacies are required by PBMs and insurers to duplicate inventory. In addition to stocking a $45.00 generic that's dispensed to the majority of our patients, we also have to stock a $678.00 brand name drug because some insurers only pay for the brand name medication. This requirement reduces cash flow and places greater burden on an already stretched to the limit inventory budget. Example: Adderall - - My guess is that the PBM receives a nice sized rebate from the manufacturer for requiring a pharmacy to use the brand name to fill the prescription.

6. PBM's charge what are called D.I.R. fees to pharmacies for transmitting claims to the health insurance company. In fiscal 2019, Tobin's paid $102,000.00 in DIR fees which was an 89% increase over the prior year. The objective of these enormous increases is to force local community pharmacies to close their doors and limit patient access to the personalized care that independent pharmacies provide. Instead, patients are forced to use mail order pharmacies or pharmacies affiliated with the insurance companies. After a period of time, patients will forget about the immediate consultations, cautions about potential interactions and courteous, personalized service that was provided to them AT NO CHARGE by their community pharmacist. They will get used to the lack of service provided to them by mail order pharmacies and think this is the norm. The end result is **DIMINISHED PATIENT CARE** leading to increased hospitalizations and drug related injuries.

7. **Eighty-five percent of all prescriptions filled in the US are controlled by three PBMs**, OptumRx, CVS-Caremark and Express Scripts. Together they exert monopoly like control on pharmacies. That's another reason local pharmacies are forced to lose money on prescriptions because there is no transparency in pricing. In fact, almost 21% of prescriptions

processed at our pharmacy are paid by insurers **below ingredient cost** which does not take into consideration any overhead. **No business can survive this much theft from the bottom line**! How many road builders would we have in Wisconsin if they were paid in this manner? Here is a typical example of how pharmacies are **short changed** by the PBMs: On December 24th we filed a claim for two boxes of Cromolyn Sodium oral solution. We were paid $226.80 for the least expensive product available to us -- our cost was $377.98 so we incurred a loss of $151.18. What a wonderful present from the PBM on Christmas Eve just so we could provide proper care to the patient being treated for systemic mastocytosis! Now, what we still don't know is how much more will be subtracted from the amount we were paid in 2-4 months due to the DIR fees charged to Tobin's by the PBM. This practice of taking more money away from the pharmacy's reimbursement is commonly called a "clawback." When we ask the PBM to justify the underpayment, we receive the following explanation – "Claim sent to PBM and PBM declined to research as this claim had already been forwarded for research in the past. Or this one – "PBM research indicates the MAC **will not** be raised at this time." No logical explanation for their action and no regulations with **teeth** to prevent the PBM from paying less than the ingredient cost. In the extremely rare case of a PBM making an

adjustment, the change is only for future claims. This is the equivalent of catching someone robbing a bank for the sixth time and allowing them to keep the money they've already stolen.

8. Since **PBMs and health insurers control the price patients pay for 95% of all prescriptions dispensed**, they can increase prices at will, with very little if any competition or oversight. I hope you're beginning to see that by passing Assembly bill 114, you will not only be providing oversight to the practices of PBM's, but you will also be helping to lower prescription drug prices to the consumer. If PBMs can increase fees to pharmacies by 89% in one year, **who knows what will happen to patient co-pays! What ever became of FREE ENTERPRISE where prices were controlled through competition?**

9. Since local independent pharmacies are being forced out of business, many **patients living in underserved rural communities will lose regular access to their primary healthcare provider, their friendly, knowledgeable pharmacist.**

10. **We need PBM audit reform**. What is currently done under the guise of Fraud, Waste and Abuse prevention is

really about giving the PBM's the ability to take additional money from the pharmacy months or years later for legitimate prescriptions. High cost medications are targeted during these audits and any clerical error is used as an excuse to deny payment. The results of the audit are mailed to us and a deduction in payment is taken by the PBM. Their letter states, "No post audit documentation is accepted." Once again because there is no oversight of the PBM's activities, they are allowed to take money from pharmacies at their sole discretion.

11. **Local pharmacies do a lot more for their community than dispense prescriptions.** These are small business owners who volunteer their time, donate to civic groups and non-profits, employ their neighbors, and serve patients for whom, in many cases, the local pharmacist is the only nearby healthcare provider. Moreover, **local pharmacies**, NOT PBMS, **pay local taxes** that help support their community's infrastructure. The PBMs are forcing pharmacy owners to make some very tough decisions, and potentially **millions of people will be adversely affected**."

It's time for you, our legislators to stop the unscrupulous activities of the PBM middle men in Wisconsin by passing Assembly bill 114 to prevent the unregulated PBMs from indiscriminately raising patient co-pays and ripping off

taxpayers and pharmacists. These greedy corporations cannot be allowed to avoid state regulation and engage in abusive, manipulative and deceptive business practices. You as legislators have an opportunity to land a devastating blow to PBMs but this must be done swiftly. According to a survey of 5000 community pharmacy owners, 58 percent said they may be forced to close their doors in the next two years further limiting patient access to quality healthcare. The time to act is now, not next week, not next month or next year, but NOW! Please vote YES to passing assembly bill 114 before it's too late.

Mr./Madam Chairman, committee members, thank you for allowing me to speak to you this afternoon.

The BIG Three PBM's:

1. **Express Scripts:** Parent Company: Cigna Life Insurance Company. **Cigna bought Express Scripts for $67 billion.** The largest pharmacy benefit management (PBM) organization in the United States. **Express Scripts** had 2016 revenues of $100.752 billion.
2. **CVS Health**: 2018 data: Completed a **$70 billion acquisition of Aetna** Insurance. Revenues increased 12.5% to 54.4 billion.
3. **Optum:** Parent company United Health Care Group. Optum is expected to account for 50% of United Health's earnings in the upcoming year. They project earnings to be $112 billion in 2020.

The Maryland Department of Health recently released a report showing PBMs serving the state Medicaid plan pocket $72 million through spread pricing. As a result of the audits, the department will prohibit spread pricing beginning in 2021 and recommended additional Medicaid reforms to prevent pharmacy access issues, particularly for rural patients. Why aren't we doing the same thing in the State of Wisconsin?

Similar measures contained in Assembly bill 114 have been passed in **40 other states**, please help us by passing this bill. The PBM's and insurance companies have decimated local, independent pharmacies throughout the country.

The time to act is NOW!

Response Pricing		
Patient Pay Amount (505-F5)		$0.00
Ingredient Cost Paid (506-F6)		$226.75
Dispensing Fee Paid (507-F7)		$0.05
Flat Sales Tax Amount Paid (558-AW)		$0.00
Percentage Sales Tax Amount Paid (559-AX)		$0.00
Total Amount Paid (509-F9)		$226.80
Basis of Reimbursement Determination (522-FM)		6=MAC Pricing Ingredient Cost Paid

MedicarePartD Results | Print | Clos

Claim date 12/24/2019 Cromolyn Sodium Oral Solution 100mg/5ml Dispense 960 ml. NDC 69784=0200-96

The paid claim is for two boxes. We were paid $226.80 and using the least expensive product available to us as shown below from our two wholesalers McKesson and Cardinal, our cost was $377.98 for two boxes or a loss of $151.18.

CATALOG : SEARCH RESULTS

x2 = $377.98

PAGE LINES: 400 PAGE COUNT: 1 of 1

☐ Exclude Drop Ship ☐ Exclude Non Stocked Items GO

Mck Item #	Pref Ind	Hist	Description	NDC	Non Returnable?	AWP	Est. Net	Purchase Price	Retail Price	Unit Price	Price Ind	Contract/Special MDQ	DC Qty	Quantity	Gen Equiv	Do Not Sub	Available	Results	Vendor Supply Info	Last Date Invoiced	Case Rnd Ind	UOM
3752136		✓	CROMOLYN SOD 100MG/5MLWOOD 96@	69784020096		$622.0	$188.99	269.99	622.00	$1.9687	1STP1-A	1	>100	1	GE	☐				Dec 26, 2019	N	CT

QTY	STOCK	CIN NDC/UPC	TRADE NAME MFR	STRENGTH	FORM	SIZE	TYPE	NET COST	INVOICE COST	NET UOI COST	RETAIL PRICE	CONTRACT	NOTES
0	■ ⓘ	5436043 69784-0200-96	CROMOLYN SODIUM WOODWA	100MG/5ML	CONC	96x5 ML	Rx	$269.06	$269.06	$2.8027		DDSRCB	
Substitute Item			☐ Do not Substitute										
0	●	5406848 42571-0132-52	CROMOLYN SODIUM MICROL	100MG/5ML	CONC	96X5 ML	Rx	$269.67	$269.67	$2.8091		DDSRCB	
Alternatives with Same Size, Form, Strength													
0	■ ⓘ	4545752 16571-0600-96	CROMOLYN SODIUM RISING	100MG/5ML	CONC	96X5 ML	Rx	$244.60	$244.60	$2.5479		DDMSRA	UD
0	■ ⓘ	5171145 51525-0470-09	CROMOLYN SODIUM MYLANP	100MG/5ML	CONC	96X5 ML	Rx	$516.86	$516.86	$5.3840			UD
0	▼	5136916 00037-0678-96	GASTROCROM MYLANS	100MG/5ML	CONC	96X5 ML	Rx	$906.28	$906.28	$9.4404			UD

Tobin Drug Oconomowoc Inc
General Ledger
For the Period From Oct 1, 2017 to Sep 30, 2018

Fiscal 18

Filter Criteria includes: 1) IDs from 6240-08 to 6240-08. Report order is by ID. Report is printed with

Account	Account Description	Date	Trans Description	Debit Amt	Credit Amt
			AM EX TOTAL		**150.00**
			Independent Pharmacy Corporation TOTAL		**550.00**
			McKesson TOTAL		**4,292.30**
			MCKESSON Pharmacy Systems LLC TOTAL		**19,483.47**
			OmniSYS, LLC. TOTAL		**833.80**
6240-08	RX Processing Fees	8/31/18	RX INS FEE ADJ	3,015.12	
6240-08	RX Processing Fees	8/31/18	RX INS FEE ADJ	4,838.49	
6240-08	RX Processing Fees	10/31/17	RX INS FEES ADJ	765.93	
6240-08	RX Processing Fees	10/31/17	RX INS FEES ADJ	948.42	
6240-08	RX Processing Fees	12/30/17	RX INS FEES ADJ	1,055.29	
6240-08	RX Processing Fees	12/30/17	RX INS FEES ADJ	1,123.30	
6240-08	RX Processing Fees	1/31/18	RX INS FEES ADJ	1,016.99	
6240-08	RX Processing Fees	1/31/18	RX INS FEES ADJ	486.47	
6240-08	RX Processing Fees	1/31/18	RX INS FEES ADJ	1,093.75	
6240-08	RX Processing Fees	2/15/18	RX INS FEES ADJ	2,298.32	
6240-08	RX Processing Fees	2/28/18	RX INS FEES ADJ	2,277.02	
6240-08	RX Processing Fees	2/28/18	RX INS FEES ADJ	6.32	
6240-08	RX Processing Fees	3/19/18	RX INS FEES ADJ	2,280.80	
6240-08	RX Processing Fees	3/31/18	RX INS FEES ADJ	2,084.76	
6240-08	RX Processing Fees	3/31/18	RX INS FEES ADJ	7.14	
6240-08	RX Processing Fees	3/31/18	RX INS FEES ADJ	665.47	
6240-08	RX Processing Fees	4/30/18	RX INS FEES ADJ	5,137.19	
6240-08	RX Processing Fees	4/30/18	RX INS FEES ADJ	1,759.70	
6240-08	RX Processing Fees	4/30/18	RX INS FEES ADJ	802.16	
6240-08	RX Processing Fees	5/31/18	RX INS FEES ADJ	64.70	
6240-08	RX Processing Fees	5/31/18	RX INS FEES ADJ	39.70	
6240-08	RX Processing Fees	5/31/18	RX INS FEES ADJ	980.37	
6240-08	RX Processing Fees	5/31/18	RX INS FEES ADJ	3,946.84	
6240-08	RX Processing Fees	6/30/18	RX INS FEES ADJ	2,757.02	
6240-08	RX Processing Fees	6/30/18	RX INS FEES ADJ	2,963.07	
6240-08	RX Processing Fees	7/31/18	RX INS FEES ADJ	3,870.76	
6240-08	RX Processing Fees	7/31/18	RX INS FEES ADJ	490.48	
6240-08	RX Processing Fees	9/21/18	RX INS FEES ADJ	3,794.07	

Tobin Drug Oconomowoc Inc
General Ledger
For the Period From Oct 1, 2017 to Sep 30, 2018

Filter Criteria includes: 1) IDs from 6240-08 to 6240-08. Report order is by ID. Report is printed with

Account	Account Description	Date	Trans Description	Debit Amt	Credit Amt
6240-08	RX Processing Fees	9/30/18	RX INS FEES ADJ	3,679.93	
			RX INS FEES ADJ TOTAL		**54,249.58**
			RX-NET TOTAL		**3,060.00**

Total Fees Charged to Tobin's Fiscal Year 2018 **$ 82,619.15**

Just PBM Fees FISCAL YR 2018 **$ 54,099.58**

Fiscal 18

Fiscal 18

Tobin Drug Oconomowoc Inc
General Ledger
For the Period From Oct 1, 2018 to Sep 30, 2019

Fiscal 19

Filter Criteria includes: 1) IDs from 6240-08 to 6240-08. Report order is by ID. Report is printed with

Account II	Account Description	Date	Trans Description	Debit Amt	Credit Amt	
			Independent Pharmacy Corporation Total			**600.00**
			McKesson Total			**4,816.65**
			MCKESSON Pharmacy Systems LLC Total			**18,740.93**
			OmniSYS, LLC. Total			**1,547.60**
			True Up Total			**(2,874.80)**
6240-08	RX Processing Fees	6/30/19	RX INS FEES	4,188.33		
6240-08	RX Processing Fees	6/30/19	RX INS FEES	3,672.53		
6240-08	RX Processing Fees	10/31/18	RX INS FEES ADJ	419.13		
6240-08	RX Processing Fees	10/31/18	RX INS FEES ADJ	1,564.42		
6240-08	RX Processing Fees	10/31/18	RX INS FEES ADJ	4,127.35		
6240-08	RX Processing Fees	11/30/18	RX INS FEES ADJ	3,031.23		
6240-08	RX Processing Fees	11/30/18	RX INS FEES ADJ	3,683.67		
6240-08	RX Processing Fees	12/31/18	RX INS FEES ADJ	4,076.11		
6240-08	RX Processing Fees	12/31/18	RX INS FEES ADJ	5,053.69		
6240-08	RX Processing Fees	1/31/19	RX INS FEES ADJ	5,083.24		
6240-08	RX Processing Fees	1/31/19	RX INS FEES ADJ	2,677.54		
6240-08	RX Processing Fees	1/31/19	RX INS FEES ADJ	349.89		
6240-08	RX Processing Fees	1/31/19	RX INS FEES ADJ	1,206.16		
6240-08	RX Processing Fees	2/28/19	RX INS FEES ADJ	4,709.16		
6240-08	RX Processing Fees	3/31/19	RX INS FEES ADJ	4,440.42		
6240-08	RX Processing Fees	3/31/19	RX INS FEES ADJ	3,971.69		
6240-08	RX Processing Fees	4/23/19	RX INS FEES ADJ	5,489.47		
6240-08	RX Processing Fees	4/30/19	RX INS FEES ADJ	3,902.03		
6240-08	RX Processing Fees	5/15/19	RX INS FEES ADJ	1,557.01		
6240-08	RX Processing Fees	5/31/19	RX INS FEES ADJ	3,633.40		
6240-08	RX Processing Fees	5/31/19	RX INS FEES ADJ	3,681.14		
6240-08	RX Processing Fees	7/31/19	RX INS FEES ADJ	4,122.40		
6240-08	RX Processing Fees	7/31/19	RX INS FEES ADJ	1,648.49		
6240-08	RX Processing Fees	7/31/19	RX INS FEES ADJ	2,400.03		
6240-08	RX Processing Fees	8/31/19	RX INS FEES ADJ	6,602.29		
6240-08	RX Processing Fees	8/31/19	RX INS FEES ADJ	5,764.80		
6240-08	RX Processing Fees	9/30/19	RX INS FEES ADJ	2,929.86		
6240-08	RX Processing Fees	9/30/19	RX INS FEES ADJ	2,397.89		

Tobin Drug Oconomowoc Inc
General Ledger
For the Period From Oct 1, 2018 to Sep 30, 2019

Filter Criteria includes: 1) IDs from 6240-08 to 6240-08. Report order is by ID. Report is printed with

6240-08	RX Processing Fees	9/30/19	RX INS FEES ADJ	3,715.65	
6240-08	RX Processing Fees	9/30/19	RX INS FEES ADJ	64.90	
6240-08	RX Processing Fees	9/30/19	RX INS FEES ADJ	267.40	
6240-08	RX Processing Fees	2/28/19	RX INS FEES AJD	2,902.93	
			RX INS FEES ADJ Total		**103,334.25**
			RX-NET Total		**2,317.50**
6240-08	RX Processing Fees	4/9/19	SURE SCRIPTS / CHECK #208296/ 03/28/19	-1,131.31	
			SURE SCRIPTS TOTAL		**-1,131.31**

Total Fees Charged to Tobin's Fiscal Year 2019 **$ 127,350.82**

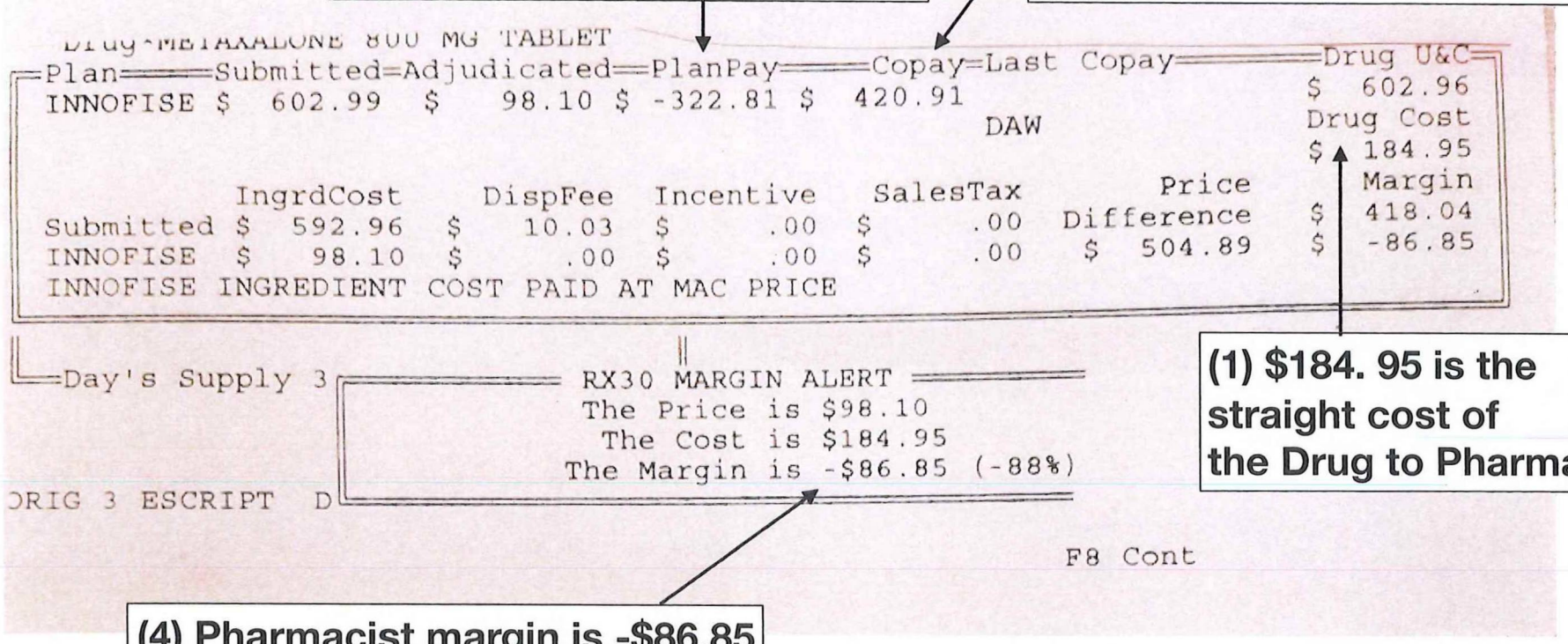
Just PBM Fees FISCAL YR 2019 **$ 102,202.94**

Fiscal 19

Fiscal 19

PATIENT LOSES- PHARMACIST LOSES- PBM WINS

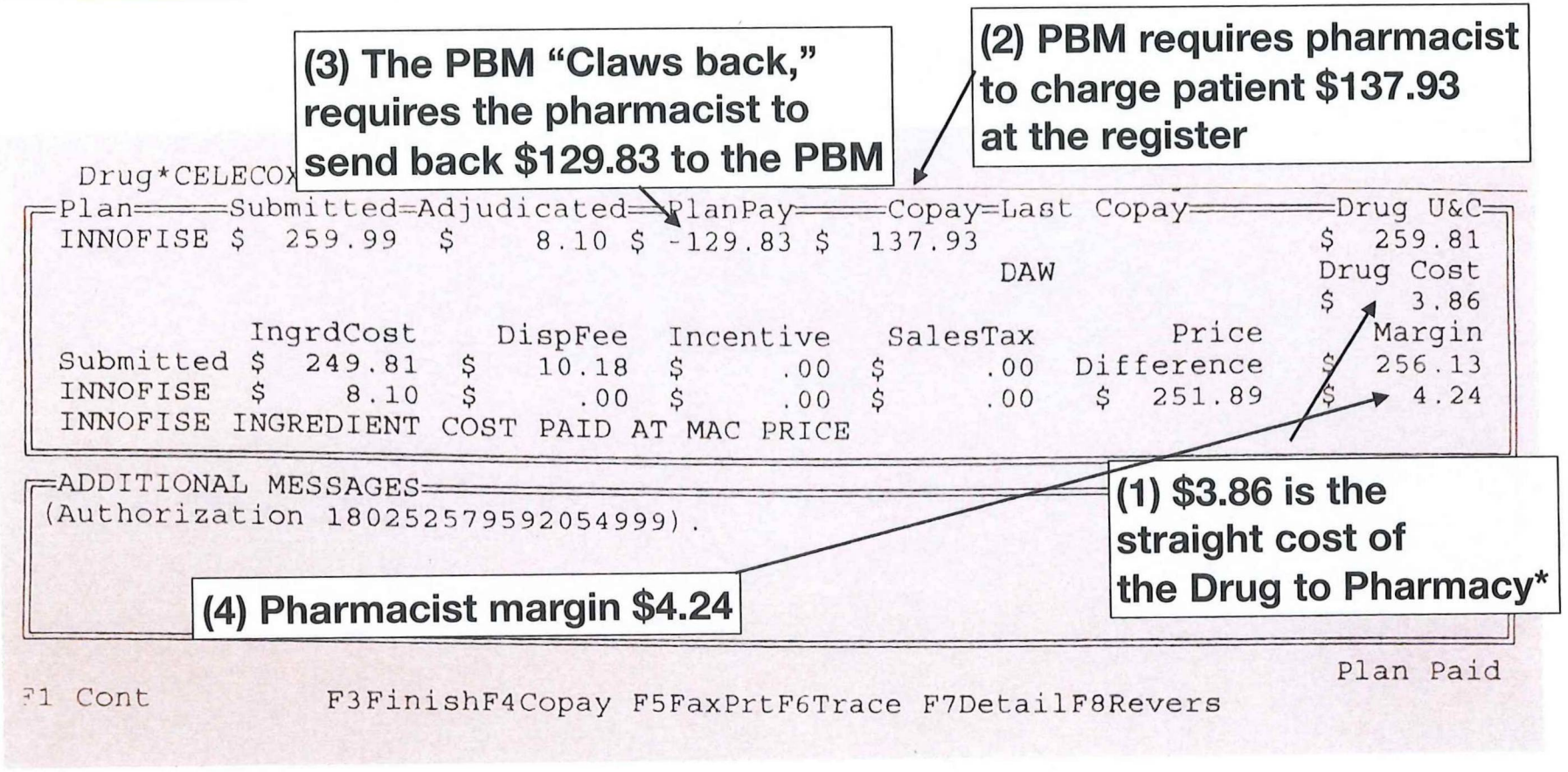
Metaxalone 800 MG tablet (Generic muscle relaxer)



* Straight cost= what the pharmacy paid the distributor for the pharmaceutical, does not included embedded pharmacy costs

PATIENT LOSES- PHARMACIST LOSES- PBM WINS

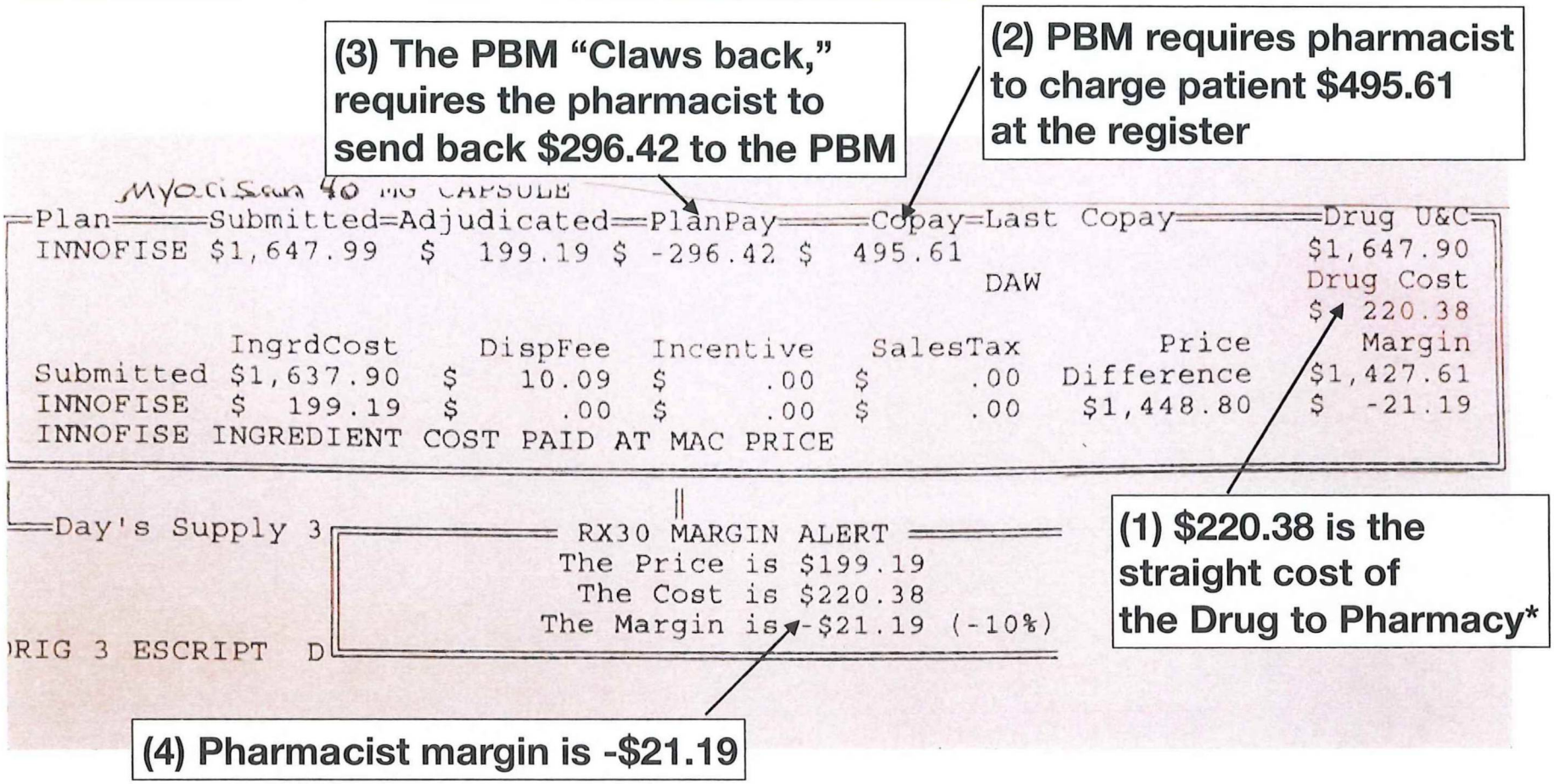
Celecoxib 200 MG capsule (Generic Celebrex, arthritis medication)



* Straight cost= what the pharmacy paid the distributor for the pharmaceutical, does not included embedded pharmacy costs

PATIENT LOSES- PHARMACIST LOSES- PBM WINS

Myorisan 40 MG Capsule (Generic severe acne medication)



* Straight cost= what the pharmacy paid the distributor for the pharmaceutical, does not included embedded pharmacy costs

PATIENT LOSES- PBM WINS

Dofetilide (Generic anti-arrhythmic agent, irregular heart beat)

Fill date	Mail Order	Fill date	Hometown Pharmacy
3-21-2019	**$519.33**		
5-24-2019	**$454.80**		
8-26-2019	**$1,362.89**		
11-19-2019	**$611.69**		
		12-18-19	**$150.50**

PATIENT LOSES- PBM WINS

Ropinirole (Generic drug used to treat Parkinson, Restless Leg Syndrome)

Fill date	Mail Order	Fill date	Hometown Pharmacy
3-11-2019	**$174.81**		
8-20-2019	**$155.20**		
		12-18-19	**$19.00**

PATIENT LOSES- PBM WINS

Pindolol (Generic drug, beta blocker)

Fill date	Mail Order	Fill date	Hometown Pharmacy
3-20-2019	**$131.00**		
6-13-2019	**$61.69**		
8-20-2019	**$61.69**		
		12-18-2019	**$10.85**

Tobin Drug Oconomowoc Inc
RX Gross Profit
10/01/2018 thru 09/30/2019

10/01/18 thru 09/30/19	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	12 MON AVERAGE	12 MON TOTAL	
SALES	235,264.59	231,196.33	214,953.36	223,053.00	202,957.77	232,995.70	224,403.52	234,136.92	212,160.07	217,032.28	230,011.76	231,286.64	224,121.00	2,689,451.94	
INVENTORY PURCHASES	198,846.59	182,853.63	190,793.42	191,174.25	169,161.46	179,752.99	203,041.54	186,435.52	167,011.80	185,653.47	177,660.15	195,375.45	185,646.69	(2,227,760.27)	
Total Other Expenses														(517,436.51)	
PROFIT	36,418.00	48,342.70	24,159.94	31,878.75	33,796.31	53,242.71	21,361.98	47,701.40	45,148.27	31,378.81	52,351.61	35,911.19	38,474.31	(55,744.84)	Pharmacy Operations Loss
GROSS PROFIT PERCENTAGE	15.48%	20.91%	11.24%	14.29%	16.65%	22.85%	9.52%	20.37%	21.28%	14.46%	22.76%	15.53%	17.11%	-2.07%	

Other Expenses

Rebates from McKesson	(136,117.00)	*COGS account*
Rebates from McKesson	(9,996.00)	$833 In Rebate & Discount Account
Rx Processing Fees	127,350.82	
Credit Card Fees Rx Only	28,146.42	
Pharmacy Labor	428,697.91	Dave 60% & OTC Labor is at 50%
Pharmacy ER Taxes	32,921.33	
Pharmacy 401K	12,510.70	
Parata Robotics Maintenance	4,900.00	
Vials/Labels/Toner	5,610.51	ALL TRI STATE INVOICES
Pharmacy Dues & Services	100.00	
Rent/Sq. Ft.	23,311.82	
Total Other Expenses	517,436.51	

RENT CALCULATION

RENT	21,411.00	
SQUARE FEET FOR STORE	13,821.00	
	1.55	*$ PER SQUARE FEET*
PHARMACY SQUARE FEET**	1,254	
	1,943	Rent for Pharmacy per month
12 MONTHS	12	
	23,311.82	Rent for 12 months

****Actual Footage for Pharmacy ONLY**

56 x 24 is Pharmacy.	1,344
3 x 10 is Consulting Room.	30
15 x 8 is deducted for Stairwell.	(120)
Total Pharmacy Square Feet	1,254

WMC

WISCONSIN MANUFACTURERS & COMMERCE

MEMO

TO: Assembly Committee on Health

FROM: Chris Reader, Senior Director of Workforce and Employment Policy, WMC

RE: Testimony on Assembly Bill 114

DATE: February 5, 2020

Chairman Sanfelippo and members of the committee, thank you for the opportunity to testify on Assembly Bill 114 this afternoon. Representative Schraa, thank you for your focus on health care costs and for searching for ways to help bring costs down for Wisconsin consumers.

