MICHAEL SCHRAA

STATE REPRESENTATIVE • 53RD ASSEMBLY DISTRICT

P.O. Box 8953
Madison, WI 53708

Office: (608) 267-7990
Toll-Free: (608) 534-0053
Rep.Schraa@legis.wi.gov

Senate Bill 100 Testimony

Thank you Chairman Testin and members of the Senate Health and Human Services Committee for allowing me to testify today on Senate Bill 100 which pertains to licensure and regulation of PBMs 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 SB 100 accomplishes quite simply is better patient outcomes.

PBMs 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 enrollees. PBMs 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 PBMs formulary list, so manufacturers will offer kickbacks or rebates to the PBMs 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 PBMs 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 three major PBMs that now control **80%** of the prescription drug market. That means three PBMs 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 per 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, OptumRX and CVS Caremark. So this is where things get a little cloudy and complicated. In 2018, Cigna Insurance completed their purchase of Express Scripts. OptumRX is owned by United Health Group. CVS Health owns CVS Pharmacy and the PBM CVS Caremark. Two years ago, CVS Health acquired Aetna Insurance Company. As you can see, PBMs are now vertically integrated with managed healthcare companies, insurance companies, retail and mail order and specialty pharmacies. These relationships 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?

PBMs 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 PBMs 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 PBMs I previously mentioned. Just below Walmart, Apple and Amazon, you have United Health which owns OptumRX. 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.

PBMs are forcing State Legislatures to get involved in reform because of their actions and unfair business practices. It isn't often that a bill is introduced with three quarters of the legislature signing on as cosponsors. SB 100 currently has 99 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 to 5 years. If you watched President Trump last week in his State of the Union Address, he specifically calls out PBMs, 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. SB 100 requires PBMs to be licensed with the Commissioner of Insurance. Our bill also requires PBMs to submit annual transparency reports to OCI. The bill gives certainty to pharmacies participating in a PBMs preferred network, that pharmacy accreditation standards will be consistent. SB 100 would also codify in Wisconsin State Statutes a federal law removing the "Gag Clause" that PBMs 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 daughter's health decline significantly, this fight became personal for me and my family. My wife, Christine, 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, SB 100 sets fair and equitable standards related to audits that PBMs perform on pharmacies.

We have a variety of individuals and 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 PBMs have inflicted on their lives and 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: Senator Testin and members of the Senate Committee on Health and Human Services

From: Representative Debra Kolste, 44th Assembly District

Date: February 12th, 2020

Re: 2019 Senate Bill 100

Thank you, Chairman Testin, Vice-Chair Kooyenga, and fellow committee members, for holding a public hearing on Senate Bill 100.

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.

Senate Bill 100 attempts to give some relief to pharmacists in their dealings with PBMs and their use of audits.

I thank Senator Roth, Senator Erpenbach, and Representative Schraa for their work on this legislation. Thank you for your consideration of Senate Bill 100 and I respectfully ask for your support of this bill.

Debra Kolste

Deb Kolste
44th Assembly District

State Capitol, PO Box 8952, Madison, WI 53708 • (608) 266-7503 • Toll-free: (888) 947-0044 • FAX: (608) 282-3644
E-mail: rep.kolste@legis.wi.gov • Website: http://kolste.assembly.wi.gov

Good Afternoon Everyone,

My name is Christine Schraa. 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.

Our daughter 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.

My family's greatest hurdle over the last 2 years has been receiving the prescribed medications our doctors feel are necessary to manage our illnesses and provide the best quality of life. I am talking about meds that have been available for years to the public. Meds that prior to a couple years ago have been more affordable. A few years ago, these drugs were at least more affordable. Now the cost of some of these meds have gone through the roof.

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. 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.

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. 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, which was denied. The claim would be considered only if I tried at least 3 different medications on a list of covered meds from their formulary list. I explained my issues, stating that I had tried one of the meds unsuccessfully and was allergic. I was informed both written and orally that I was denied my medication that I had been on for years until I tried the PBM's listed alternatives. That's right, I was forced to try medications that I was allergic to, unless I agreed to pay the cash cost of $1000 every three months for Dexilant. So I tried some of the medications until I was so sick I couldn't do it anymore. I was sick from not having the medication I needed and sick from the medications I was forced to try. It took over two months of suffering before our PBM pharmacist finally approved Dexilant.

At the end of the day, I still need to fight each year to take this medication. Approval is just for one year, so I continue the fight. 2 years ago I was paying $35 per month. That changed to $185 every three months. That is a 90.4857% increase.

Now I would like to talk about my daughter Annie. Annie is a beautiful young 18 year old that attends Lourdes Academy in Oshkosh. She works at our business, Leons Frozen Custard,

volunteers, participates in school clubs and teaches Vacation Bible School during the summer. She continues to impress her father and me with her academic vigor and continued achievement of highest honors.

Lupus, or Systemic Lupus Erythematosis (SLE), is a long-term autoimmune disease. Just 20 years ago, it had a survival rate of over 50% by the end of 5 years. Annie has SLE. I am happy to say that it now 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.

Annie was placed on birth control pills to help control her symptoms. 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. Enough that her specialist at UW-Madison started talking about Annie starting immunosuppressants if things didn't turn around. Some of you may know, immunosuppressants are prescribed for individuals with significant Autoimmune Disorders or Cancer. 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. All because my daughter was not able to use the medication that was successful for her. 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. How is that even possible? Even so, I am grateful that 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.

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. Some people just get tired of the rejections and stop advocating for themselves. It becomes disheartening and defeating. People should not be forced to choose between life-saving medications and food to live. I think passing AB 114 is a great springboard to take us in the direction we need to go. Thank you so much for your time and attention to this challenging but needed reform.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, Governor
Mark V. Afable, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
ociinformation@wisconsin.gov
oci.wi.gov

Date: February 12, 2020

To: Senator Patrick Testin, Chair
Senator Dale Kooyenga, 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 Senate Bill 100 and SSA 1, 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 Senate Bill 100 (SB 100) 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 does not believe that the fiscal note for SB 100 is impacted by the Senate Substitute Amendment 1 (SSA 1). 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 expertise to ensure PBM compliance with the requirements SB 100 with SSA 1 places on those entities. Under the bill, PBMs are required to register with OCI and adhere to 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 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 SB 100.**

The new PBM requirements detailed in SB 100, 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 SB 100 cannot be adequately funded with the current $100 annual fee associated with EBPA licensure.

As noted in the original fiscal note, "SB 100 creates Wis. Stat § 649.05(2), which requires a PBM to 'pay any registration fee set by the commissioner.'" SSA 1 removes that authority for OCI to set and assess a registration fee. In order to appropriately fund the regulatory work outlined by SB 100 and SSA 1, OCI would prefer the original language be included in the final bill.

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 SB 100.

Wisconsin Legislative Council

Anne Sappenfield
Director

TO: SENATOR ROGER ROTH

FROM: Andrea Brauer and Steve McCarthy, Staff Attorneys

RE: Comparison of 2019 Assembly Bill 114, Relating to Pharmacy Benefit Managers, and Assembly Substitute Amendment 1

DATE: February 10, 2020

This memorandum responds to your request for a comparison of 2019 Assembly Bill 114, relating to pharmacy benefit managers (PBMs), and Assembly Substitute Amendment 1 to the bill.

LICENSING AND REGISTRATION OF PBMS

The Bill

The bill requires PBMs to be registered with the Office of the Commissioner of Insurance (OCI), and requires OCI to promulgate rules governing the conduct of PBMs, using the 2018 National Association of Insurance Commissioner's Model PBM Act as a model, to the extent it does not conflict with state insurance laws.[1] Under the bill, a PBM is defined to mean an entity doing business in Wisconsin that contracts to provide claims processing services, to otherwise administer or manage prescription drug benefits, or both, on behalf of an insurer or other entity that provides prescription drug benefits.

Specifically, the bill requires OCI's rules to include: (1) requirements for the development and maintenance of formularies and other PBM procedures (which may not allow insurers or PBMs to require enrollees to obtain specialty drugs by mail order); (2) information that PBMs must provide to consumers; (3) requirements and procedures for a standardized medical exceptions approval process; (4) requirements for nondiscrimination in PBM design; (5) record keeping and reporting requirements; (6) responsibilities for the PBM in oversight and contracting; and (7) required disclosures by a health benefit plan, self-insured health plan, or PBM. OCI is also granted authority to discipline a PBM for misconduct and to use its general enforcement authority under ch. 601, Stats.

The bill also specifies that a licensed pharmacy or licensed wholesale distributor that acts as a PBM is required to be registered as a PBM. However, the following are not required to be registered as a PBM: a person who is already licensed by OCI as an insurer, a licensed health care provider providing services to a patient, and entities that provide claims processing services or administration of prescription drugs only for the Medicaid program. [SECTION 16, pages 10-14.]

[1] The text of the model act is available here: https://www.naic.org/store/free/MDL-022.pdf. OCI's general authority to adopt standards of the National Association of Insurance Commissioners does not apply to proposed model acts or model regulations. [s. 601.41 (3) (b), Stats.]

The Substitute Amendment

The substitute amendment deletes the registration requirements under the bill and instead requires PBMs to be licensed by OCI under the licensure framework that currently applies to employee benefits plan administrators, except that a PBM that also performs services as an administrator is only required to obtain an administrator license. [SECTION 38, page 20.] There is overlap between the function of a PBM and that of an administrator. OCI explained in its hearing testimony for the bill:

> 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.** [Emphasis in original, referring to the bill as unamended.]

Under the substitute amendment, a PBM is defined to mean an entity that contracts to administer or manage prescription drug benefits on behalf of an insurer, another entity that provides prescription drug benefits, or a health care cooperative incorporated under ch. 185, Stats. [SECTIONS 18 and 27, pages 12 and 18.] An administrator is defined as a person who directly or indirectly solicits or collects premiums or charges or otherwise effects coverage or adjusts or settles claims for a plan, subject to a list of exceptions such as insurers and employers acting on behalf of their employees. [SECTION 23, page 17; and s. 633.01 (1), Stats.] In practice, the specific role of each PBM is determined by contract. PBMs are often tasked with negotiating drug prices and rebates, creating a pharmacy network, creating and operating a drug formulary, and handling claims payments. PBMs can also play a role in determining when and in which order certain drugs are covered. If any of the PBM's responsibilities include collecting premiums or charges, effecting coverage, or settling claims, the PBM is already required under current law to be licensed as an administrator.

The substitute amendment subjects PBMs that are not currently licensed as administrators to many of the requirements that apply to administrators, except for certain fiduciary responsibilities and standards for claims payments. An applicant for a PBM license must fulfill the same criteria as an applicant for an administrator license; the applicant must supply a bond, guarantee faithful performance of the PBM, designate an individual to directly administer the benefit, show that it intends to act in good faith through the designated individuals, and show that each officer is competent and trustworthy. [SECTION 39, pages 20-21.]

The substitute amendment does not significantly change licensure requirements for PBMs that are already licensed as administrators. The only explicit difference in the substitute amendment, as compared to current law, is that the substitute amendment adds two new grounds for discipline, stating that "if the licensee is a PBM," OCI may revoke, suspend, or limit the license if: (1) the PBM's methods or practices in administering a prescription drug benefit endanger the interests of enrollees or the public; or (2) the financial resources of the PBM are inadequate to safeguard the interests of enrollees or the public. It appears that these new standards would apply to a licensed administrator that also acts

as a PBM, since the substitute amendment specifically recognizes that some administrators also perform services as a PBM. [SECTIONS 38 and 41, pages 20 and 24.]

As compared to OCI's authority over registered PBMs under the bill, the substitute amendment does not authorize OCI to create rules governing the business conduct of licensed PBMs. However, under the substitute amendment, OCI can discipline PBMs as well as administrators for general misconduct, such as being unqualified to perform their responsibilities, or utilizing practices that endanger the interests of insureds or the public. [s. 633.15 (2), Stats.] The substitute amendment adds that if OCI suspends or revokes a PBM license, it can allow the PBM to continue to provide services for the purpose of providing continuity of care. [SECTION 43, page 24.]

RELATIONSHIP BETWEEN PBMS AND PHARMACIES

"Gag Clause" Prohibition

Under the bill, any disability insurance policy or self-insured health plan, or any PBM that provides services under a contract with the policy or plan may not include in any contract for pharmacy services a provision that prohibits or penalizes a pharmacist from disclosing either the cost of the prescribed drug or device to the individual or the availability of any therapeutically equivalent alternative prescribed drugs or devices or alternative methods of purchasing the prescribed drug or device, including paying cash, that are less expensive to the individual. [SECTION 13, pages 7-8.]

Under the substitute amendment, any disability insurance policy or self-insured health plan, or any PBM that provides services under a contract with the policy or plan, may not restrict or penalize a pharmacy from informing a plan or policy enrollee of the difference between the out-of-pocket cost of a drug and the amount an individual would pay for the drug without using any health plan or health insurance coverage. [SECTION 15, pages 8-9.]

Claim Reductions

Under the bill, a PBM may not retroactively deny or reduce a pharmacist's or pharmacy's claim after adjudication of the claim unless the original claim was submitted fraudulently, the payment for the original claim was incorrect because the pharmacy or pharmacist had already been paid for the pharmacy services, or the pharmacy services were not rendered by the pharmacist or pharmacy. [SECTION 16, page 15.]

Under the substitute amendment, a PBM may not retroactively deny or reduce a pharmacist's or pharmacy's claim after adjudication of the claim unless the original claim was submitted fraudulently, the payment for the original claim was incorrect, the pharmacy services were not rendered by the pharmacist or pharmacy, the pharmacist or pharmacy violated state or federal law in making the claim or performing the service that is the basis for the claim, or the reduction is permitted in a contract between a pharmacy and a PBM and is related to a quality program. [SECTION 21, page 13.]

PBM Networks

Under the bill, an insurer, self-insured health plan, or PBM is prohibited from requiring or penalizing a person who is covered under a disability insurance policy or self-insured health plan to use or for not using a specific retail, specific mail order, or other specific pharmacy provider within the network of pharmacy providers under the policy or plan. [SECTION 13, pages 8-9.]

The bill also requires that a PBM must provide a reasonably adequate and accessible pharmacy network for providing prescribed drugs or devices for a health benefit plan that allows convenient patient access to pharmacies within a reasonable distance from a plan participant's residence. A PBM may not include any mail-order pharmacy in its calculations of network adequacy. Additionally, a PBM must also submit to OCI a PBM network adequacy report describing the PBM network and accessibility to the network for health benefit plan participants. [SECTION 16, page 19.]

Additionally, under the bill, a PBM may not do any of the following:

- Unless approved by OCI, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including a fee for receiving and processing a pharmacy claim, developing or managing claims processing services in a PBM network, or participating in a PBM network.
- Unless approved by OCI after consulting with the Pharmacy Examining Board, require pharmacist or pharmacy accreditation standards or certification requirements in addition to, more stringent than, or inconsistent with any requirements of the Pharmacy Examining Board.
- Reimburse a pharmacy or pharmacist an amount less than the amount that the PBM reimburses an affiliate of the PBM for providing the same services.
- After termination of a pharmacy or pharmacist from a PBM, fail to make payments to a pharmacist or pharmacy for services that were properly rendered and provided before termination.
- Prohibit, restrict, or limit a pharmacy or pharmacist from disclosing information to OCI, law enforcement, or a state or federal governmental official that is investigating or examining a complaint or conducting a review of a PBM's compliance with the requirements under this section. [SECTION 16, pages 14-15.]

The substitute amendment requires only that a PBM must provide to a pharmacy, within 30 days of receipt of a written request from the pharmacy, a written notice of any certification or accreditation requirements used by the PBM as a determinant of network participation. A PBM may change its accreditation requirements no more frequently than once every 24 months. [SECTION 21, page 12.]

Audits of Pharmacy or Pharmacist

Both the bill and the substitute amendment include procedures that apply when certain entities,[2] including a defined network plan, insurer, self-insured plan, or PBM, conduct an audit of a pharmacist or pharmacy. The bill and the substitute amendment also specify what an auditor must do with the results of an audit of a pharmacist or pharmacy.

Audit Requirements

The bill provides that an entity conducting an audit of pharmacist or pharmacy records must do all of the following:

- If the audit is an audit on the premises of the pharmacist or pharmacy, notify the pharmacist or pharmacy in writing of the audit at least two weeks before conducting the audit.
- Refrain from auditing a pharmacist or pharmacy within the first seven days of a month unless the pharmacist or pharmacy consents to an audit during that time.