Wisconsin Manufacturers & Commerce is the largest business trade association in Wisconsin, representing over 3,800 employers from every sector of the economy, from every corner of the state. According to our most recent CEO survey, conducted at the end of 2019, rising health care costs remains a top concern for employers. The only item that ranked of greater concern for employers is their inability to find enough workers. On health care costs, 77% reported having their health care costs grow over the last year, resulting in higher costs and fewer benefits for workers and their families. Again, WMC thanks you for looking at the issue in search of solutions.

Employers want to provide affordable health insurance benefits to their workers and their families, including pharmaceutical benefits. Employers not only want to do this, we need to do so in order to attract talent. To accomplish that goal and be able to continue providing benefits, employers rely on health plans and pharmacy benefit managers (PBMs) to help manage costs.

PBMs are part of the solution as employers search for affordable health plans for their workers. PBMs negotiate price discounts, saving consumers, which means employers and patients, millions on their annual prescription drug spend. They do so through scale – like any business that negotiates for discounts based on volume. In order to do so, however, they must be free to work in the marketplace without unnecessary government obstruction or heavy handed regulations. To be free to contract with providers who will give them the best price. To use cost effective solutions like mail delivery of pharmaceuticals when appropriate. And to adjust their pricing structure in real time in response to marketplace events that may move drug prices up and down.

As we reviewed the original language of AB 114, we were concerned that a few items included in that bill would have the opposite impact than was intended. Thankfully, the authors recognized this as a large issue that requires stakeholder discussions in order to find a workable solution that will keep costs down while not causing unintended consequences. The Substitute Amendment before you today is the result of those discussions and shows a willingness from all sides to

develop a proposal that works for Wisconsin that will increase transparency, protect patients, and ensure employers are able to continue to rely on PBMs to help deliver affordable pharmaceutical benefits to their workforce. As the discussions continue on this proposal, we are confident that a final product will be ready in time for passage in this committee and in the full Assembly.

Again, I thank the author and this committee for your attention to the issue of rising health care costs. From hospital prices on down, health care costs are too high in Wisconsin today. This is leading to higher costs for employers to provide insurance coverage, higher copays and deductibles for workers and their families, and ultimately a reduction in employer-sponsored benefits offered.

To:	Members, Assembly Committee on Health
From:	Rebecca Hogan, on behalf of the Alliance of Health Insurers
	Mary Haffenbredl, on behalf of America's Health Insurance Plans
Date:	February 5, 2020
Re:	Testimony on AB 114 with a pending substitute amendment

The Alliance of Health Insurers (AHI) is a nonprofit state advocacy organization created to preserve and improve upon consumer access to affordable health insurance in Wisconsin, both via the private sector and public programs.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Prescription medications are an important part of medical treatment. Over the past several decades, health plans' prescription drug benefits have provided access to needed medications for tens of millions of Americans. In addition, under the Affordable Care Act (ACA), every health insurance policy must include a comprehensive "essential health benefits" package covering ten categories of services, including prescription drug coverage.

Prescription drug costs in the United States are skyrocketing. In 2018, $335 billion was spent on prescription drugs. CMS estimates that, over the next decade, spending for retail prescription drugs will be the fastest growth health category and will consistently outpace that of other health spending.

In response, over the past decade, employers, HMOs, health care insurers, and various government entities have turned to pharmacy benefit management companies (PBMs) as an efficient and effective way to administer prescription drug benefits. PBMs are the primary lever available to health plans to ensure that their customers can obtain the medications they need at the lowest possible cost; and that providers and pharmacies are providing quality care.

Our members and employers work with PBMs because they attempt to mitigate increasing costs by using their expertise and technology solutions to administer certain essential functions of a prescription drug benefit for health plans by:

- Using clinically based services to reduce medication errors, achieve higher rates of medication adherence, and improve health outcomes.
- Negotiating directly with manufactures and pharmacists to obtain discounts for their customers in the form of lower out-of-pocket costs. The level of comparable volume and

cost reductions PBMs can generate cannot be achieved by many health plans, most employers, or individuals.

- Implementing of cost-cutting strategies that include discount pharmacy networks, incentives to use therapeutic alternatives, formulary management (including manufacturer rebates), mail-order pharmacies, drug-use reviews, and disease management.
- Educating their consumers about safe, effective, and lower cost generic drugs.

PBMs have been found to save payers – employers - and patients nearly $1,000 per enrollee per year and reduce costs by $6 for every $1 spent on their services. PBMs also pass rebates and savings through to their clients. In 2015, 37% of employer plans required 100% of rebates to pass through to plan sponsors (up from 29% in 2014), which helps contain health care cost growth for everyone in the system.

Because Assembly Bill 114 as originally drafted would have jeopardized cost-cutting strategies PBMs and health insurers use to manage the costs of prescription drugs, AHI and AHIP participated in a coalition that worked with one of the bill authors, Chairman Sanfelippo, and Speaker Vos to come up with legislation that incorporates regulation of PBMs while protecting patients and payers from increased costs to their pharmacy benefits.

AHI and AHIP sincerely appreciate the opportunity to work through issues with the policy makers. We have a substitute before you today that:

- Does not restrict a pharmacy or penalize a pharmacy for informing an enrollee under the policy or plan of the lowest cost option for their drug.
- Requires a pharmacy to have available to the public a listing of the retail price, updated monthly or more often, of the 100 most commonly prescribed prescription drugs available for purchase at the pharmacy.
- Requires a PBM to be licensed with the Office of the Commissioner of Insurance (OCI) or to have an employee benefit plan administrator license under current law.
- Clarifies when a PBM can retroactively deny a pharmacy or pharmacist's claim.
- Requires PBMs to report aggregate rebate amounts that the PBM received from all pharmaceutical manufacturers but retained and did not pass through to health benefit plan sponsors and the percentage of the aggregate rebate amount that is retained rebates.

At the time this statement was drafted there were some remaining provisions under review. We are interested in partnering with policy makers to address these quickly and to get a bill ready for passage. We have a joint goal to address the rising cost of prescription drug medications and offer affordable plans to employers and our enrollees.

Thank you for this opportunity to testify before you today.

Wisconsin Physicians Service Insurance Corporation
d/b/a WPS Health Solutions

Statement on Assembly Bill 114

WPS Health Solutions is a Monona-based not-for-profit health insurance company that employs more than 2,500 Wisconsinites in offices in Dane County, Brown County, and Marathon County, and we insure more than 150,000 members in Wisconsin.

We seek to provide quality health care coverage at the lowest cost, not just at the point-of-sale, but through the premiums paid by and on behalf of our members. Wisconsin has one of the most robustly competitive health insurance markets in the nation, and as we compete with our worthy rivals in the health insurance market, we face tremendous pressure to keep costs down.

Additionally, the Affordable Care Act requires us to publicly report the portion of premium dollars spent on health care and quality improvement, and requires us to spend at least 80% our individual and small group premiums and 85% of our large group premiums on health care and quality improvement or we must pay a rebate to our customers. To clarify, if we charge consumers too much money for their health insurance, federal law requires us to pay a refund to our customers. As you look through the list of businesses supporting Assembly Bill 114, how many of them are required by law to provide a refund when they charge their customers too much?

WPS Health Solutions utilizes a pharmacy benefit manager (PBM) to reduce the cost of prescription drugs for its members. We do not own a PBM, so we routinely issue a Request For Proposal to a number of PBMs and then negotiate a contract with the most responsive offeror. In light of the robustly competitive health insurance market in Wisconsin and the Affordable Care Act's rebate requirement for medical loss ratios, we do this for one and only one reason—to reduce costs.

We oppose Assembly Bill 114 because it interferes with the freedom of contract. It intrudes upon our ability to negotiate the best arrangement with a PBM to provide the lowest cost solution for providing prescription drug benefits to our members. By restricting our use of networks, mail order prescription drug benefits, preferred providers, and cost sharing agreements, it obstructs our tools for managing costs while *increasing overall costs* for consumers and employers.

We oppose Assembly Bill 114 because it expands government regulation to vendors of insurance companies. As a Wisconsin insurer, we are accountable to and regulated by the Wisconsin Commissioner of Insurance. This bill extends the state government's regulatory reach to business entities that are not insurance companies. It increases the head count and budget of the Office of the Commissioner of Insurance, but Commissioner Mark Afable attests to the fact that his office cannot determine how much it will increase administrative and claims costs, nor can he determine how the increased regulation will impact premium costs to consumers and employers. Increased regulation without proven reductions in *overall costs* hurts Wisconsin consumers and employers.

We are concerned that Assembly Bill 114 violates the Employee Retirement Income Security Act (ERISA) preemption for self-insured health plans because it extends regulation to PBMs. The Eighth Circuit Court of Appeals ruled in *Rutledge v. Pharmaceutical Care Management Association* that ERISA preempted an Arkansas law regulating PBMs because it both related to, and had a connection with, employee benefits plans governed by ERISA. Last month, the Supreme Court of the United States

granted cert in *Rutledge,* and a decision is not likely until this summer. Pursuing this legislation without knowing whether it will comport with the Supreme Court's decision in *Rutledge* is likely a fool's errand.

WPS Health Solutions opposes Assembly Bill 114 because its proponents have done nothing to prove that it lowers costs for Wisconsin consumers and employers. We are committed to working with members of the Wisconsin Senate and Assembly to enact health care reforms that truly and demonstrably reduce health care costs for Wisconsinites.

Assembly Hearing – Ab 114

February 5, 2020

We would like to thank Representatives Schraa and Kolste and Senators Erpenbach and Roth for being authors of the PBM transparency bill AB114. The original draft was well researched and written and would have helped Wisconsin "catch –up" to what other states have put in place to try and stop the abuses perpetrated upon patients, payers and citizens of our country and working to lower the costs of prescription medicines.

PBM's were in essence invented in the 80's and 90's when the shift of payers for prescriptions from individuals to payers (companies and governments) with the intent to "manage formularies" for these companies that lacked internal expertise and to combine purchasing power of multiple companies to lower prices. During these formative years there were many PBM's and there were some market forces to create competition and information was more challenging to obtain and understand.

During the past decade there has been a dangerous consolidation both horizontally and vertically. Horizontally only three PBMs' now control more than 75% of all US citizens forming an oligopoly and suppressing competition and imposing harsh conditions on the supply chain. Vertically – PBMs have purchased or started their own mail order and specialty pharmacies and retail pharmacies and forcing patients to their preferred channels and often at higher prices.

Our health care system is full of "smoke and mirrors" and many things are implied by PBM's but the reality of prescription prices and the cost of health care significantly contradicts their assertions. Research and fact finding is needed to clear the smoke and turn the mirrors into windows so more transparency can be seen to make better decisions and lower prescription and health care costs.

The following are examples of "assertion" and fact finding to shed more light in this complicated topic.

Assertion #1 – High prescription prices are the fault of manufacturers

Manufacturers spend 6 billion per year on traditional marketing channels (TV/ literature) but by far their greatest marketing is spent on PBM rebates – 150 billion. This shows that their path to selling their products is to buy their way on to PBM formularies. This is $500 for every United States citizen.

Mylan was subpoenaed to testify to the United States Senate Health committee regarding the high price for "epipens" – they testified with the breakdown of the cost – please see their infographic attached". It depicts their net to be $275, middlemen led by PBM's added $285, wholesalers added $ 30 and retailers added $20 for total cost to patient/health plan/payer of $610. We have seen no argument from PBMs with this infographic.

Eli Lilly was also subpoenaed regarding Humalog – form of insulin – this showed a similar infographic but even more dramatic - manufacturer gets $135, middlemen led by PBM's take $435 , wholesalers $20 and retailers $7.

We have had discussions with many manufacturers and they consistently state that 8-14% of their sales price is "formulary fees" with rebates, admin fees, marketing fees and data fees also being added into costs and being paid to PBM's. These other revenue streams to PBM's are many times not disclosed to a health plan/ payer but clearly add to the costs of prescription medicines.

Assertion #2 – PBMs are aligned with health plans/ payers. Please find in the binder the "non-fiduciary clause" inserted in most PBM contracts with health plans/ payers. This creates a clear legal "buyer beware" clause that allows them to not act in the payers best interests and allows them to not disclose everything that would be expected in a typical fiduciary relationship.

Assertion #3 – PBMs lower costs – combined with the formulary fees above please find in your binder a sheet depicting the 52 ways PBM's create revenue streams. Please note this list was formulated by a transparent PBM.

Assertion #4 – PBM's have "preferred pharmacies" as they get "volume" discounts. Please find attached facts where Caremark paid independent pharmacies a small fraction of what they paid their preferred pharmacy (their owned pharmacy) significantly more and then charged the payer/ taxpayer the higher amount. We also have information from a TPA – third party administrator that PBMs will often pay independents lower amounts to "balance" their payments and offset higher amounts paid to bigger chains.

Assertion #5 – PBMS provide better care - you will hear ample evidence that patient care suffers from lack of access and lack of communication. During the PHARM 7 hearings and PEB hearings - they argued vigorously that they should remain exempted from having to perform a patient consultation a new prescription or change of formulary – the very basics of patient care of pharmacy – teaching the potential side effects and potential drug interactions with food and supplements.

Assertion #6 – Better adherence. Adherence is a patient ingesting a medicine as prescribed by their provider. PBMS claim their self-owned mail order performs better and is a reason to limit access for patients. There is ample evidence they simply mail medicines without regard or communication if patients are actually ingesting and utilizing. IN fact there is significant waste and abuse and extra costs being forced upon payers/ taxpayers and patients and the need to dispose of significant amounts of medicine and increasing risk of non-patients having access to these medicines.

Assertion #7 – Independent pharmacies are not competent or competitive in today's marketplace. This is absolutely not true due to following facts:

Cost of prescription medicine is combination of the following 5 factors:

1) Cost of drug
2) Cost of labor to dispense the drug
3) Cost of local overhead to dispense that drug
4) Cost of corporate overhead to dispense the drug

5) Profit expectation of the company dispensing the drug

Most will look only at cost of drug and assume the giants have a vast differential and therefore have a total cost lower than independents. They do get better volume discounts but most independents combine their purchasing with others and although they don't match the large chains they are closer than a normal citizen would expect. At Hometown we find for non-specialty the chains will beat us by only $1.86 per average RX.

The chains and mail order also win on cost of labor as their model is built to spend very little time with patients. At Hometown they beat us by $2 per Rx – as we want our pharmacists to spend more time with patients delivering more in depth care.

Independents win by local overhead battle as their locations are on Main Street and smaller focusing more on health care than on "as seen on tv retail merchandise". Hometown wins this category by $3.84 per Rx

Independents dominate in the corporate overhead category. Selling, general and administrative costs the big chains millions of dollars where typical independents have the pharmacists and their care teams share the administrative burden. Hometown beats the chains by more than $9 per RX in this category.

Ownership expectations – Independents also dominate in this category- often willing to provide care at breakeven or modest profit levels versus the large returns that the large chains and PBM owned pharmacies have to earn to appease their Wall Street investors.

When you add the 5 costs together – Independents are very hard to beat.

The PBM's and chains learned this a decade ago – and the way to compete is to prevent access or limit patient choice. Thus you see "preferred pharmacies" and different co-pays if you go to a pharmacy of patient choice thus penalizing patients for going to a health care provider they know and trust. The response is PBMs don't receive the volume discounts but they never prove these exist and hide behind the "proprietary information". We point to the findings of Arkansas to prove this point emphatically. We also will present evidence where mail order prices are much greater retail prices at an Independent pharmacy.

Also – Consumer reports consistently reports that Independents receive much higher customer satisfaction scores than chains or mail order.

Thus we are the low cost provider with best customer satisfaction scores and PBM's are steering patients to their owned pharmacies and charging payers/patients and taxpayers more. There is evidence of this around the country. We recommend the committee review the website 46brooklyn.com - a data research firm regarding prescription pricing.

Assertion# 8 -Wisconsin has highly competitive health insurance marketplace. A study from the Kaiser Family foundation depicts Wisconsin as having a highly competitive marketplace – which is true in regards to the number of insurance companies in the market. However – the same Kaiser foundation and the Mueller study shows Wisconsin has the 2nd HIGHEST healthcare prices in the nation. Please find 4 studies in the packet for your review.

In summary – Pharmacy Benefit Managers operate in the shadows. They take no risk, they perform no research and development, they manufacture nothing, they do nothing in logistics, they don't see patients, they are not regulated, they create the rules for most participants in health care and they have created at least 52 ways to create profits at the extra expense of patients, payers and taxpayers.

We thank you for your consideration of supporting AB 114.

We are available at any time to provide more information and being a resource for the committee and legislators of Wisconsin

Best Regards;

Dan Strause

Managing Member - Hometown Pharmacies

HUMALOG

Where the Money *Really* Goes

Pharmacists United for TRUTH & TRANSPARENCY

ELI LILLY
(Manufactures the Insulin Drug)

$135* NET PRICE

+

BROKERS

PHARMACY BENEFIT MANAGERS (PBM)
(Negotiates Discounts & Rebates; Contracts with Groups & Insurers to Manage Pharmacy Benefits)

HEALTH INSURERS

$25 | $407

$432

+

WHOLESALERS
(Purchases from Drug Manufacture & Sells to Pharmacies)

$20

+

PHARMACY RETAILERS
(Sells & Dispenses Drug to Patients)

$7**

=

PATIENTS

$594 PHARMACY COUNTER PRICE

DEMAND TRANSPARENCY

*As reported by Eli Lilly 3/24/2019.

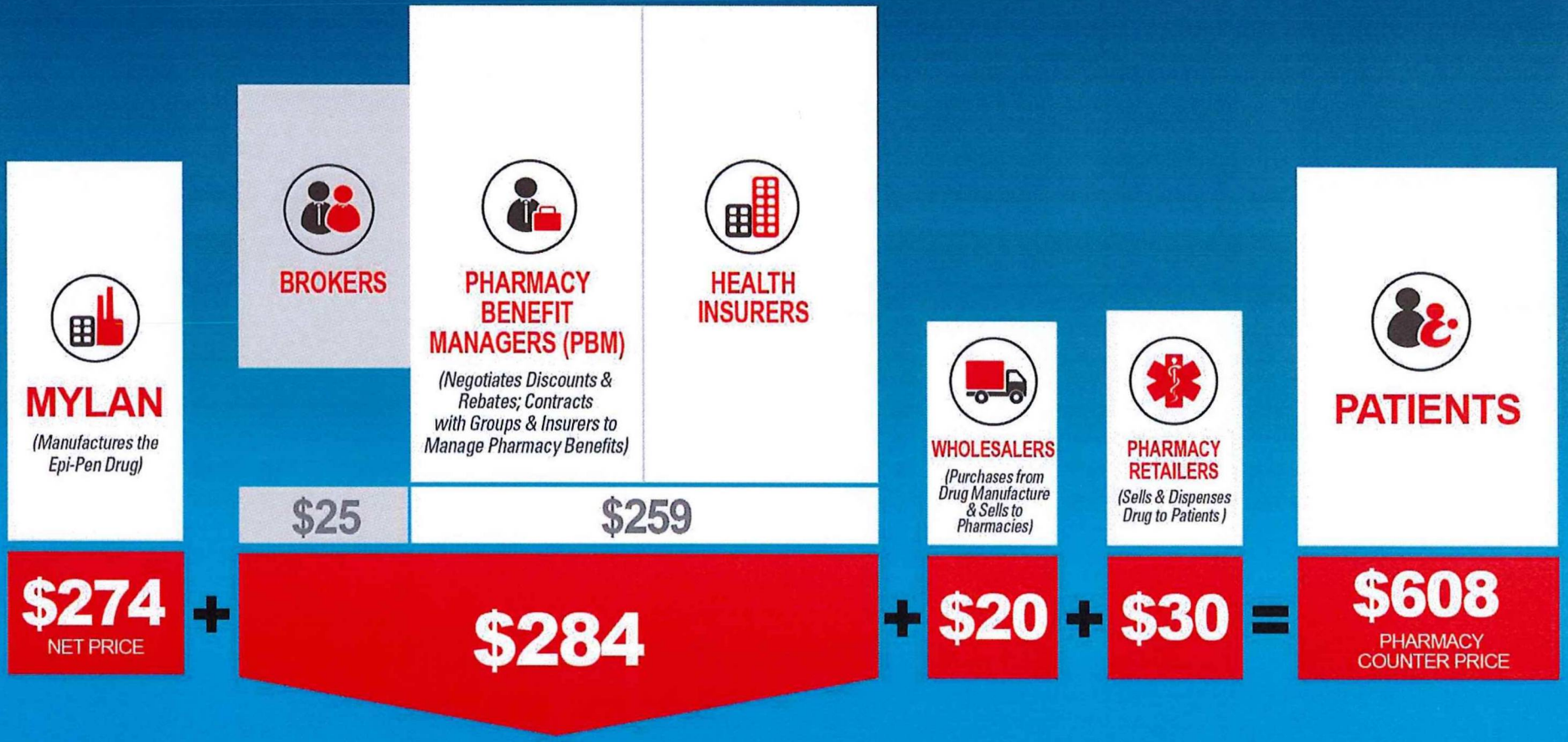
**Conservative estimate, actual price may be closer to $1. Most pharmacies in contact with PUTT have reported losses on all insulin dispensed due to below-cost reimbursements.

TruthRX.org

EPIGATE

Where the Money *Really* Goes

Pharmacists United for TRUTH & TRANSPARENCY



DEMAND TRANSPARENCY

TruthRX.org

LOCAL SCHOOL BOARD PLAN

#PROVEIT

PBM PAYS LOCAL PHARMACY

$450

PBM PAYS THEMSELVES FOR THEIR OWN SPECIALTY PHARMACY

$6,600*

Where are **YOUR** plan sponsor dollars going in **YOUR** plan?

**** Do NOT allow your PBM to steer prescriptions to themselves—they will maximize THEIR profit at YOUR expense.***

PHARMACISTS UNITED for Truth & Transparency

truthrx.org

Traditional PBMs

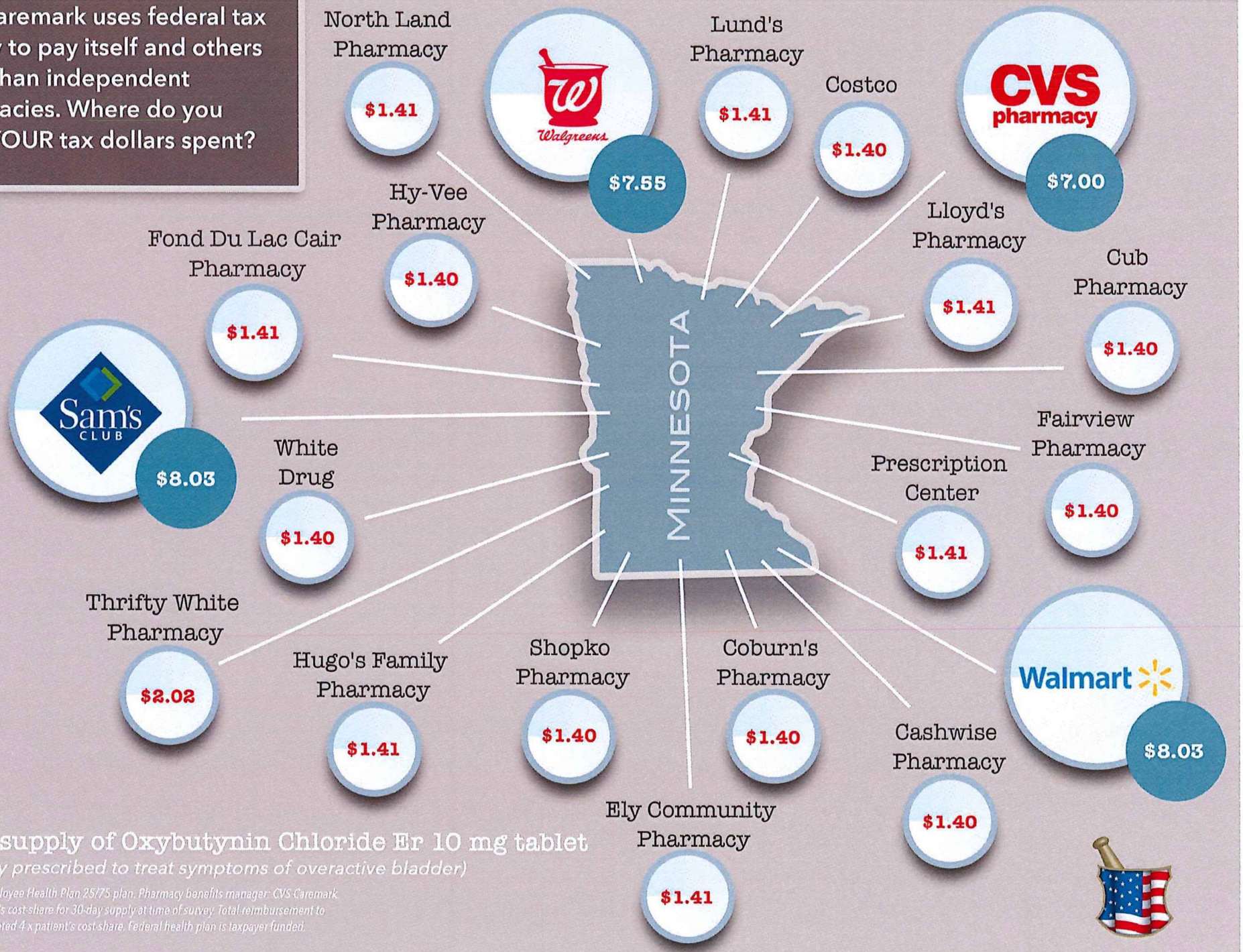
either party may terminate the Agreement on thirty (30) days prior written notice to the other.

5.2 Fiduciary Acknowledgements. ESI offers pharmacy benefit management services, products and programs ("PBM Products") for consideration by all clients, including Sponsor. The general parameters of the PBM Products, and the systems that support these products, have been developed by ESI as part of ESI's administration of its business as a PBM. The parties agree that they have negotiated the financial terms of this Agreement in an arm's-length fashion. Sponsor acknowledges and agrees that, except for the limited purpose set forth in Section 2.3(c), neither it nor the Plan intends for ESI to be a fiduciary (as defined under ERISA or state law) of the Plan, and, except for the limited purpose as set forth in Section 2.3(c), neither will name ESI or any of ESI's wholly-owned subsidiaries or affiliates as a "plan fiduciary." Sponsor further acknowledges and agrees that neither ESI nor any of ESI's wholly-owned subsidiaries or affiliates: (a) have any discretionary authority or control respecting management of the Plan's prescription benefit program, except as set forth in Section 2.3(c), or (b) exercise any authority or control respecting management or disposition of the assets of the Plan or Sponsor. Sponsor further acknowledges that all such discretionary authority and control with respect to the management of the Plan and plan assets is retained by Sponsor or the Plan. Upon reasonable notice, ESI will have the right to terminate PBM Services to any Plan (or, if applicable, Members) located in a state requiring a pharmacy benefit manager to be a fiduciary to Sponsor, a Plan, or a Member in any capacity.

5.3 Disclosure of Certain Financial Matters. In addition to the Administrative Fees paid to ESI by Sponsor

FEDERAL TAX DOLLARS USED AGAINST INDEPENDENT PHARMACIES

CVS Caremark uses federal tax money to pay itself and others more than independent pharmacies. Where do you want YOUR tax dollars spent?



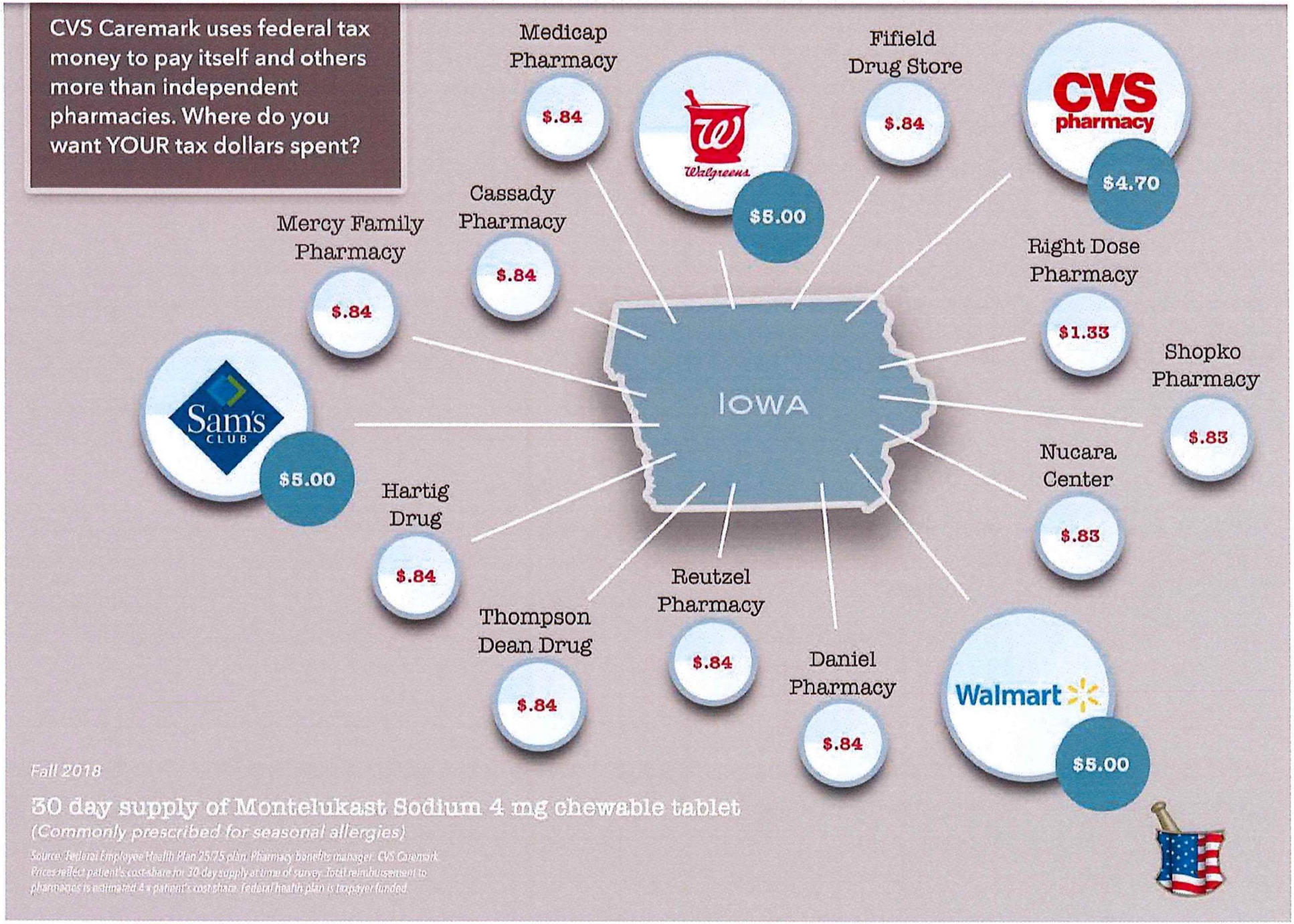
Fall 2018

30 day supply of Oxybutynin Chloride Er 10 mg tablet

(Commonly prescribed to treat symptoms of overactive bladder)

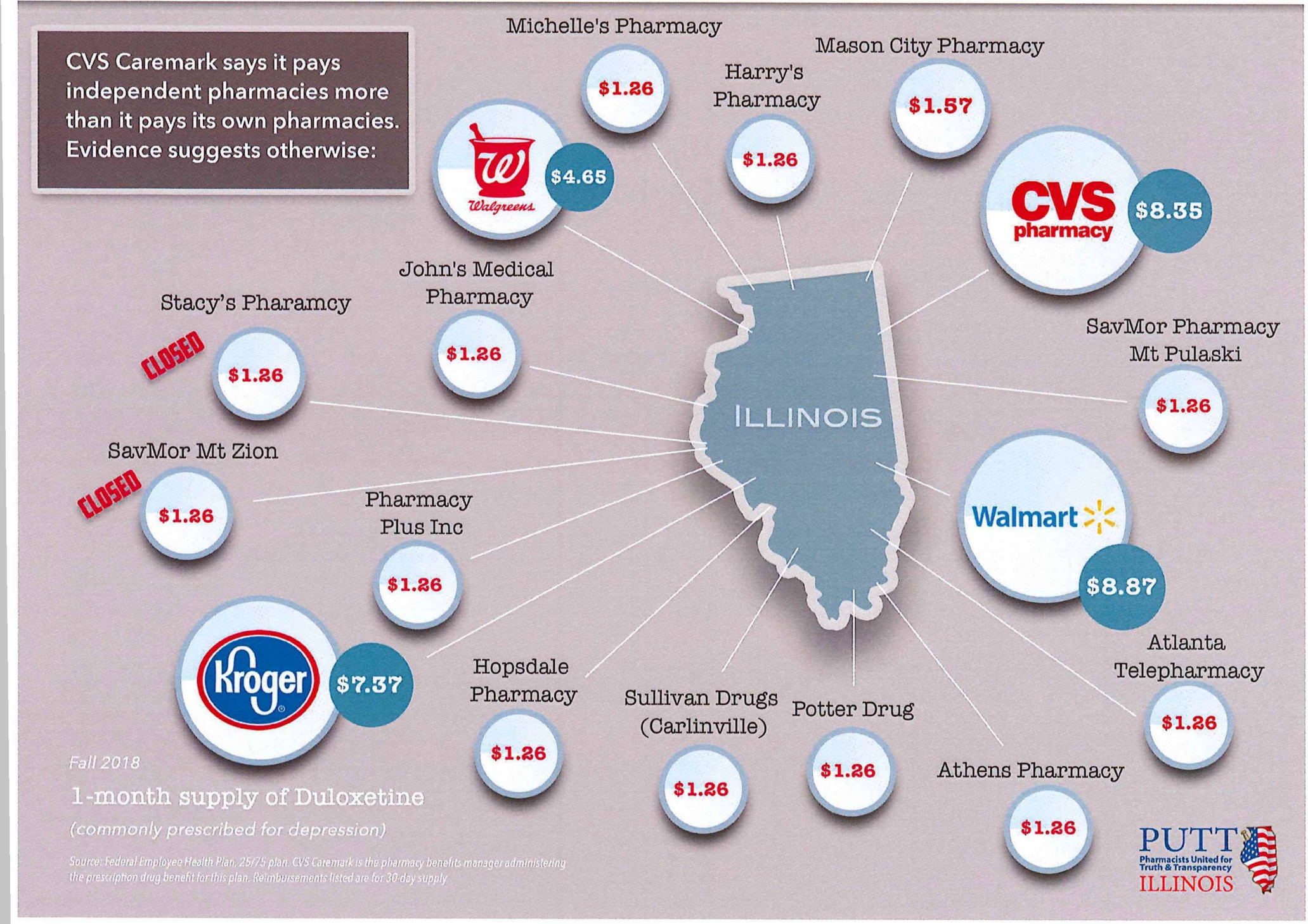
Source: Federal Employee Health Plan 25/75 plan. Pharmacy benefits manager: CVS Caremark. Prices reflect patient's cost-share for 30-day supply at time of survey. Total reimbursement to pharmacies is estimated 4 x patient's cost-share. Federal health plan is taxpayer funded.

Federal Tax Dollars Used Against Independent Pharmacies



FEDERAL TAX DOLLARS USED AGAINST INDEPENDENT PHARMACIES

CVS Caremark says it pays independent pharmacies more than it pays its own pharmacies. Evidence suggests otherwise:



Fall 2018

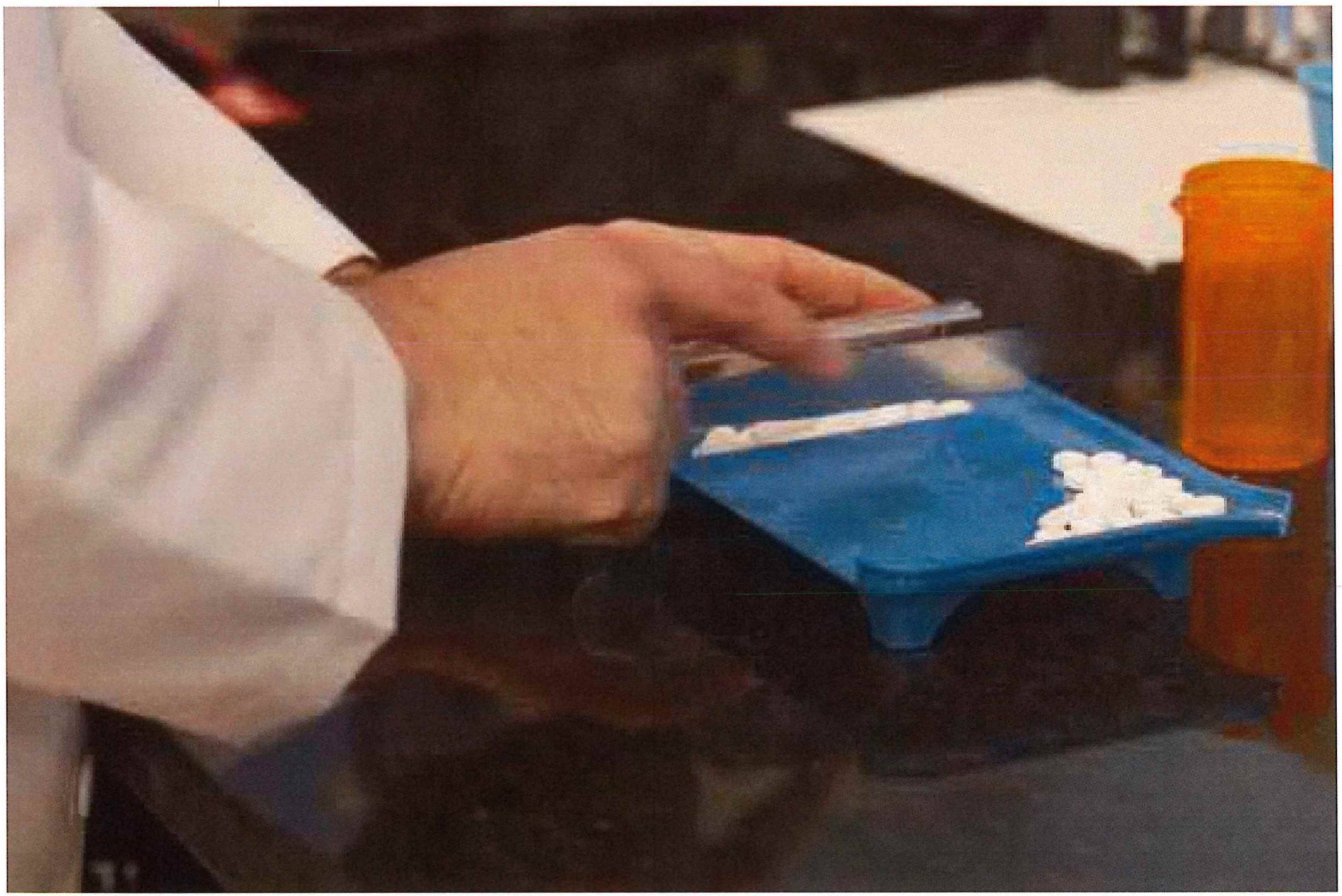
1-month supply of Duloxetine

(commonly prescribed for depression)

Source: Federal Employee Health Plan, 25/75 plan. CVS Caremark is the pharmacy benefits manager administering the prescription drug benefit for this plan. Reimbursements listed are for 30-day supply.

PUTT
Pharmacists United for Truth & Transparency
ILLINOIS

The New York Times https://nyti.ms/2Oiw42e



How Chaos at Chain Pharmacies Is Putting Patients at Risk

Pharmacists across the U.S. warn that the push to do more with less has made medication errors more likely. "I am a danger to the public," one wrote to a regulator.

By Ellen Gabler

Jan. 31, 2020

For Alyssa Watrous, the medication mix-up meant a pounding headache, nausea and dizziness. In September, Ms. Watrous, a 17-year-old from Connecticut, was about to take another asthma pill when she realized CVS had mistakenly given her blood pressure medication intended for someone else.

Edward Walker, 38, landed in an emergency room, his eyes swollen and burning after he put drops in them for five days in November 2018 to treat a mild irritation. A Walgreens in Illinois had accidentally supplied him with ear drops — not eye drops.

For Mary Scheuerman, 85, the error was discovered only when she was dying in a Florida hospital in December 2018. A Publix pharmacy had dispensed a powerful chemotherapy drug instead of the antidepressant her doctor had prescribed. She died about two weeks later.

The people least surprised by such mistakes are pharmacists working in some of the nation's biggest retail chains.

In letters to state regulatory boards and in interviews with The New York Times, many pharmacists at companies like CVS, Rite Aid and Walgreens described understaffed and chaotic workplaces where they said it had become difficult to perform their jobs safely, putting the public at risk of medication errors.

They struggle to fill prescriptions, give flu shots, tend the drive-through, answer phones, work the register, counsel patients and call doctors and insurance companies, they said — all the while racing to meet corporate performance metrics that they characterized as unreasonable and unsafe in an industry squeezed to do more with less.

"I am a danger to the public working for CVS," one pharmacist wrote in an anonymous letter to the Texas State Board of Pharmacy in April.

"The amount of busywork we must do while verifying prescriptions is absolutely dangerous," another wrote to the Pennsylvania board in February. "Mistakes are going to be made and the patients are going to be the ones suffering."

[Read how you can protect yourself against medication errors.]

State boards and associations in at least two dozen states have heard from distraught pharmacists, interviews and records show, while some doctors complain that pharmacies bombard them with requests for refills that patients have not asked for and should not receive. Such refills are closely tracked by pharmacy chains and can factor into employee bonuses.

Michael Jackson, chief executive of the Florida Pharmacy Association, said the number of complaints from members related to staffing cuts and worries about patient safety had become "overwhelming" in the past year.

CVS Health ranks eighth on the Fortune 500 list and has nearly 10,000 pharmacies across the United States. Jeenah Moon for The New York Times

The American Psychiatric Association is particularly concerned about CVS, America's eighth-largest company, which it says routinely ignores doctors' explicit instructions to dispense limited amounts of medication to mental health patients. The pharmacy's practice of providing three-month supplies may inadvertently lead more patients to attempt suicide by overdosing, the association said.

"Clearly it is financially in their best interest to dispense as many pills as they can get paid for," said Dr. Bruce Schwartz, a psychiatrist in New York and the group's president.

A spokesman for CVS said it had created a system to address the issue, but Dr. Schwartz said complaints persisted.

Regulating the chains — five rank among the nation's 100 largest companies — has proved difficult for state pharmacy boards, which oversee the industry but sometimes allow company representatives to hold seats. Florida's nine-member board, for instance, includes a lawyer for CVS and a director of pharmacy affairs at Walgreens.

Aside from creating potential conflicts of interest, the industry presence can stifle complaints. "We are afraid to speak up and lose our jobs," one pharmacist wrote anonymously last year in response to a survey by the Missouri Board of Pharmacy. "PLEASE HELP."

Officials from several state boards told The Times they had limited authority to dictate how companies ran their businesses. Efforts by legislatures in California and elsewhere have been unsuccessful in substantially changing how pharmacies operate.

A majority of state boards do not require pharmacies to report errors, let alone conduct thorough investigations when they occur. Most investigations focus on pharmacists, not the conditions in their workplaces.

In public meetings, boards in at least two states have instructed pharmacists to quit or speak up if they believe conditions are unsafe. But pharmacists said they feared retaliation, knowing they could easily be replaced.

The industry has been squeezed amid declining drug reimbursement rates and cost pressures from administrators of prescription drug plans. Consolidation, meanwhile, has left only a few major players. About 70 percent of prescriptions nationwide are dispensed by chain drugstores, supermarkets or retailers like Walmart, according to a 2019 Drug Channels Institute report.

CVS garners a quarter of the country's total prescription revenue and dispenses more than a billion prescriptions a year. Walgreens captures almost 20 percent. Walmart, Kroger and Rite Aid fall next in line among brick-and-mortar stores.

In statements, the pharmacy chains said patient safety was of utmost concern, with staffing carefully set to ensure accurate dispensing. Investment in technology such as e-prescribing has increased safety and efficiency, the companies said. They denied that pharmacists were under extreme pressure or faced reprisals.

"When a pharmacist has a legitimate concern about working conditions, we make every effort to address that concern in good faith," CVS said in a statement. Walgreens cited its confidential employee hotline and said it made "clear to all pharmacists that they should never work beyond what they believe is advisable."

Errors, the companies said, were regrettable but rare; they declined to provide data about mistakes.

The National Association of Chain Drug Stores, a trade group, said that "pharmacies consider even one prescription error to be one too many" and "seek continuous improvement." The organization said it was wrong to "assume cause-effect relationships" between errors and pharmacists' workload.

The specifics and severity of errors are nearly impossible to tally. Aside from lax reporting requirements, many mistakes never become public because companies settle with victims or their families, often requiring a confidentiality agreement. A CVS form for staff members to report errors asks whether the patient is a "media threat," according to a photo provided to The Times. CVS said in a statement it would not provide details on what it called its "escalation process."

The last comprehensive study of medication errors was over a decade ago: The Institute of Medicine estimated in 2006 that such mistakes harmed at least 1.5 million Americans each year.

Jonathan Lewis said he waited on hold with CVS for 40 minutes last summer, after discovering his antidepressant prescription had been refilled with another drug.

Mr. Lewis, 47, suspected something was wrong when he felt short of breath and extremely dizzy. Looking closely at the medication — and turning to Google — he figured out it was estrogen, not an antidepressant, which patients should not abruptly quit.

"It was very apparent they were very understaffed," Mr. Lewis said, recalling long lines inside the Las Vegas store and at the drive-through when he picked up the prescription.

Pharmacists have written to state regulatory boards about their safety concerns.

"My fellow pharmacists and pharmacy technicians are at our breaking point. Chain pharmacy practices are preventing us from taking care of our patients and putting them at risk of dangerous medication errors."

New Jersey pharmacist

Too Much, Too Fast

The day before Wesley Hickman quit his job as a pharmacist at CVS, he worked a 13-hour shift with no breaks for lunch or dinner, he said.

As the only pharmacist on duty that day at the Leland, N.C., store, Dr. Hickman filled 552 prescriptions — about one every minute and 25 seconds — while counseling patients, giving shots, making calls and staffing the drive-through, he said. Partway through his shift the next day, in December 2018, he called his manager.

"I said, 'I am not going to work in a situation that is unsafe.' I shut the door and left," said Dr. Hickman, who now runs an independent pharmacy.

Dr. Hickman felt that the multitude of required tasks distracted from his most important jobs: filling prescriptions accurately and counseling patients. He had begged his district manager to schedule more pharmacists, but the request was denied, he said.

CVS said it could not comment on the "individual concerns" of a former employee.

With nearly 10,000 pharmacies across the country, CVS is the largest chain and among the most aggressive in imposing performance metrics, pharmacists said. Both CVS and Walgreens tie bonuses to achieving them, according to company documents.

Nearly everything is tracked and scrutinized: phone calls to patients, the time it takes to fill a prescription, the number of immunizations given, the number of customers signing up for 90-day supplies of medication, to name a few.

The fact that tasks are being tracked is not the problem, pharmacists say, as customers can benefit from services like reminders for flu shots and refills. The issue is that employees are heavily evaluated on hitting targets, they say, including in areas they cannot control.

In Missouri, dozens of pharmacists said in a recent survey by the state board that the focus on metrics was a threat to patient safety and their own job security.

"Metrics put unnecessary pressure on pharmacy staff to fill prescriptions as fast as possible, resulting in errors," one pharmacist wrote.

Of the nearly 1,000 pharmacists who took the survey, 60 percent said they "agree" or "strongly agree" that they "feel pressured or intimidated to meet standards or metrics that may interfere with safe patient care." About 60 percent of respondents worked for retail chains, as opposed to hospitals or independent pharmacies.

Surveys in Maryland and Tennessee revealed similar concerns.

The specific goals are not made public, and can vary by store, but internal CVS documents reviewed by The Times show what was expected in some locations last year.

Staff members were supposed to persuade 65 percent of patients picking up prescriptions to sign up for automatic refills, 55 percent to switch to 90-day supplies from 30-day, and 75 percent to have the pharmacy contact their doctor with a "proactive refill request" if a prescription was expiring or had no refills, the documents show.

Pharmacy staff members are also expected to call dozens of patients each day, based on a computer-generated list. They are assessed on the number of patients they reach, and the number who agree to their requests.

Representatives from CVS and Walgreens said metrics were meant to provide better patient care, not penalize pharmacists. Some are related to reimbursements to pharmacies by insurance companies and the government. CVS said it had halved its number of metrics over the past 18 months.

But dozens of pharmacists described the emphasis on metrics as burdensome, and said they faced backlash for failing to meet the goals or suggesting they were unrealistic or unsafe.

"Any dissent perceived by corporate is met with a target placed on one's back," an unnamed pharmacist wrote to the South Carolina board last year.

In comments to state boards and interviews with The Times, pharmacists explained how staffing cuts had led to longer shifts, often with no break to use the restroom or eat.

"I certainly make more mistakes," another South Carolina pharmacist wrote to the board. "I had two misfills in three years with the previous staffing and now I make 10-12 per year (that are caught)."

Much of the blame for understaffing has been directed at pressure from companies that manage drug plans for health insurers and Medicare.

Acting as middlemen between drug manufacturers, insurers and pharmacies, the companies — known as pharmacy benefit managers, or P.B.M.s — negotiate prices and channel to pharmacies the more than $300 billion spent on outpatient prescription drugs in the United States annually.

The benefit managers charge fees to pharmacies, and have been widely criticized for a lack of transparency and applying fees inconsistently. In a letter to the Department of Health and Human Services in September, a bipartisan group of senators noted an "extraordinary 45,000 percent increase" in fees paid by pharmacies from 2010 to 2017.

While benefit managers have caused economic upheaval in the industry, some pharmacy chains are players in that market too: CVS Health owns CVS Caremark, the largest benefit manager; Walgreens Boots Alliance has a partnership with Prime Therapeutics; Rite Aid owns a P.B.M., too.

The Pharmaceutical Care Management Association, the trade group representing benefit managers, contends that they make prescriptions more affordable, and pushes back against the notion that P.B.M.s are responsible for pressures on pharmacies, instead of a competitive market.

Pharmacists have written to state regulatory boards about their safety concerns.

"I am expected to make 50-100 phone calls in addition to answering phone calls, consultations, vaccinations and prescription verification. This has resulted in dispensing errors. A member of our staff misfilled a narcotic prescription for immediate release rather than extended release which resulted luckily in only patient fatigue, but it could have easily been deadly."

South Carolina pharmacist

Falling Through the Cracks

Dr. Mark Lopatin, a rheumatologist in Pennsylvania, says he is inundated with refill requests for almost every prescription he writes. At times Dr. Lopatin prescribes drugs intended only for a brief treatment — a steroid to treat a flare-up of arthritis, for instance.

But within days or weeks, he said, the pharmacy sends a refill request even though the prescription did not call for one. Each time, his office looks at the patient's chart to confirm the request is warranted. About half are not, he said.

Aside from creating unnecessary work, Dr. Lopatin believes, the flood of requests poses a safety issue. "When you are bombarded with refill after refill, it's easy for things to fall through the cracks, despite your best efforts," he said.

Pharmacists told The Times that many unwanted refill requests were generated by automated systems designed in part to increase sales. Others were the result of phone calls from pharmacists, who said they faced pressure to reach quotas.

In February, a CVS pharmacist wrote to the South Carolina board that cold calls to doctors should stop, explaining that a call was considered "successful" only if the doctor agreed to the refill.

"What this means is that we are overwhelming doctor's office staff with constant calls, and patients are often kept on medication that is unneeded for extended periods of time," the pharmacist wrote.

CVS says outreach to patients and doctors can help patients stay up-to-date on their medications, and lead to lower costs and better health.

Dr. Rachel Poliquin, a psychiatrist in North Carolina who says she constantly gets refill requests, estimates that about 90 percent of her patients say they never asked their pharmacy to contact her.

While Dr. Poliquin has a policy that patients must contact her directly for more medication, she worries about clinics where prescriptions may get rubber-stamped in a flurry of requests. Then patients — especially those who are elderly or mentally ill — may continue taking medication unnecessarily, she said.

The American Psychiatric Association has been trying to tackle a related problem after hearing from members that CVS was giving patients larger supplies of medication than doctors had directed.

While it is common for pharmacies to dispense 90 days' worth of maintenance medications — to treat chronic conditions like high blood pressure or diabetes — doctors say it is inappropriate for other drugs.

For example, patients with bipolar disorder are often prescribed lithium, a potentially lethal drug if taken in excess. It is common for psychiatrists to start a patient on a low dose or to limit the number of pills dispensed at once, especially if the person is considered a suicide risk.

But increasingly, the psychiatric association has heard from members that smaller quantities specified on prescriptions are being ignored, particularly by CVS, according to Dr. Schwartz, the group's president.

CVS has created a system where doctors can register and request that 90-day supplies not be dispensed to their patients. But doctors report that the registry has not solved the problem, Dr. Schwartz said. In a statement, CVS said it continued to "refine and enhance" the program.

Dr. Charles Denby, a psychiatrist in Rhode Island, became so concerned by the practice that he started stamping prescriptions, "AT MONTHLY INTERVALS ONLY." Despite those explicit instructions, Dr. Denby said, he received faxes from CVS saying his patients had asked for — and been given — 90-day supplies.

Dr. Denby, who retired in December, said it was a "baldfaced lie" that the patients had asked for the medication, providing statements from patients saying as much.

"I am disgusted with this," said Dr. Denby, who worries that patients may attempt suicide with excess medication. "There are going to be people dead only because they have enough medication to do the deed with."

'We Already Have Systems in Place'

Alton James never learned how the mistake came about that he says killed his 85-year-old mother, Mary Scheuerman, in 2018.

He knows he picked up her prescription at the pharmacy in a Publix supermarket in Lakeland, Fla. He knows he gave her a pill each morning. He knows that after six days, she turned pale, her blood pressure dropped and she was rushed to the hospital.

Mary Scheuerman died in December

2018 after taking a powerful chemotherapy drug mistakenly dispensed by a Publix pharmacy. Her son said she was supposed to have received an antidepressant.

Mr. James remembers a doctor telling him his mother's blood had a toxic level of methotrexate, a drug often used to treat cancer. But Mrs. Scheuerman didn't have cancer. She was supposed to be taking an antidepressant. Mr. James said a pharmacy employee later confirmed that someone had mistakenly dispensed methotrexate.

Five days after entering the hospital, Mrs. Scheuerman died, with organ failure listed as the lead cause, according to medical records cited by Mr. James.

The Institute for Safe Medication Practices has warned about methotrexate, listing it as a "high-alert medication" that can be deadly when taken incorrectly. Mr. James reported the pharmacy's error to the group, writing that he wanted to raise awareness about the drug and push Publix, one of the country's largest supermarket chains, to "clean up" its pharmacy division, according to a copy of his report provided to The Times.

Trexall, a brand name for the drug methotrexate, can be used to treat cancer.

The company acknowledged the mistake and offered a settlement, Mr. James wrote, but would not discuss how to avoid future errors, saying, "We already have systems in place."

Last September, Mr. James told The Times that Publix wanted him to sign a settlement agreement that would prevent him from speaking further about his mother's death. Mr. James has since declined to comment, saying that the matter was "amicably resolved."

A spokeswoman for Publix said privacy laws prevented the company from commenting on specific patients.

It can be difficult for patients and their families to decide whether to accept a settlement.

Last summer, CVS offered to compensate Kelsey and Donavan Sullivan after a pediatrician discovered the reflux medication they had been giving their 4-month-old for two months was actually a steroid. To be safely weaned, the baby had to keep taking it for two weeks after the error was discovered.

"It was like he was coming out of a fog," Mrs. Sullivan recalled.

The couple, from Minnesota, are still considering a settlement but haven't agreed to anything because they don't know what long-term consequences their son might face.

The kinds of errors and how they occur vary considerably.

The paper stapled to a CVS bag containing medication for Ms. Watrous, the Connecticut teenager with asthma, listed her correct name and medication, but the bottle inside had someone else's name.