---

[2] Note that the bill, but not the substitute amendment, includes a "3rd-party payer" as an entity covered by the bill's auditing requirements.

- If the audit involves clinical or professional judgement, conduct the audit by or in consultation with a pharmacist licensed in this state or the Pharmacy Examining Board.
- Limit the audit review to claims submitted no more than two years before the date of the audit.
- Audit each pharmacist or pharmacy under the same standards and parameters as other similarly situated pharmacists or pharmacies.
- Establish a written appeals process that allows appeals of preliminary and final reports and allows for mediation if either party is dissatisfied with the appeal.
- Allow the pharmacist or pharmacy to use records of a hospital, physician, or other health care provider to validate the pharmacist's or pharmacy's records and use any prescription that complies with requirements of the Pharmacy Examining Board to validate claims in connection with a prescription, refill of a prescription, or change in prescription. [SECTION 16, page 16.]

The substitute amendment specifies that "audit" means a review of the accounts and records of a pharmacy or pharmacist by or on behalf of an entity that finances or reimburses the cost of health care services or prescription drugs. The substitute amendment provides that an entity conducting an on-site or desk audit of pharmacist or pharmacy records must do all of the following:

- If the audit is an audit on the premises of the pharmacist or pharmacy, notify the pharmacist or pharmacy in writing of the audit at least two weeks before conducting the audit.
- Refrain from auditing a pharmacist or pharmacy within the first five business days of a month unless the pharmacist or pharmacy consents to an audit during that time.
- If the audit involves clinical or professional judgment, conduct the audit by or in consultation with a pharmacist licensed in any state.
- Limit the audit review to no more than 250 separate prescriptions.
- Limit the audit review to claims submitted no more than two years before the date of the audit, unless required otherwise by state or federal law.
- Allow the pharmacist or pharmacy to use authentic and verifiable records of a hospital, physician, or other health care provider to validate the pharmacist's or pharmacy's records relating to delivery of a prescription drug and use any valid prescription that complies with requirements of the Pharmacy Examining Board to validate claims in connection with a prescription, refill of a prescription, or change in prescription.
- Allow the pharmacy or pharmacist to document the delivery of a prescription drug or pharmacist services to an enrollee under a health benefit plan using either paper or electronic signature logs.
- Before leaving the pharmacy after concluding the on-site portion of an audit, provide to the representative of the pharmacy or the pharmacist a complete list of the pharmacy records reviewed. [SECTION 21, pages 13-14.]

Use of Audit Results

The bill provides that an entity that has conducted an audit of a pharmacist or pharmacy must do all of the following:

- Deliver to the pharmacist or pharmacy a preliminary report of the audit within 60 days after date of the conclusion of the audit.

- Allow a pharmacist or pharmacy that is the subject of an audit at least 30 days after the date the pharmacist or pharmacy receives the preliminary report to provide documentation to address any discrepancy found in the audit.
- Deliver to the pharmacist or pharmacy a final audit report within 90 days of the date the pharmacist or pharmacy receives the preliminary report or the date of the final appeal of the audit, whichever is later.
- Refrain from assessing a recoupment or other penalty on a pharmacist or pharmacy until the appeal process is exhausted and the final report is delivered to the pharmacist or pharmacy.
- Base a finding of overpayment or underpayment of a claim on the actual overpayment or underpayment and not on a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
- Exclude dispensing fees from calculations of overpayments.
- Refrain from using extrapolation in calculating the recoupments or penalties for an audit.
- Refrain from charging interest until the final report under has been delivered. [SECTION 16, pages 16-17.]

The substitute amendment provides that an entity that has conducted an audit of a pharmacist or pharmacy must do all of the following:

- Deliver to the pharmacist or pharmacy a preliminary report of the audit within 60 days after the date the auditor departs from an on-site audit or the pharmacy or pharmacist submits paperwork for a desk audit. A preliminary report must include claim-level information for any discrepancy reported, the estimated total amount of claims subject to recovery, and contact information for the entity or person that completed the audit so the pharmacist or pharmacy subject to the audit may review audit results, procedures, and discrepancies.
- Allow a pharmacist or pharmacy that is the subject of an audit to provide documentation to address any discrepancy found in the audit within 30 days after the date the pharmacist or pharmacy receives the preliminary report.
- Deliver to the pharmacist or pharmacy a final audit report, which may be delivered electronically, within 90 days of the date the pharmacist or pharmacy receives the preliminary report or the date of the final appeal of the audit, whichever is later. The final audit report must include any response provided to the auditor by the pharmacy or pharmacist and consider and address the pharmacy's or pharmacist's response.
- Refrain from assessing a recoupment or other penalty on a pharmacist or pharmacy until the appeal process is exhausted and the final report delivered to the pharmacist or pharmacy.
- Refrain from accruing or charging interest between the time the notice of the audit is given and the final report has been delivered.
- Exclude dispensing fees from calculations of overpayments.
- Establish and follow a written appeals process that allows a pharmacy or pharmacist to appeal the final report of an audit and allow the pharmacy or pharmacist as part of the appeal process to arrange for, at the cost of the pharmacy or pharmacist, an independent audit.
- Refrain from subjecting the pharmacy or pharmacist to a recoupment or recovery for a clerical or record-keeping error in a required document or record, including a typographical or computer

error, unless the error resulted in an overpayment to the pharmacy or pharmacist. [SECTION 21, pages 15-16.]

Other Provisions

The bill also provides all of the following relating to audits of a pharmacy or pharmacist:

- If an audit of a pharmacist or pharmacy identifies a clerical or record-keeping error in a required document or record, the entity conducting the audit may not request recoupment of funds from the pharmacist or pharmacy based on such an error unless the entity proves the pharmacist or pharmacy intended to commit fraud or unless the error by the pharmacist or pharmacy results in actual financial harm to the PBM, a health benefit plan, or a consumer.
- Information obtained in an audit is confidential and may not be shared unless the information is required to be shared under state or federal law. An entity conducting an audit may have access to the previous audit reports on a particular pharmacy conducted by the same entity.
- Any entity that conducts an audit must provide to the health benefit plan a copy of the final report of the audit and a disclosure of any recoupment amount assessed as a result of the audit.
- A PBM or entity conducting an audit may not pay an auditor employed by or contracted with the PBM or entity based on a percentage of the amount recovered in an audit. [SECTION 16, pages 17-18.]

The substitute amendment also provides all of the following relating to audits of a pharmacy or pharmacist:

- Information obtained in an audit is confidential and may not be shared unless the information is required to be shared under state or federal law and except that the audit may be shared with the entity on whose behalf the audit is performed. An entity conducting an audit may have access to the previous audit reports on a particular pharmacy only if the audit is conducted by the same entity.
- If an entity is conducting an audit that is complying with the substitute amendment's requirements in auditing a pharmacy or pharmacist, the pharmacy or pharmacist that is the subject of the audit may not interfere or refuse to participate in the audit.
- A PBM or entity conducting an audit may not pay an auditor employed by or contracted with the PBM or entity based on a percentage of the amount recovered in an audit. [SECTION 21, pages 16-17.]

DISCLOSURES AND TRANSPARENCY REQUIREMENTS

The bill and substitute amendment include provisions that require certain disclosures and transparency requirements for both PBMs and pharmacies.

Requirements for PBMs

PBM Transparency Reporting

Under the bill, every PBM must submit an annual report to OCI and the Legislature that contains the aggregate amount of all rebates that the PBM received from all pharmaceutical manufacturers by each health benefit plan sponsor and for all health benefit plan sponsors combined, the aggregate administrative fee amount that the PBM received from all pharmaceutical manufacturers by each health benefit plan sponsor, and for all health benefit plan sponsors combined, the aggregate rebate amount 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.

The bill also provides that OCI must publish PBM transparency reports on OCI's website, but must do so in a manner that does not disclose any trade secrets. [SECTION 16, pages 18-19.]

Under the substitute amendment, every PBM must submit an annual report to OCI that contains the aggregate rebate amount 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. Information required to be included in the report is limited to contracts held with pharmacies located in this state.

The substitute amendment also provides that these reports must be considered a trade secret under the uniform trade secret act under s. 134.90, Stats. Lastly, the substitute amendment provides that OCI may not expand upon the specified reporting requirement, except that OCI may effectuate the transparency reporting requirements. [SECTION 21, page 17.]

Conflicts of Interest and Regulation of Certain Business Practices

The bill provides that, if a PBM makes a formulary substitution in which the substitute drug costs more than the originally prescribed drug, the PBM must disclose to the health benefit plan sponsor the cost of the drugs and any benefit that accrues, directly or indirectly, to the PBM related to the substitution. A PBM is also prohibited from requiring that a pharmacy or pharmacist enter into one contract in order to enter into another contract. Lastly, a PBM must notify a health benefit plan sponsor in writing of any activity, policy, or practice of the PBM that presents a conflict of interest, directly or indirectly, with either of the requirements described above. [SECTION 16, page 15.]

The substitute amendment does not include any of the above provisions relating to conflicts of interest or PBM business practices.

Requirements for Pharmacies

Pharmacy Disclosures to Consumers

The bill does not include any provisions relating to disclosures by a pharmacy to consumers.

The substitute amendment requires that each pharmacy must post a sign that describes a pharmacist's ability to substitute a less expensive drug product equivalent or interchangeable biological product.

The substitute amendment also requires that the Pharmacy Examining Board must create a list of the 100 most commonly prescribed generic drug product equivalents and provide the list to each pharmacy on an annual basis. Each pharmacy must make available to the public information on how to access the list. Each pharmacy must also make available for the public information on how to access the U.S. Food and Drug Administration's (FDA) lists of all currently approved interchangeable biological products.

Lastly, each pharmacy must have available for the public a listing of the retail price, updated no less frequently than monthly, of the 100 most commonly prescribed prescription drugs, which includes brand name and generic equivalent drugs and biological products and interchangeable biological products, that are available for purchase at the pharmacy. [SECTIONS 7-9, pages 6-7.]

OTHER COVERAGE REQUIREMENTS

Drug Substitutions

The bill prohibits a disability insurance policy or self-insured health plan, or any PBM that provides services under a contract with the policy or plan, to require covered individuals to pay an increased cost-sharing amount for a **newly prescribed** drug or device, if: (1) the substitution for the originally prescribed drug or device is suggested by the plan or PBM; and (2) the newly prescribed drug is a therapeutic equivalent to the originally prescribed drug or device that is being substituted. In addition, the bill requires plans and PBMs to develop a procedure to ensure that, **within a coverage year**, the policy or plan does not deny coverage, or add new exclusions, limitations, deductibles, copayments, or coinsurance if the prescribing provider states in writing that the prescribed drug is more suitable for the person's condition than alternative drugs or devices that are covered under the policy or plan. [SECTION 13, page 9.]

The substitute amendment requires a disability insurance policy or self-insured health plan, or any PBM that provides services under a contract with the policy or plan, to provide enrollees with written notice 30 days in advance of a formulary change that removes the enrollee's prescription drug from the formulary or that reassigns the enrollee's prescription drug to a benefit tier that has a higher deductible, copayment, or coinsurance, except that no notice is required in either of the following circumstances:

- The FDA no longer approves the drug, has issued a warning or other statement regarding the drug, or has approved the drug for use without a prescription.
- One of the following is added to the formulary at the same benefit tier or at a benefit tier that has a lower deductible, copayment, or coinsurance than the benefit tier from which the prescription drug is being removed or reassigned: (1) a generic prescription drug that is approved by the FDA for use as an alternative to the prescription drug; or (2) a prescription drug in the same pharmacologic class or with the same mechanism of action. In either of these circumstances, if an enrollee attempts to fill or refill the drug, the pharmacist or pharmacy must notify the enrollee of the formulary change.

The substitute amendment also provides that if an enrollee has had an adverse reaction to the substituted drug, the pharmacist or pharmacy may fill one 30-day supply of the originally prescribed drug at the cost-sharing amount that applies for the prescription drug at the time of the substitution. [SECTION 15, pages 9-11.]

Cost-Sharing Limitations

The bill states that a disability insurance policy, self-insured plan, or PBM may not require an enrollee to pay at the point of sale for a covered prescription drug an amount that is greater than the lowest of: (1) the cost-sharing amount for the drug under the policy or plan; or (2) the amount that a person would pay for the drug if purchased without using any health plan or health insurance coverage. [SECTION 13, page 8.] This requirement is the same in the substitute amendment. [SECTION 15, page 9.]

If you have any questions, please feel free to contact us directly at the Legislative Council staff offices.

AB:SM:ty

February 12, 2020

The Honorable Patrick Testin
Chair, Senate Committee on Health and Human Services
Wisconsin State Capitol
2 East Main Street, Rm. 411 South
Madison, WI 53703

RE: NATIONAL COMMUNITY PHARMACISTS ASSOCIATION COMMENTS ON SB 100

Dear Chair Testin, Vice-Chair Kooyenga, and members of the Senate Committee on Health and Human Services,

I am writing to supplement NCPA's testimony provided during the committee's hearing on February 12. We support Wisconsin's efforts to protect patients from PBM abuses that raise out-of-pocket costs and threaten access to pharmacy services. We are thrilled to see that 22 senators have coauthored the bill and 70 representatives have joined as cosponsors, showing that Wisconsin is committed to putting patients first.

Despite the widespread support for the bill's provisions, we are concerned that amendments to SB 100 will remove many of the protections for Wisconsin patients. Therefore, to ensure patient access to pharmacy services is protected, we urge you not to remove several key provisions from the bill.

Retain provisions limiting PBM self-dealing and conflicts of interest

As introduced, SB 100 contains several provisions that would limit PBM self-dealing and conflicts of interest. These provisions are necessary to ensure a patient's ability to make his or her own healthcare decisions is not superseded by a PBM's conflict of interest.

The introduced version of the bill would ensure patients have access to an adequate network of pharmacy providers and prohibit a PBM from steering patients to a specific pharmacy. It is not uncommon for a PBM to remove patient choice by requiring a patient to utilize a PBM-owned pharmacy, often a mail-order pharmacy. The PBM is then free to reimburse its pharmacy at more favorable rates, a practice that would also be prohibited under the introduced version of the bill. These provisions would ensure a patient's choice of pharmacy is left to the patient and is informed by what's in the patient's best interest, instead of what's in the PBM's best interest.

The introduced version of the bill would limit a PBM's authority to establish arbitrary pharmacy accreditation requirements as a condition of network participation. PBMs have no place interfering in the regulatory aspect of pharmacists and pharmacies operating in the state. The Wisconsin Department of Safety and Professional Services and the Pharmacy Examining Board already have the necessary credentialing, accreditation, and licensing requirements for pharmacies in place to serve and protect the residents of Wisconsin. Additional accreditation and certification requirements implemented by PBMs beyond those mandated by the state are beyond the scope of appropriate PBM practices and serve to limit patient access to trusted pharmacies by creating arbitrarily narrow provider networks.

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

NCPA urges you to retain these provisions in SB 100 so that Wisconsin patients will have greater control over their own healthcare decisions.

Retain provisions that lower patients' out-of-pocket costs

As introduced, SB 100 contains several provisions that would prohibit PBM practices that increase patients' out-of-pocket costs. Those provisions would prohibit retroactive claim reductions and adjudication fees. 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. They are done under the guise of opaque "adjudication fees" or retroactive claim adjustments. 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. The introduced version of SB 100 would ensure patients' cost shares reflect the true cost of their health care services.

NCPA urges you not to amend this language to allow for retroactive claim adjustments if such an adjustment is permitted in the contract between the PBM and pharmacy. Such an amendment would fail to protect patients from higher out-of-pocket costs. All PBM abuses that disadvantage patients and pharmacies are contractual in nature. PBMs are able to get away with these abuses because of their concentrated market share and their use of take-it-or-leave-it contracts that impede a pharmacy's ability to negotiate.[1] Additionally, patients are not parties to these contracts, even though the contracts directly impact their costs.

If SB 100 allows a PBM to contract away its obligations under the bill, then the bill's protections will be rendered meaningless. Therefore, we urge you to retain SB 100's provisions without amendments that would weaken the bill's protections for patients.

Retain provisions that protect pharmacy communication with government officials

As introduced, SB 100 would prohibit a PBM from penalizing a pharmacist for disclosing information to the commissioner, law enforcement, or a state or federal governmental official that is investigating a PBM's compliance with the law. States, such as Maryland, have found "independent pharmacists do not file complaints [with the Insurance Administration] because they are then retaliated against by the PBMs through audits and increased scrutiny."[2] Such retaliatory tactics allow prohibited PBM abuses to continue without consequence. To enforce the requirements of this bill, the state must have the means to determine when the requirements are not being satisfied. Therefore, we urge you to retain the provisions that would allow pharmacies and pharmacists to discuss potential violations without fear of retaliation from PBMs.

---

[1] *See* GAO-13-176 ("over half of the PSAOs we spoke with reported having little success in modifying certain contract terms as a result of negotiations. This may be due to PBMs' use of standard contract terms and the dominant market share of the largest PBMs. Many PBM contracts contain standard terms and conditions that are largely non-negotiable.").

[2] Maryland Insurance Administration. "Maryland Insurance Administration Pharmaceutical Services Workgroup Report" 13 (Jan. 21, 2018).

Conclusion

As introduced, SB 100 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 SB 100 and retain the introduced version's protections. Thank you, again, for your time. If you need additional information, please do not hesitate to contact me at matthew.magner@ncpanet.org.

Sincerely,

Matthew Magner, JD
Director, State Government Affairs

cc: Members of the Senate Committee on Health and Human Services

NATIONAL TAXPAYERS UNION

Mr. Chair and Members of the Senate Committee on Health, let me first express our gratitude for holding a public hearing on Senate Bill 100.

We are here today on behalf of the National Taxpayers Union to speak in favor of Pharmacy Benefit Reform and Senate Bill 100 which will increase transparency in pharmacy benefits and pharmaceutical costs, an overdue modification to a current structure that does not always benefit patients or taxpayers.

Wisconsin pharmacies, patients and taxpayers deserve transparent pricing structures, one that will afford patients flexibility in their prescription drug plans and provide an improved understanding of pharmaceutical costs, resulting in increased consumer choice and freer markets.

Reforming the way Pharmacy Benefit Managers (PBMs) operate in pharmaceutical markets allows health plan payers to know the amount paid to pharmacies, which, in turn, affords the health plan to know the percentage paid to PBMs. Implementing spread pricing disclosure agreements and audit requirements provide taxpayers and consumers the facts regarding prescription drug costs.

Additionally, when pharmacists are free to openly share pharmaceutical options with patients about the availability of lower-cost alternatives to a prescribed medication - or when there is a lower cash price for a drug - the patient's out-of-pocket costs may be substantially reduced. By eliminating contractual "gag clauses" patients have more affordable options.

Unfortunately, the current system incentivizes manufacturers to pay higher rebates to PBMs for exclusive placement on a plan's formulary. While the intent of the rebate is to reduce overall pharmaceutical costs, far too frequently, savings from the rebates are not passed along to the patient. An increase in cost transparency encourages PBMs to pass manufacturer rebates directly to the patient.

As pharmaceutical plan designers, marketers and managers, PBMs have a financial interest in designing plans that can restrict pharmacy options and limit competitive market forces. Current law, allows PBMs to require patients to use certain pharmacies, and charge plan sponsors more without having to disclose the price difference between competing pharmacies. By modifying the current system consumers and taxpayers have more control over their prescription drug costs.

Pharmacy Benefit Reform is necessary to ensure medication affordability and access for Wisconsin consumers. Thank you again for holding a public hearing on this important issue.

Sincerely,

Leah Vukmir
Vice President of Government Affairs

Jess Ward
Director of Government Affairs

HOMETOWN PHARMACY

Senate Bill 100 is extremely important legislation that will protect the health and finances of the people of Wisconsin. Requiring pharmacy benefit managers (PBM) to register with OCI would be a positive step forward to monitor and regulate their practices. Below are just a few ways that PBMs manipulate patients, employers and pharmacies. The sooner the current legislation and future legislation can regulate these practices, the better off Wisconsin residents and employers will be.

Cash price – There are numerous times per week that a patient could save money by having the pharmacy process their prescription through our Hometown cash plan. Unfortunately we are not allowed to tell patients this due to the gag clauses that are in our "take it or leave it" contracts. See attachment 1-2 for examples of this situation.

Claw backs – This is a dollar amount that the insurance company has the pharmacy collect as either a copay and then the PBM collects a portion of the copay from the pharmacy, sometimes all of the copay. It's as if the pharmacy is acting as a bill collector for the PBM. They have never disclosed what these claw backs are for. You can see an example of this in attachment 1-2.

Patient charged more during deductible phase – At the beginning of the year many of our patients have a deductible that needs to be met before their full coverage kicks in. We see many times that the PBMs approve a larger dollar amount to be paid to the pharmacy while the patient is paying down their deductible. Then once the deductible is met, and the insurance company is paying the full amount, the payment to the pharmacy goes down. We are suppose to be paid based on the same contracted rate no matter what time of the year. See attachment 3-4 for example of this.

DIR fees – Direct and indirect renumeration fees.

- How they affect pharmacies - These are arbitrary fees charged to a pharmacy for claims that were processed 3-6 months prior. These fees were originally written into the Medicare Part D law to help the government pay for the program, but have been used by the PBMs to put money in their pockets and squeeze the little pharmacies out in the hopes to leave only the PBM owned pharmacies. They claim these fees are based on the pharmacy's performance of set metrics, but do not clearly define them. They also vary from PBM to PBM, so it is very convoluted. The big kickers is, may times after the DIR fee is taken from the pharmacy (months after the original transaction) we actually lose money. What other business setting would this happen?
- How they affect patients – For Medicare Part D patients, their total dollars spent on prescriptions is added up as they get prescriptions, and when they meet a specific amount they reach what's called the donut hole or coverage gap. When they reach the donut hole, they will then pay more out of their pockets for each prescription. Because DIR fees are

1350 W. College Avenue, Ste A • Appleton, WI 54914
Phone: 920-739-9232 • **Fax:** 920-739-5813
www.hometownpharmacyrx.com

accessed months after the claim is paid, the patient might get into the donut hole faster than they really should have. Even after the DIR fee is taken from the pharmacy none of it is credited to the patient.

Mail Order – Patients are forced to go mail order usually because their employer is persuaded by lower premiums for the insurance. The reality is the PBMs can offer a lower premium because they will make up the money lost in premiums with the prescription claims paid to their own mail order pharmacy. The dollar amount paid per prescription to their mail order pharmacy is usually significantly more than what would have been paid to a retail pharmacy. The reality is this actually will end up costing the employer more in the long run and will likely cause their premiums to go up the following year, giving them a never ending increase in premiums.

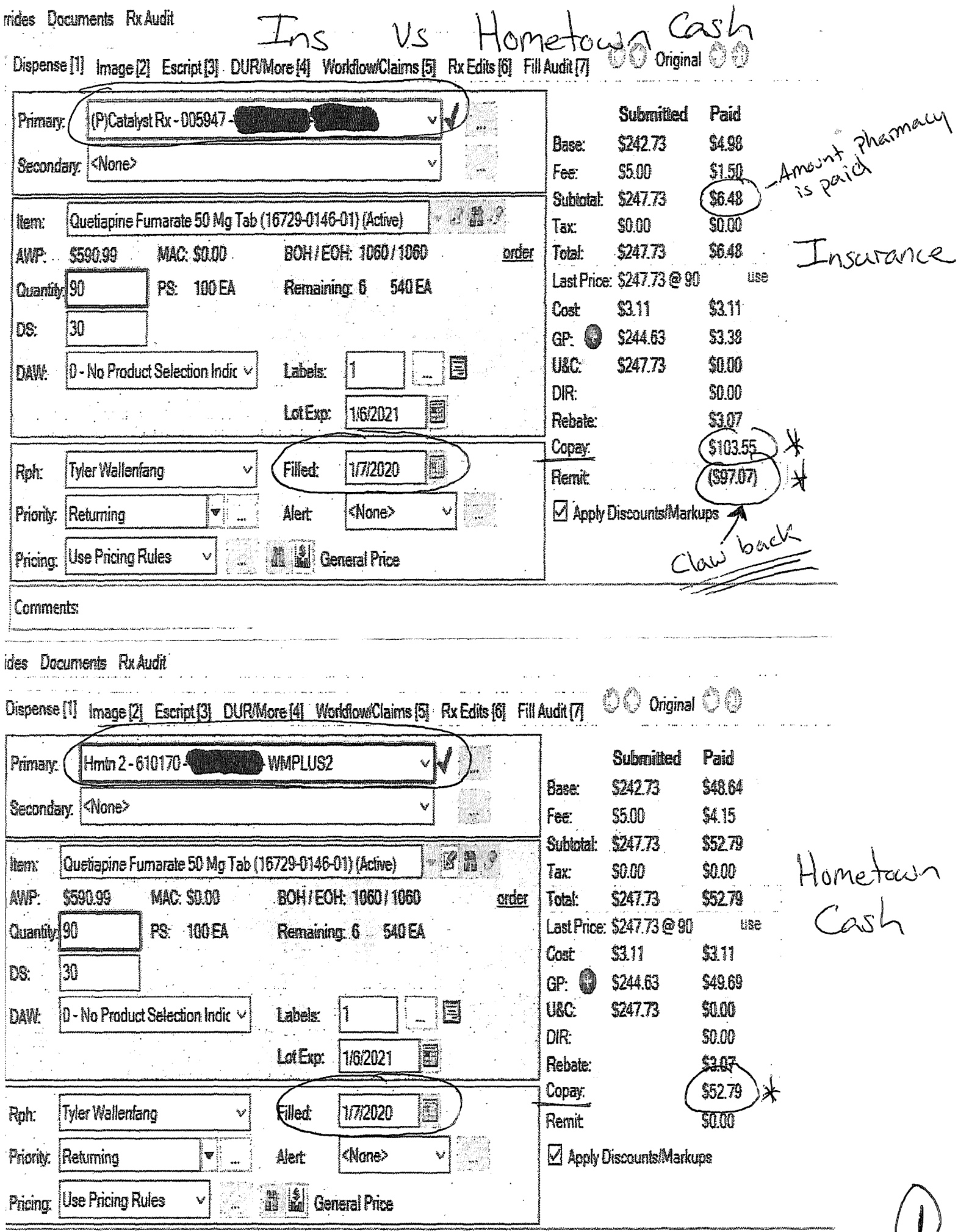
Another negative of mail order pharmacy is the amount of waste that is created. One thing that mail order pharmacies will boast is their compliance rates of their patients. Unfortunately this is technically an artificial stat. The compliance rate they report is actually just their fill rate. The mail order pharmacy auto fills these prescriptions and sends them to the patient even if they were not requested by the patient. Many times the patients have requested the mail order pharmacy to stop sending the prescription and yet they continue to be charged to the patient and sent. Sometimes the medication that continues to be sent is one that the doctor has discontinued. This leads to two issues. First, a patient accumulates a medication that he/she is no longer taking and will need to dispose of. Second, a patient could possibly continue to take a medication they are not suppose to be taking, which is not a good situation at all.

Audits – When audits first came about, they were designed to check on a random selection of claims the pharmacy submitted to make sure they are submitting claims correctly. For the past few years, PBMs unfairly target high cost medications in their audits on pharmacies. The reason for this is to recoup as much money as possible. Most, if not all, of the prescription claims that are recouped are minor clerical errors and not technically fraudulent. Additionally, if a PBM does recoup money for errors the pharmacy committed, no portion of the recouped money is ever returned to the plan sponsor (employer).

Thank you for taking the time to read through my testimony. If you have any questions please feel free contact me via email, twallenfang@hometownpharmayrx.com, or phone (920) 739-9232.

Tyler Wallenfang

1350 W. College Avenue, Ste A • Appleton, WI 54914
Phone: 920-739-9232 • **Fax:** 920-739-5813
www.hometownpharmacyrx.com


rides Documents Rx Audit
Ins Vs Hometown Cash
Dispense [1] Image [2] Escript [3] DUR/More [4] Workflow/Claims [5] Rx Edits [6] Fill Audit [7]
Original
Primary: (P)Catalyst Rx - 005947 -
Secondary: <None>
Item: Quetiapine Fumarate 50 Mg Tab (16729-0146-01) (Active)
AWP: $590.99 MAC: $0.00 BOH / EOH: 1060 / 1060 order
Quantity: 90 PS: 100 EA Remaining: 6 540 EA
DS: 30
DAW: 0 - No Product Selection Indic Labels: 1
Lot Exp: 1/6/2021
Rph: Tyler Wallenfang Filled: 1/7/2020
Priority: Returning Alert: <None>
Pricing: Use Pricing Rules General Price
Comments:
Submitted Paid
Base: $242.73 $4.98
Fee: $5.00 $1.50
Subtotal: $247.73 $6.48
Tax: $0.00 $0.00
Total: $247.73 $6.48
Last Price: $247.73 @ 90 use
Cost: $3.11 $3.11
GP: $244.63 $3.38
U&C: $247.73 $0.00
DIR: $0.00
Rebate: $3.07
Copay: $103.55
Remit: ($97.07)
Apply Discounts/Markups
Amount Pharmacy is paid
Insurance
Claw back
ides Documents Rx Audit
Dispense [1] Image [2] Escript [3] DUR/More [4] Workflow/Claims [5] Rx Edits [6] Fill Audit [7]
Original
Primary: Hmtn 2 - 610170 - WMPLUS2
Secondary: <None>
Item: Quetiapine Fumarate 50 Mg Tab (16729-0146-01) (Active)
AWP: $590.99 MAC: $0.00 BOH / EOH: 1060 / 1060 order
Quantity: 90 PS: 100 EA Remaining: 6 540 EA
DS: 30
DAW: 0 - No Product Selection Indic Labels: 1
Lot Exp: 1/6/2021
Rph: Tyler Wallenfang Filled: 1/7/2020
Priority: Returning Alert: <None>
Pricing: Use Pricing Rules General Price
Comments:
Submitted Paid
Base: $242.73 $48.64
Fee: $5.00 $4.15
Subtotal: $247.73 $52.79
Tax: $0.00 $0.00
Total: $247.73 $52.79
Last Price: $247.73 @ 90 use
Cost: $3.11 $3.11
GP: $244.63 $49.69
U&C: $247.73 $0.00
DIR: $0.00
Rebate: $3.07
Copay: $52.79
Remit: $0.00
Apply Discounts/Markups
Hometown Cash
1

Ins Vs Hometown Cash

rides Documents Rx Audit

Dispense [1] Image [2] DUR/More [3] Workflow/Claims [4] Rx Edits [5] Fill Audit [6]

Original

Primary: (P)Advance Rx Mgmt PDP - 004336 [redacted] - RX

Secondary: <None>

Item: Duloxetine Hcl Dr 60 Mg Cap (51991-0748-90) (Active)

AWP: $226.23 MAC: $0.00 BOH / EOH: 2010 / 2010 order

Quantity: 30 PS: 90 EA Remaining: 0 0 EA

DS: 30

DAW: 0 - No Product Selection Indic Labels: 1

Lot Exp: 1/14/2021

Rph: George Gosz Filled: 1/15/2020

Priority: Waiting Alert: <None>

Pricing: Use Pricing Rules General Price

	Submitted	Paid
Base:	$99.00	$56.54
Fee:	$5.00	$4.00
Subtotal:	$104.00	$60.54
Tax:	$0.00	$0.00
Total:	$104.00	$60.54
Last Price:	$104.00 @ 30	use
Cost:	$3.51	$3.51
GP:	$100.49	$57.03
U&C:	$104.00	$0.00
DIR:		$0.00
Rebate:		$3.47
Copay:		$63.54
Remit:		($3.00)

Apply Discounts/Markups

Insurance

Clawback

Comments:

rides Documents Rx Audit

Dispense [1] Image [2] DUR/More [3] Workflow/Claims [4] Rx Edits [5] Fill Audit [6]

Original

Primary: Hmtn - 610170 [redacted] WMPLUS2

Secondary: <None>

Item: Duloxetine Hcl Dr 60 Mg Cap (51991-0748-90) (Active)