Directions on the prescription for Mr. Walker, the Illinois man who got ear drops instead of eye drops from Walgreens, were clear: "Instill 1 drop in both eyes every 6 hours." He later saw the box: "For use in ears only."

In September, Stefanie Davis, 31, got the right medicine, Adderall, but the wrong dose. She pulled over on the interstate after feeling short of breath and dizzy with blurred vision. The pills, dispensed by a Walgreens in Sun City Center, Fla., were each 30 milligrams instead of her usual 20. She is fighting with Walgreens to cover a $900 bill for her visit to an emergency room.

Fixes That Fall Short

State boards and legislatures have wrestled with how to regulate the industry. Some states have adopted laws, for instance introducing mandatory lunch breaks or limiting the number of technicians a pharmacist can supervise.

But the laws aren't always followed, can be difficult to enforce or can fail to address broader problems.

The National Association of Chain Drug Stores says some state boards are blocking meaningful change. The group, for instance, wants to free up pharmacists from some tasks by allowing technicians, who have less training, to do more.

It also supports efforts to change the insurance reimbursement model for pharmacies. Health care services provided by pharmacists to patients, such as prescribing birth control, are not consistently covered by insurers or allowed in all states. But it has been difficult to find consensus to change federal and state regulations.

While those debates continue, some state boards are trying to hold companies more accountable.

Often when an error is reported to a board, action is taken against the pharmacist, an obvious target. It is less common for a company to be scrutinized.

The South Carolina board discussed in November how to more thoroughly investigate conditions after a mistake. It also published a statement discouraging quotas and encouraging "employers to value patient safety over operational efficiency and financial targets."

California passed a law saying no pharmacist could be required to work alone, but it has been largely ignored since taking effect last year, according to leaders of a pharmacists' union. The state board is trying to clarify the law's requirements.

In Illinois, a new law requires breaks for pharmacists and potential penalties for companies that do not provide a safe working environment. The law was in response to a 2016 Chicago Tribune investigation revealing that pharmacies failed to warn patients about dangerous drug combinations.

Some states are trying to make changes behind closed doors. After seeing results of its survey last year, the Missouri board invited companies to private meetings early this year to answer questions about errors, staffing and patient safety.

CVS and Walgreens said they would attend.

Research was contributed by Susan C. Beachy, Jack Begg, Alain Delaquérière and Sheelagh McNeill.

All PBMs are Not Created Equal

"...that current PBM models lack transparency and are overly complicated."

Transparency & Pass-Through are not the same.

PBM Model	Revenue Streams	Disclosure
Traditional	No limits	None
Transparent	Some limits	Required
Pass-Through	Strict limits	Required
Hybrid	Varies	Sometimes

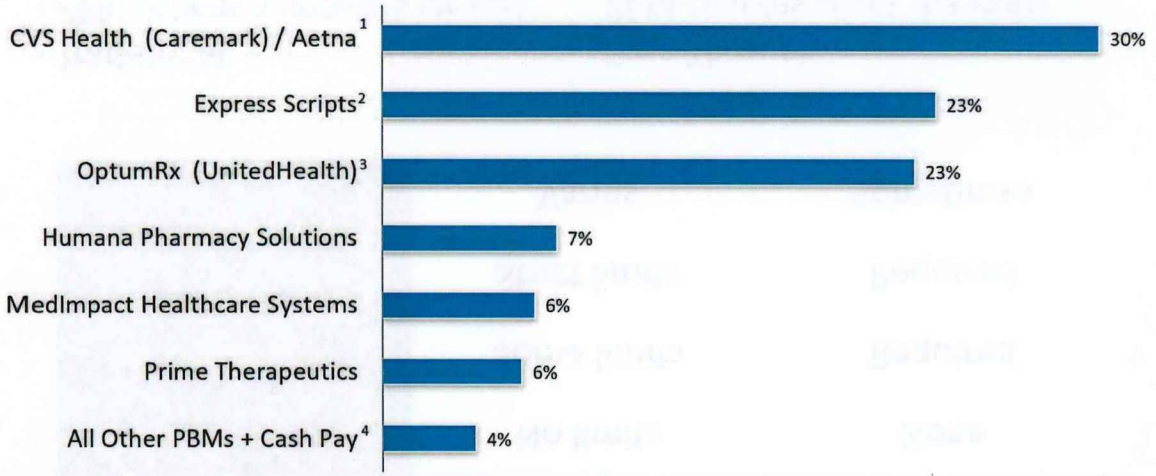
Traditional
PBM retains a network spread, rebates, and other revenues streams as compensation.

Pass-Through
PBM charges client the exact amount it pays pharmacies. PBM is compensated with an agreed upon fee for service.

Who are PBMs?

76% of the all prescription claims are processed by the "Big 3"

PBM Market Share, by Total Equivalent Prescription Claims Managed, 2018



1. Includes pro forma combination of claims processed by Aetna. Excludes double counting of network claims for mail choice claims filled at CVS retail pharmacies.
2. Includes Anthem. During 2019, Anthem claims will be transitioning to IngenioRx.
3. Includes Cigna. By the end of 2020, Cigna claims will transition to Express Scripts.
4. Figure includes some cash pay prescriptions that use a discount card processed by one of the 6 PBMs shown on the chart.

Source: Drug Channels Institute research and estimates. Total equivalent prescription claims includes claims at a PBM's network pharmacies plus prescriptions filled by a PBM's mail and specialty pharmacies. Includes discount card claims. Note that figures may not be comparable with those of previous reports due to changes in publicly reported figures of equivalent prescription claims. Total may not sum due to rounding.

This chart appears as Exhibit 76 in *The 2019 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute*. Available at http://drugch.nl/pharmacy

DRUG CHANNELS
INSTITUTE

"Drug channel companies are MUCH bigger than Manufacturers."

Adam Fein, PhD

DRUG CHANNELS INSTITUTE

Drug Channel Companies on the 2018 *Fortune* 500 List

Company (stock symbol)	2018 *Fortune* 500 Rank	Revenues ($B)	Revenues, % vs. 2016	Market Value (as of 3/29/18)	Revenue per Employee ($M)	Profit as % of Revenues	Profit as % of Assets	Annualized Return to Investors (2007-2017)	Total Return to Investors (2017)	Employees (000s)
McKesson (MCK)	6	$198.5	3.1%	$29.1	$3.1	2.6%	8.3%	10%	11.9%	64.5
CVS Health (CVS)	7	$184.8	4.1%	$63.1	$0.9	3.6%	7.0%	8%	-5.7%	203.0
AmerisourceBergen (ABC)	11	$153.1	4.3%	$18.9	$7.9	0.2%	1.0%	17%	19.4%	19.5
Cardinal Health (CAH)	14	$130.0	6.9%	$19.7	$3.2	1.0%	3.2%	6.0%	-12.8%	40.4
Walgreens Boots Alliance (WBA)	19	$118.2	0.7%	$64.9	$0.4	3.4%	6.2%	8.8%	-10.5%	290.0
Express Scripts Holding (ESRX)	25	$100.1	-0.2%	$38.8	$3.8	4.5%	8.3%	7.4%	8.5%	26.6
Rite Aid (RAD)	94	$32.8	6.9%	$1.8	$0.5	0.0%	0.0%	-3.4%	-76.1%	70.4
Average	25	$131.1	3.7%	$33.8	$2.8	2.2%	4.9%	7.6%	-9.3%	102.1
Median	14	$130.0	4.1%	$29.1	$3.1	2.6%	6.2%	7.7%	-5.7%	64.5

Source: Drug Channels Institute analysis of 2018 *Fortune* 500 list
Published on Drug Channels (http://www.DrugChannels.net) on June 12, 2018.

DRUG CHANNELS INSTITUTE

Traditional PBMs

PBM Average Wholesale Prices: A Non-Constant

There are 40 total AWP's for Nexium 40mg ranging in price from $78 - >$10,000

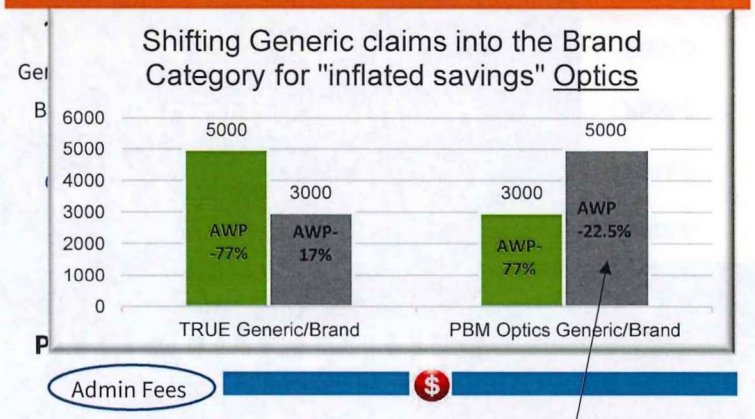
Fallacy of Average Wholesale Price (AWP) Contracting

AWPs have no relevance in projecting final client costs from PBM to PBM; therefore, the intent of any employer should be to procure medications at the lowest cost per pill.

Nexium 40mg (AstraZeneca)				Quantity: 30 Pills		
PBM	NDC Code	AWP	AWP for 30	Discount	Disp. Fee	Total Rx Cost
PBM A	00440786190	$10.51	$315.30	-15%	$1.50	$269.51
PBM B	54868451003	$8.60	$258.00	-16%	$1.00	$217.72
PBM C	50436312101	$13.25	$397.50	-17%	$0.75	$330.68
PBM D	68115086730	$9.52	$285.60	-24%	$0.00	$217.06
PBM E	47463054030	$14.13	$423.90	-40%	$0.00	$254.34
ASTRAZENECA	00186504225	$7.52				
Fiduciary PBM	00186504225	$7.52	$225.60	-15%	$3.00	$194.76

What will you **pay** your PBM for **brand** and **generic** drugs?

PBM Profit Levers



Example: Moved 2000 claims that processed at AWP-77% into the brand category that has a guarantee of only AWP-17%. This falsely gives the client the impression of a successful and competitive contract.

AWP-77% applied to 2000 extra "Generic" claims gives the "illusion" of better discounts AWP-22.5%

"Brand Drug" means a prescription drug identified as such in [redacted]'s master drug file using indicators from First Databank (or other source nationally recognized in the prescription drug industry used by [redacted] for all clients) on the basis of a standard Brand/Generic Algorithm utilized by [redacted] for all of its clients, a copy of which may be made available for review by Administrator, Client, or its Auditor upon request. Notwithstanding the foregoing, certain prescription drug medications that are licensed and then currently marketed as brand name drugs, where there exists at least one (1) competing prescription medication that is a generic equivalent and interchangeable with the marketed brand name drug, may process as "Generic Drugs" for Prescription Drug Claim adjudication and Member Copayment purposes.

Beware of this contract language!

- First, the pricing source is very open ended and allows PBM to pick the better unit cost price between the various providers (MediSpan and FDB).
- This allows PBM to move a large number of claims of generic claims (AWP -7.50%) to be moved to the brand category (AWP- 17.00%) for guarantee purposes. This falsely "inflates" the brand category and provides the appearance that brands are achieving a higher discount when in reality PBM is moving generic claims that processed at AWP-77% to the brand category which raises the overall effective rate.
- The line that states "There exists at least one competing medication" is not in the clients' best interest. This is allowing PBM to move the majority of medication to another category for guarantee purposes, many other PBMS have language that states medication must be produced by more than 2 manufacturers.
- The last line indicates that the adjudication logic is not consistent with the guarantee logic.

southernscripts
a New Kind of Pharmacy Benefit Management

Pass-Through PBM

Southern Scripts contractually warrants that our sole source of revenue is the administration fee

southernscripts
a New Kind of Pharmacy Benefit Management

If your PBM can't agree to this contract language...

Brand Drug Product shall mean a Covered Product with a proprietary name or trademark that has been determined a Covered "brand" Product by Southern Scripts using MediSpan MultiSource and Brand Name Code Indicators (MNOY).

Generic Drug Product means a drug identified by its chemical or non-proprietary name considered to be bioequivalent to the Brand Drug Product that has been determined to be a Covered "generic" Product by Southern Scripts using MediSpan MultiSource and Brand Name Code Indicators (MNOY).

Rebate(s) shall mean any and all manufacturer derived revenue such as rebates, discounts, administrative fees, and any other revenue earned by Customer as provided for through the rebate aggregator for a particular pharmaceutical product provided by the drug manufacturer for placement of the manufacturer's pharmaceutical product on the Applicable Plan Formulary.

Pass-Through shall mean the method of charging Customer no more than the actual amount paid by Southern Scripts to a Network Pharmacy including all discounts, professional fees, taxes and dispensing fees and is applicable to all participating Network Pharmacies. Regarding Rebates, Pass-Through shall mean all Rebate earnings received by Southern Scripts from manufacturers or rebate aggregators, including administrative fees, will be retained by the Customer.

Don't sign the contract!

If your PBM is earning revenues because they are in fact the ultimate decision maker regarding:

- What Drugs Your Members Take
- Where the Drugs Come From
- How Much They Cost

How can you be certain your interests are aligned?

What will you pay your PBM?

southernscripts
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Southern Scripts Repricing Compared to the Big 3

Caremark Prospect

05/01/2018 – 04/30/2019 • Pricing Summary • 18,412 Rx

Current PBM	Total
Current Gross Cost	$3,658,579
Member Paid	-$265,142
Plan Paid	$3,393,437

Southern Scripts	Total
NetGross Cost	$3,198,889
Savings from Variable Copay	-$140,643
Savings from Clinical Management	-$143,950
Gross Cost	$2,914,296
Est Member Paid	-$231,828
Plan Paid	$2,682,468
Rebates: Core Formulary	$551,223
SS Administration Fee	$147,296
Net Plan Costs	**$2,278,541**

Savings	Total
Plan Savings	$1,114,896
Plan Savings Per Script	$60.55

Additional Vendor Programs (Optional)	Savings
Savings from Reference Pricing	$0
Savings from PriceMDs	-$248,427
Savings from INTLMailOrder	-$212,975

Optum Prospect

01/01/2018 – 12/31/2018
Pricing Summary • 4,140 Rx

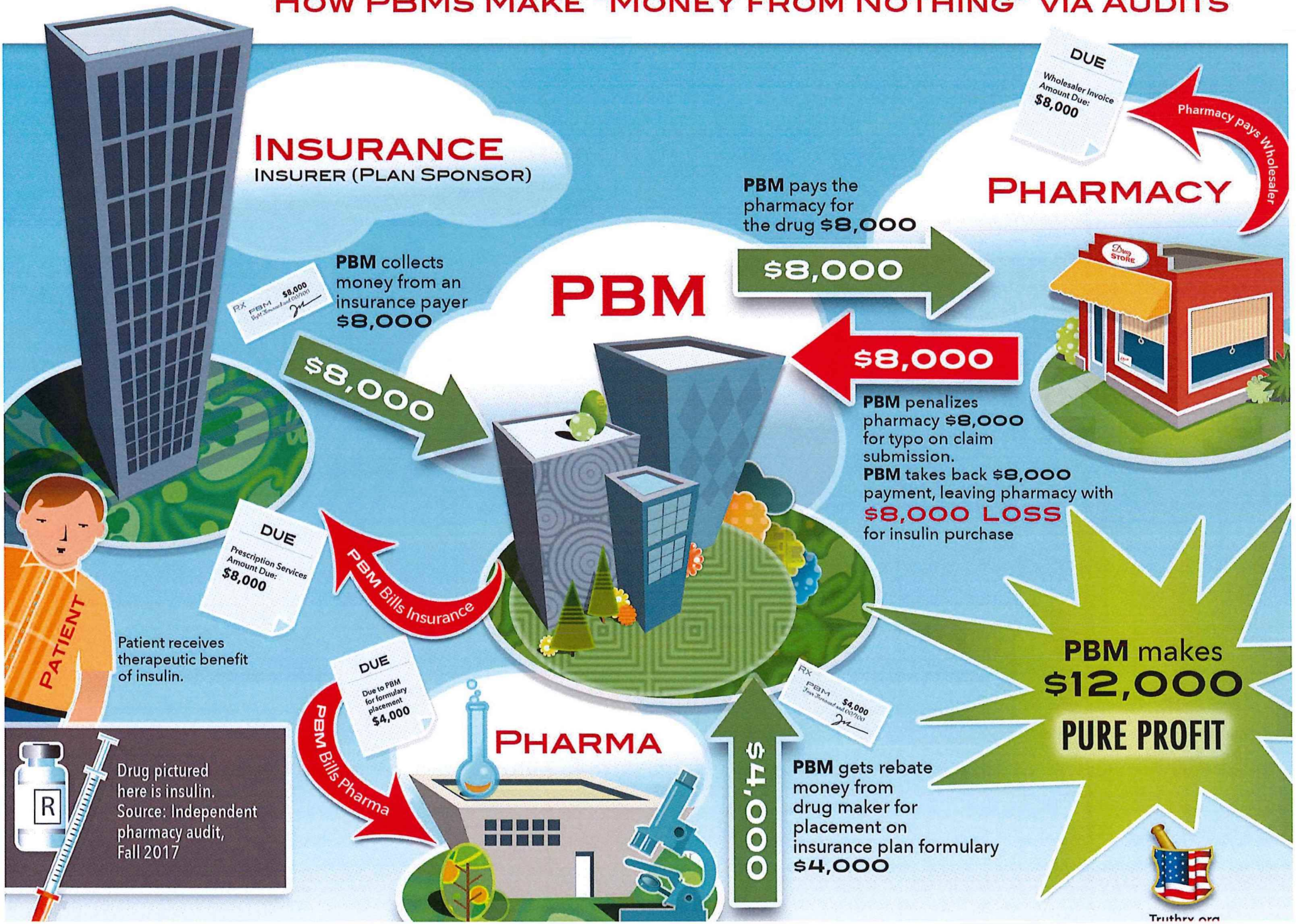
Current PBM	Total
Current Gross Cost	$866,623
Member Paid	-$24,233
Plan Paid	$842,390

Southern Scripts	Total
NetGross Cost	$743,313
Savings from Variable Copay	-$43,130
Savings from Clinical Management	-$33,449
Gross Cost	$666,734
Est Member Paid	-$20,785
Plan Paid	$645,949
Rebates: Controlled Incentive Formulary	$51,601
SS Administration Fee	$33,120
Net Plan Costs	**$627,468**

Savings	Total
Plan Savings	$214,922
Plan Savings Per Script	$51.91
Open Incentive Formulary Rebates** ***If standard Formulary is elected use this rebate amount in the calculation.* *First Choice Network has certain plan design requirements.*	-$45,216

Additional Vendor Programs (Optional)	Savings
Savings from Reference Pricing	$0
Savings from PriceMDs	-$67,853
Savings from INTLMailOrder	-$59,745

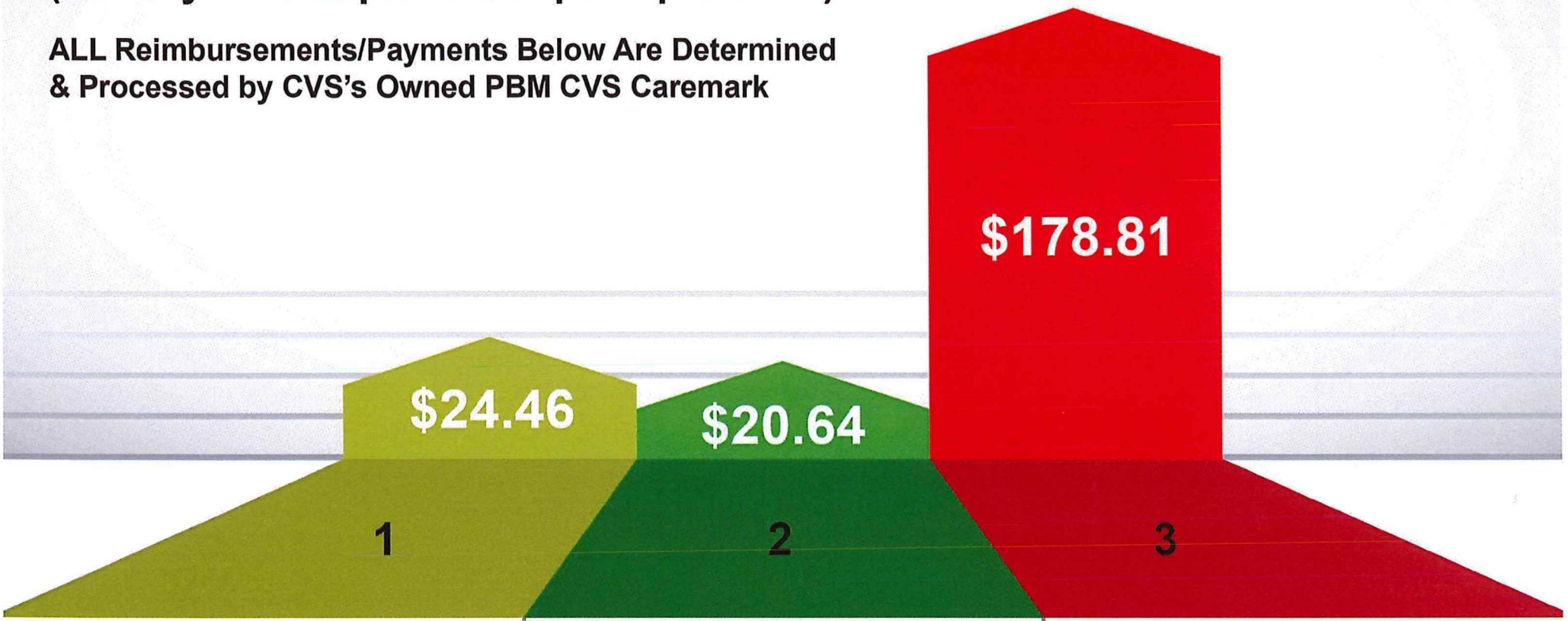
How PBMs Make "Money from Nothing" via Audits



Is this why the only coverage allowed is through mail ORDER PHARMACY OWNED BY insurance's PBM?

(Usually CVS/Express Scripts/Optum RX)

ALL Reimbursements/Payments Below Are Determined & Processed by CVS's Owned PBM CVS Caremark



No Insurance Good RX Discount Card

How Much CVS Reimbursed/Paid Our Preferred Pharmacy Only After Media Involvement ($10 Copay)

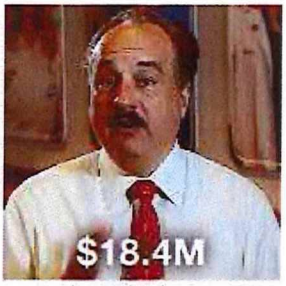
How Much CVS Caremark Reimbursed/Paid Their Mail Order Pharmacy 8x More Than Our Preferred Pharmacy ($0 Copay)

PHARMACISTS UNITED FOR TRUTH AND TRANSPARENCY **TruthRx.org**

PBM EXECUTIVE SALARIES

Bruce Broussard
President/CEO
Humana

Mark Bertolini
CEO
Aetna



Larry Merlo
President/CEO
CVS Health

Steven Hemsley
CEO
United HC

David Cordani
CEO
Cigna

Tim Wentworth
President/CEO
Express Scripts

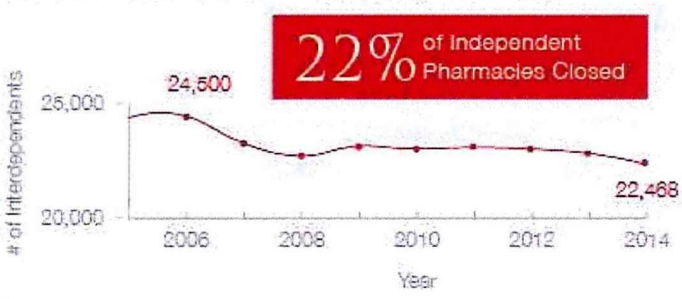
Larry Renfro
CEO
OptumRx

George Paz
Chairman of the
Board/Prior CEO
Express Scripts

Jon Roberts
President/Exec VP
CVS Caremark

Helena Foulkes
President/Exec VP
CVS Pharmacy

PBMs Negatively Impact the Small Business Pharmacy Climate



Where Money From EpiPen Purchases Really Goes

HELP US PUSH FOR PBM REFORM!
TruthRx.org/PBMReform

Taxpayers would save an estimated 50% on prescription drug prices if PBMs were removed.

*source: SEC.gov. Information based on latest DEF 14A reporting.

Blog

Search

Study finds Wisconsin has high healthcare prices

Posted by: Alex Bielinski

31 MAY

0

A study released this month by the nonprofit Health Care Cost Institute found that Wisconsin has the second highest healthcare prices among the 41 states it surveyed. The study was based on claims data from UnitedHealthcare, Aetna, and Humana, which the Institute said represents 34% of total commercial claims in Wisconsin. The study found that prices in Wisconsin for over 200 common medical services were on average

81% higher than the national average, and that the price of 20% of these services are double the national average.

The study's findings are generally in line with other recent national studies that have found that Milwaukee and Madison are among the costliest cities for health care, and that physician payments are 50% higher in Milwaukee than the Midwest average. The results are also in line with the reality that Wisconsin has some of the highest individual insurance premiums in the country. What's more, Froedtert Hospital in Wauwatosa is raising its rates by 5% overall for the second year in a row, including 10% increases for inpatient intensive care and nursery hospitalizations.

On the other hand, the study's findings seem at odds with other recent studies that show Wisconsin is making progress on controlling healthcare prices. For example, a 2015 study sponsored by the Greater Milwaukee Business Foundation on Health found that between 2003 and 2014, the increase in average southeast Wisconsin hospital commercial payment levels was less than 50% of the rate of increase in the national Hospital Component of the Consumer Price Index.

The Executive Director of the Health Care Cost Institute, David Newman, hopes that the study will prompt employers and individual consumers to ask why healthcare prices are higher in some places than others. However, as Guy Boulton of the Milwaukee Journal Sentinel points out, most patients do not pay attention to healthcare prices because many bills are paid by their employers and insurance companies – even though in the end these patients pay for the high prices in the form of lower wages.

This last point is especially important given that two-thirds of Americans would have difficulty coming up with $1,000 in an emergency to pay an unexpected bill. While some may say this illustrates the need for rich health plans with low out of pocket costs, the reality is that these types of plans eat up money that could otherwise be paid as wages, which makes it harder for employees to build savings.

To solve the problem of high healthcare prices, both employers and employees will need to change their behavior by educating themselves and making the choice to avoid high cost health plans and medical

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2018 WI Health Insurance Cost Ranking Report

Summary of Findings

This is the 12th annual report on Wisconsin's regional health insurance costs.

The report documents conclusively the dramatic statewide impact of health insurance hyperinflation in Wisconsin before the passage of the Affordable Care Act (ACA) and after. Although health insurance inflation overall has moderated since the passage of the health care reform law, especially for large employers, this report shows that Wisconsin still has much work to do to address high health insurance costs and large regional disparities.

A major new finding this year is that health insurance rates actually went down from 2017-2018 for large and medium sized employers, an unprecedented result in the history of the report. This is in striking contrast to increases on the individual and small employer markets. The implications of this apparent decoupling of rates between different types of health insurance is discussed in the report.

Also new this year, the report documents the cost savings to consumers that would result if Wisconsin opened BadgerCare at cost to small employers and people who buy insurance on their own.

The report is also extremely relevant to the debate over whether to repeal the ACA, and if it is repealed what should replace it. The report offers historical comparisons of health insurance hyperinflation in Wisconsin before and after the implementation of ACA, broken down by each metro area in the state.

The 2018 Wisconsin Health Insurance Cost Ranking Report sheds light on how health insurance hyperinflation is impacting the major regions of the state, and therefore provides valuable insights for policymakers. As in the past eleven reports, this year's report shows that although costs are high across Wisconsin, some regions of the state pay thousands of dollars more for health insurance than others.

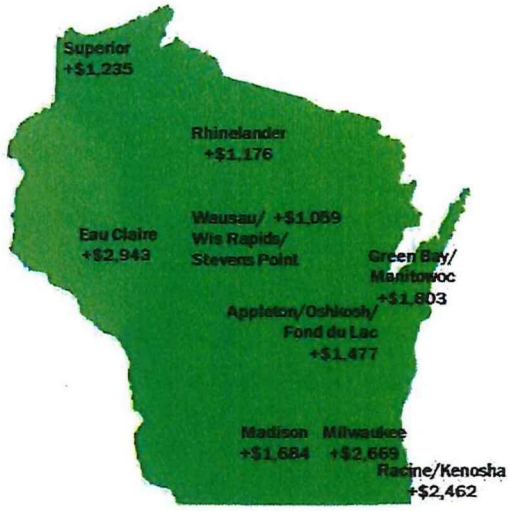
Click here to download the full 2018 WI Health Insurance Cost Rankings Report

Key Findings in 2018 Report ***(See cost ranking charts in full report)***

Key Findings in 2018 Report (See ranked charts in next section)

1. Wisconsin Health Care Hyperinflation is a Long Term Trend. Wisconsin large group health insurance costs (premiums and deductibles) have more than tripled since the year 2000, increasing 209% statewide, with regional rates of inflation varying between a low of 168% in Madison to highs of 366% in Green Bay, 258% in Oshkosh, 248% in Appleton, and 220% in Milwaukee, for benefits packages that are less generous (See Chart 7).

How Much More Private Health Insurance Is For Small Businesses Than a BadgerCare Public Option Would Be.
2018 Average Price, Annually, Premiums & Deductibles



2. The Rate of Health Care Hyperinflation Was Much Higher Before the Implementation of ACA. The rate of health insurance hyperinflation for large group insurance was 15x higher in the 13 years before the implementation of ACA than it has been in the 5 years since (15% per year statewide before vs 1% per year after, see Charts 3 & 4). Over three-quarters of Wisconsinites under the age of 65 get their insurance on the large group market. While this does not prove that the ACA is responsible for the decrease in the rate of inflation, it does call into question the claim that the health care law caused health insurance rates for most health consumers to dramatically increase.