AWP: $226.23 MAC: $0.00 BOH / EOH: 2010 / 2010 order

Quantity: 30 PS: 90 EA Remaining: 0 0 EA

DS: 30

DAW: 0 - No Product Selection Indic Labels: 1

Lot Exp: 1/14/2021

Rph: George Gosz Filled: 1/15/2020

Priority: Waiting Alert: <None>

Pricing: Use Pricing Rules General Price

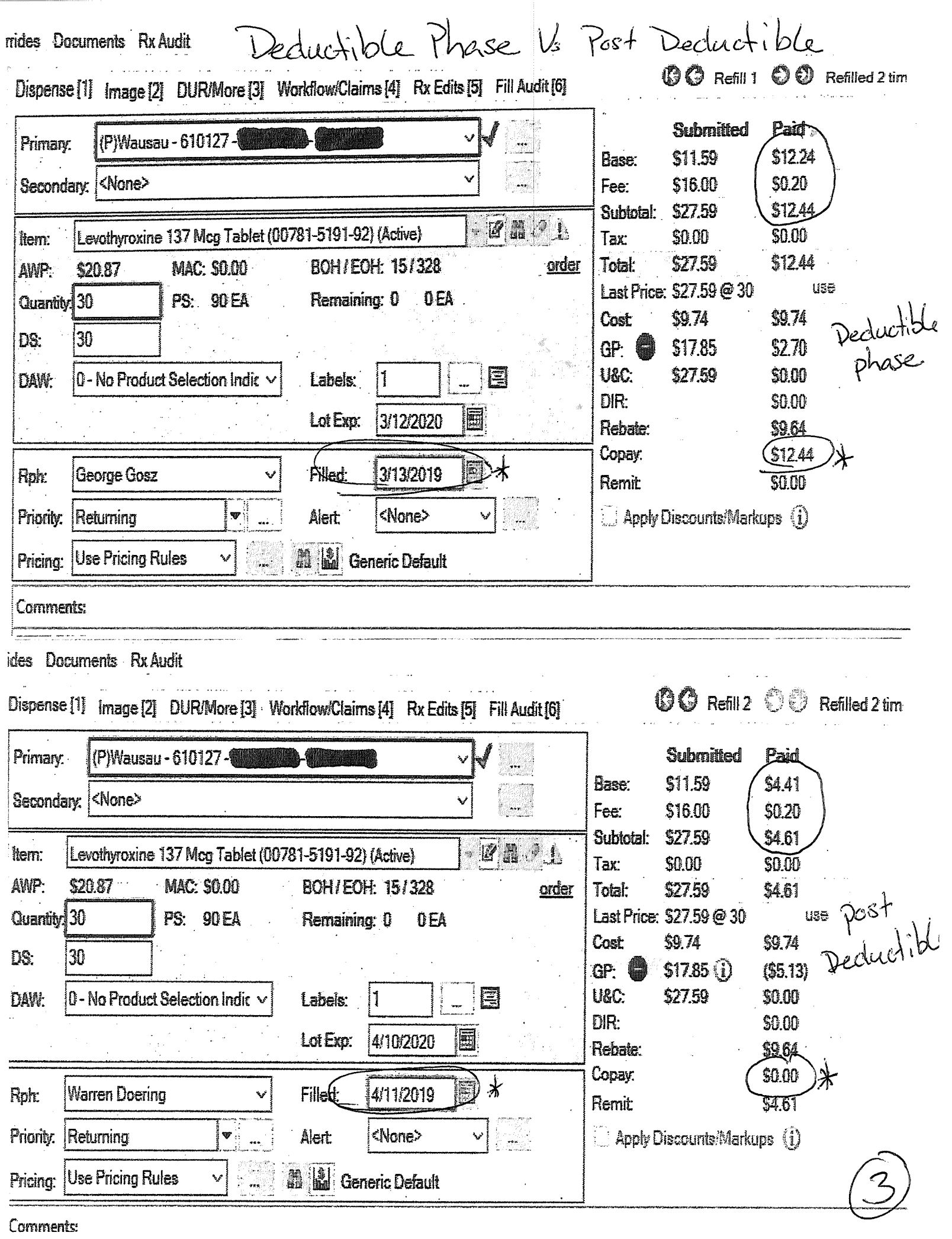
	Submitted	Paid
Base:	$99.00	$13.96
Fee:	$5.00	$4.15
Subtotal:	$104.00	$18.11
Tax:	$0.00	$0.00
Total:	$104.00	$18.11
Last Price:	$104.00 @ 30	use
Cost:	$3.51	$3.51
GP:	$100.49	$14.60
U&C:	$104.00	$0.00
DIR:		$0.00
Rebate:		$3.47
Copay:		$18.11
Remit:		$0.00

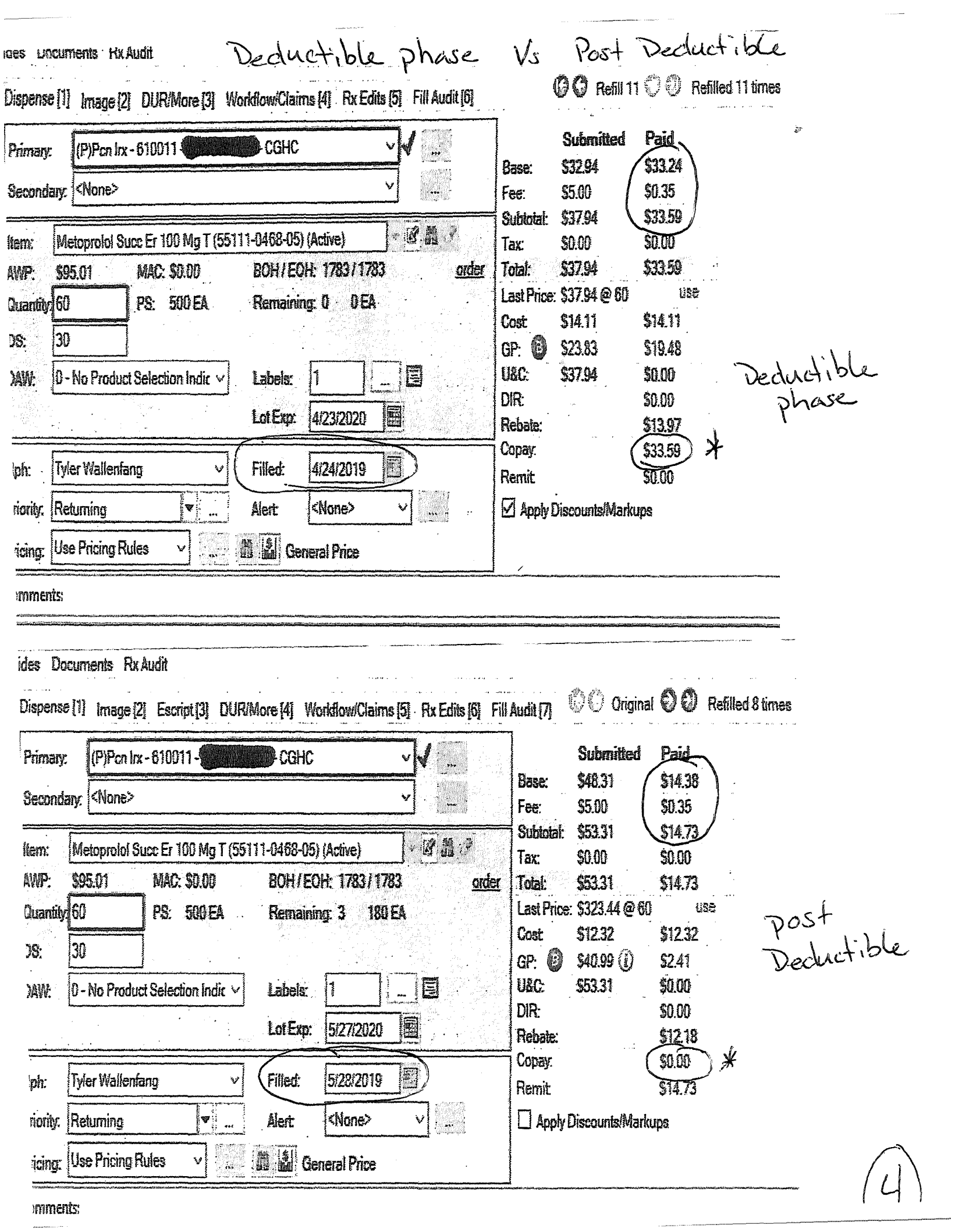
Apply Discounts/Markups

Hometown Cash

Comments:

(2)


rides Documents Rx Audit
Deductible Phase Vs Post Deductible
Dispense [1] Image [2] DUR/More [3] Workflow/Claims [4] Rx Edits [5] Fill Audit [6]
Refill 1
Refilled 2 tim
Primary: (P)Wausau - 610127 -
Secondary: <None>
Item: Levothyroxine 137 Mcg Tablet (00781-5191-92) (Active)
AWP: $20.87 MAC: $0.00 BOH / EOH: 15 / 328 order
Quantity: 30 PS: 90 EA Remaining: 0 0 EA
DS: 30
DAW: 0 - No Product Selection Indic
Labels: 1
Lot Exp: 3/12/2020
Rph: George Gosz
Filled: 3/13/2019
Priority: Returning
Alert: <None>
Pricing: Use Pricing Rules
Generic Default
Comments:
Submitted Paid
Base: $11.59 $12.24
Fee: $16.00 $0.20
Subtotal: $27.59 $12.44
Tax: $0.00 $0.00
Total: $27.59 $12.44
Last Price: $27.59 @ 30 use
Cost: $9.74 $9.74
GP: $17.85 $2.70
U&C: $27.59 $0.00
DIR: $0.00
Rebate: $9.64
Copay: $12.44
Remit: $0.00
Apply Discounts/Markups
Deductible phase
ides Documents Rx Audit
Dispense [1] Image [2] DUR/More [3] Workflow/Claims [4] Rx Edits [5] Fill Audit [6]
Refill 2
Refilled 2 tim
Primary: (P)Wausau - 610127 -
Secondary: <None>
Item: Levothyroxine 137 Mcg Tablet (00781-5191-92) (Active)
AWP: $20.87 MAC: $0.00 BOH / EOH: 15 / 328 order
Quantity: 30 PS: 90 EA Remaining: 0 0 EA
DS: 30
DAW: 0 - No Product Selection Indic
Labels: 1
Lot Exp: 4/10/2020
Rph: Warren Doering
Filled: 4/11/2019
Priority: Returning
Alert: <None>
Pricing: Use Pricing Rules
Generic Default
Comments:
Submitted Paid
Base: $11.59 $4.41
Fee: $16.00 $0.20
Subtotal: $27.59 $4.61
Tax: $0.00 $0.00
Total: $27.59 $4.61
Last Price: $27.59 @ 30 use
Cost: $9.74 $9.74
GP: $17.85 ($5.13)
U&C: $27.59 $0.00
DIR: $0.00
Rebate: $9.64
Copay: $0.00
Remit: $4.61
Apply Discounts/Markups
post Deductible
3


Deductible phase Vs Post Deductible
ides Documents Rx Audit
Dispense [1] Image [2] DUR/More [3] Workflow/Claims [4] Rx Edits [5] Fill Audit [6]
Refill 11 Refilled 11 times
Primary: (P)Pcn Irx - 610011 - CGHC
Secondary: <None>
Item: Metoprolol Succ Er 100 Mg T (55111-0468-05) (Active)
AWP: $95.01 MAC: $0.00 BOH / EOH: 1783 / 1783 order
Quantity: 60 PS: 500 EA Remaining: 0 0 EA
DS: 30
DAW: 0 - No Product Selection Indic
Labels: 1
Lot Exp: 4/23/2020
Rph: Tyler Wallenfang
Filled: 4/24/2019
Priority: Returning
Alert: <None>
Pricing: Use Pricing Rules
General Price
Comments:
Submitted Paid
Base: $32.94 $33.24
Fee: $5.00 $0.35
Subtotal: $37.94 $33.59
Tax: $0.00 $0.00
Total: $37.94 $33.59
Last Price: $37.94 @ 60 use
Cost: $14.11 $14.11
GP: $23.83 $19.48
U&C: $37.94 $0.00
DIR: $0.00
Rebate: $13.97
Copay: $33.59 *
Remit: $0.00
Apply Discounts/Markups
Deductible phase
ides Documents Rx Audit
Dispense [1] Image [2] Escript [3] DUR/More [4] Workflow/Claims [5] Rx Edits [6] Fill Audit [7]
Original Refilled 8 times
Primary: (P)Pcn Irx - 610011 - CGHC
Secondary: <None>
Item: Metoprolol Succ Er 100 Mg T (55111-0468-05) (Active)
AWP: $95.01 MAC: $0.00 BOH / EOH: 1783 / 1783 order
Quantity: 60 PS: 500 EA Remaining: 3 180 EA
DS: 30
DAW: 0 - No Product Selection Indic
Labels: 1
Lot Exp: 5/27/2020
Rph: Tyler Wallenfang
Filled: 5/28/2019
Priority: Returning
Alert: <None>
Pricing: Use Pricing Rules
General Price
Comments:
Submitted Paid
Base: $48.31 $14.38
Fee: $5.00 $0.35
Subtotal: $53.31 $14.73
Tax: $0.00 $0.00
Total: $53.31 $14.73
Last Price: $323.44 @ 60 use
Cost: $12.32 $12.32
GP: $40.99 $2.41
U&C: $53.31 $0.00
DIR: $0.00
Rebate: $12.18
Copay: $0.00 *
Remit: $14.73
Apply Discounts/Markups
Post Deductible
4

LEGISLATIVE HEARING -SB100

My name is Mike Zagelow. I'm a pharmacy owner in Fort Atkinson and have also previously worked in multiple corporate pharmacy roles.

What PBMs cost the residents of Wisconsin will only begin to come to light if you bring this bill to fruition. I realize SB100 won't solve everything immediately but the needed PBM oversight and transparency has to start somewhere.

"Power tends to corrupt, and absolute power corrupts absolutely."

The phrase Lord Acton coined in 1887 has never been more appropriate than with the current state of the Pharmacy Benefit Management industry.

Being able to monopolize access medication coverage has empowered PBMs to the point of corruption.

REBATES- See the attached example.

PBMs force manufacturers to pay to have their products on formulary with no responsibility to disclose or share rebates with the patients they cover and no responsibility for resulting product changes to be in the best financial interest of the patients or the plan sponsor.

IL's husband is a GM retiree and her PBM is Express scripts. Express Scripts mandates brand name Humalog for $454 (we lose $34) while the generic would cost $234 (and we lose $17). It looks to the patient like they are getting a good deal with only a $15 copay but what they don't realize is their plan has to pay an extra $220 each month for the brand name with no certainty that Express Scripts will disclose or share whatever rebate they are getting that lead them to cover a brand name that costs and extra $3000 per year.

WE NEED PBM TRANSPARENCY AND OVERSIGHT

PREFERRED PHARMACIES

The "preferred pharmacy" designation is a way of controlling pharmacy access and forcing patients to the pharmacy the PBM chooses. PBM's will tell you this is a necessary negotiating tool to negotiate lower reimbursements but what they won't tell you is that they usually working to force patients to pharmacies where they have an ownership stake and it benefits the PBM rather than the patient.

SB and her husband were 30 year customers at my pharmacy. The husband has significant health issues and SB is the bread winner at a local company Nasco. This year Nasco employees were forced to mandatory mail order. Prescriptions have taken more than two weeks and it takes a half hour on hold to a NON-RPh about their medications. I have been filling meds RB (the husband) needs when mail order doesn't get them there, either at a reduced cash price or by calling his PBM so they can override prescriptions to go through at a loss for me. I've also been answering patient questions when they can't get through to Servu. Who is going to take care of customers like these if we let PBM's drive out the community pharmacies and force everyone to PBM owned mail order facilities?

WE NEED PBM OVERSIGHT

MG is retired and stays at home to care for husband GG. They had Aetna and could only go to Shopko but when Shopko closed they were told they had to go out of town to CVS or pay $47 per Rx while it would be $0 copy at CVS. MG no longer drives and they are dependent on our delivery service that can get any new medications to GG (the huysband) the same day they are ordered. We put MG on a charge account to help her absorb the higher copays until we could eventually get her on a new Med D plan.

If we really want true competition in the marketplace for the best and most affordable care we should legislate that patients be able to go to their pharmacy of choice so that all pharmacies are held accountable by freedom of choice, not because they are locked in financially.

WE NEED PBM OVERSIGHT

SPECIALTY PHARMACY

PBM's use the term specialty pharmacy inconsistently and will tell you that the reason for this designation is to ensure patients are well cared for when taking meds that require extra monitoring.

My patient JM was forced by his PBM to get his expensive cancer drug Xtandi from a specialty pharmacy by his PBM. Their failure to screen for the interaction between Xtandi with his antiarrhythmic drug diltiazem landed JM in the ER with a racing heart and later on meds for anxiety. Screening for interactions by simply having all his records together at one pharmacy would have protected JM.

I submit to you that the greatest driver of closed specialty networks is to force these high $ Rx's to corporate partners of PBMs.