3. The Rates for Large Group Health Insurance are Increasing Much More Slowly than Small Group and Individual Market. For the first time in the 12 year history of this report, the rates for large group insurance declined (Chart 10). Also, the annual inflation rate since the full implementation of the ACA 5 years ago is only 1% (Chart 4). The most trusted national data shows a very low rate of inflation for employer-based coverage between 2017 and 2018. On the other hand, rates continue to increase dramatically for individual market and small group insurance (Charts 11 & 12). This decoupling between insurance markets has substantial implications which are discussed in the policy implications sections below (also see methodological note on large group insurance at the end of last section).

4. Opening Access to Public Insurance for Individuals and Small Employers Would Dramatically lower costs. The proposed BadgerCare Public Option bill would reduce premiums and deductibles by an average of over $1,700 on the small group market and over $4,400 on the individual market, and even more in some high cost metro areas (Charts 15 and 16). This is discussed further in the policy implications section.

5. Regional Cost Disparities Persist. As in all 12 years of this report, there continue to be wide cost variations between higher and lower cost areas of the state. For example, there is a $1,785.72 difference in annual premiums on the large group market between Oshkosh, the highest-cost area, and Madison, the lowest-cost area (Chart 2). There is an even larger disparity on the individual market of $3,939.76 per year between Green Bay, the highest cost area, and the part of Wisconsin east of the Twin Cities (chart

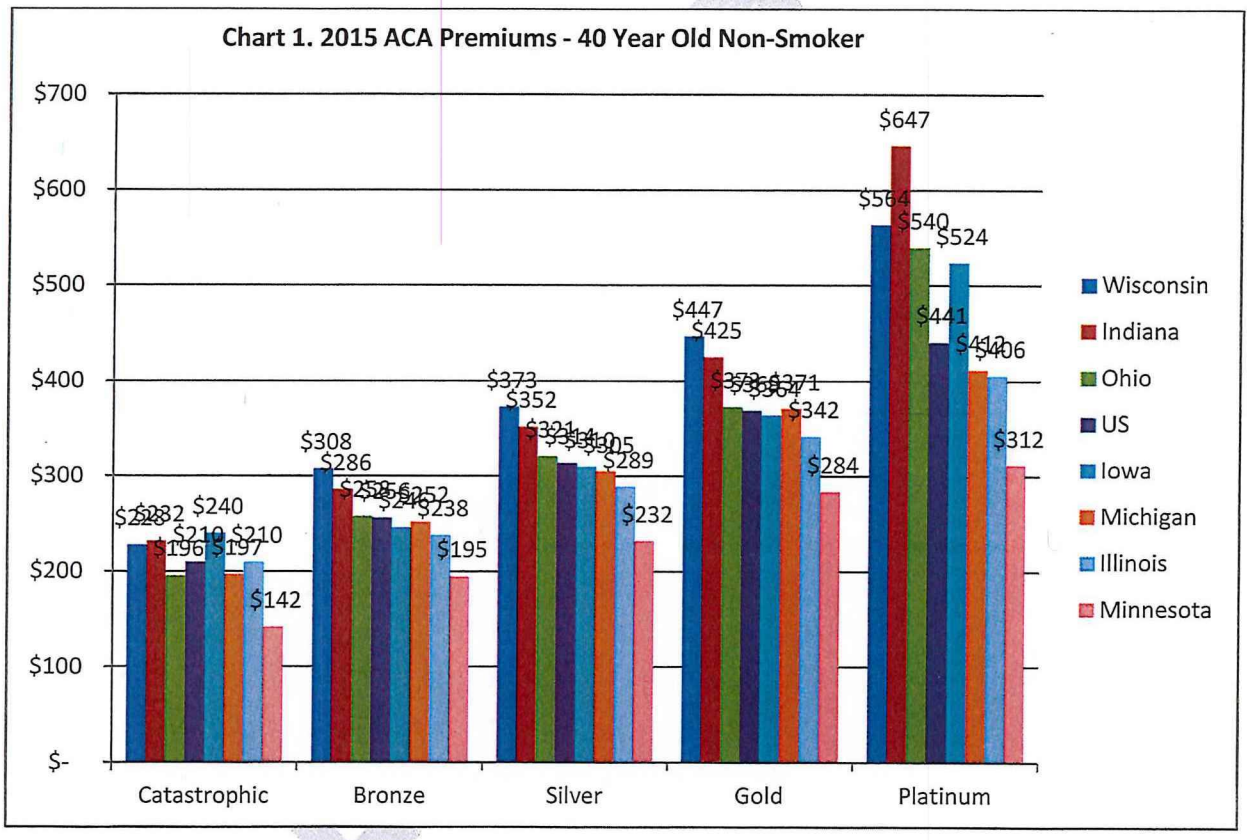
6). Regional disparities are evident for all kinds of insurance (Chart 1, Chart 5).

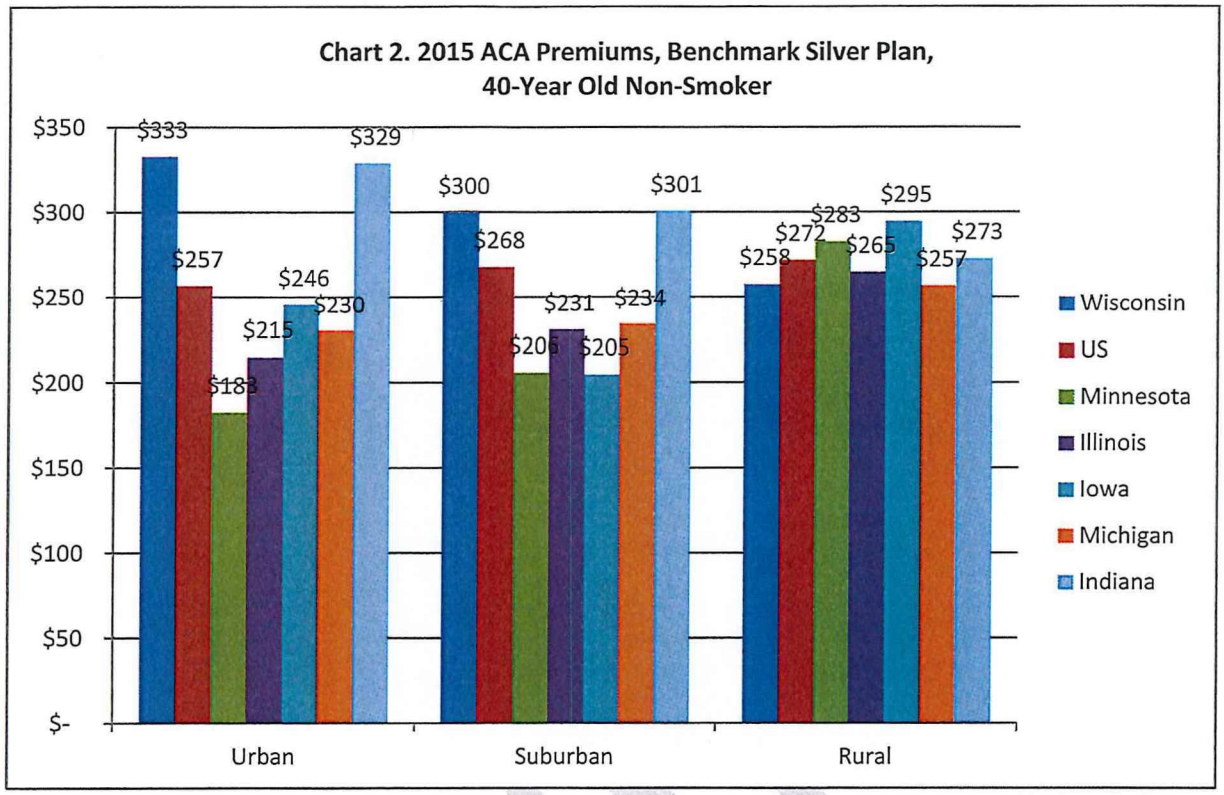
Click here to download the full 2018 WI Health Insurance Cost Rankings Report

CITIZEN ACTION OF WISCONSIN

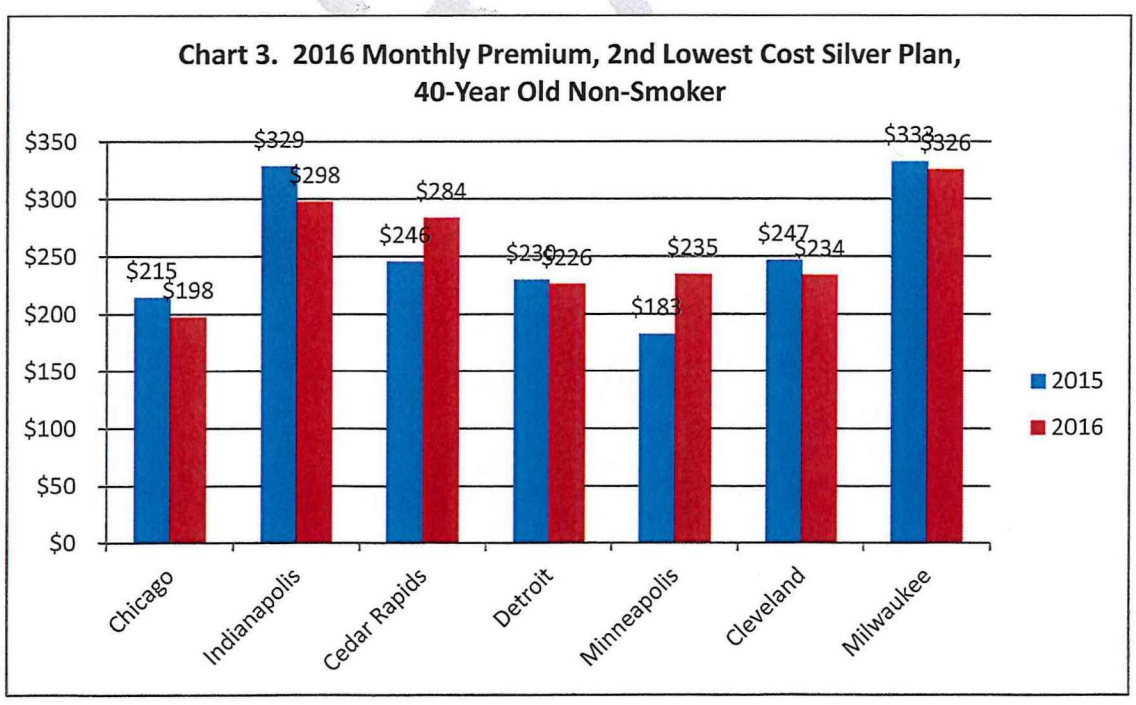
Examining the Factors behind Wisconsin's Health Insurance Premiums Levels: Why do they seem high relative to other states?

Wisconsin insurance premiums are among the highest nationally, both rural[1] and urban[2]. Reports echo one another: A ranking of Affordable Care Act (ACA) benchmark silver plans in a major city in each state ranks Milwaukee as having the fifth most-expensive premiums.[2, 3] (Charts 1 and 2)[4] Western Wisconsin ranked nationally in 2014 as one of "10 Places Where Health Insurance Costs The Most."[5]





Wisconsin's ACA plan premiums for 2016 show a lower rate of increase from 2015 than the national average, with silver plans up 4.7% in Wisconsin and 7.5% nationally.[6] Nonetheless, Wisconsin's exchange-based premiums remain comparatively high (Chart 3).[7]



Outside of the premiums for qualified health plans offered through the ACA exchange, Wisconsin's premiums for employer-sponsored coverage appear closer to the average for the U.S. and other states regionally (Table 1).[8] Yet Wisconsin ranked 42 out of all states nationally in 2012 total single premium per enrolled employee at private sector establishments that offer health insurance.[9]

Table 1. Average total premium per enrolled employee at private-sector establishments that offer health insurance, 2014

	Single	Family
Indiana	$6,041	$17,223
Illinois	$6,126	$17,193
Ohio	$5,930	$15,974
Wisconsin	$5,868	$17,209
United States	$5,832	$16,655
Minnesota	$5,832	$16,361
Michigan	$5,610	$15,608
Iowa	$5,557	$15,899

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2014 Medical Expenditure Panel Survey-Insurance Component. Tables 2C and 2D.

This paper reviews state-level factors that may contribute to the price of Wisconsin's health insurance, including regulation, market composition, variations in utilization, prices, charity care, quality, and other considerations.

Call out box:

Wisconsin's insurance market is more pluralistic, and its delivery system more consolidated, than most other states. The pricing structure reflects these differences, resulting in relatively modest insurance profits alongside more robust provider margins.

Insurance Regulation

Democratic lawmakers in Wisconsin's legislature are circulating a bill that calls for a stronger review process of health insurance rate increases, with additional reporting requirements and public input.[10] This year, many national carriers are seeking large rate increases, and seven major Wisconsin health insurers have filed for rate increases from 10 to 32% for 2016, adding to the call for scrutiny in Wisconsin[11] and nationally[12,13]. When premiums seem high, and when rates increase, critics often turn first to insurance companies – "the bogeymen of American health care" [14] -- suggesting that this industry gains from the lack of strict regulatory review and weak oversight.[15,16]

Closer regulatory review may be warranted. But high rates or large increases may or may not result from excessive profit-taking or administrative waste across the insurance industry. In fact, data from Wisconsin's health plans and provider market suggest other factors at play.

Medical Loss Ratio

The Affordable Care Act requires health insurance companies to disclose their Medical Loss Ratio (MLR), which is how much they spend on health care relative to administrative costs, salaries, marketing, and profits. If an insurance company spends less than 80% (individual and small group market), or 85% (large group market) of premiums on medical care and efforts to improve the quality of care, it must refund the portion of premium that exceed this limit.

Wisconsin's average Medical Loss Ratio refund[17] for 2013 was one of the lowest among other states in the upper Midwest and nationally (Table 2). Table 2.1 suggests that the premiums charged by Wisconsin's insurance carriers are paid out to cover the costs of medical care and quality improvement efforts as defined by MLR guidelines, and moreso than are the premiums charged in other states. Beyond this, many of Wisconsin's insurance companies, particularly state-based, do not generally exceed the 3.2% national average profit margin[18], although with notable exceptions (Table 3).[19]

Table 2. 2013 MLR Average Refund by State, Based on MLR reports filed through June 30, 2014

	All Markets	Individual Market	Small Group Market	Large Group Market
Wisconsin	**$52**	**$52**	**0**	**0**
U.S. average	$80	$85	$79	$73
Minnesota	$522	0	0	$522
Illinois	$120	$88	$492	$83
Iowa	$206	$230	0	$194
Indiana	$84	$106	$82	$628
Michigan	$118	$115	$104	$154
Ohio	$69	$207	$50	0

Source: Centers for Medicare & Medicaid Services. (2014). 2013 MLR Refunds by State.

Table 2.1 PPACA Medical Loss Ratios 2011 and 2012[20]

	All Markets	Individual Market	Small Group Market	Large Group Market
Wisconsin	**94.6**	**93.8**	**94.6**	**94.7**
Minnesota	91.3	92.0	87.2	92.7
Illinois	86.9	82.3	84.1	88.9
Iowa	87.3	84.6	83.8	93.3
Indiana	87.6	83.2	85.6	95.2
Michigan	86.1	82.1	83.6	92.1
Ohio	90.8	95.2	87.7	92.8

Source: U.S. GAO. (2014, July). Private Health Insurance. Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees. U.S. GPO GAO 14-580

Table 3. Wisconsin Insurance Carriers, Net Profits & Market Share 2014			
Insurance Carrier	Net Profit (as a percentage of premiums) 2014	Market Share, 2014	Net income in $
MEDICA INSURANCE CO	16%	1.4	4,813,000
BLUE CROSS BLUE SHIELD OF WI	12%	6.0	84,327,346
GROUP HEALTH COOP OF EAU CLAIRE	12%	1.1	12,538,000
MANAGED HEALTH SERVICES INS CORP	6%	1.1	6,718,000
UNITEDHEALTHCARE INSURANCE CO	6%	10.6	2,658,055,000
COMPCARE HEALTH SERVICES INS CORP	4%	4.0	29,097,842
CHILDRENS COMMUNITY HEALTH PLAN INC	4%	2.4	9,678,000
SECURITY HEALTH PLAN OF WI INC	3%	5.4	28,271,775
UNITEDHEALTHCARE OF WI INC	2%	1.8	31,035,039
HUMANA INSURANCE CO	2%	4.3	505,268,000
PHYSICIANS PLUS INS CORP	1%	2.1	2,871,908
GUNDERSEN HEALTH PLAN INC	1%	2.8	2,312,000
WISCONSIN PHYSICIANS SERVICE INS CORP	1%	2.8	3,617,773
UNITY HEALTH PLANS INS CORP	1%	7.4	4,649,507
NETWORK HEALTH PLAN	1%	3.5	2,489,429
HEALTH TRADITION HEALTH PLAN	0%	1.5	385,000
DEAN HEALTH PLAN INC	0%	8.7	183,337
COMMUNITY CARE HEALTH PLAN INC	0%	1.0	-5,577
HUMANA WISCONSIN HEALTH ORG INS CORP	0%	2.1	-929,000
MOLINA HEALTHCARE OF WI INC	-1%	1.5	-933,000
MERCYCARE HMO INC	-2%	1.0	-1,927,000
WEA INSURANCE CORP	-5%	6.2	-28,004,000
GROUP HEALTH COOP OF SOUTH CENTRAL WI	-5%	3.7	-18,747,000
Source: Wisconsin Commissioner of Insurance. Wisconsin Insurance Report, Business of 2014			

Utilization

Wisconsin's high premium prices, rather than reflecting excessive administrative costs or profits, could reflect payments for more services because of higher utilization and/or a higher need population. But Wisconsin's population, overall, does not show higher need for medical services relative to states nationally or within the upper Midwest region, as measured by relative health status and other factors.[21]

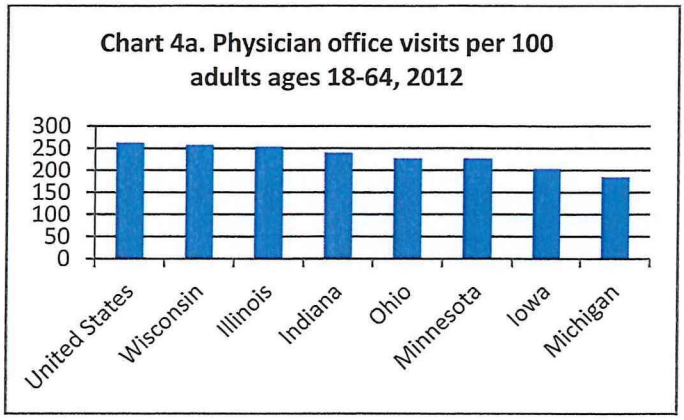
Wisconsin's use of ambulatory services, measured as average number of physician office visits, do not vary in any significant manner from the regional or national rates, nor does percentage of physician office visits with private insurance as the expected source of payment (Charts 4a,4b,4c).[22] Nor do Wisconsin residents utilize hospital services at a higher rate than do residents of other states and may in fact utilize fewer services (Table 4).[23]

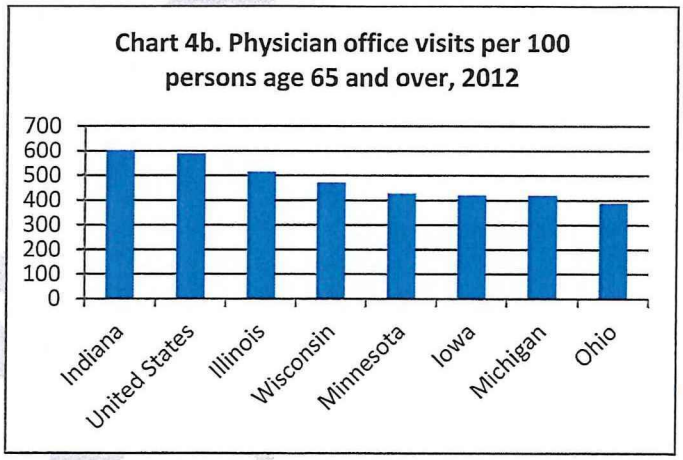
Table 4. Providers & Service Use Indicators, Hospital Utilization 2013

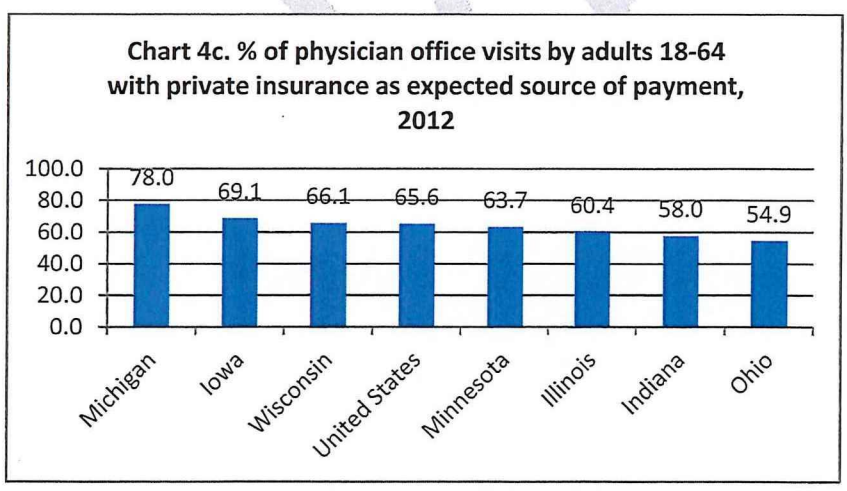
	Hospital Outpatient Visits per 1,000 Population	Hospital Inpatient Days per 1000 Population	Hospital Emergency Room Visits Per 1,000 Population	Hospital Admissions per 1,000 Population
Wisconsin	**2,873**	**489**	**365**	**99**
U.S. average	2,145	577	423	106
Minnesota	2,152	626	357	104
Illinois	2,547	533	408	111
Iowa	3,433	648	418	106
Indiana	2,800	556	476	107
Michigan	3,291	597	493	117
Ohio	3,220	616	560	126

With service volume comparable to other states, Wisconsin's higher premium prices could stem from other factors: 1) other risk pool factors, 2) higher prices paid to its supplier or services -- health care providers, 3) a less favorable payer mix with lower payment by government payers, and/or 4) higher quality care, requiring more resources invested. Ultimately, it will be important to understand the value that Wisconsin residents receive for the dollars invested, particularly as Wisconsin hospitals and health systems often rank at or near the top in national ratings for quality.

Call-Out Box:
Wisconsin hospitals and health systems often rank at or near the top in national ratings for quality.







Source: National Center for Health Statistics. Variation in physician office visit rates by patient characteristics and state, 2012. NCHS data brief, no 212.

Risk Pools

Wisconsin's robust insurance market includes several carriers in the individual, small, and large group markets,[24] with the level employer-sponsored health insurance coverage significantly exceeding the U.S. rate (Table 5).[25] A variety of factors, outside the scope of this paper, contributed to the pluralistic nature of the insurance market, which has been supported by the

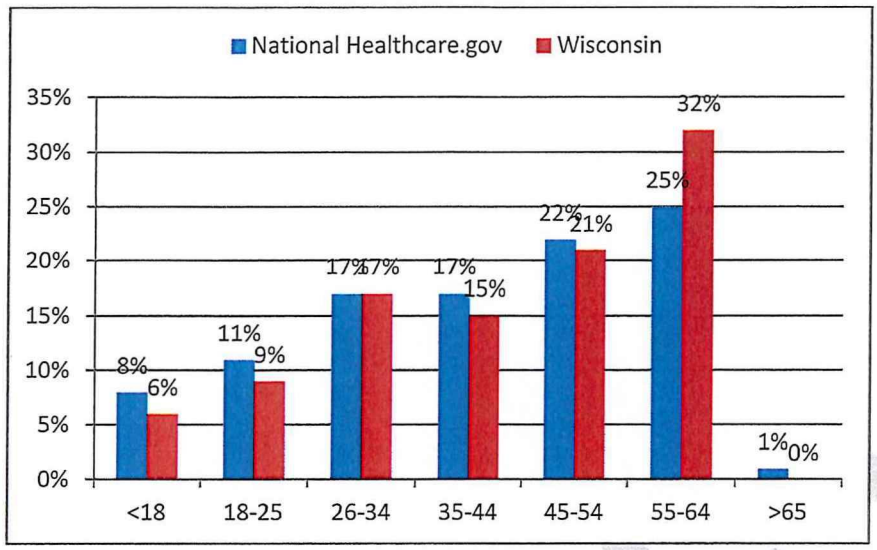
presence of a state-operated high risk pool (pre-ACA) and a relatively limited regulatory oversight.[26] Private c overage declined with the recent recession and continued climb in health insurance prices (Table 6).[27] But Wisconsin's relatively generous eligibility levels for Medicaid/Badgercare allowed the state to maintain a comparatively low rate of uninsured.[28]

Table 5. Sources of Health Insurance, 2013				
	Employer	Other Private	Medicaid	Uninsured
United States	48.2%	6.0%	15.6%	13.4%
Ohio	47.3%	5.5%	14.8%	13.2%
Indiana	52.3%	6.5%	13.6%	12.0%
Illinois	50.4%	8.0%	17.2%	11.1%
Michigan	52.6%	5.0%	15.7%	10.7%
Iowa	54.1%	7.3%	14.4%	9.0%
Wisconsin	55.1%	5.5%	13.1%	8.9%
Minnesota	57.3%	8.7%	12.7%	6.8%
Source: Kaiser Family Foundation. State Health Facts. Health Insurance Coverage of the Total Population, 2013.				

These circumstances determined the demographic and risk characteristics of the remaining uninsured and the persons who were and are likely to enroll in the ACA's qualified health plans. Indeed, Wisconsin's enrollment to date skews relatively older than the national group of those enrolled thus far (Chart 5).[29] Such demographics may contribute to Wisconsin's relatively higher ACA premiums, in that an older group might be considered a higher risk pool.

Table 6. Employer-sponsored health insurance coverage, % of population under age 65, 2001/01 and 2009/10			
	2001/01	**2009/10**	**Change**
Wisconsin	**78.1%**	**68.4%**	**-9.7**
U.S. average	68.5%	59.0%	-9.4
Minnesota	77.3%	68.1%	-9.2
Illinois	72.0%	61.2%	-10.8
Iowa	76.9%	66.9%	-10.1
Indiana	76.4%	62.7%	**-13.6**
Michigan	76.9%	63.9%	-13.0
Ohio	75.2%	63.2%	-12.0
Source: Gould, E. (2012, February 23). A decade of declines in employer-sponsored health insurance. Economic Policy Institute.			

Chart 5: Age Distribution of ACA QHP Enrollees as of February 15, 2015



Source (Chart 4 and Table 7): U.S. DHHS, ASPE. (2015, March 10). Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report, Period: For the period: November 15, 2014 – February 15, 2015

Wisconsin's ACA enrollees are also more likely to depend on federal subsidies (Table 7). This could indicate that they are, as a group, of lower income. However, the use of the federal premium subsidies and cost-sharing reductions depends on health plan metal level choice as well as income, so this distribution may reflect other factors beyond demographics of those seeking coverage.

Table 7

	Percent with Advanced Premium Tax Credit (Premium Subsidy)	Percent with Cost-Sharing Reduction
Wisconsin	90.7%	58.6%
National	85.0%	57.4%

Price Negotiations: Insurance and Providers

Insurers gain negotiating leverage for lower prices from providers by gaining market share — the percentage of enrollees/covered lives. With a large market share, insurers can assure patient volume to their contracted providers, and thus gain discounts. As well, insurers can use narrow networks to increase the volume available to its contracted providers, and thereby enhance negotiating leverage. Insurers with market power have the ability to obtain greater price discounts from providers who need to be in an insurer's provider network.[30]

A health plan, in seeking to bargain for lower prices from a provider, requires sufficient substitutes of one provider for another (provider competition) such that the insurer can credibly use exclusion form the network as negotiating leverage. Attention has thus been

growing toward the market power of health care providers, assessing the ability of dominant hospitals and large physician group practices to negotiate higher prices.[31]

Lower provider payments may, in theory, lead to reduced insurance premiums. But insurance carriers stand as an intermediary between health care providers and insurance purchasers ("insureds"). A dominant insurer with market power, while leveraging provider discounts, may elect to increase margins rather than reducing premiums for insureds.

Indeed, the recently announced mergers among large insurance carriers nationally has amplified this concern.[32,33] Evidence suggests that insurance market consolidation will not alleviate the problem and will likely exacerbate it. In fact, recent studies have demonstrated how more health plans competing in a market results in lower ACA premiums.[34,35]

But this is not the only factor. The dynamic in effect will depend on the degree of insurance market concentration relative to provider concentration in a particular market. New data reveal the complexity, showing lower premiums for plans in markets with higher levels of insurer concentration relevant to insurer bargaining with hospitals, and higher premiums for plans in markets with higher levels of hospital market concentration.[36] The challenge lies in finding the right balance.

...[T}here is substantial evidence that a large share of health care cost increases is caused by dominant providers charging high prices. There are a number of reasons to be skeptical of the idea that consolidated insurers will bargain down prices with providers. There is no compelling economic evidence that "bilateral" monopoly produces better results for consumers; and even if a dominant payor succeeds in bargaining successfully with providers it has little incentive to pass along the savings to its policyholders." Greaney, Health Affairs Blog, July 16, 2015.

Consolidated Provider Markets

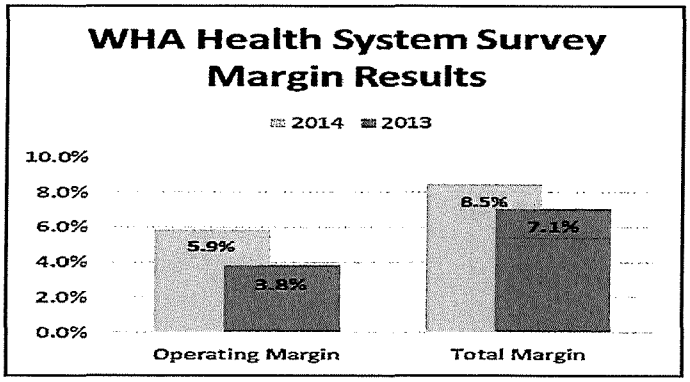
Large, integrated delivery systems, with large provider panels, affiliated hospitals, and strong reputations, dominate Wisconsin's health care sector. The trend in both horizontal and vertical integration has accelerated both nationally and in the state. In Wisconsin, most physicians practice in large groups or integrated health systems with 50 or more physicians.[37] And the state's major systems have recently joined together into two large networks – AboutHealth and the Integrated Health Network -- for contracting purposes.[38,39,40]

These partnerships offer opportunity for development of Accountable Care Organizations, quality improvement, and other collaborations, and may help sustain small, community, and rural hospitals[41], although questions remain about these benefits.[42] At the same time, such consolidation may further increase the health systems' negotiating positions relative to the insurance companies.

The literature offers lively debate about the effect of hospital market concentration on hospital prices.[43,44] Most studies find price increases associated with hospital consolidation,[14,45] even in small systems.[46] Large multi-hospital systems operating in different geographic markets may also negotiate to tie their business together, such that all system's facilities receive higher payment rates.

> "The U.S. health care market has become less competitive as consolidation among health care providers has increased, leaving the market vulnerable to increases in prices by dominant providers without a corresponding increase in quality." Catalyst for Payment Reform[47]

Wisconsin's hospitals, all not-for-profit entities, show a broad range of operating margins, but some quite robust (Table 15, attached).[48] The state's hospitals increased their net income in 2014, to an average of 12.2%, while the state's 19 largest health systems averaged an 8.5% total margin and a 5.9% operating margin.[49]



Source: WHA Information Center, LLC. Guide to Wisconsin Hospitals, Fiscal Year 2014, page 8. August 2014.

Southeastern Wisconsin has attracted significant focus. A newly released study that compared 40 health care market prices for 2011-13 identified the Milwaukee-Waukesha-West Allis market as one of eight "noticeable outliers with higher inpatient and outpatient prices."[50]

A 2010 study across health systems in eight metropolitan markets nationally, found significant market power among Milwaukee providers to negotiate higher-than-competitive prices, with inpatient care payment rates, relative to Medicare, among the highest.[51] The period in which payment rates increases slowed, between 2003-2012, occurred during a decline in overall market concentration among the area's hospitals.[52,]

Several other studies since then have reported the state's higher premiums, charges, and profits both regionally and nationally.[53,54,55] (Table 8).

Table 8. Wisconsin payment rates, spending, and profits relative to region, nation

Study	Data Range	Finding
Health Care Cost Institute. September 2015	2011-2015	Compares 40 health care markets nationally, reporting Milwaukee-Waukesha-West Allis market's inpatient and outpatient prices above average. Identified as one of eight "noticeable outlier" markets. Also reports that Green Bay has lower than average inpatient prices and higher than average outpatient prices.
Dreyer, T, Koss, J, Udow-Phillips, M. A Tale of Three Cities: Hospital and Health System Costs in the Midwest. Issue Brief. April 2015. Center for Healthcare Research & Transformation. Ann Arbor, MI	FY 2013	In FY2013, Milwaukee's health systems all had operating and total profit margins far above the national benchmarks. Operating margins ranged from 4.1 to 12.2 percent, compared to a benchmark of 2.2 percent. Total margins ranged from 6.6 to 15.2 percent, compared to a benchmark of 4.2 percent. (Total profit margin is referred to as "excess" profit margin by health care rating agencies such as Standard and Poor's.) (Note: This research was supported by Blue Cross/Blue Shield, an insurance carrier. Wisconsin Hospital Association reports that it was unable to replicate the margins reported in this study.) [56]
		Wisconsin's health systems had higher operating and total profit margins than the national benchmark, with operating margins ranging from 5.8 to 10.6 percent, and the total margins ranging from 15.6 to 16.2 percent. In FY2013, Wisconsin's per-capita hospital costs were $3,107, compared to $2,974 for Indiana and $2,624 for Michigan.
Kieffer K, Giese C, Herrle GJ. Commercial Physician Payment Level Comparison: Southeast Wisconsin Versus Selected Midwest Markets. Milliman report to the Greater Milwaukee Business Foundation on Health. June 12, 2014.	2012	The average per-unit commercial physician payment levels in southeast Wisconsin were almost 50% higher than the Midwest average per-unit payment rates. Southeast WI specialty payment levels ranged from approximately 15% to 95% higher than combined Midwest averages. The difference was estimated to have increased southeast Wisconsin commercial health insurance premiums by approximately 15% compared with estimated premium rates based on the Midwest average physician payment levels.
Milliman, July 23, 2014. reporting trends in Southeast Wisconsin hospitals' commercial payment rates	2003-2012	The increase in average commercial payment levels for southeastern Wisconsin hospitals had slowed substantially, to just 50% of the national rate of increase. This slowing rate occurred in parallel with a consistent decline in overall market concentration among the area's hospitals.

relative to national levels.		http://www.gmbfh.org/documents/20140723KeyFactorsPowerpoint.pdf
U.S. Government Accountability Office (GAO), 2014, Reporting the geographic variation of commercial insurance costs among 78 metropolitan areas.	2009-2010	Milwaukee and Madison ranked among the top seven nationally for both hospital inpatient spending and for professional services, with figures adjusted for difference in cost of living and demographics, in analysis of inpatient services and professional service spending, assessing the number of services, intensity, and price, by metropolitan statistical area (MSA), for each of the three high-cost procedures - coronary stent placement, laparoscopic appendectomy, and total hip replacement. The **price of the initial hospital inpatient admission was the largest contributor to differences** in private sector episode spending across MSAs. When GAO examined how volume, intensity, and prices contributed to differences in spending on professional services, it found that for all three procedures services in MSAs in the highest-spending quintile had higher average prices and higher average intensity than services in MSAsin the lowest-spending quintile, with **price having a greater impact than intensity.**

The U.S. GAO, in its 2014 study that identified Milwaukee and Madison among the top spending areas of the country, notes the significant effect that prices have on geographic variation in spending:

> "These findings are consistent with our finding on hospital inpatient spending and with existing research on private sector data, which has generally found that variation in prices drives overall variation in spending across geographic areas. While high-priced areas tend to have lower utilization and vice versa, the variation in prices has a larger effect."

Table 13: Professional Services Spending, Number of Services, Intensity, and Price, by Metropolitan Statistical Area (MSA), for Laparoscopic Appendectomy Episodes

		Average adjusted spending (in dollars)		Average for professional services		
Rank	MSA	Episode	Professional services	Volume (number of services)	Intensity	Price per unit of intensity (in dollars)
1	Salinas, CA[a]	25,924	2,106	5.06	5.51	75.59
2	Madison, WI[a]	18,123	4,090	4.45	5.67	161.98
3	Milwaukee-Waukesha-West Allis, WI[a]	18,096	3,752	4.68	5.77	136.82
4	Charleston, WV[a]	17,640	2,632	4.16	6.45	98.06
5	[a,b]	16,588	2,613	4.75	5.77	95.28
6	[a,b]	16,323	2,104	3.53	6.51	91.45
7	Grand Rapids-Wyoming, MI[a]	15,444	2,058	4.54	6.42	70.67
8	Colorado Springs, CO[a]	15,318	4,054	4.38	5.95	155.40
9	Orlando-Kissimmee-Sanford, FL[a]	15,267	2,423	5.20	5.77	80.79
10	San Diego-Carlsbad-San Marcos, CA[a]	14,859	3,130	5.19	5.64	106.89

Table 14: Professional Services Spending, Number of Services, Intensity, and Price, by Metropolitan Statistical Area (MSA), for Total Hip Replacement Episodes

		Average adjusted spending (in dollars)		Average for professional services		
Rank	MSA	Episode	Professional services	Volume (number of services)	Intensity	Price per unit of intensity (in dollars)
1	Salinas, CA[a]	57,990	4,048	8.30	6.52	74.72
2	Dallas-Fort Worth-Arlington, TX[a]	41,129	4,181	8.35	6.68	74.91
3	San Diego-Carlsbad-San Marcos, CA[a]	37,906	5,450	8.74	6.38	97.81
4	[a,b]	37,669	4,792	13.05	4.89	75.05
5	[a,b]	36,936	4,450	6.78	7.49	87.72
6	Madison, WI[a]	36,258	9,794	5.11	9.47	202.36
7	Milwaukee-Waukesha-West Allis, WI[a]	35,963	6,774	6.67	7.78	130.68
8	New York-Northern New Jersey-Long Island, NY-NJ-PA[a]	35,682	7,839	14.23	4.46	123.44
9	Houston-Sugar Land-Baytown, TX[a]	35,332	5,003	10.08	5.92	83.92
10	San Antonio-New Braunfels, TX[a]	35,319	4,099	15.03	4.03	67.62

Insurance Markets: Statewide vs. Regional Variation

These studies may not capture the regional price variation that occurs within the state, or even among carrier types. The GAO study, for example, excluded managed care and capitated arrangements, which represent the majority commercial enrollees in Dane County. Such plans are able to leverage significantly lower prices from providers[57] and, for Dane County's community-based health plans, offer lower premiums.[58]

Wisconsin has one of the most competitive insurance environments in the U.S., with 19 companies offering individual coverage, 31 companies offering small group coverage, 31

companies offering large group coverage.[59] A measure called the Herfindahl-Hirschman Index (HHI) demonstrates Wisconsin's relatively broad distribution of market share across many viable carriers. HHI values range from 0 to 10,000, where zero indicates perfect competition and 10,000 indicates a complete monopoly.[60,61,62] (Table 9)

Table 9. Relative Competition of State Insurance Markets: Herfindahl-Hirschman Index, Market Share, and # of Insurers by State

	HII Index			Market Share of Largest Insurer			# of Insurers with >5% Market Share		
Market	Indiv	Small Group	Large group	Indiv	Small Group	Large group	Indiv	Small Group	Large group
Wisconsin	**1,479**	**1,443**	**871**	**23%**	**31%**	**14%**	**6**	**7**	**9**
U.S. average	3,888	3,841	4,038	55%	57%	57%	3	4	4
Minnesota	3,872	3,036	3,317	57%	38%	45%	4	4	3
Illinois	4,757	4,031	5,574	68%	60%	73%	3	4	3
Iowa	7,128	4,726	5,964	84%	64%	76%	3	3	3
Indiana	3,888	3,568	4,038	59%	56%	60%	3	3	3
Michigan	3,234	3,871	3,139	53%	59%	51%	3	3	4
Ohio	2,623	2,468	2,293	35%	38%	39%	3	5	4

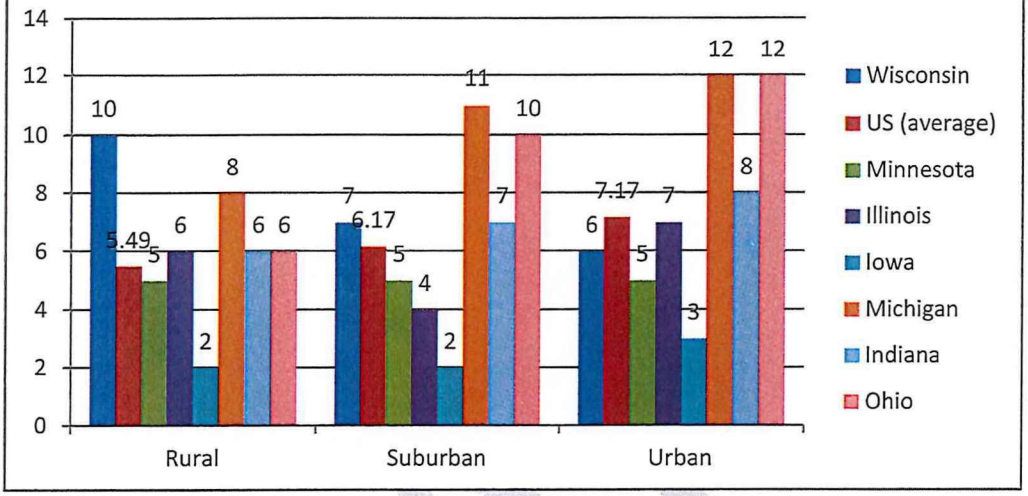
Source: Kaiser Family Foundation. State Health Facts. Insurance Market Competitiveness.

An important caveat here: The HHI requires a properly defined geographic market, and Wisconsin's plans are sold within regions. These HHI figures here provide only a general view of the degree of competition that might exist within a state, and do not reveal the true competition that might exist at the local level. An alternative indicator of such competition, in the case of the ACA, might be the number of carriers offering products within each rating region. Using this metric, Wisconsin's level of carrier competition in rural, suburban, and urban rating regions appears relatively strong alongside other upper Midwest states (Chart 6).[63]

Wisconsin's comparatively pluralistic insurance market reduces the bargaining power of any one insurer, as providers can refuse participation with one carrier in favor of another local carrier's network.[64] This likely provides Wisconsin's health systems the ability to negotiate higher prices.

In contrast, other states often have a few dominant insurance carriers. Table 6 shows that other upper-Midwest states generally have a single large insurer with over 50 percent market share, putting those carriers in a strong position to negotiate prices with providers who want or need to be in their networks.

Chart 6. Number of Carriers Offering ACA Plans, 2015



The HHI can also be used to measure competitiveness and market power of hospitals and health systems. Two separate studies in California did this, finding statistically significant relationships between hospital concentration and exchange premiums across regions of that state.[65,66] Wisconsin, with a highly integrated provider system, would be likely to demonstrate a similar dynamic, although such hypothesis awaits further investigation.

Call-Out Box: Wisconsin's comparatively pluralistic insurance market reduces the bargaining power of any one insurer, as providers can refuse participation with one carrier in favor of another local carrier's network. This likely provides Wisconsin's health systems the ability to negotiate higher prices.

Other Purchasers: Self-Insured Firms

The effect on prices of self-insured payers in the market is not clear. The number of self-insured payers in a market could add negotiating leverage and affect the collective negotiating leverage of the payer sector. Or self-insured employers could reduce the bargaining power of other payers in that more self-insured take volume away from other payers thus reducing their market share and bargaining power. Self-insured payers may negotiate directly with providers, as a group through vehicles like Madison's Alliance or, like Milwaukee's Business Health Care Group, work through an insurance company as their third-party administrator.

The prevalence in self-insured plans varies by state. However, Wisconsin's proportion of self-insured firms does not differ in any notable manner from other states in the upper Midwest or nationally (Table 10)[67], so this would not explain observed differentials in premiums across states.

Table 10. Percentage of Private–Sector Enrollees in Self-Insured Plans at Establishments Offering Health Insurance, by Firm Size and State, 2014

	Total	<50 employees	≥ 50 employees	100-999 employees	≥ 1,000 employees
Minnesota	71.5	18.1	79.0	55.3	91.8
Indiana	72.3	18.8	79.2	68.2	87.6
Ohio	63.9	11.4*	74.4	56.5	86.8
Iowa	67.1	10.8	76.2	54.0	94.1
Wisconsin	60.9	7.6*	69.5	42.5	88.4
Michigan	56.0	7.2*	66.6	35.4	84.6
Illinois	52.9	17.3	60.4	35.2	73.5
United States	59.7	10.8	68.7	41.4	85.2

*Figure does not meet stand of reliability or precision

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2014 Medical Expenditure Panel

Benefit Design and Insurance Mandates

The scope of the benefit package also affects the premium rates, and states often mandate coverage of various services. The initiation of the essential health benefits (EHB) standard under the Affordable Care Act may reduce variation among states in the scope of insurance coverage benefits.[68] However, some state-specific mandates may not be covered within the federal EHB, and state variation will remain. To the degree that one state's mandate exceed others, it could put upward pressure on prices. However, Wisconsin's mandated benefits fall in the middle range of mandates shared by others states regionally and nationally,[69,70] so this would not explain the observed differentials in premiums across states.

Provider-Owned Health Plans

Wisconsin's market may differ from others in the prevalence and strength of its provider-owned health plans – that is, health insurance plans owned by a hospital or health system. Indeed, Wisconsin leads the region and the nation with nine provider-led plans (Table 11), second only to the state of Texas.[71]

Table 11. Number of Provider-Led Health Plans	
State	**Health Plans**
Wisconsin	9
Michigan	7
Illinois	6
Indiana	6
Ohio	6
Minnesota	4
Iowa	2
Source: McKinsey&Company, 2015	

Such health plans may provide strategic and economic advantages to a hospital-based system, and also potential to support the transition to value-based care. This model can increase net provider revenue through a narrow network, increased patient volume, aligned incentives between payer and provider, and other mechanisms. However, the limited data available suggest that provider-owned plans generally do not offer lower premiums for ACA products compared to non-provider-owned plans.[72] This unique aspect of Wisconsin's market may support the strong clinical and economic performance of the state's integrated delivery systems, but do not appear to place downward pressure on insurance premiums overall.

Charity Care and the Uninsured

The ACA has brought substantial reductions in uncompensated care costs[73], even in states that did not adopt ACA Medicaid expansion.[74,75] Previously strained not-for-profit hospitals are finding some relief.[76] In Wisconsin, over 159,000 childless adults had gained BadgerCare coverage by April 2015[77], and over 183,000 Wisconsin residents effectuated insurance coverage through Affordable Care Act qualified health plans.[78] Wisconsin's hospitals have provided less charity care than the national average, as detailed over time[79] and currently in Table 12.[80]

The point here: To the degree that providers might seek to compensate for charity care in their pricing structure ("shift costs") to private insurers, Wisconsin's providers do not need to do so more than other states. Charity and uncompensated care in Wisconsin would, therefore, not explain the differentially high prices charged, nor would it explain higher insurance premiums in Wisconsin relative to other states.

Table 12

Financial Indicators (expressed as a percentage of adjusted revenue)	Type of Hospital					
	Critical Access %		Other Rural %		Urban %	
	WI	All States	WI	All States	WI	All States
Charity care costs	1.0	1.8	1.2	1.9	0.9	3.5
Non-Medicare and non-reimbursable Medicare bad debt costs	1.7	4.7	1.3	4.3	1.7	2.1
Uncompensated care (charity care and bad debt) costs	2.8	6.6	2.8	6.3	2.7	5.6
Unreimbursed cost of means-tested government programs (Medicaid, SCHIP, state/local indigent care programs)	2.6	3.6	2.9	3.8	2.7	3.4
Source: 2012 Medicare Hospital Cost Reports, reported by Flex Monitoring Team, 2015						

Note: Problems have been reported with hospitals' Medicare cost reports, which provide the data used in this table, including inconsistent, invalid and inaccurate reporting by hospitals.[81] *No other data source, however, yet exists to allow for comparison of hospital across states.*

Low Medicaid Payments & Cost Shifting

Hospitals most commonly cite low payments by Medicaid and Medicare for needing to shift costs to private payers, thereby increasing premiums in the private market.[82] Hospitals nationally broadly assert this problem.[83] As such, if this indeed occurs, it would not explain Wisconsin's relatively higher premiums in comparison to other states that also struggle with this dynamic.

Call out box:

To the degree that providers might seek to compensate for charity care and Medicaid shortfalls in their pricing structure ("shift costs") to private insurers, Wisconsin's providers do not need to do so more than other states.

It might be argued that Wisconsin's payment shortfall exceeds the shortfall experienced by other states and, if so, would thereby put higher cost-shifting pressure on private insurance premiums. Wisconsin, however, shows a relatively favorable Medicaid-to-Medicare Fee Index alongside other states (Table 13).

This index uses only fee-for service Medicaid, and Medicaid managed care payments are often lower. Providers in a state that has a disproportionately higher level of Medicaid managed care might experience relatively greater burden from payment shortfalls. However, Table 13 shows Wisconsin's relatively lower percentage of Medicaid members in managed care compared to

the other states in the upper Midwest regions.[84] This factor would therefore not compromise the Medicaid-to-Medicare ratio more so than other states.

As well, Wisconsin's population brings a relatively favorable payer mix, with relatively fewer uninsured and Medicaid-reliant residents and larger percentages of commercially insured persons (Table 14).[85] This would indicate that whatever Medicaid payment shortfall might exist would not explain Wisconsin's differentially higher private insurance premium prices.

Messages about this can be confusing: The U.S. GAO reported in 2014 that Wisconsin's Medicaid payment rates relative to private insurance stood among the lowest in the country.[86] That finding compares Medicaid payments as a percentage of Wisconsin's hospitals' charges. But to the degree that Wisconsin's hospitals list high prices on their chargemasters, the Medicaid payment percentage will appear relatively low.[87] Such difficulty in using hospital charges as a yardstick for discerning true cost has been well explained in the literature.[88]

Table 13. Medicaid-to-Medicare Fee Index, 2012

	All Services	Primary Care	Other Services	% of Medicaid in managed care, 2011**
Wisconsin	.77	.60	1.01	63.7%
United States	.66	.59	.70	74.2%
Iowa	.88	.77	.90	91.1%
Minnesota	.71	.73	.72	65.7%
Illinois	.62	.54	.64	67.8%
Indiana	.62	.55	.69	70.3%
Ohio	.61	.59	.63	75.4%
Michigan	.71	.46	.50	88.4%

Sources:
*State Health Facts, Kaiser Family Foundation, based on Medicaid and Medicare fee-for-service rates
** State Health Facts. Kaiser Family Foundation. Total Medicaid Managed Care Enrollment, 2011.

Further, what looks like significant losses to government programs and related higher payments by private insurance may be, in fact, weak cost controls related to markets lacking competition.[89] Hospitals in concentrated markets will have high private payment rates and negative Medicare or Medicaid margins to the degree that they feel less pressure to contain relatively higher operating costs, including salaries, amenities, and building projects.

Table 14. Health Insurance Coverage of the Total Population, 2013

	Employer	Other Private	Medicaid	Medicare	Other Public	Uninsured
Minnesota	57.3%	8.7%	12.7%	13.5%	N/A	6.8%
Wisconsin	55.1%	5.5%	13.1%	16.7%	N/A	8.9%
Iowa	54.1%	7.3%	14.4%	13.9%	1.2%	9.0%
Michigan	52.6%	5.0%	15.7%	15.2%	0.8%	10.7%
Indiana	52.3%	6.5%	13.6%	14.4%	1.2%	12.0%
Illinois	50.4%	8.0%	17.2%	12.3%	1.0%	11.1%
United States	48.2%	6.0%	15.6%	14.7%	2.0%	13.4%
Ohio	47.3%	5.5%	14.8%	17.5%	1.7%	13.2%

Source: Kaiser Family Foundation. Health Insurance Coverage of the Total Population, 2013.

Of course, cost-containment efforts are occurring everywhere, particularly as Medicare – which sets prices rather than negotiating them – demands.[90] For example, Milwaukee's Froedtert Health, a three-hospital system, recently reported efficiencies through several cost-containment efforts, including the moving some of its outpatient services to physician offices and clinics.[91] The payer mix has also improved, with a lower proportion of self-pay patients and a higher proportion of Medicaid patients. Froedtert's operating margin has improved, reported at 7.9% to date for 2015, up from 5% in fiscal 2014. It remains to be seen whether or when this might translate to lower insurance premiums.

Quality/Cost = Value

Wisconsin's integrated delivery systems have gained national recognition as models of care transformation.[92,93] Wisconsin hospitals and health systems consistently rank at or near the top in national ratings for quality.[94,95], although not consistently across all measures.[96]

Hospitals report that they and their affiliated health systems subsidize other community services with revenue from core hospital operations, including physician clinics, hospice, nursing homes, home health, assisted living, for example -- services that may not be financially viable on their own.[97] These elements are important, and such quality and service provision may merit some of the higher insurance premiums Wisconsin residents' experience.

As well, the National Committee for Quality Assurance in 2014 ranks five Wisconsin-based health plans in the top 50 commercial health plans, 11 in the top 100.[98] This may be the value returned from any marginal difference between Wisconsin's and other states' insurance premiums.

A substantial literature explores the relationship between health care costs, and quality, with no definitive conclusions. A 2013 systematic review by RAND concludes that the evidence is inconsistent, in some cases showing small to moderate associates either positive or negative between cost and quality.[99] The Dartmouth Atlas, which investigates variations in quality and price, acknowledges this lack of consistency in findings, but insists that many health systems do provide high-quality at lower cost -- and that more spending is not needed to achieve better outcomes.[100]

Going Forward

The health insurance industry has long sustained allegations of consumer abuses and excessive profit.[101] Yet, even on a national level, insurers' profits appear to contribute a small part to premiums relative to the inexplicably variable expense of medical services.[102] This emerging realization has brought scrutiny to hospitals, with critiques of their pricing, charging, and consolidation practices coming from across the ideological spectrum.[103,104,105,106,107]

Yet hospitals are also active partners, and often leaders, in health care transformation. The Wisconsin Hospital Association helped found the state's multi-payer claims database and its associated payment reform initiative[108] and has championed the public reporting of quality and price measures among its members.[109] Hospitals advocated for the ACA's Medicaid expansion[110] and have supported safety net providers.[111] Wisconsin, with its strong, high quality integrated delivery systems, has earlier experience with both the upsides and the challenges of this future trend market structure.

What solutions do lend themselves to this challenge? It is important to recognize the potential upsides of health care integration, currently being pursued through Accountable Care Organization models, which promise to reduce fragmentation, improve care coordination, and achieve efficient utilization. For these reasons, federal antitrust enforcement may be a blunt instrument.[112]

The answer to Wisconsin's high premiums does not lie in a simple tamping down on the insurance sector. Wisconsin's insurance market is more pluralistic, and its delivery system more consolidated, than most other states. The pricing structure reflects these differences. These understandings should inform the policy and programmatic solutions to the state's relatively high insurance premiums.

Market solutions currently underway include price transparency, consumer-directed health care, reference pricing, and narrow networks. These approaches, however, will not work in concentrated markets that offer little choice or competitions among providers.[113] Some propose the application of antitrust rules to promote more competitive contracting between insurers and providers.[114] Direct rate regulation has garnered renewed interest, although

these approaches may suffer from inherent complexity, the risk of agency capture, and bureaucratic inefficiencies. [115]

Financial incentives in health care are changing such that all providers now endeavor to reduce overutilization and become more efficient. Promising signs are emerging that health care providers can achieve substantial gains in productivity.[116]

The dialogue ahead should focus on how Wisconsin residents and state government can leverage their substantial investment, watch carefully, and hold accountable all of those to whom the funds flow.