WE NEED PBM TRANSPARENCY AND OVERSIGHT

DISCOUNT CARDS - See the attached example

This is a racket that PBM's exploit as well. I have a patient from Scotland who gets medication from me. He doesn't have insurance so he brought in a pharmacy discount card administered by Optum Rx that he received for being in AARP. Our cash price for the first medication I test was $17 and we made about $3. If we ran it under the Optum discount card the patient was charged $169.15 and Optum clawed back $164.38 leaving the pharmacy with a loss of $9.32 and the patient with a copay that would be $152 higher... of course we didn't run it but obviously there who would or the card's wouldn't exist. I shared this information with the patient who exclaimed "what a racket" in his best Scottish accent and commented that PBM's make him miss the simplicity of socialized medicine back home.

WE NEED PBM TRANSPARENCY AND OVERSIGHT

SPREAD

PBMs charge insurance companies or governments a higher price for

medications and reimburse pharmacies at much lower rate without sharing or disclosing the difference known as spread.

WE NEED PBM TRANSPARENCY

AUDIT

PBMs use control over access to medication coverage to force pharmacies to accept onerous audit rules that they then use as a revenue source. Audits are an understandable part of any business but the use of disproportionate penalties in response to inconsequential clerical errors is frustrating and the fact the PBM's are not required to share the audit recoupments with plan sponsors is maddening.

WE NEED PBM TRANSPARENCY AND OVERSIGHT

REIMBURSEMENT

PBMs use control over access to medication coverage to force pharmacies to accept reimbursement rates where many prescriptions are filled at a loss...leading to pharmacy closures and less competition for the PBM's chain pharmacy partners and less competition for the PBM owned mail order pharmacies.

PBMs have become adept at the creation of complicated pricing schemes.

A typical PBM contract that a pharmacy must sign or risk losing access to patients uses a % discount off a fictitious list price called "average wholesale price" (or AWP), sometimes adding in a small dispensing fee and then subtracting large penalties for direct and indirect remuneration known as DIR fees that can be charged to the pharmacy months later.

WE NEED PBM TRANSPARENCY AND OVERSIGHT

DIR FEES

Began as a way to drive performance, these fees for Direct and Indirect Remuneration have become an expanding revenue source for PBM's

These DIR fees are based on grading scales that the PBM's themselves create with measurements set to ensure they are able to pull more money back from the pharmacies providing patient care.

DIR fees alone are a key factor in the many pharmacy closings we have seen over the last few years and PBM's in Wisconsin are NOT currently required to share the fees they collect with patients or plan sponsors.
WE NEED PBM TRANSPARENCY AND OVERSIGHT

LETTERS
We have come to expect that with each new plan year, varying PBM's will send false or misleading letters to patients in an attempt to move market share to mail order or chain pharmacy partners with no retraction once inaccuracies are pointed out and no current regulating authority to hold them accountable.
WE NEED PBM TRANSPARENCY AND OVERSIGHT

I voice my support today for Senate Bill 100

I acknowledge that with every bill there is some level of compromise but I ask that you resist the pressure from the PBM industry to water down these bills to remove the teeth from this legislative effort.
WE NEED PBM TRANSPARENCY AND OVERSIGHT

Thank you.

PATIENT LOSES- PLAN SPONSOR LOSES-PHARMACIST LOSES
PBM WINS

PBM, <u>because of rebates</u>, disincentivizes the patient from choosing the Generic ($235 copay) for the more expensive brand name ($15 copay);

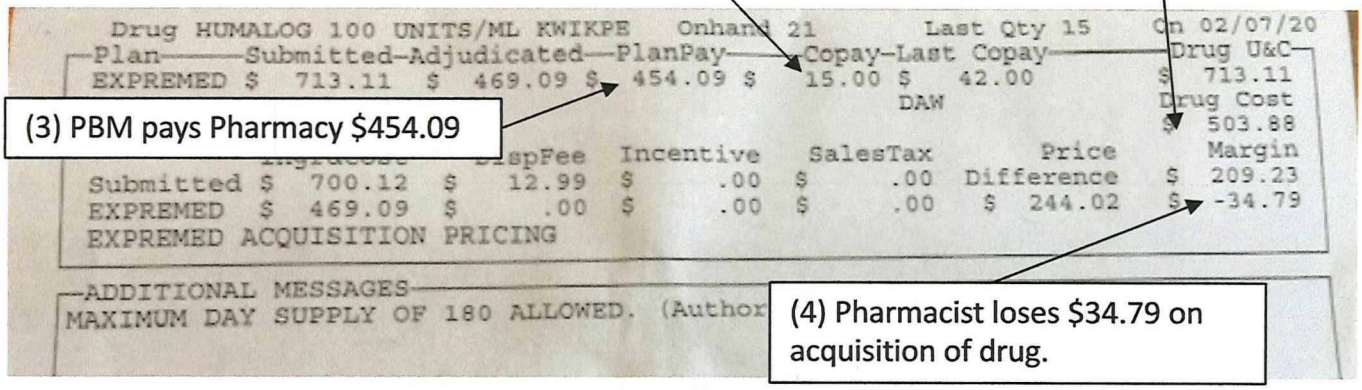
- Plan sponsor loses because they are paying nearly double for the more expensive drug.
- Patient loses because the cost will eventually show up in the premium.
- Pharmacist loses because they aren't being fully reimbursed for the cost of the drug in either scenario, let alone covering dispensing.

Humalog 100 UNITS/ML (Brand name Insulin)

(1) Brand name drug cost $503.88 (straight cost of the Drug to Pharmacy*)

(2) PBM sets patient copay at $15 for brand name drug

(3) PBM pays Pharmacy $454.09



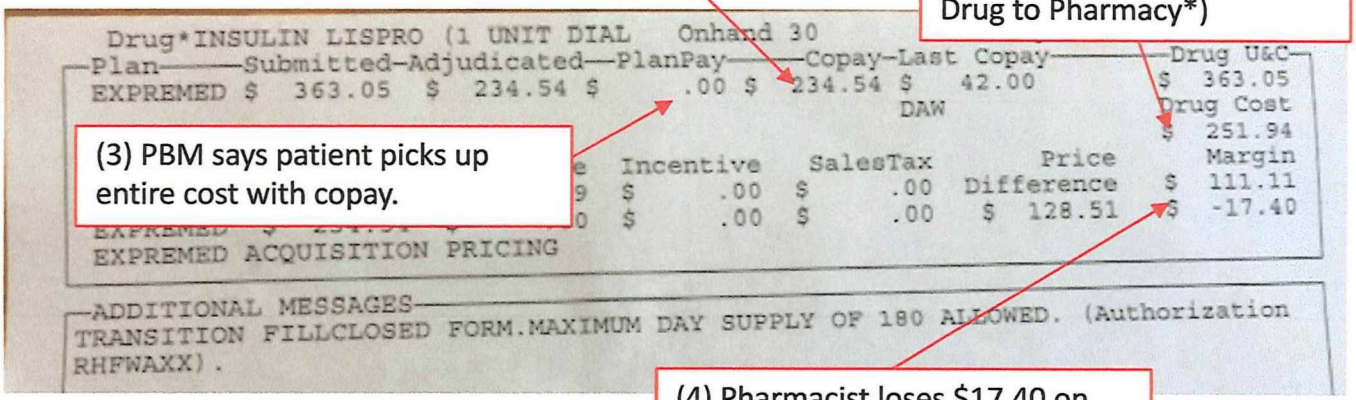
(4) Pharmacist loses $34.79 on acquisition of drug.

LISPRO (1 unit dial) (Generic Insulin)

(2) PBM says patient copay on generic is $234.54

(1) Generic drug cost $251.94 (straight cost of the Drug to Pharmacy*)

(3) PBM says patient picks up entire cost with copay.



(4) Pharmacist loses $17.40 on acquisition of drug.

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

Nasco
to
Mail Order

To Whom it May Concern,

We - at our workplace were told starting in January of 2020 we had to use mail order service & not be able to go to the pharmacy of our choice. If we went to our pharmacy instead of mail order our drugs would not be covered. A lot of us would rather get our prescriptions locally at a pharmacy we choose in person & know they are in hand, a person Face to face to talk to & not being lost in mail or mix up or late. I've heard stories (both good & bad of mail order service - some who tried it liked it, others did not. We were told we have to use this or not be covered to keep the medications cheaper for us. Before they are mailed out to you must pre-pay them which could be a problem if there is a problem (you are charged & can't return drugs. I wish to keep my name & work place anonymous via the HIPPA Law.

Thank-you & Good Luck

Forced to Preferred out of town pharmacy

Feb. 2 - 2020

Wisconsin State Legislature
State Capitol
Madison, Wi.

To all Legislators:

Permit me to share a very upsetting and troublesome problem that affected my husband and myself concerning our Part D prescription insurance program:

My husband, Eighty-Five years of age suffered a stroke some time ago. He lost his short-term memory and is in the beginning stages of Dementia. He can no longer drive a car.

I, his wife, Eighty-Two years old, is his sole care-giver. Since we have no children or family nearby, it is one of my tasks to take care of his many medications.

Our insurance directed us to use Shop-Co as the only pharmacy they would allow, which we did for a number of years.

Then as you know, Shop-Co went out of business and we were informed by

our insurance that we must now obtain our prescriptions from pharmacies outside our city.

I no longer drive out of the city limits. I'm just grateful I can obtain other medical needs, groceries, etc. within our city of Fort Atkinson.

We could not change insurance companies for the window was not open to do ~~this~~ thus causing many, many months of a perplexing situation.

I'm writing to ask you as legislators to regulate our drug companies in this matter. I do not feel they should have the power to tell us where we can obtain our prescriptions.

It happens within our city of Fort we have a splendid Hometown Pharmacy that even offers the free service of delivery! This a rare gift to senior citizens.

Please give us free choice to use them as our pharmacy!

Thank you for reading this letter and then working on this serious problem.

Grant & Marlene Hentz
457 Cherokee Ln.
Fort Atkinson, WI.

Drug SILDENAFIL CITRATE 20 MG TA Ohmaid 432 Last Qty 30 On 02/11/20

Plan	Submitted	Adjudicated	PlanPay	Copay	Last Copay	Drug U&C
195	$ 673.08	$ 4.77	$ -164.38	$ 169.15	$ 17.24	$ 673.08
				DAW		Drug Cost
						$ 14.09

	IngrdCost	DispFee	Incentive	SalesTax	Price	Margin
Submitted	$ 660.09	$ 12.99	$ .00	$ .00	Difference	$ 658.99
195	$ 3.27	$ 1.50	$ .00	$ .00	$ 668.31	$ -9.32

195 INGREDIENT COST PAID AT MAC PRICE

ADDITIONAL MESSAGES
(Authorization 200425215946027999).

Discount card claw back (what optum gets)

Discount card price

Cash price

Plan Paid

F1 Cont F3FinishF4Copay F5FaxPrtF6Trace F7DetailF8Revers

Optum Administered Discount Card for AARP

what pharmacy whole profit using discount card → 9.32

PBM's

Address to Wisconsin's Senate

Mr. Chairman and committee members, I'm Dave Schultz, pharmacist 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**. We've experienced and adapted to many business challenges over the years, but we have never faced anything as unscrupulous and unfair as the current reimbursement model being forced upon community pharmacies by the PBM's.

I urge the senate to pass bill 100 pertaining to the regulation of activities by Pharmacy Benefit Managers, in the state of Wisconsin.

In fiscal 2019, Tobin's paid $92,623.00 in DIR fees which was an 81% increase over the prior year.

In the first three months of fiscal 2020 **DIR fees have increased by <u>44%</u> over last year!**

31,586.92	2020
21,955.60	2019
9,631.32	Difference

Twenty one percent of all the prescriptions we fill at Tobins are being paid by the PBM's **<u>below</u> the cost of the medication.** (See Attachment)

In fiscal 2019, **we lost $55,384 on $2,692,651 of prescription sales** because the PBM's are being allowed to arbitrarily pay and take whatever they want from community pharmacies.

During the assembly hearing, the common theme from the PBM side was that they do not want legislators to pass any regulations that might increase the cost of healthcare to businesses or patients. My question for them is, why are they disproportionately targeting those of us in the trenches who are providing the care? Why are PBM's placing the burden on community pharmacies while nothing is being done to control big Pharma drug increases or reducing PBM profits and executive bonuses? We need real transparency, not smoke and mirrors.

Patients have already experienced the forced pharmacy staff layoffs due to the huge DIR fee increases. These staff reductions will lead to DIMINISHED PATIENT CARE, increased drug related injuries, hospitalizations, deaths and **YES increased healthcare costs**! 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 particularly affecting those living in underserved rural communities.

I have attached a Florida Pharmacy Association Report that highlights some of the unfair practices PBM's are allegedly involved in. Although the cost-of-dispensing (COD) incurred by pharmacists in Florida is $10.24 per claim, according to the state's COD analysis, it found that pharmacies were paid a weighted average of $2.72 per claim in 2018 which is **a loss of $7.52**. The authors noted, however, that not all pharmacies seem to be experiencing this pressure equally. In 2018, **the state's 5 largest specialty pharmacies collected 28%** of the available profits paid to all providers in Florida Medicaid managed care, **despite dispensing just 0.4% of all managed care claims**. And to top it off, **PBM's were found to pay their own affiliated pharmacies differently than independent community pharmacies**. The example cited was generic Abilify, **the CVS affiliated pharmacy was paid $11.18 while the community pharmacy was paid $0.53 for the same medication**. That really sounds fair doesn't it? I want to point out that PBM's tell us what to charge for their member's prescription. Therefore, they can charge a higher price when a patient comes to their local pharmacy and a much lower price when the patient has their prescription filled at a PBM affiliated pharmacy or mail order. In addition, PBM's expect pharmacists to **convince the physician** to prescribe a medication to their members that meets the PBM's health guide lines. Pharmacies get **penalized** if they don't convince the doctor. Talk about the tail wagging the dog!

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 extract 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. When the results of the audit are mailed to us and a deduction in payment is taken by the PBM, the 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. We also learned in**

the Assembly hearing that pharmacies in Wisconsin are audited at a higher rate than neighboring states that have passed necessary audit reform. I wonder why?

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 PBM has cut a deal with the brand drug manufacturer. This requirement reduces cash flow and places greater burden on an already stretched to the limit inventory budget. The PBM's claim this pay to play practice lowers healthcare costs, but if it does it once again is at the expense of community pharmacies!

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.

If half the money that big Pharma and the PBM's spend on consumer advertising was spent on health education, healthcare costs would decrease, but wait, there is no profit in that for big Pharma or PBM's so I guess that isn't an option!

It's time for you, our senators to rein in the unprincipled activities of the PBM's in Wisconsin by passing Senate bill 100. These **profit driven** corporations cannot be allowed to avoid state regulation and engage in abusive, manipulative and deceptive business practices. **You as legislators have an opportunity to begin to level the playing field to the benefit of patients and community pharmacies**. The time to act is now! Please vote YES to passing Senate bill 100 before it's too late.

Mr. Chairman, committee members, thank you for giving me the opportunity to speak to you this afternoon.

Florida Pharmacy Association Report Outlines Concerns About PBM, MCO Manipulations

2020-02-05 19:00:00

Aislinn Antrim, Assistant Editor

Editor's Note: This article was updated 3:32 pm February 6, 2020 with additional information.