Table 15. Wisconsin Hospitals, Margins and Net Income, 2014				
Hospital	*City*	*Operating Margin*	*Total Hospital Net Income*	*Net Income*
Oakleaf Surgical Hospital	Altoona	23.1%	11.7%	$4,649,443
Amery Regional Medical Center	Amery	1.2%	1.7%	$909,984
Aspirus Langlade Hospital	Antigo	9.7%	13.3%	$11,592,380
Appleton Medical Center	Appleton	10.2%	10.4%	$25,782,118
St. Elizabeth Hospital	Appleton	18.7%	18.8%	$35,731,389
Memorial Medical Center	Ashland	12.0%	13.7%	$8,248,811
Baldwin Area Medical Center	Baldwin	1.1%	2.2%	$719,397
St.Clare Hospital& Health Services	Baraboo	10.9%	12.3%	$7,810,178
Mayo Clinic Health System	Barron	5.8%	6.8%	$3,857,524
Beaver Dam Community Hospitals	Beaver Dam	-0.5%	6.9%	$6,349,492
Beloit Health System	Beloit	3.3%	4.4%	$9,263,867
Berlin Memorial Hospital	Berlin	-0.3%	-0.6%	-$404,566
Black River Memorial Hospital	Black River Falls	3.6%	4.5%	$1,907,750
Mayo Clinic Health System	Blooomer	2.2%	2.8%	$928,227
Gunderson Boscobel Area Hospital and Clinics	Boscobel	5.0%	5.2%	$879,214
Wheaton Franciscan-Elmbrook Memorial Campus	Brookfield	16.1%	16.1%	$20,902,887
Aurora Memorial Hospital of Burlington	Burlington	20.4%	20.5%	$16,036,586
Calumet Medical Center	Chilton	16.0%	17.8%	$4,609,699
St.Joseph's Hospital	Chippewa Falls	6.7%	18.2%	$14,358,776
Columbus Community Hospital	Columbus	7.2%	8.6%	$2,894,888
Cumberland Healthcare	Cumberland	0.2%	1.1%	$243,397
Memorial Hospital of Lafayette Co	Darlington	-0.2%	1.1%	$147,546
Upland Hills Health Inc	Dodgeville	4.2%	6.1%	$2,429,645
Chippewa Valley Hospital	Durand	-6.8%	-6.8%	-$1,077,398
Ministry Eagle River Memorial Hospital	Eagle River	5.8%	11.7%	$2,000,652
Mayo Clinic Health System in Eau Claire	Eau Claire	21.3%	24.8%	$71,287,695
Sacred Heart Hospital	Eau Claire	14.2%	27.2%	$71,029,948
Edgerton Hospital & Health Services	Edgerton	-4.8%	-4.7%	-$864,139
Aurora Lakeland Medical Center in Elkhorn	Elkhorn	17.5%	17.5%	$14,391,806
Agnesian HealthCare / St. Agnes Hospital	Fond du Lac	0.8%	4.7%	$15,586,593
Fort HealthCare	Fort Atkinson	2.9%	6.0%	$7,543,255
Midwest Orthopedic Specialty Hospital	Franklin	47.1%	47.2%	$36,562,839
Wheaton Franciscan Healthcare - Franklin	Franklin	7.5%	7.5%	$5,030,322
Moundview Memorial Hospital & Clinics, Inc	Friendship	0.5%	1.7%	$265,599
Orthopaedic Hospital of Wisconsin	Glendale	41.7%	41.7%	$25,395,507

Aurora Medical Center in Grafton	Grafton	18.3%	18.3%	$34,927,262
Burnett Medical Center	Grantsburg	0.3%	1.2%	$195,616
Aurora BayCare Medical Center in Green Bay	Green Bay	32.9%	32.8%	$116,107,909
Bellin Hospital	Green Bay	9.0%	8.1%	$32,944,129
St. Mary's Hospital Medical Center	Green Bay	11.7%	16.0%	$21,974,971
St. Vincent Hospital	Green Bay	6.2%	17.5%	$53,597,894
Aurora Medical Center in Hartford	Hartford	10.7%	10.7%	$6,139,990
Hayward Area Memorial Hospital	Hayward	7.3%	8.7%	$3,053,502
Gundersen St. Joseph's Hospital & Clinics	Hillsboro	6.1%	6.6%	$1,251,967
Hudson Hospital & Clinics	Hudson	3.0%	3.2%	$1,693,106
Mercy Hospital and Trauma Center	Janesville	2.5%	3.2%	$13,320,088
St. Mary's Janesville Hospital	Janesville	8.8%	9.3%	$5,986,782
Aurora Medical Center in Kenosha	Kenosha	34.8%	34.8%	$63,166,120
UHS, Inc	Kenosha	9.3%	12.6%	$39,296,519
Gundersen Lutheran Medical Center	La Crosse	27.5%	13.5%	$94,755,893
Mayo Clinic Health System - Franciscan Healthcare in La Crosse	La Crosse	8.8%	8.8%	$20,399,367
Rusk County Memorial Hospital	Ladysmith	-2.2%	-2.3%	-$438,106
Mercy Walworth Hospital and Medical Center	Lake Geneva	2.5%	2.5%	$1,742,071
Grant Regional Health Center	Lancaster	1.7%	4.1%	$1,038,226
Meriter-UnityPoint Health	Madison	5.7%	9.9%	$47,322,521
St. Mary's Hospital	Madison	13.8%	16.1%	$70,318,542
UW Hospital & Clinics	Madison	6.1%	7.6%	$103,843,169
Holy Family Memorial Inc	Manitowoc	0.9%	2.6%	$3,384,290
Bay Area Medical Center	Marinette	4.0%	11.2%	$12,485,012
Ministry Saint Joseph's Hospital	Marshfield	10.7%	14.9%	$57,337,604
Mile Bluff Medical Center	Mauston	3.2%	3.4%	$2,467,563
Aspirus Medford Hospital & Clinics, Inc	Medford	15.3%	20.6%	$13,090,6180
Community Memorial Hospital of Menomonee Falls, Inc	Menomonee Falls	5.6%	6.5%	$11,966,850
Mayo Clinic Health System - Red Cedar, Inc	Menomonie	13.9%	15.4%	$14,645,301
Columbia Center Birth Hospital	Mequon	-7.9%	-7.9%	-$458,0480
Columbia St Mary's Inc - Ozaukee Campus	Mequon	5.5%	5.4%	$6,750,345
Ministry Good Samaritan Health Center	Merrill	-5.1%	6.0%	$1,459,317
Aurora Sinai Medical Center	Milwaukee	1.4%	1.4%	$2,710,967
Aurora St. Luke's Medical Center / South Shore	Milwaukee	18.4%	18.4%	$220,860,272
Children's Hospital of Wisconsin	Milwaukee	10.8%	10.2%	$58,593,863
Columbia St. Mary's Hospital Milwaukee	Milwaukee	3.7%	3.6%	$11,620,151
Froedtert Memorial Lutheran Hospital Inc	Milwaukee	10.2%	10.4%	$119,975,542
Wheaton Franciscan Healthcare - St. Francis	Milwaukee	-14.4%	-14.4%	-$33,605,096

Wheaton Franciscan - St. Joseph Campus	Milwaukee	3.4%	3.4%	$6,291,509
Monroe Clinic	Monroe	4.4%	6.4%	$11,289,636
Children's Hospital of Wisconsin - Fox Valley	Neenah	-4.7%	-4.7%	-$943,288
Theda Clark Medical Center	Neenah	10.3%	10.8%	$20,213,300
Memorial Medical Center	Neilsville	-2.2%	-1.2%	-$271,568
ThedaCare Medical Center - New London	New London	17.2%	13.1%	$4,079,467
Westfields Hospital	New Richmond	4.3%	4.9%	$2,472,963
Oconomowoc Memorial Hospital	Oconomowoc	0.2%	4.1%	$4,052,862
Bellin Health Oconto Hospital	Oconto	-4.5%	-4.4%	-$494,476
St Clare Memorial Hospital	Oconto Falls	-20.2%	-19.8%	-$6,030,090
Osceola Medical Center	Osceola	7.5%	8.0%	$2,624,753
Aurora Medical Center in Oshkosh	Oshkosh	20.1%	20.1%	$22,696,335
Mercy Medical Center	Oshkosh	4.0%	4.2%	$4,477,146
Mayo Clinic Health System - Oakridge in Osseo	Osseo	-1.4%	-1.0%	-$210,701
Flambeau Hospital	Park Falls	4.0%	3.7%	$741,217
Southwest Health Center	Platteville	2.5%	9.9%	$3,193,652
Divine Savior Healthcare	Portage	2.9%	5.5%	$4,292,048
Crossing Rivers Health	Prairie du Chien	6.9%	7.8%	$3,157,254
Sauk Prairie Healthcare	Prairie du Sac	-3.1%	-2.0%	-$1,486,950
Wheaton Franciscan Healthcare - All Saints, Inc	Racine	9.1%	9.5%	$34,328,534
Reedsburg Area Medical Center	Reedsburg	7.3%	8.6%	$5,150,789
Ministry Saint Mary's Hospital	Rhinelander	2.4%	2.6%	$3,424,137
Lakeview Medical Center	Rice Lake	14.1%	14.3%	$9,922,748
The Richland Hospital Inc	Richland Center	6.1%	7.6%	$3,019,005
Ripon Medical Center Inc	Ripon	2.0%	2.2%	$500,824
River Falls Area Hospital	River Falls	14.8%	14.8%	$6,097,889
Shawano Medical Center	Shawano	8.1%	-11.0%	-$3,556,548
Aurora Sheboygan Memorial Medical Center	Sheboygan	23.2%	23.2%	$34,739,425
St. Nicholas Hospital	Sheboygan	2.1%	7.3%	$5,746,689
Indianhead Medical Center / Shell Lake	Shell Lake	-0.4%	18.6%	$1,545,213
Mayo Clinic Health System - Franciscan Healthcare in Sparta	Sparta	11.7%	11.7%	$2,127,578
Spooner Health System	Spooner	8.9%	11.1%	$1,996,980
St. Croix Regional Medical Center	St.Croix Falls	4.9%	8.9%	$6,267,361
Ministry Our Lady of Victory Hospital	Stanley	-5.1%	-5.1%	-$837,277
Ministry Saint Michael's Hospital	Stevens Point	7.5%	10.9%	$21,378,538
Stoughton Hospital Association	Stoughton	4.5%	0.4%	$131,019
Ministry Door County Medical Center	Sturgeon Bay	7.1%	11.5%	$8,558,030
Aurora Medical Center in Summit	Summit	10.3%	10.3%	$11,621,510
St. Mary's Hospital of Superior	Superior	19.2%	21.5%	$9,236,738

Tomah Memorial Hospital	Tomah	7.9%	11.9%	$5,117,017
Ministry Sacred Heart Hospital	Tomahawk	18.6%	18.6%	$3,081,389
Aurora Medical Center of Manitowoc County	Two Rivers	17.2%	17.2%	$11,364,796
Vernon Memorial Healthcare	Viroqua	4.2%	5.4%	$3,483,560
Watertown Regional Medical Center	Watertown	-1.3%	2.5%	$2,426,246
Waukesha Memorial Hospital	Waukesha	7.5%	16.1%	$76,881,169
Riverside Medical Center	Waupaca	12.9%	14.2%	$5,224,983
Waupun Memorial Hospital	Waupun	14.8%	14.8%	$5,901,887
Aspirus Wausau Hospital	Wausau	9.9%	16.4%	$64,443,427
Midwest Spine and Orthopedic Hospital and Wisconsin Heart Hospital	Wauwatosa	-1.8%	-1.8%	-$764,993
Aurora West Allis Medical Center	West Allis	28.0%	28.0%	$76,354,614
St. Joseph's Community Hospital of West Bend Inc	West Bend	15.2%	15.2%	$16,744,915
Ministry Saint Clare's Hospital	Weston	10.0%	10.0%	$10,509,529
Gundersen Tri-County Hospital & Clinics	Whitehall	-3.2%	-2.7%	-$444,755
Wild Rose Community Memorial Hospital	Wildrose	-4.0%	-5.1%	-$653,532
Riverview Hospital Association	Wisconsin Rapids	7.2%	12.2%	$11,937,943
Howard Young Medical Center	Woodruff	9.4%	19.9%	$13,032,154

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Title: **Individual Insurance Market Competition | The Henry J. Kaiser Family Foundation**
Timeframe: **2018**

Location	Herfindahl-Hirschman Index (HHI)	Market Share of Largest Insurer	Number of Insurers with Greater than 5% Market Share	Footnotes
United States	*4997*	*60%*	*3*	*1*
California	N/A	N/A	N/A	*2*
New York	1506	25%	7	
Wisconsin	**1377**	**24%**	**6**	
Pennsylvania	2797	41%	5	
Texas	2416	39%	5	
Ohio	2189	36%	5	
Virginia	2081	25%	5	
Illinois	6106	77%	4	
Kansas	4931	67%	4	
Idaho	3454	50%	4	
Washington	3187	48%	4	
Georgia	3217	47%	4	
Oregon	3106	45%	4	
Tennessee	3115	45%	4	
Massachusetts	2919	44%	4	
New Mexico	3198	42%	4	
Colorado	2833	41%	4	
Minnesota	2787	39%	4	
Missouri	2651	37%	4	
Nebraska	5999	75%	3	
West Virginia	5307	68%	3	
Nevada	4893	65%	3	
Arkansas	4713	63%	3	
New Hampshire	4559	61%	3	
Michigan	4010	60%	3	
Mississippi	4655	56%	3	
Arizona	4095	50%	3	
Indiana	4040	47%	3	
Montana	3533	43%	3	
South Dakota	3255	36%	3	
Louisiana	8479	92%	2	
North Dakota	7534	86%	2	
Utah	7411	85%	2	
District of Columbia	7079	82%	2	
Florida	5238	69%	2	
Maryland	5632	69%	2	
Connecticut	5623	68%	2	
Vermont	5581	67%	2	
New Jersey	5020	62%	2	
Hawaii	5173	59%	2	
Iowa	4895	59%	2	
Maine	4821	59%	2	
Kentucky	5042	55%	2	
Rhode Island	4981	52%	2	
Alaska	9975	100%	1	
Delaware	9942	100%	1	
Alabama	9507	97%	1	
South Carolina	9413	97%	1	
Wyoming	9463	97%	1	
North Carolina	9304	96%	1	
Oklahoma	9138	96%	1	

Notes
Plans that shared a parent company or insurer group were collapsed into one insurer for the purposes of this analysis. Data include comprehensive major medical coverage only.

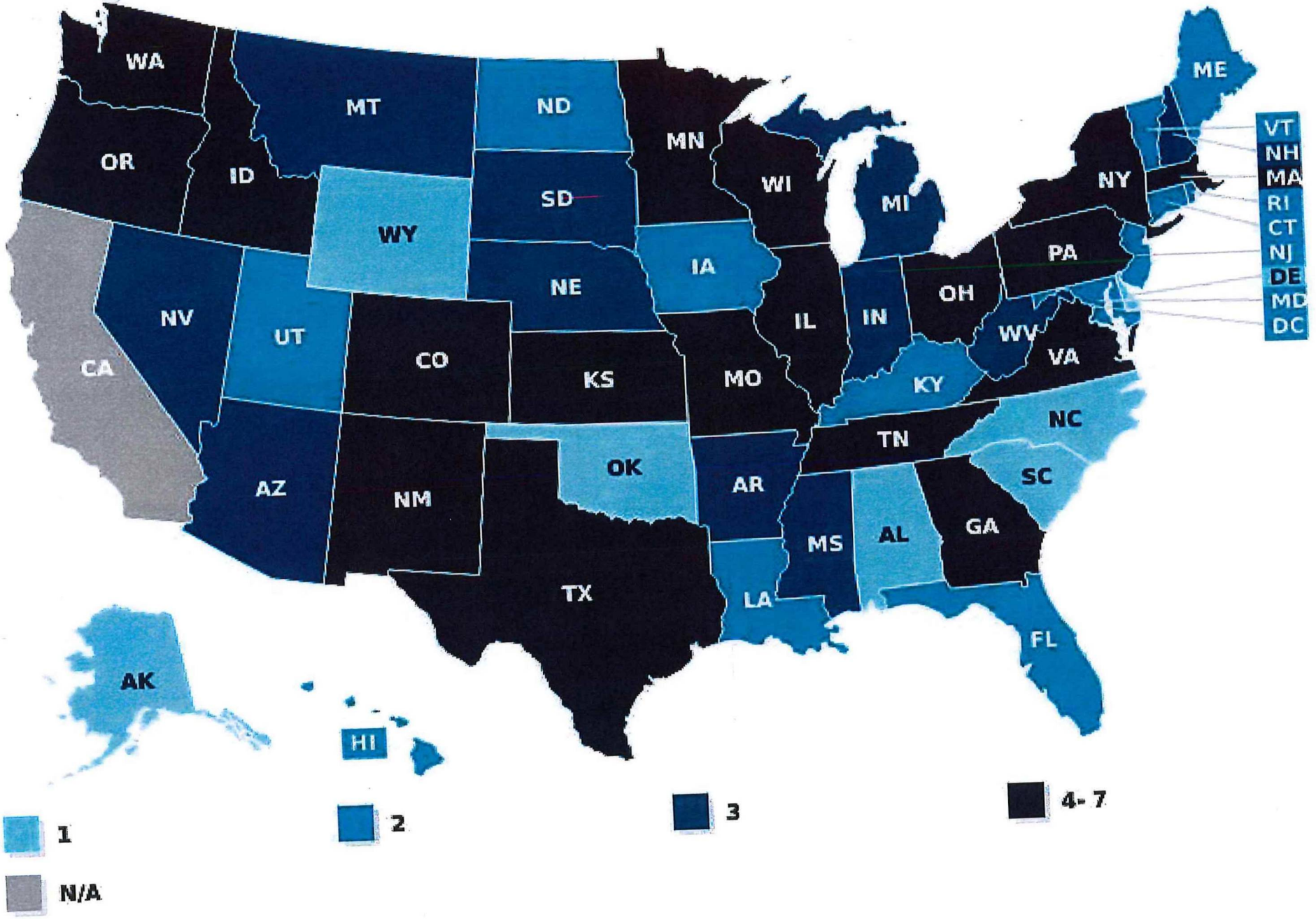
Sources
Kaiser Family Foundation analysis of data from the California Department of Managed Healthcare and SHCE data from [Health Coverage Portal TM](https://www.markfarrah.com/products/health-coverage-portal/), a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners. Mini-med companies with a medical focus were included.

Definitions
The **Herfindahl-Hirschman Index (HHI)** is a measure of how evenly market share is distributed across insurers in the market. HHI values range from 0 to 10,000, with an HHI closer to zero indicating a more competitive market and closer to 10,000 indicating a less competitive market. An HHI index below 1,000 generally indicates a highly competitive market; an HHI between 1,000 and 1,500 indicates an unconcentrated market; a score between 1,500 and 2,500 indicates moderate concentration; and a value above 2,500 indicates a highly concentrated (uncompetitive) market.

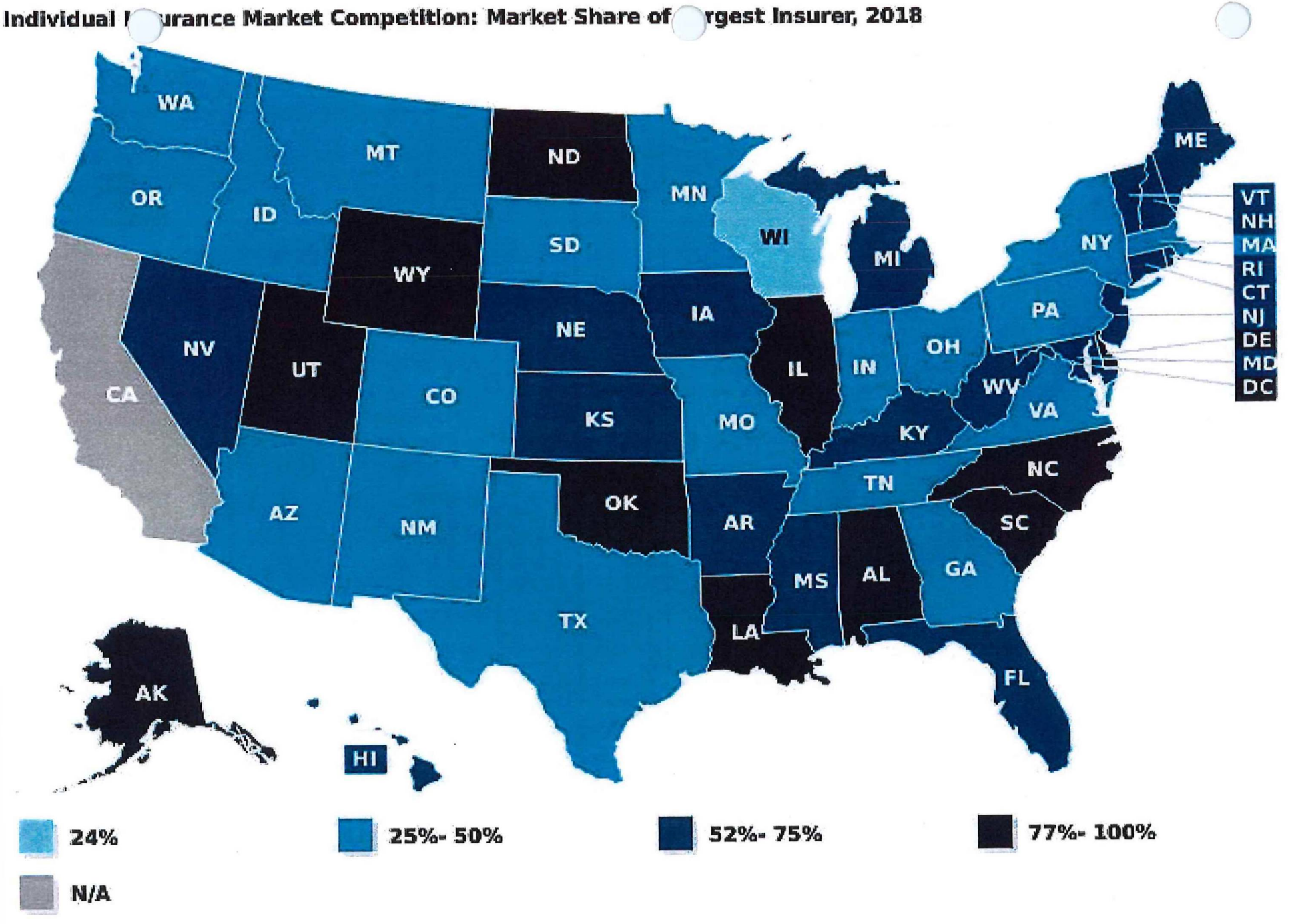
***N/A*:** Data not available.

Footnotes
1. United States data included in this table represent national averages.
2. 2018 data for California will not be available until December 2019.

Individual Insurance Market Competition: Number of Insurers with Greater than 5% Market Share, 2018

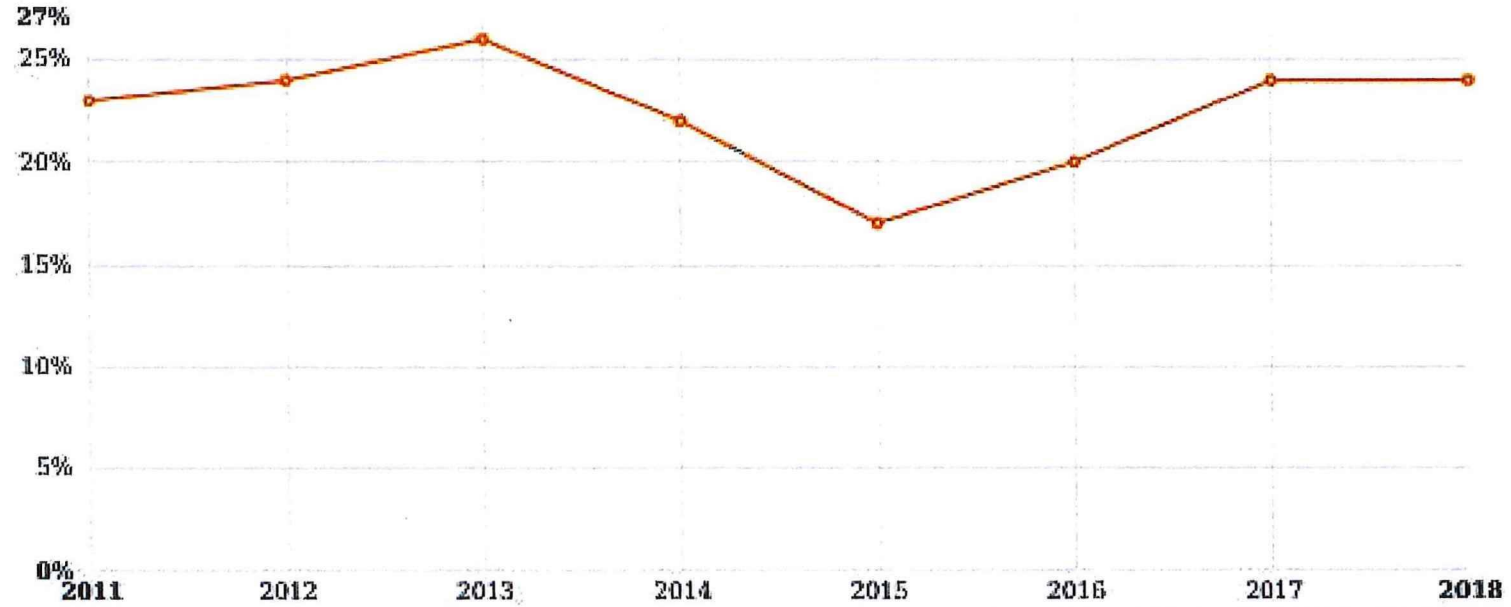


SOURCE: Kaiser Family Foundation's State Health Facts.



SOURCE: Kaiser Family Foundation's State Health Facts.

Individual Insurance Market Competition: Market Share of Largest Insurer, 2011 - 2018



SOURCE: Kaiser Family Foundation's State Health Facts.

Title: Large Group Insurance Market Competition | The Henry J. Kaiser Family Foundation
Timeframe: 2018

Location	Herfindahl-Hirschman Index (HHI)	Market Share of Largest Insurer	Number of Insurers with Greater than 5% Market Share	Footnotes
United States	*4469*	*59%*	*4*	*1*
California	N/A	N/A	N/A	*2*
Wisconsin	**1250**	**21%**	**8**	
New York	1173	16%	7	
Virginia	2356	41%	6	
Pennsylvania	2244	39%	6	
Georgia	2134	35%	6	
Oklahoma	3478	54%	5	
Oregon	2609	44%	5	
District of Columbi	2709	42%	5	
Ohio	2540	41%	5	
Washington	2473	34%	5	
Connecticut	2016	26%	5	
Michigan	3789	58%	4	
Maryland	3812	55%	4	
New Mexico	3969	55%	4	
New Jersey	3453	53%	4	
Colorado	3143	49%	4	
Arizona	3193	49%	4	
Kansas	3522	45%	4	
Florida	2943	44%	4	
Utah	2843	42%	4	
Texas	2925	42%	4	
Missouri	2641	36%	4	
Montana	6985	83%	3	
Arkansas	6143	77%	3	
Rhode Island	6254	77%	3	
Nebraska	5840	74%	3	
Tennessee	5395	72%	3	
Illinois	5303	71%	3	
Maine	5177	69%	3	
Delaware	5038	68%	3	
Kentucky	5155	68%	3	
Louisiana	4729	66%	3	
Nevada	4800	66%	3	
North Carolina	4951	66%	3	
Hawaii	4990	66%	3	
South Dakota	4587	64%	3	
Massachusetts	3952	60%	3	
New Hampshire	4524	58%	3	
Minnesota	3628	49%	3	
Alaska	8554	92%	2	
Vermont	8224	90%	2	
Wyoming	7423	86%	2	
Mississippi	7274	84%	2	
West Virginia	6673	80%	2	
Iowa	6373	79%	2	
Idaho	5059	68%	2	
Indiana	4678	65%	2	
North Dakota	4658	51%	2	
Alabama	8859	94%	1	
South Carolina	8517	92%	1	

Notes

Plans that shared a parent company or insurer group were collapsed into one insurer for the purposes of this analysis. Data include comprehensive major medical coverage only.

Sources

Kaiser Family Foundation analysis of data from the California Department of Managed Healthcare and SHCE data from [Health Coverage Portal TM](https://www.markfarrah.com/products/health-coverage-portal/), a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners. Mini-med companies with a medical focus were included.

Definitions

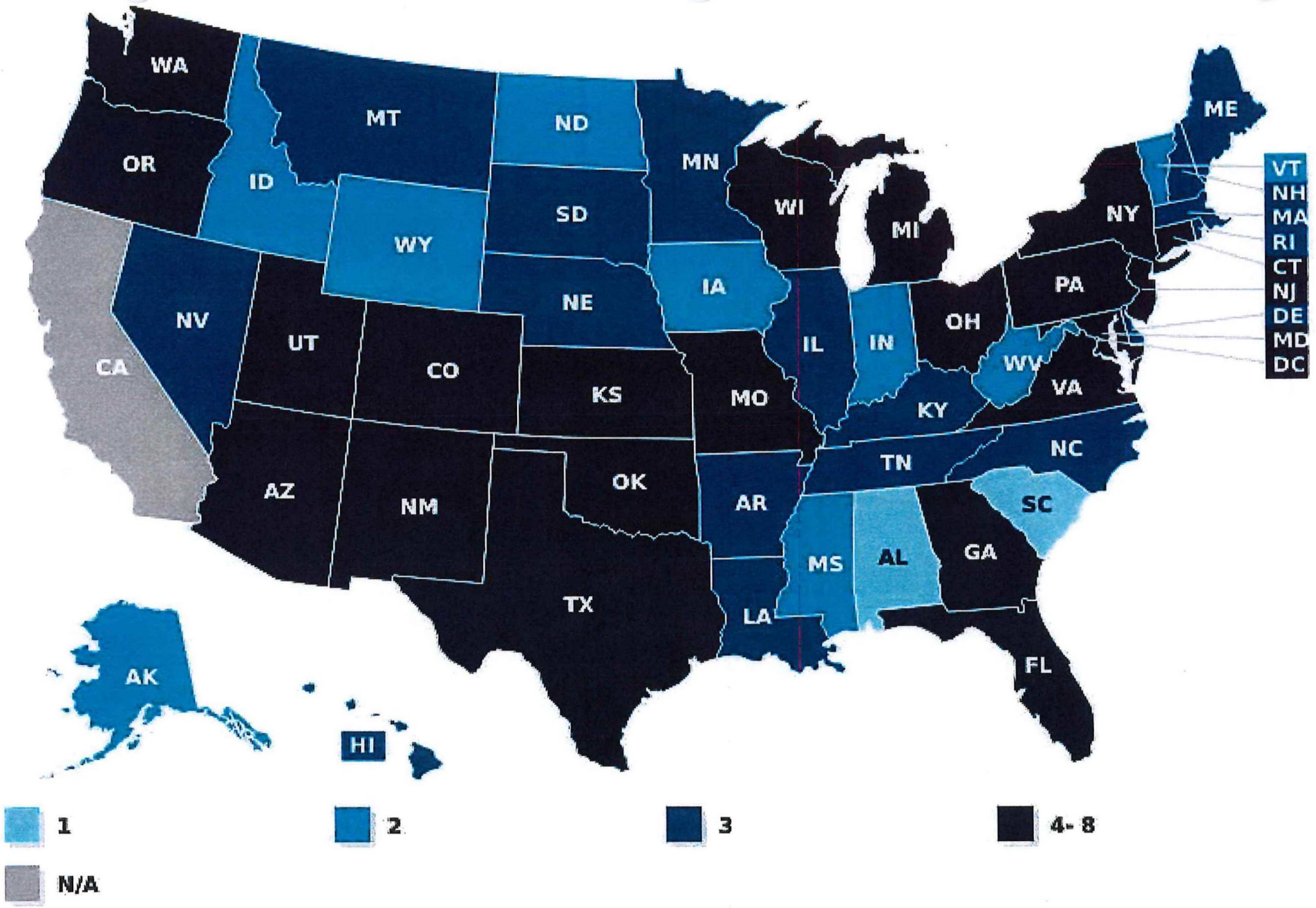
The *Herfindahl-Hirschman Index (HHI)* is a measure of how evenly market share is distributed across insurers in the market. HHI values range from 0 to 10,000, with an HHI closer to zero indicating a more competitive market and closer to 10,000 indicating a less competitive market. An HHI index below 1,000 generally indicates a highly competitive market; an HHI between 1,000 and 1,500 indicates an unconcentrated market; a score between 1,500 and 2,500 indicates moderate concentration; and a value above 2,500 indicates a highly concentrated (uncompetitive) market.

***N/A*:** Data not available.

Footnotes

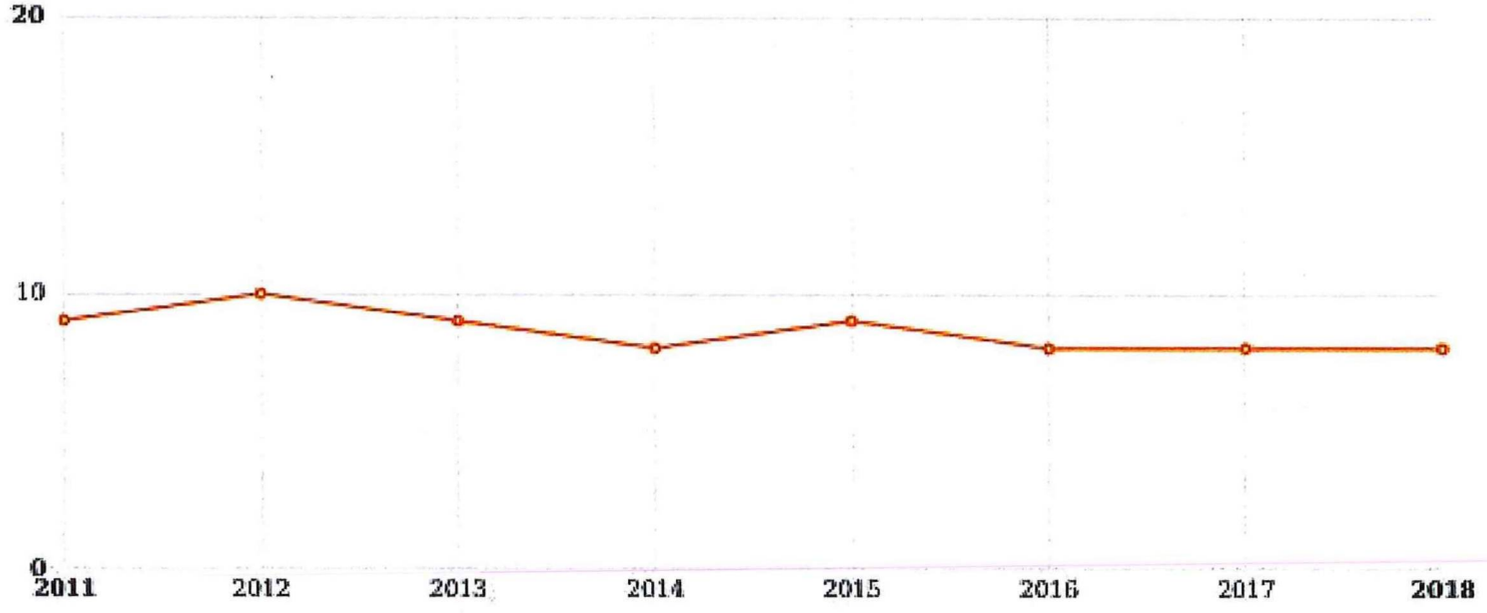
1. *United States data included in this table represent national averages.*
2. *2018 data for California will not be available until December 2019.*

Large Grou nsurance Market Competition: Number of Ins ers with Greater than 5% Market Share, 201

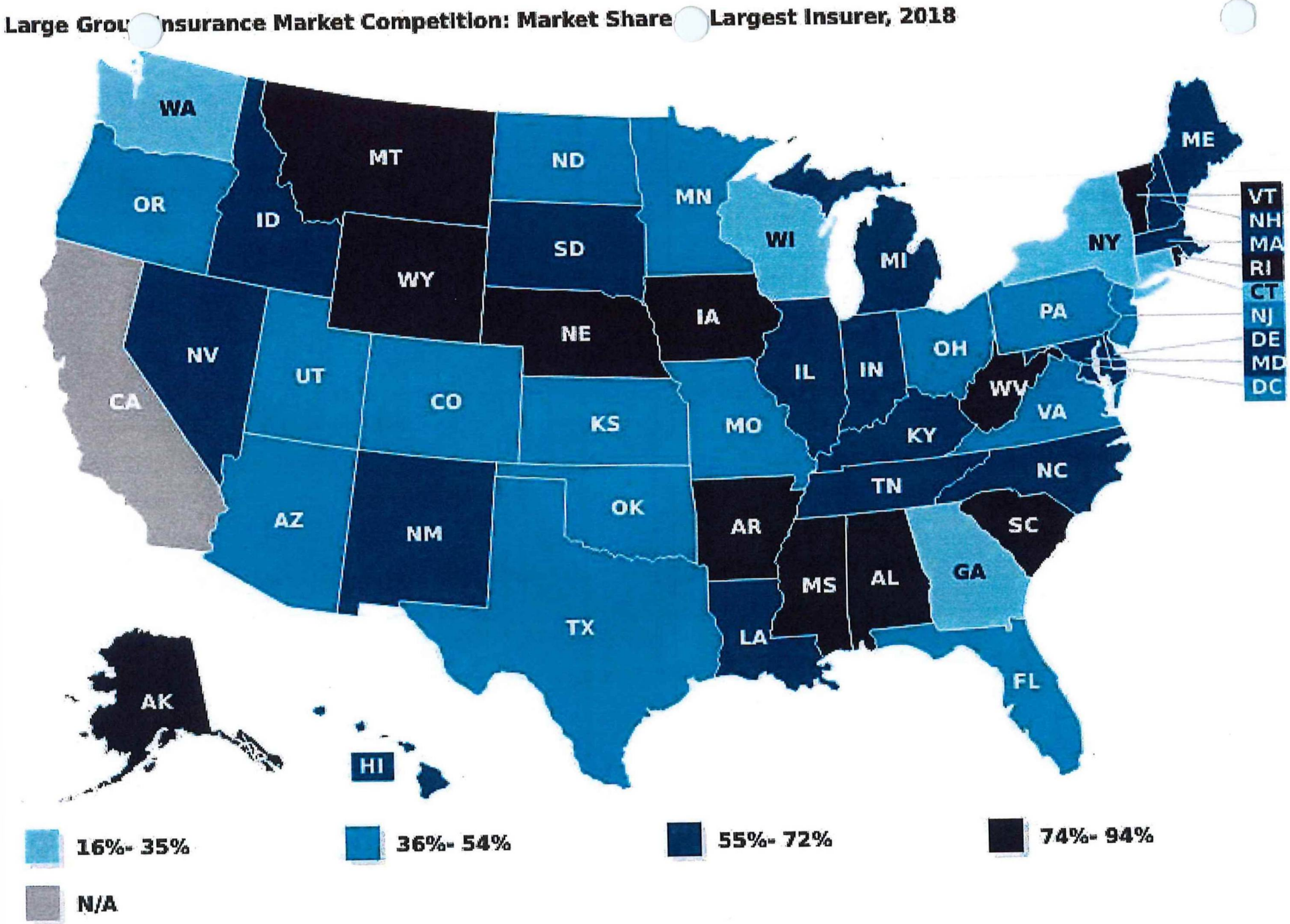


SOURCE: Kaiser Family Foundation's State Health Facts.

Large Group Insurance Market Competition: Number of Insurers with Greater than 5% Market Share, 2011 - 2018

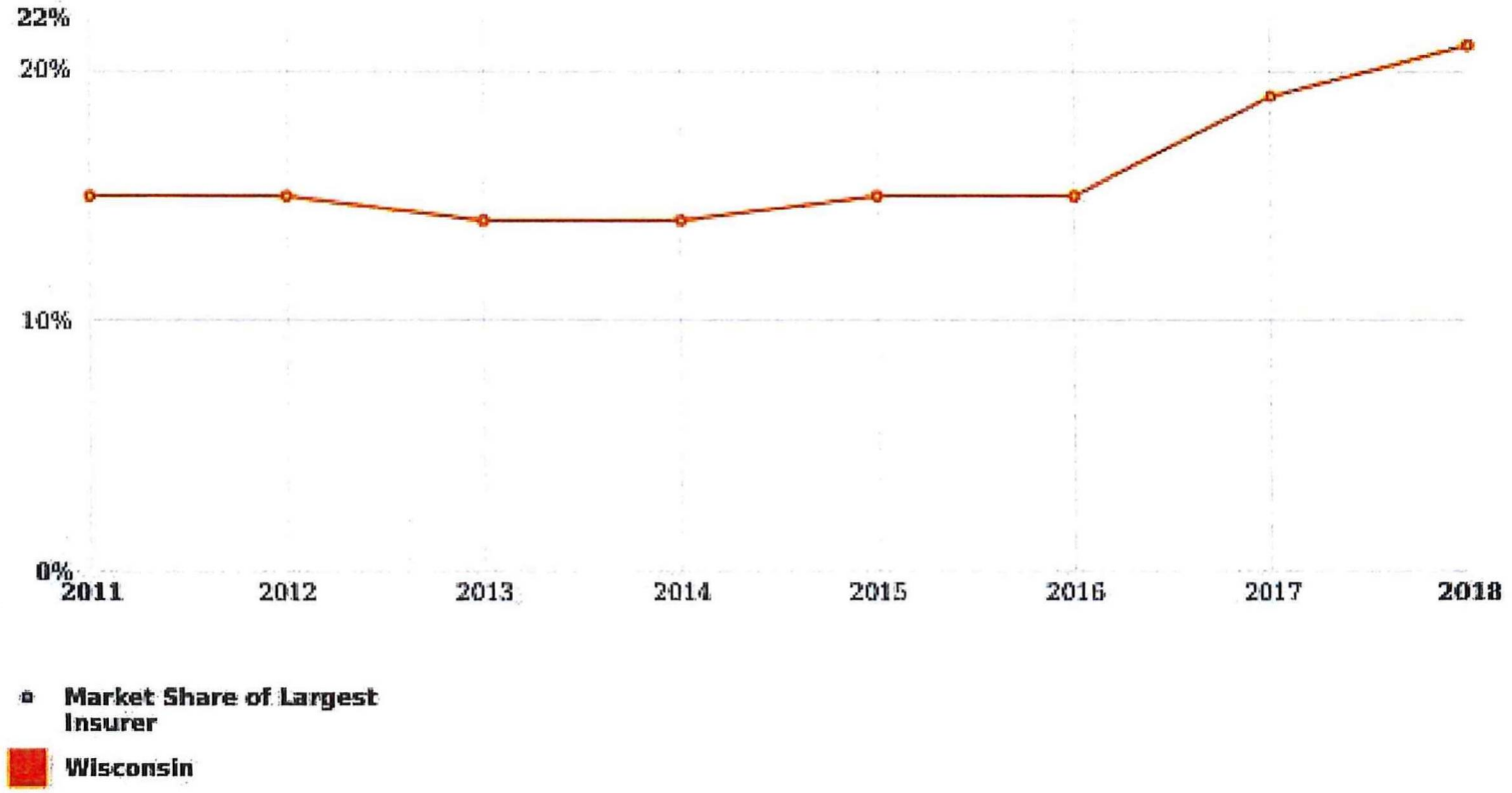


SOURCE: Kaiser Family Foundation's State Health Facts.



SOURCE: Kaiser Family Foundation's State Health Facts.

Large Group Insurance Market Competition: Market Share of Largest Insurer, 2011 - 2018



SOURCE: Kaiser Family Foundation's State Health Facts.

Title: Small Group Insurance Market Competition | The Henry J. Kaiser Family Foundation
Timeframe: 2018

Location	Herfindahl-Hirschman Index (HHI)	Market Share of Largest Insurer	Number of Insurers with Greater than 5% Market Share	Footnotes
United States	*4642*	*60%*	*3*	*1*
California	N/A	N/A	N/A	*2*
Pennsylvania	2117	33%	7	
Wisconsin	**1531**	**30%**	**7**	
Nevada	4548	65%	5	
Florida	3144	39%	5	
Oregon	2455	38%	5	
Missouri	3055	38%	5	
Michigan	4607	65%	4	
Kansas	4094	59%	4	
Georgia	3690	55%	4	
Massachusetts	3386	53%	4	
Maine	3568	53%	4	
Indiana	3772	53%	4	
New York	3093	51%	4	
Hawaii	3341	49%	4	
Idaho	3611	49%	4	
Arizona	3047	45%	4	
Colorado	3095	44%	4	
Minnesota	3243	44%	4	
Connecticut	2851	42%	4	
Virginia	2620	40%	4	
New Mexico	2764	39%	4	
Washington	2935	37%	4	
Ohio	2495	33%	4	
North Dakota	7256	84%	3	
Rhode Island	6766	81%	3	
West Virginia	6797	81%	3	
Louisiana	6804	81%	3	
South Dakota	6034	76%	3	
Utah	5570	72%	3	
Oklahoma	5095	68%	3	
Texas	4552	64%	3	
New Jersey	4649	64%	3	
Tennessee	4858	64%	3	
Arkansas	4604	62%	3	
Montana	4552	54%	3	
Kentucky	3987	51%	3	
Mississippi	7585	86%	2	
South Carolina	7601	86%	2	
Wyoming	7608	86%	2	
Iowa	7090	83%	2	
Delaware	7158	83%	2	
District of Columbia	6549	79%	2	
Illinois	5732	73%	2	
Alaska	5808	71%	2	
Maryland	5505	69%	2	
Vermont	5493	66%	2	
Nebraska	4703	56%	2	
North Carolina	4699	53%	2	
New Hampshire	4879	51%	2	
Alabama	9305	96%	1	

Notes
Plans that shared a parent company or insurer group were collapsed into one insurer for the purposes of this analysis. Data include comprehensive major medical coverage only.

Sources
Kaiser Family Foundation analysis of data from the California Department of Managed Healthcare and SHCE data from [Health Coverage Portal TM](https://www.markfarrah.com/products/health-coverage-portal/), a market database maintained by Mark Farrah Associates, which includes

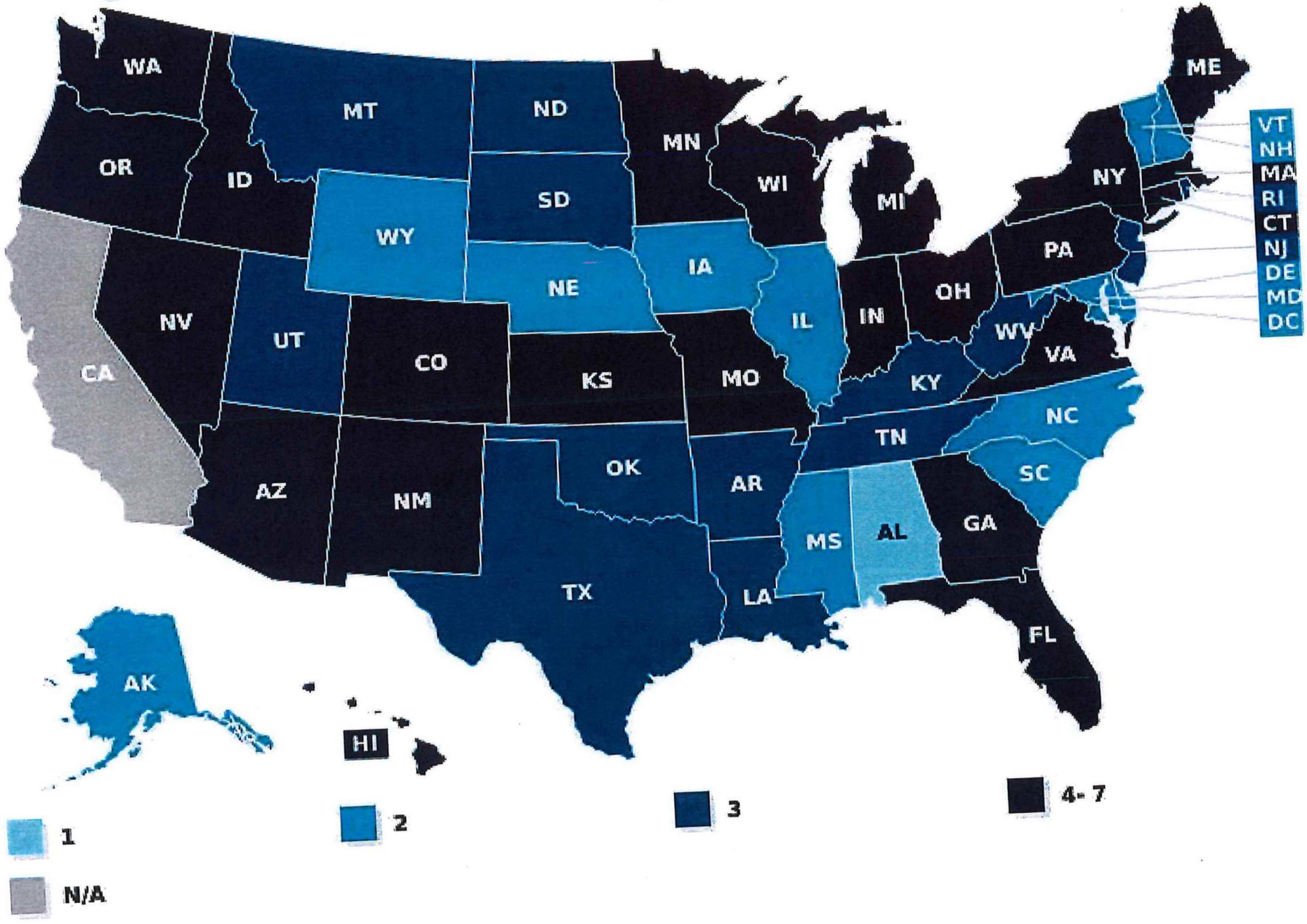
Definitions

The *Herfindahl-Hirschman Index (HHI)* is a measure of how evenly market share is distributed across insurers in the market. HHI values range from 0 to 10,000, with an HHI closer to zero indicating a more competitive market and closer to 10,000 indicating a less competitive market. An HHI index below 1,000 generally indicates a highly competitive market; an HHI between 1,000 and 1,500 indicates an unconcentrated market; a score between 1,500 and 2,500 indicates moderate concentration; and a value above 2,500 indicates a highly concentrated (uncompetitive) market.

N/A: Data not available.

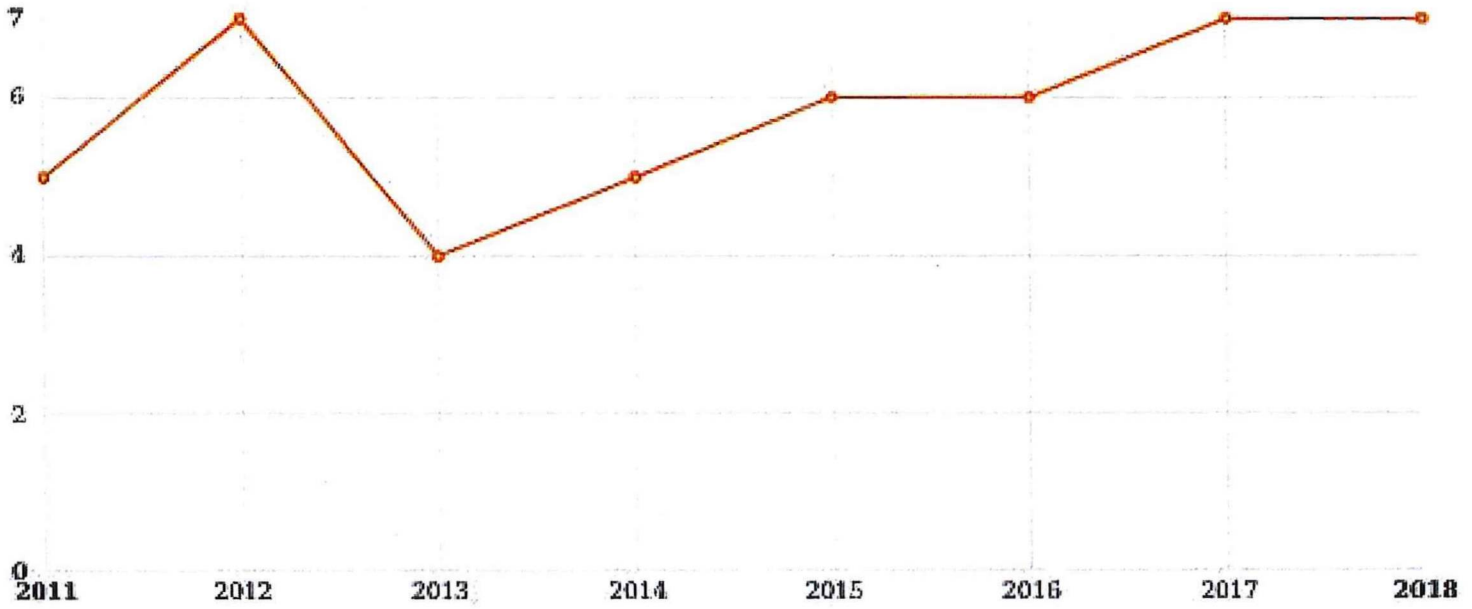
Footnotes
1. United States data included in this table represent national averages.
2. 2018 data for California will not be available until December 2019.

Small Group Insurance Market Competition: Number of Insurers with Greater than 5% Market Share, 2018



SOURCE: Kaiser Family Foundation's State Health Facts.

Small Group Insurance Market Competition: Number of Insurers with Greater than 5% Market Share, 2011 - 2018

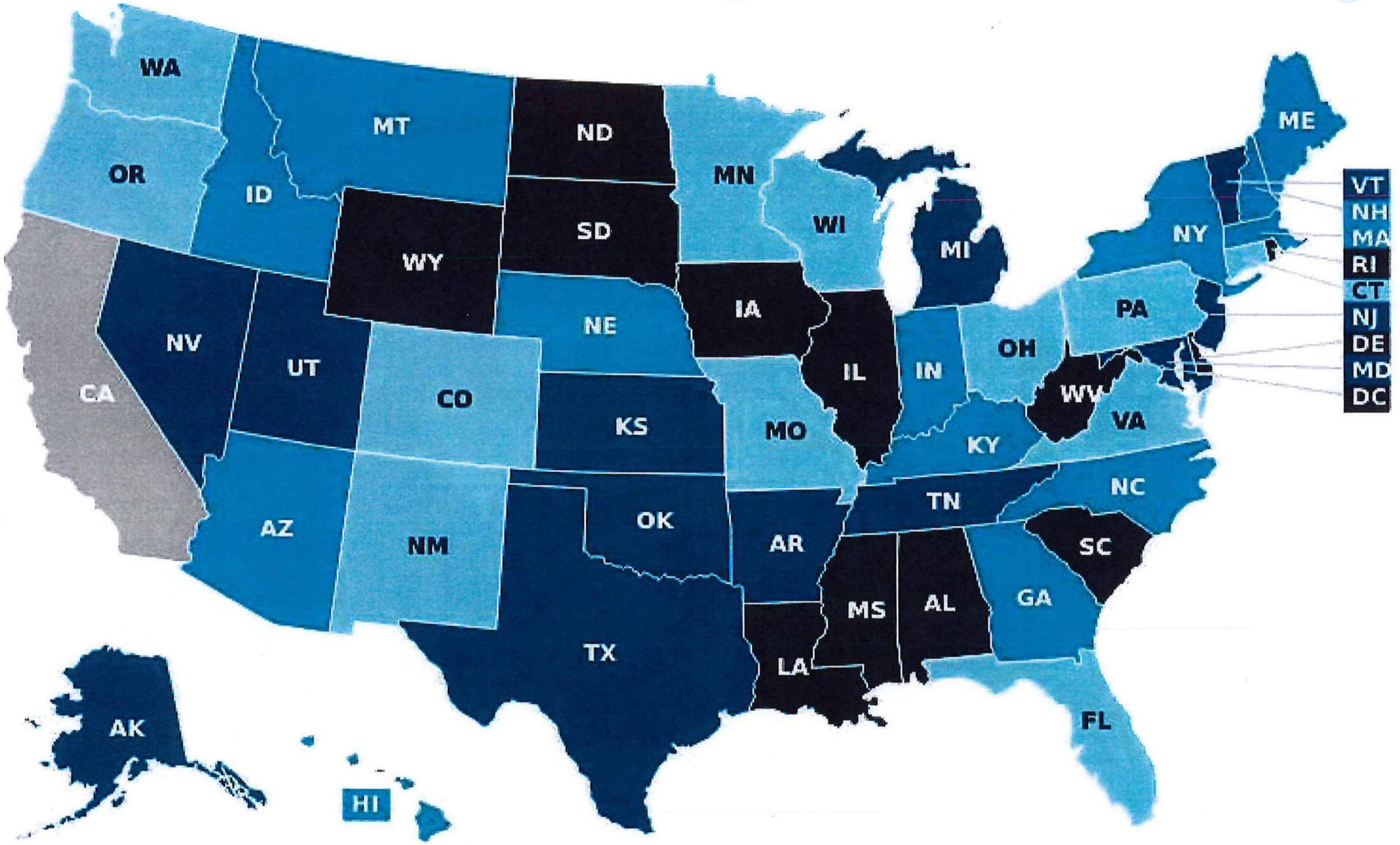


Number of Insurers with Greater than 5% Market Share

Wisconsin

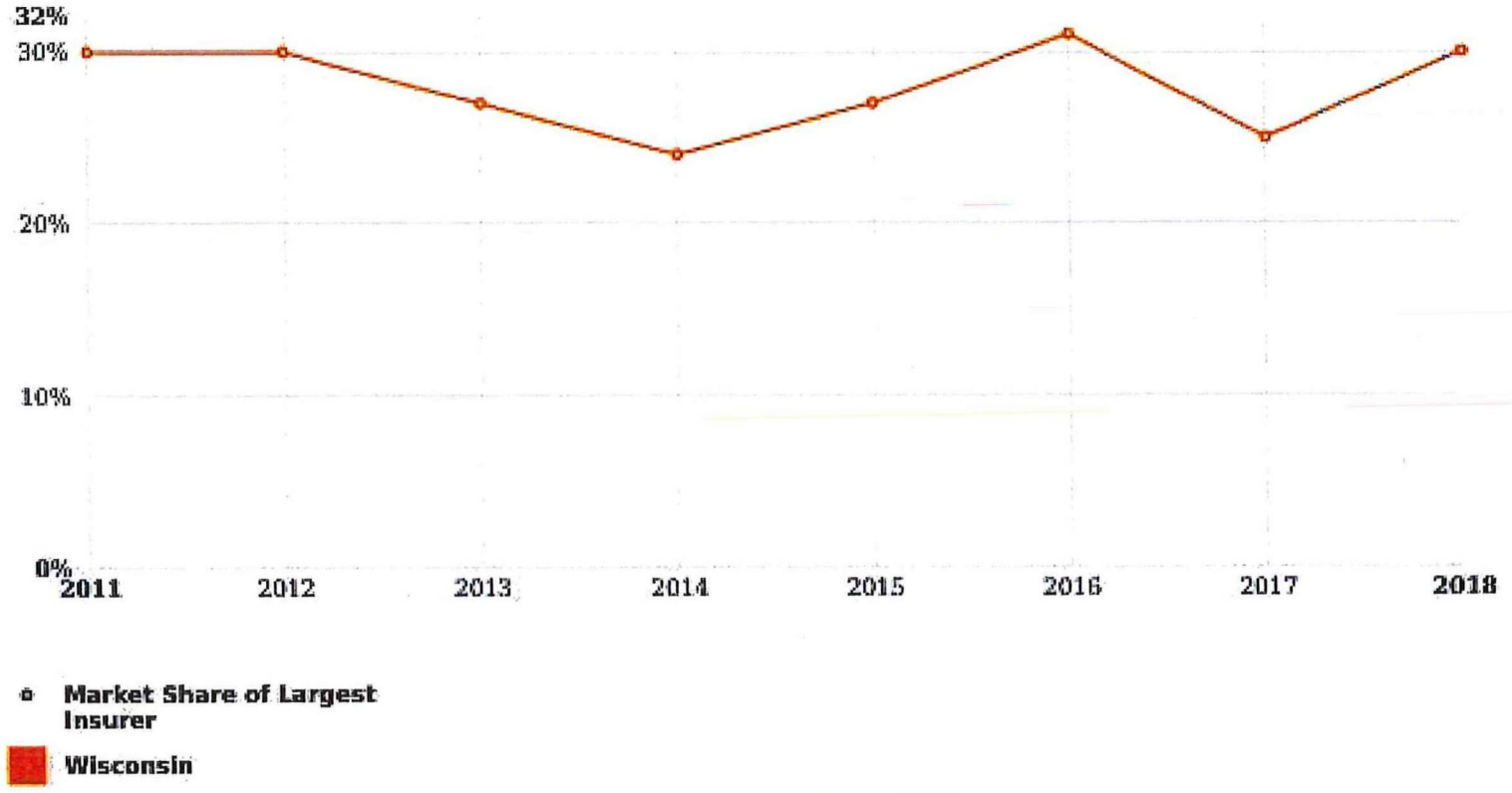
SOURCE: Kaiser Family Foundation's State Health Facts.

Small Group Insurance Market Competition: Market Share of Largest Insurer, 2018



SOURCE: Kaiser Family Foundation's State Health Facts.

Small Group Insurance Market Competition: Market Share of Largest Insurer, 2011 - 2018



SOURCE: Kaiser Family Foundation's State Health Facts.