A new report from the Florida Pharmacy Association and American Pharmacy Cooperative, Inc, alleges that pharmacy benefit managers (PBMs) in the state are favoring their own affiliated pharmacies in the Florida Medicaid program, both by driving customers to those pharmacies and by reimbursing them at higher rates.[1]

"This report reinforces the need for Congress to reform Medicaid managed care," said National Community Pharmacists Association CEO B. Douglas Hoey, RPh, MBA, in a statement.[2]

Although the cost-of-dispensing (COD) incurred by pharmacists in Florida is $10.24 per claim, according to the state's COD analysis, this required pharmacy reimbursement methodology does not apply to Medicaid managed care organizations (MCOs) that contract with PBMs. The report's analysis of Florida's top 7 MCOs found that pharmacies were paid a weighted average of $2.72 per claim in 2018—significantly lower than the $10.24 COD and down from $7.70 in 2014.[1]

The authors noted, however, that not all pharmacies seem to be experiencing this pressure equally. In 2018, the state's 5 largest specialty pharmacies collected 28% of the available profits paid to all providers in Florida Medicaid managed care, despite dispensing just 0.4% of all managed care claims.[1]

Based on these findings, the authors wrote, "MCOs and PBMs appear to be using their control in managed care to incrementally shift dollars to their affiliated companies."[1]

Generic and Branded Drug Spend Analysis

The authors said PBMs set generic prices differently for different pharmacies, which can create a significant advantage for pharmacies affiliated with the PBM. For example, they noted the displacement of Walgreens pharmacies by CVS pharmacies in both Staywell/Wellcare and Sunshine/Centene MCOs during the period when CVS Caremark was providing PBM services to those organizations.[1]

Furthermore, the report said payments for generic drugs vary greatly across MCOs and between PBMs within the same MCO. As an example, the authors noted that in 2018, Sunshine/Centene (managed partly by CVS Caremark) reported the cost of generic aripiprazole (Abilify, Otsuka America Pharmaceutical) to be $11.18, $0.53, and $0.24 at CVS, Small Pharmacies, and Public, respectively.[1]

Finally, the authors said MCOs and PBMs frequently require generic specialty drugs to be dispensed at their affiliated pharmacies, and the reported payments to these pharmacies then far exceed their COD.[1]

When it comes to branded drugs, the authors said similar manipulations occur. They noted that claims

dispensed at affiliated or specialty pharmacies are being reported with a weighted average margin over acquisition cost of up to $200 per claim within Florida's MCOs. The integration of payers, PBMs, and affiliated pharmacies therefore locks out market competition, the authors said, which could bring savings to Florida Medicaid.[1]

"These hidden mechanisms can create incentives in the supply chain to dispense certain drugs over others, which is tantamount to serving some patients over others," the authors said.[1]

In a response to the accusations, a representative from the Pharmaceutical Care Management Association (PCMA), a national trade association that represents PBMs, said the group behind the report is seeking higher profits at the expense of patients, who they said would pay more for prescriptions.

"In fact, there are over 32% more independent pharmacies open today in Florida than 10 years ago," the statement from PCMA said.[3]

CVS Health also responded to the report in an email to *Pharmacy Times*. In a prepared statement, the national company cited lowering member costs as a key priority for the business, and that CVS Health never forces customers to utilize a CVS Pharmacy.[4]

"Every day, PBMs work with employers, managed care organizations, and commercial health plans throughout Florida to reduce prescription drug costs for our members and improve their health," the statement said.[4] "Our members have access to a broad and diverse pharmacy network beyond CVS, including independent pharmacies. Members can receive access to their medications throughout our network of 68,000 pharmacies, including independent and mail-order pharmacies."

According to CVS Health, it suppoorts independent pharmacies, and data from the National Community Pharmacists Association indicates that the number of independent pharmacies in the state increased from 2011 to 2018. "Florida's independent pharmacies are valuable members of our network and in the aggregate, CVS Caremark reimburses them at a higher rate than chains, including CVS Pharmacy," the company continued.[4]

Overall Drug Spend and Reimbursement Trends

The report concluded with several key trends for Florida Medicaid's pharmacy profitability, based on their previous analyses of the various players and their roles, including ever-rising prices and lower reimbursements; however, PCMA disputed this claim.

"In Florida, PBMs will save consumers and health care programs more than $43 billion over 10 years, and have helped the state Medicaid program save $2.3 billion," the statement from PCMA noted.[3]

According to the report, overall margins offered by Florida's top 6 MCOs to the state's pharmacy providers have materially declined from $7.43 in 2014 to a low of $3.45 per claim in 2019. This decline, they said, is partially attributable to increased mergers in the state. Specifically, recent mergers among the largest MCOs in the state within Florida Medicaid could risk worsening the financial picture for small pharmacies.[1]

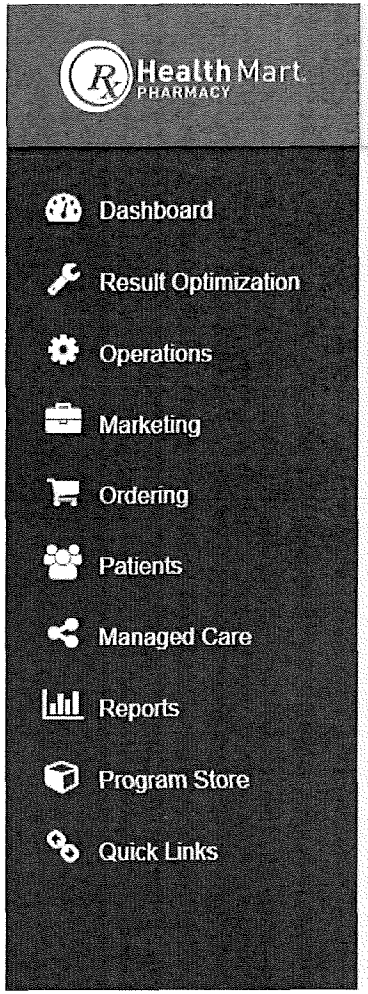
"The market is being rigged by the PBMs against community pharmacies and their patients," Hoey said in a statement.[2]

Although the report is concerning, Hoey added that independent pharmacies are still vital to patient care.

"Despite that, surveys of pharmacies repeatedly demonstrate that independently owned pharmacies lead the pack in pleasing consumers," he said.[2]

REFERENCES

1. Sunshine in the Black Box of Pharmacy Benefits Management: Florida Medicaid Pharmacy Claims Analysis. National Community Pharmacists Association, January 30, 2020. ncpa.co/pdf/florida-3aa-medicaid-pharmacy-analysis.pdf. Accessed February 4, 2020.
2. NCPA: Fla. Report a Searing Indictment of PBM Greed in Medicaid [news release]. National Community Pharmacists Association, January 30, 2020. https://www.ncpanet.org/newsroom/news-releases/2020/01/30/ncpa-fla.-report-a-searing-indictment-of-pbm-greed-in-medicaid-neighborhood-pharmacies-urge-accountability-action-to-rein-in-pbms. Accessed February 4, 2020.
3. RE: Seeking Statement on NCPA Florida Report [email]. February 4, 2020.
4. CVS Health Statement on Florida story. [email] February 6, 2020



Tobin's Health Mart Pharmacy, ...

New

Generics Campaign for February 2020

Don't miss out on the generics promotional items valid through February 29, 2020! Learn More

PERFORMANCE METRICS

Favorites | Financial | Operational | Clinical | Marketing

Set Goals

Edit

Underwater Claims

Metric Details

Percentage of claims paid below ingredient cost: The % of claims underwater are those where the reimbursement was less than the estimated cost of the drug.

Value Change

2.69% Change between months- Data Range: Dec 2019 vs. Nov 2019

3.8% Change since January- Data Range: Dec 2019 vs. Jan 2019

TOBIN DRUG OCONOMOWOC INC
PBM FEE INCREASES

FISCAL YEAR	PBM FEES	$ INC	% INC
2019	92,623.24	41,517.96	81%
2018	51,105.28	31,906.56	166%
2017	19,198.72	5,610.48	41%
2016	13,588.24	3,566.18	36%
2015	10,022.06		

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														(517,075.30)	
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	(55,383.63)	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%	-2.06%	

Other Expenses

Rebates from McKesson	(136,117.00)	COGS account
Rebates from McKesson	(9,996.00)	$833 in Rebate & Discount Account
Rx Processing Fees	119,514.61	
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	23,311.82	
CAM	2,490.00	
Utilities (Phone, Trash, Elec)	4,985.00	
Total Other Expenses	**517,075.30**	

LOSS PER PRESCRIPTION **(1.24)**

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

Rxs Filled Fiscal 2019 44,676

Pharmacy Society of Wisconsin

TO: Senate Committee on Health & Human Services

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

DATE: February 12, 2020

SUBJECT: **Testimony in Favor of Senate Bill 100**

Thank you, members of the Senate Committee on Health & Human Services, for the opportunity to provide testimony in support of Senate Bill 100. My name is Matt Mabie and I am the Chairman of the Board of Directors of the Pharmacy Society of Wisconsin. 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.

701 Heartland Trail
Madison, WI 53717
t: 608.827.9200 f: 608.827.9292
info@pswi.org www.pswi.org

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 SB 100. I am happy to answer any questions you may have.

TO: Senate Committee on Health

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

DATE: February 12, 2020

SUBJECT: **Testimony in Favor of Senate Bill 100**

Thank you, members of the Assembly Committee on Health, for the opportunity to provide testimony in support of Senate Bill 100. 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 incentivizing 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 SB100 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

To:	Members, Senate Committee on Health and Human Services
From:	Rebecca Hogan, on behalf of the Alliance of Health Insurers
	Mary Haffenbredl, on behalf of America's Health Insurance Plans
Date:	February 12, 2020
Re:	Testimony on SB 100 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[1] 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.[2]

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.

---

[1] *National Health Expenditure Projections, 2018*

[2] *National Health Expenditure Projections, 2017-2016*.

- 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.[3] 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.[4]

Because Senate Bill 100 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 bill authors and other legislative leaders 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.

---

[3] *The Return on Investment (ROI) of PBM Services*. Visante on behalf of PCMA. November 2016

[4] *Prescription Drug Benefit Cost and Plan Design Report.* Pharmacy Benefit Management Institute. July 2015.

WMC

WISCONSIN MANUFACTURERS & COMMERCE

MEMO

TO: Senate Committee on Health and Human Services

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

RE: Testimony on Senate Bill 100

DATE: February 12, 2020

Chairman Testin and members of the committee, thank you for the opportunity to testify on Senate Bill 100 today. Senators Erpenbach and Roth, 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) as partners 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 SB 100, 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 Senate.

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.

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

Statement on Senate Bill 100

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.

MMAC
Metropolitan Milwaukee
Association of Commerce

SB 100 TESTIMONY

Steve Baas, Senior VP Government affairs and Public Policy
Metropolitan Milwaukee Association of Commerce
February 12, 2020

While on its face this bill might seem to be a highly technical debate between different business models in the health care, insurance and pharmaceutical sectors, MMAC has a keen interest in this legislation because of the very practical "downstream" impacts the regulations under discussion here have on the availability and affordability of health care for private sector employers.

Over the past decade, employers have become increasingly creative in finding ways to offer and expand affordable health care options to their employees. Things like discount and mail order prescriptions, exclusive plan contracts, cost-based employee incentives, and plan flexibility have all been used as effective tools for providing more benefits at less cost to our employers.

We appreciate the hard work the authors, the legislative leadership and all the interests impacted by this bill have been doing to be sensitive to concerns like ours and craft a consensus version of this legislation that does not add additional complexity and cost to the already cumbersome health care challenges faced by employers.

There is an old proverb that "When bull elephants fight, the grass always loses." As you work to address the concerns of the 'bull elephant' industry sectors struggling over the technical details of this legislation, I hope you will bear in mind that private employers are the ones on the front lines of both health care access and health care affordability for the majority of our state's residents. In light of that fact, I urge you to remain sensitive to the impact your decisions may have on the ability of businesses large and small across our state to creatively control health care costs and increase health care accessibility for their workers.

###

756 North Milwaukee Street, Suite 400 • Milwaukee, Wisconsin 53202
Phone (414) 287.4100 • Fax (414) 271.7753 • mmac.org

TO: Representative Michael Schraa
Representative Debra Kolste
Senator Roger Roth
Senator Jon Erpenbach

FROM: Alliance of Health Insurers
America's Health Insurance Plans
Pharmaceutical Care Management Association
Wisconsin Association of Health Plans

DATE: May 3, 2019

RE: Concerns with Senate Bill 100/Assembly Bill 114 ("PBM Bill")

As health insurance providers and pharmacy benefit managers (PBMs), we are committed to providing Wisconsin patients with quality, affordable health care coverage. Out-of-control prescription drug prices are getting in the way of Wisconsin patients' access to necessary medications—but the PBM bill does not solve the price problem.

Per your request, we compiled detailed concerns with the bill. Our concerns are organized by the following themes: cost; patient access; patient safety; market competition; pharmacy quality and value-based contracting; fraud, waste, and abuse; freedom of contract; and government regulation. Within these themes, we identify provisions of concern and provide the rationale for our opposition. In some instances, a provision is listed under more than one theme.

We appreciate the opportunity to work with you to ensure Wisconsin patients have affordable access to prescription drugs. As you may know, we support ensuring that patients know about and pay the cash price for a drug if it's lower than their plan's cost-sharing amount. This is already standard industry practice. In addition, so-called pharmacist "gag clauses" were banned by federal legislation passed in October 2018. The federal law can be found here.

Cost Concerns

Many provisions in the PBM bill will increase the cost of drugs and the cost of administering a prescription drug benefit. As the Office of the Commissioner of Insurance (OCI) said in its evaluation of the impact of the bill, the bill contains "numerous requirements for insurers, self-insured plans, and pharmacy benefit mangers that have the potential to increase administrative costs." OCI pointed to the bill's audit requirements, network adequacy requirements, reporting requirements, and cost-sharing limitations as having the potential to increase costs. In addition, OCI noted the PBM bill "may limit insurers from utilizing certain methods currently employed to reduce pharmaceutical costs, which may result in additional prescription drug costs for insurers."

Section 13; 632.861(3); Page 8, Lines 7-19

Description: The bill prohibits a health insurance provider or PBM from requiring an individual to pay any more than the lowest of the following: 1) the applicable copay for a drug; 2) the allowable claim amount for a prescription drug; 3) the amount the person would pay for a drug if the person purchased the drug without insurance or any other source of drug benefits or discounts; 4) the amount the pharmacist or pharmacy is reimbursed for a prescription drug from the PBM or health plan.

Response: As previously mentioned, we support ensuring patients know about and pay the cash price for a drug if it's lower than their plan's cost-sharing amount. However, we oppose using the allowable claim amount (#2) and the amount the pharmacist or pharmacy is reimbursed (#4) because these are negotiated payments based on many interdependent factors—not just the amount charged or reimbursed for a single drug. In addition, there are circumstances in which a health insurance provider is not involved in the payment of a pharmacy (e.g., when a patient has not met their deductible).

We also note that health insurance providers and PBMs do not have advance knowledge of "any other source of drug benefits or discounts" (#3) available to a patient. Furthermore, this clause could be abused by drug manufacturers that provide copay coupons or other incentives to encourage the prescription of high-cost drugs—which raises costs for everyone.

Section 13; 632.861(5)(a); Page 9, Lines 3-10

Description: The bill prohibits a health insurance provider or PBM from requiring an individual to pay increased cost-sharing for a "newly prescribed drug or device" if the substitution for the "originally prescribed drug or device" is suggested by the health insurance provider or PBM and if the "newly prescribed drug or device" is therapeutically equivalent to the "originally prescribed drug or device."

Response: We oppose this provision because it assumes a static drug market that does not exist. New drugs come to market on an ongoing basis and drug manufacturers increase the cost of their products multiple times each year. This dynamic market means the relative cost and value of drugs is constantly in flux. Thus, the "originally prescribed drug or device" as described under this bill is likely to have a much higher price than it did previously. Furthermore, the "newly prescribed drug or device" may have greater efficacy or fewer side effects, which delivers a clear benefit to patients. Health insurance providers and PBMs make good faith efforts to minimize the impact of formulary changes on patient cost-sharing, but imposing this statutory requirement could lead to situations that increase costs. In its fiscal estimate for this bill, the Department of Employee Trust Funds (DETF) noted this provision impacts a tool the state uses to contain drug costs for the State Group Health Insurance Program.

Section 13; 632.861(5)(b); Page 9, Lines 11-23

Description: The bill requires a health insurance provider or PBM to ensure that a patient is not denied coverage for or subjected to new exclusions, limitations, deductibles, copayments, or coinsurance if: 1) the prescribed drug or device was covered when the individual either enrolled in or renewed coverage, whichever is later; and 2) the prescribing provider states, in writing, that the drug or device is more suitable for the individual's condition than alternative covered drugs or devices.

Response: We oppose this provision for the same reasons we oppose 632.861(5)(a). This provision renders health insurance providers and PBMs unable to respond to cost concerns in real-time. Under this provision, drug manufacturers could increase their prices mid-year without consequences.

Formularies deliver cost savings by making pharmaceutical manufacturers compete on value. When drug companies increase their prices multiple times each year, health insurance providers and PBMs are forced to revisit their formularies to ensure drugs are available at an affordable price. Furthermore, if a new drug comes to market that is more effective and costs less, patients should get the benefit of that better drug at a lower price. There are usually many equivalent drugs to treat a condition, which are evaluated for inclusion on a formulary by independent clinicians based on the best-available evidence. When a formulary is adjusted, it is because a group of experienced clinicians have determined it is clinically appropriate.

Section 13; 632.861(4); Page 8, Lines 20-24; Page 9, Lines 1-2
Description: The bill prohibits a health insurance provider or PBM from "penalizing" an individual for using a specific retail, mail-order, or pharmacy provider within a health insurance provider or PBM's network. A "penalty" includes an increase in premium, deductible, copayment, or coinsurance.

Response: We oppose this section because it will prevent health insurance providers and PBMs from providing patients incentives (i.e., lower cost-sharing) to use lower cost pharmacies, including mail-order and specialty pharmacies. Under this provision, higher cost pharmacies would not be incentivized to provide lower prices. In addition, some patients' out-of-pocket costs would increase because they could no longer financially benefit from using lower cost pharmacies. Providing a patient with lower cost-sharing is a **reward**—not a penalty.

Section 16; 649.10(2)(a); Page 12, Lines 8-13
Description: The bill prohibits health insurance providers and PBMs from requiring a patient to obtain a drug from a mail-order pharmacy because the drug requires special handling, provider coordination, or patient education.

Response: Specialty pharmacies dispense medications that are rarely-used, have serious side effects, and/or treat complex conditions. Drugs dispensed by specialty pharmacies are very expensive, and often require special handling and storage. As a result, many specialty drugs are only available through certain pharmacies. In addition, specialty pharmacy staff coordinate a patient's care by providing close monitoring, collecting data, and sharing that information between the patient's health care providers. On top of providing these valuable services, specialty pharmacies provide drugs at a significant discount. Although specialty medications comprise a small proportion of total prescriptions, they account for an outsized share of drug spending. This means that the discounts offered by specialty pharmacies lead to significant cost savings. In its fiscal estimate, DETF noted that this provision may impact the State Group Health Insurance Program's specialty medication program. DETF said, "The required use of specialty pharmacies increases the quality of clinical services provided to participants and provides cost savings to the state due to negotiated prices with the preferred specialty pharmacy. Projected savings for implementing this program for the 2018 plan year were $1.2 million. The changes proposed in this bill may limit savings to the program." We oppose this provision because it would lead to higher costs and lower quality of care.

Section 16; 649.30(2)(c); Page 14, Lines 17-21
Description: The bill prohibits a PBM from reimbursing a pharmacy or pharmacist less than the amount the PBM reimburses "an affiliate" for providing the same services. The PBM is required to compare the amounts calculated on a per-unit basis using the same generic product identifier or generic code number.

Response: We oppose this provision because contracts differ between pharmacies due to negotiations and they are not always readily comparable at the drug level. Pharmacy contracts also differ by the method of determining "discounts." Without the ability to have different payment terms, PBMs would need to resort to pricing calculations that would fail to take into account all of the nuances of different pharmacies, resulting in higher overall prices for the sake of comparability.

Section 16; 649.30(3)(b); Page 15, Lines 11-12
Description: The bill prohibits a PBM from requiring a pharmacy or pharmacist to enter into one contract in order to enter into another contract.

Response: We oppose this provision because it could be interpreted to allow pharmacies to cherry pick which health insurance provider or PBM clients it will serve, and statutorily prevent health insurance providers and PBMs from ensuring that all their customers receive the benefit of negotiated discounts. This could lead to increased costs for some patients.

Section 16; 649.45(1); Page 19; Lines 11-15
Description: The bill requires a PBM to provide "a reasonably adequate and accessible" network, but prevents mail-order pharmacies from being included in the calculation of network adequacy.

Response: Mail-order pharmacies are often lower-cost and more convenient for patients, and help ensure patients can access drugs no matter where they live. Furthermore, as we described previously, specialty pharmacies provide a higher quality of care while offering significant cost-savings. We oppose this provision because prohibiting these pharmacies from being considered as part of a network adequacy evaluation would likely lead to higher costs. Furthermore, this provision could increase costs by tilting negotiations in favor of pharmacies with no local competitors.

Patient Access Concerns
The PBM bill undercuts the use of mail-order pharmacies, which benefit patients by providing low-cost and convenient access to a variety of prescription drugs—including medications for chronic conditions. In its evaluation of the impact of the bill, OCI said, "limitations on mail-order pharmacies could reduce access to prescription medications for some consumers with limited mobility or with limited access to transportation, particularly in rural communities." For these reasons, we oppose the following provisions:

- Section 13; 632.861(4); Page 8, Lines 20-24; Page 9, Lines 1-2.
- Section 16; 649.10(2)(a); Page 12, Lines 8-13.
- Section 16; 649.30(2)(c); Page 14, Lines 17-21.
- Section 16; 649.45(1); Page 19; Lines 11-15.

Patient Safety Concerns
The PBM bill does not allow health insurance providers and PBMs to respond to prescription drug safety and efficacy data in real-time. The bill also prevents health insurance providers and PBMs from implementing pharmacy standards that help keep patients safe.

Section 13; 632.861(5)(b); Page 9, Lines 11-23
Description: The bill requires a health insurance provider or PBM to ensure that a patient is not denied coverage for or subjected to new exclusions, limitations, deductibles, copayments, or coinsurance if: 1) the prescribed drug or device was covered when the individual either enrolled in or renewed coverage, whichever is later; and 2) the prescribing provider states, in writing, that the drug or device is more suitable for the individual's condition than alternative covered drugs or devices.

Response: We oppose this provision because the known risks and benefits of a drug change over time. For example, additional safety concerns can emerge after a new drug is brought to market and used on a broader, more diverse population than was tested in clinical trials. Based on new data, a drug can be labeled with new safety warnings or even pulled from the market. Health insurance providers and PBMs take safety concerns seriously, and should be able to change their formularies when new data emerge in order to favor drugs that have less dangerous side effects or are comparatively more effective.

Section 16; 649.10(2)(a); Page 12, Lines 8-13
Description: The bill prohibits health insurance providers and PBMs from requiring a patient to obtain a drug from a mail-order pharmacy because the drug requires special handling, provider coordination, or patient education.

Response: Specialty pharmacies dispense medications that are rarely-used, have serious side effects, and/or treat complex conditions. Drugs dispensed by specialty pharmacies are very expensive, and often require special handling and storage. Specialty pharmacy staff also coordinate a patient's care by providing close monitoring, collecting data, and sharing that information between the patient's health care providers. In addition, specialty pharmacies offer tailored patient assistance, such as drug monitoring and adherence programs or 24/7 customer support. These services are not generally offered by a typical retail pharmacy. We oppose this provision because pharmacies that dispense specialty drugs must be able to meet higher-than-normal standards to ensure quality care and patient safety.

Market Competition Concerns
Provisions of the PBM bill limit competition between pharmacies, and undercut health insurance provider and PBM negotiations. The cumulative effect of these provisions will likely be to create an anti-competitive pharmacy market with higher costs.

Section 13; 632.861(4); Page 8, Lines 20-24; Page 9, Lines 1-2
Description: The bill prohibits a health insurance provider from "penalizing" an individual for using a specific retail, mail-order, or pharmacy provider within a health insurance provider or PBM's network. A "penalty" includes an increase in premium, deductible, copayment, or coinsurance.

Response: We oppose this provision because it will prevent health insurance providers and PBMs from providing savings to patients who use lower cost pharmacies. Providing a patient with lower cost-sharing is a **reward**—not a penalty.

Section 16; 649.30(2)(c); Page 14, Lines 17-21
Description: The bill prohibits a PBM from reimbursing a pharmacy or pharmacist less than the amount the PBM reimburses "an affiliate" for providing the same services.

Response: We oppose this provision because it effectively eliminates negotiations by requiring all contracts to be the same. A robust, competitive pharmacy market cannot exist under this provision.

Section 16; 649.45(1); Page 19, Lines 11-15
Description: The bill requires a PBM to provide "a reasonably adequate and accessible" network, but prevents mail-order pharmacies from being included in the calculation of network adequacy.

Response: We oppose this provision because we are concerned that network adequacy standards could exacerbate current challenges in areas with a limited number of pharmacies—primarily rural areas. Costs could significantly increase if a pharmacy takes advantage of the fact that it must be in-network in order for a network to be considered adequate. This is of particular concern when mail-order pharmacies cannot be included in the calculation of network adequacy.

Pharmacy Quality and Value-Based Contracting Concerns

The PBM bill unwisely impedes efforts to create pharmacy networks that provide higher quality care at a lower cost. We are also very concerned that the bill eliminates standards that national accrediting bodies, health insurance providers, and PBMs use to help keep patients safe.

Section 14; 649.30(2)(b); Page 14, Lines 13-16

Description: The bill prohibits health insurance providers and PBMs from requiring a level of quality that is higher than the minimum standards for obtaining a license in this state.

Response: We oppose this provision because simply being licensed to operate a pharmacy is not a marker of a pharmacy's quality of service or concern for safety. Health insurance providers and PBMs should be free to require higher standards for their patients. For example, health insurance providers and PBMs currently can require that pharmacies participate in quality-driven activities like:

- Disease state or medication-specific pharmacist training for high-cost and rarely-used medications;
- Patient outcomes management programs and quality metric reporting; and
- Accreditation to show that best practices beyond the baseline competency needed for licensure are being followed.

These activities indicate a consistent commitment to safe, coordinated, and quality patient care. Statutorily reverting the pharmacy market to the lowest common denominator would jeopardize quality improvement and safety measures required by health insurance providers and PBMs today.

Section 14; 649.30(2)(c); Page 14, Lines 17-21

Description: The bill prohibits a PBM from reimbursing a pharmacy or pharmacist less than the amount the PBM reimburses "an affiliate" for providing the same services.

Response: We oppose this provision because it would interfere with innovative pay-for-performance contracting, which rewards high-performing pharmacies for activities such as improving patient medication adherence or reducing gaps in patient treatment. These value-based activities benefit patients by ensuring safety, improving outcomes, and reducing costs. Value-based, quality-driven contracting focuses on improving patients' health outcomes and should be supported—not obstructed like it is under this bill.

Fraud, Waste, and Abuse Concerns

By setting extremely prescriptive parameters on audit procedures and health insurance provider and PBM contracting, the bill detracts from efforts to combat fraud, waste, and abuse. Health insurance providers and PBMs need greater latitude than is provided under this bill to effectively safeguard individual, employer, and government program dollars. All health care organizations are held responsible for their errors through audits and recoupment of improperly paid funds—pharmacies are not and should not be different. DETF said the audit provisions of this bill "may create opportunities for fraud, waste and abuse, which would directly impact the state's costs."

Section 16; 649.30(4); Page 15, Lines 17-23

Description: The bill prohibits a pharmacy benefit manager from retroactively denying or reducing a claim after adjudication unless the claim was fraudulent, duplicative, or the services were not rendered.

Response: We oppose this provision because it would prohibit PBMs from holding pharmacies responsible for common errors and/or not complying with applicable rules. Although most pharmacy errors do not amount to fraud, pharmacy billing can be out of compliance with state or federal law, or contribute to waste and abuse. Health insurance providers and PBMs have a fiduciary responsibility to retroactively deny or reduce improper claims, and in many cases are legally required to do so. Furthermore, by narrowing the conditions under which payments can be recovered retroactively, this provision effectively guts the effectiveness of audits—which are by definition retrospective.

Section 16; 649.35(2)(c); Page 16, Lines 10-12
Description: The bill requires an audit to be conducted by or in consultation with a licensed Wisconsin pharmacist or the pharmacy examining board when the audit involves clinical judgement.

Response: We oppose this provision because Wisconsin-specific expertise is generally not necessary for audits. In addition, audits can be effectively performed by pharmacy technicians under the supervision of a pharmacist.

Section 16; 649.35(2)(d); Page 16, Lines 13-14
Description: The bill limits the audit look-back period to two years.

Response: We oppose this provision because, under certain circumstances, two years is shorter than the look-back period in federal and state government programs.

Section 17; 649.35(3)(a)(5); Page 17, Lines 12-15
Description: The bill requires a finding of overpayment or underpayment of a claim to be based on the actual overpayment or underpayment and not on a projection.

Response: We oppose this provision because the use of projections benefits everyone by avoiding the resource- and time-intensive alternative of auditing **all** claims. Auditing a sample of claims and projecting those findings saves all parties significant time and money.

Section 17; 649.35(3)(a)(6); Page 17, Line 16
Description: The bill prohibits the inclusion of dispensing fees from calculations of overpayments.

Response: We oppose this provision because health insurance providers and PBMs should able to recoup the **full** amount paid to the pharmacy if a drug is incorrectly dispensed.

Section 17; 649.35(3)(a)(7); Page 17, Lines 17-18
Description: The bill prohibits the use of extrapolation to calculate recoupments or penalties for an audit.

Response: We oppose this provision because extrapolation can benefit everyone by avoiding the resource- and time-intensive alternative of auditing **all** claims. Furthermore, this provision effectively absolves pharmacies from the financial consequences of their errors, because the circumstances under which a recoupment or penalty can be applied is significantly narrowed. This provision will likely result in higher costs from fraud, waste, and abuse.

Section 17; 649.35(3)(b); Page 17, Lines 21-25; Page 18, Lines 1-2
Description: The bill prohibits funds from being recouped based on a clerical or record-keeping error unless the auditing entity proves the pharmacist or pharmacy intended to commit fraud or the error results in "actual financial harm" to the PBM, health insurance provider, or a consumer.

Response: We oppose this provision because it would prohibit PBMs from holding pharmacies responsible for common errors and/or not complying with applicable rules. Although most pharmacy errors do not amount to fraud, pharmacy billing can be out of compliance with state or federal law, or contribute to waste and abuse. All health care organizations are held responsible for errors through audits and recoupment, regardless of intent to commit fraud or the dollar amount of the error. Furthermore, this provision runs afoul of federal requirements regarding recoupment of federal funds, irrespective of the reason for the payment error.

Freedom of Contract Concerns
The PBM bill inappropriately imposes requirements on contracts that are freely negotiated between private parties. We oppose many of the following provisions for reasons mentioned elsewhere in this document, but also oppose these provisions because they represent government interference with freedom of contract:

- Section 16; 649.30(2)(a) through (d); Page 14, Lines 9-24
- Section 16; 649.30(3)(b); Page 15, Lines 11-12
- Section 16; 649.30(4); Page 15, Lines 17-23
- Section 16; 649.35(2)(a) through (g); Page 16, Lines 5-23
- Section 17; 649.35(3)(a)(1) through (a)(8); Page 17, Lines 1-20
- Section 17; 649.35(3)(b); Page 17, Lines 21-25; Page 18, Lines 1-2
- Section 17; 649.35(3)(c); Page 17, Lines 3-6
- Section 17; 649.35(3)(d); Page 17, Lines 7-9
- Section 17; 649.35(5); Page 17, Lines 9-12

Government Regulation Concerns
The PBM bill grants overly-broad rulemaking authority, creates regulations that duplicate current law, and even establishes rules that directly conflict with federal law and government programs.

Section 16; 649.05; Page 11, Lines 1-22
Section 16; 649.20; Page 13, Lines 3-24 & Page 14, Lines 1-5
Description: The bill establishes a new registration, regulation, and registration revocation process for PBMs through OCI.

Response: We oppose this provision because PBMs are already regulated in Wisconsin as employee benefit plan administrators (EBPA) or third-party administrators (TPAs). In order to do business in Wisconsin, PBMs currently must be licensed through OCI and comply with statutory requirements to remain in good standing. In addition, EBPAs must pay a licensing fee and penalties or license revocation are imposed if an EBPA does not comply with statutory requirements.

Section 16; 649.10; Page 11, Lines 23-25; Page 12, Lines 4-24; Page 13, Lines 1-2
Description: The bill grants OCI broad authority to "promulgate rules necessary to carry out the intent" of the bill. The bill also requires the agency to promulgate rules using the National Association of Insurance Commissioners (NAIC) Prescription Drug Benefit Management Model Act ratified in the second quarter of 2018 as a guide. Such rulemaking would include regulations around: 1) development and maintenance of formularies and other PBM procedures; 2) information provided to patients about their drug benefit; 3) a standardized PBM medical exceptions process; 4) nondiscrimination in prescription drug benefit design; 5) PBM record keeping and reporting; 6) PBM oversight and contracting; and 7) disclosures by a health insurance provider or PBM.

Response: We oppose this section because it gives a government agency virtually unrestricted regulatory authority. These rulemaking parameters are very broad and have the potential to duplicate requirements already imposed by state and federal law, and/or national accrediting bodies.
For example, the medical exceptions process is already regulated at the health insurance provider level and PBM record-keeping requirements are established by the U.S. Department of Labor under the federal Employee Retirement Income Security Act (ERISA). Furthermore, the bill enshrines in Wisconsin statute a requirement to implement a Model Act that is already being revised by the NAIC.

Section 16; 649.20; Page 13, Lines 3-6
Description: The bill provides OCI the ability to suspend or revoke a PBM's registration.

Response: This provision does not consider the potential disruption for patients. Health insurance providers must be given adequate advance notice of a suspension or revocation, and there must be an off-ramp to protect patients from the significant harm of having their drug benefit suddenly disappear.

Section 16; 649.40; Page 18, Lines 15-25; Page 19, Lines 1-8
Description: The bill requires PBMs to report certain rebate and fee information to OCI and the Legislature, and requires OCI to make information from those reports publicly available.

Response: We oppose this requirement because: 1) it would impose additional costs without a clear benefit to public policy and 2) the information could be used by bad actors to manipulate the market.

Section 16; 649.45; Page 19, Lines 9-19
Description: The bill requires a PBM to provide "a reasonably adequate and accessible" network.

Response: We oppose this provision because it could duplicate network adequacy requirements already imposed on health insurance providers by state and federal law and/or national accrediting bodies.

Section 18 (Initial Applicability) & Section 19 (Effective Date); Page 20, Lines 14-22
Description: The bill first applies to policy or plan years beginning on January 1 of the year following the year in which the bill takes effect. The bill takes effect on the first day of the fourth month beginning after publication.

Response: The bill makes significant changes to the development and administration of prescription drug benefits. It is not feasible for health insurance providers and PBMs to comply with all of the provisions of this bill under the time line envisioned. In addition, health insurance providers will require sufficient lead time to build the increased cost of drugs and the cost of administering a prescription drug benefit into member premiums and customer contracts by all applicable filing dates.

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

12 February 2020

Dear Wisconsin State Senate Committee on Health & Human Services,

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 and the passion that pharmacists have for their patients. I'd like to focus on the audit portion of Senate Bill 100 and 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. Audits are not random, and PBMs look for any technical discrepancies to deny claims, despite the patient getting their needed medication. PBMs focus on higher dollar items to increase recoupments, and these dollars are often not given back to Plan Sponsors/Employers that paid the claims. 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
Chief Operating Officer
tthiede@paasnational.com
608-541-8904
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.

2/12/2020

Coalition of Wisconsin Aging and Health Groups SB 100 Testimony—Senate Committee on Health and Human Services

Chair Testin, Vice Chair Kooyenga, members of the Committee, good morning and thank you for the opportunity to speak today. I'm Rob Gundermann, President and CEO of the Coalition of Wisconsin Aging and Health Groups and Chair of the Wisconsin Pharmacy Patient Protection Coalition. We support the substitute amendment to SB 100 because there are several provisions in it, such as the removal of the gag clause on pharmacists, that are important to our Coalition.

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 prescriptions.

Another issue in this legislation that is important to the Coalition is that of drug substitution or non-medical switching. For some people, having to switch medications can have very serious consequences. For example, when a patient is taking multiple medications, their doctor has to find the right combination that works for them without causing negative side effects, and that becomes more and more difficult as you keep adding drugs in to what essentially becomes a drug cocktail. The substitute amendment doesn't provide as much protection in this area as we would like, but in general, this legislation puts us in a better place than where we are currently and that is why we support the substitute amendment. On behalf of the Coalition, I urge your support as well.

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

30 West Mifflin St. Suite 406 ■ Madison, WI 53703
Telephone: (608)224-0606 ■ Fax: (608) 244-4064 ■ Toll Free: 800-488-2596 ■ www.cwag.org

Senate Committee on Health February 2, 2020

Dear Chairman Testin and Members of the Senate Committee;
Thank you for holding a public hearing on Senate Bill 100, which regulates pharmacy benefit managers and prohibits non-medical switching.

I have shared a letter from my patient, Larry, about his experience with pbm's requiring him to go mail order and providing inadequate care. Luckily he was actually able to manage it. Because he is tenacious, has excellent health literacy, and his memory is sharp. This is in contrast to many of our patients that have dementia or memory issues or are just overwhelmed with managing their medications. Imagine someone with low health and technology literacy being told they had to change medications midway through the year because of formulary changes or being forced to navigate the complex mail order system. Those of us in community pharmacy are often the ones helping them clean up this mess even though they aren't able to come to our pharmacy and be our patients any longer because their insurance and pbm has forced them to get prescriptions via mail order or their own pharmacy.

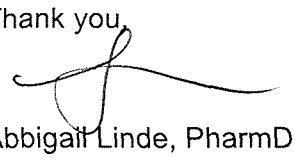
I have been a pharmacist for almost 10 years now. For the last 3 years I have been manager and owner at Beaver Dam Hometown Pharmacy. I became an owner because I wanted to be able to practice pharmacy the way I wanted to practice pharmacy and have control over that. What that means to me is being able to connect with my patients, know what they want and need and respond to those needs directly as a health care provider. In other words, I just want to be help people and take care of my patients.

I recently attended a hearing for rewriting the pharmacy rules in this state. I listened to all the mail order companies and pbms talk about how inconvenient and hard it will be to give patients consults. Whereas all the community pharmacists were attempting to persuade the pharmacy examining board to require consultations on every single prescription no matter where that prescription comes from- why? Because that's what is best and safest for the patient. Even though it might be inconvenient.

So, any business decision I make, I also put it through the lens of... is this what my patients need? Is this good for them? So when I have claims where I literally lose $100 every 30 days when I fill it... I am forced to choose between putting myself out of business or taking care of a patient that I care about? Or when the mail order would cost the patient $0 dollars but they would have a copay with me- when they are on a fixed income I understand why they are forced to make that choice. But that's not always what is best for the patient and it does NOT result in lower health care costs overall. Those same patients with memory issues, low health literacy, complex medication regimens... they need care coordination from pharmacists. In our pharmacies we do free delivery, we package medications to make it easier for patients to remember and take their medications correctly, we consult them with any changes to make sure they understand, we sync their medications and do check ins to make sure their meds are working effectively, we actively work to prevent problems and help people get off of medications....In other words, we do more than just dispense medications, but when we can't keep our doors open because of the games that pbm's are playing - then those patients have nowhere to go to get that help.

Please pass this legislation - it is a step in the right direction and it is necessary to protect the patients of wisconsin, the small businesses of WI, and in the end will decrease costs as we prevent expensive medical outcomes and prevent waste. I urge you to join the 99 co-sponsors that support this legislation and get this signed into law this session.

Thank you,



Abbigail Linde, PharmD
Hometown Pharmacy

CVS caremark™ 9501 E. Shea Boulevard MC020, Scottsdale, AZ 85260-6719

CONCURRENT CLAIM REVIEW NOTICE – RESPONSE REQUIRED
FAX ALL REQUESTED DOCUMENTATION TO 1-800-887-3105

January 28, 2020

SUN PRAIRIE HOMETOWN PHARMACY
NCPDP: 5133537
Phone: 608-825-7530
Fax: 608-825-7532

As an industry leader, CVS Caremark® values integrity and is committed to encouraging the success of our providers in our pharmacy network. A part of that commitment also includes evaluation of paid claims data to confirm their validity. CVS Caremark is reviewing the following prescriptions to ensure compliance:

RxNo	Drug Name	DOF
0262989	PRACASIL TM- CRE PLUS	1/22/2020

Documentation Due Date: January 31st, 2020
Please submit ALL of the below documentation:

Check If Yes	Requested documentation
☒	This cover sheet
☒	A copy of the original prescription
☒	Dispensing label for the Date of Fill requested
☒	A copy of the compound record, including NDCs of items used, lot numbers, expiration dates, compounding instructions, and signature of verifying pharmacist (if applicable)
N/A	A copy of ALL sub formulation(s) (when applicable)
N/A	Certificate of Analysis (when applicable)
☒	Patient signature log or delivery confirmation if mailed, demonstrating patient receipt
☒	Documentation demonstrating evidence of copay collection (e.g., proof of credit card transaction, copy of check)

Documentation will be reviewed to validate the claims data as submitted on the claim transaction. **Please validate or clarify any ambiguous information (e.g. UAD, PRN, unspecified area of application) to satisfy the quantity and day supply relationship on the claim transaction.**

Your participation as a network pharmacy requires compliance with the Provider Agreement and adherence to all applicable regulations. Please note failure to submit all the required documentation by the specified documentation due date may result in a non-compliance fee ($325 administration fee for an initial occurrence or for each non-compliant submitted claim, increasing in $325 increments for subsequent noncompliant events (e.g., $325, $650, $975).

Sincerely,
Ashley Little, CPhT
Consultant – Compound Daily Review
Phone: 480-391-4784 (voicemail line) Fax: 800-887-3105
Email: caremarkdailyreview@cvshealth.com

February 12, 2020

Good morning...

I am here to share with you some of the problems I have experienced and continue to experience working with for-profit managed health care companies, and the pharmacy benefit management (PBM) organizations they work with or own.

I am a 62-year-old male, who has had Type I diabetes for 50 years. 50 years of living with diabetes has had a major impact on how I live my life, and how I address dietary and medicinal approaches to take care of myself and attempt to control the disease. As you all may know, diabetes is one of the major causes of death worldwide, and for a Type I diabetic requires significant care in order to control blood sugar levels. Over the past few years, I've also developed some heart issues...(Atrial Fibrillation or AFib), 2 stents placed in major arteries, and suffered a heart attack. What this all means is I have to take a large number of prescription drugs in order to address daily life, including 4 insulin shots a day and 6 finger pricks to check my blood glucose levels. I like to tease by saying "I feel like a human drug store", but I take "taking care" of myself as very serious business.

Over the years, I have had medical coverage through a number of health insurance plans and programs, with different providers being involved. Some truly have a focus on the health and safety of their members / patients, and also focus on the best options at the best price, since someone such as myself finds a significant amount of my monthly income dedicated to medical supplies and pharmaceutical items. The biggest hurdle I face, and I am sure many others like myself face, are dealing with some of the health plans and providers who are only worried about their P&L statements, and in fact help inflate the profit side of those by overcharging and undercovering those that they provide health insurance and pharmaceutical benefits to. It is some of those experiences that I would like to bring to your attention today. I will share just a few examples but have many to provide if anyone would be so interested.

I must take a blood thinner...Xarelto, which is produced by Janssen Pharmaceuticals. It is an important care item for myself, as it is for the prevention of stroke in individuals like myself who have nonvalvular atrial fibrillation. It is a specific medication and cannot be substituted with other different blood thinners. I have been taking Xarelto for 5 years, and shortly after I started taking it, I found that Janssen Pharmaceutical offered Xarelto patients a program called Janssen Care Path that provides patients instant savings on out-of-pocket costs for Xarelto. You can use your program savings card when filling your

prescription at a retail or mail-order pharmacy. I signed up for the program, and for years now have gotten a 30-day supply of Xarelto for $10, which greatly reduces the cost to me for this pricey prescription. This has saved me hundreds of dollars a year on just this one drug alone. I have used this card with local pharmacies, mail order houses such as Costco, and others, with no issue whatsoever.

Back in September, we had to change our medical coverage due to my wife being downsized from her job, and our only option was to go with United Healthcare. United Healthcare is a part of the UnitedHealth Group Incorporated, which is the largest healthcare company in the world by revenue, with 2018 revenue of $226.2 billion.

United Healthcare mandates that for any medicines or prescriptions that a user takes for more than a single one-time use supply (what they call long-term care – which in my case Xarelto, as well as insulin/insulin pens, pen needles, blood test strips, and most of my medications are), the user must go through Optum Rx. For those that are unaware, Optum Rx just so happens to be owned by United Healthcare.

I put my first prescription in under this new coverage for a 90-day supply of Xarelto and was told by Optum Rx that they could not use the Care Path card or program. I was quite surprised and could not get a reason why, so I held off submitting the prescription. I instead asked my doctor to give me a 30 day script and went to Jason and Hometown Pharmacy in Sun Prairie. Jason checked everything out for me, and confirmed they could use the Care Path card and my 30-day prescription cost would be $10. Before my refill time came up for Xarelto, I was contacted by Optum RX and advised I had to get Xarelto in a 90-day prescription, and they would be charging me for the difference between what they would have charged me for a 30-day supply and the $10 I paid. I asked to speak to a Manager at Optum Rx, and was directed to an individual who repeated to me "we cannot take that card as we have negotiated contracts with many drug manufacturers and suppliers that allow us to get the best pricing for our members. In many cases we will go to different suppliers to fill a prescription, which is why you may see your pills looking different over different prescriptions, but this is all for saving you money." I responded that I understood about generic alternatives, **BUT** Xarelto did not come in a generic version, and it was only available through Janssen Pharmaceutical...hence, there could not be any "NEGOTIATION" as there were no other manufacturers to negotiate with. He ignored my response and continued to tell me they could not take the Savings Card for my prescription. I asked to speak to his manager and was directed to another individual who repeated the same thing to me, and added that "this was very

complicated and he was sure I could not understand it". I asked him to explain it to me, but he would not.

END RESULT – I paid over triple for this drug, which results in hundreds of dollars of overpayments I am making for just one drug annually.

So, the **"SAVINGS"** Optum Rx "negotiated" for me actually saved me nothing, and cost me plenty.

A number of years ago I needed to get a refill on insulin and syringes for taking insulin shots. I was down to about enough syringes to take insulin shots for 4 days and called my pharmacy to get prescription renewals. When you get syringes, one of the problems you face is that the QC done by the manufacturers is in some cases lacking, so you will get a syringe that when you take the top off, the needle is either missing or is bent in a weird shape, making the syringe unusable. The medical groups count you out the exact number of syringes you need for a 90-day supply based on the number of shots per day you are taking. If a number of those syringes are unusable, you are in trouble, and need to get a refill earlier than after the 90-day time period from when your last prescription was filled. I would always try to ask my doctor or pharmacy to give me enough "extra" syringes – say a 93 or 94 day supply – so I was protected in the case that some of those syringes were unusable...but normally the medical insurance organization would not allow it.

In this particular case, I went to refill both the insulin and syringe prescriptions but was a few days ahead of the 90-day period for the syringes. When I went to my pharmacy to pick them up, they had the insulin for me, but not the syringes, as the medical insurance group rejected the renewal due to it being before the 90-day renewal period. You cannot take insulin without a needle or syringe – you can't drink it, you can't chew it like bubble gum, and you can't swallow it like a pill or capsule. And for a Type I diabetic, who survives by taking insulin shots, where does something like this put you???

It took three days of arguing and fighting with the medical insurance group to get them to release the syringe prescription...at which point I was having to skip shots and ultimately re-use some syringes to get insulin into me. AND IF YOU ARE NOT SURE OR AWARE...A TYPE I DIABETIC WHO DOES NOT TAKE THEIR INSULIN IS GOING TO BE HOSPITALIZED AT SOME POINT AND RUN THE RISK OF DYING! NOT GETTING SICK...BUT DYING.

My final example relates to as much of a "waste" question as a cost question. One of the most critically important items a diabetic MUST HAVE is a blood glucose meter. Measuring where your blood sugar level is...during the day, before going to bed, before or after exercise, etc... is critical to both taking care of yourself in a day-to-day situation, as this determines in a large part any insulin adjustments you may need to make during your shot taking, and your long-term care and how well you are controlling your diabetes.

The picture below shows 6 different blood glucose meters that I have. A diabetic only needs 1 meter to use daily. The health care companies I have been associated with have, over the years, made changes to what blood test strips are covered under their plans – by covered meaning you are not penalized by getting a non-covered brand or strip and paying a tremendous penalty for purchasing the "non-approved" strip.

Whenever these healthcare management organizations negotiate a better deal – and being blatantly honest, a "better deal" means some type of rebate or monetary kickback that does not go to the consumer, but is made by the test strip manufacturer to gain their "preferred" status. This leaves the diabetic patient having to purchase new meters and expend costs that are 100% unnecessary.

It seems that many healthcare organizations are more concerned with their P&L's and bottom lines than with their customers health, and that is a dangerous precedent to allow to continue. As a diabetic, I have already been dealt an "uphill run" toward living a full life, just as many others with horrific diseases and medical conditions have...what we don't need is economic barriers and pitfalls created to make these day-to-day battles more difficult to address.

WHY WE AND OUR DOCTORS CANNOT HAVE THE MAJOR SAY IN OUR MEDICAL CARE, RATHER THAN FINANCIAL ANALYSTS OR ACCOUNTANTS WHO DO THE QUARTERLY FINANCIAL PROJECTIONS AND ROLL-UPS, IS BOTH DISTURBING AND SAD.

I appreciate your support of this bill and others in the future that create a level playing field and protect patients and consumers from this greed and fiduciary ignorance.

Thank you for all your efforts...

Dan Tafaro

608-630-1680

dtafaro@outlook.com

February 11, 2020
Dear Senate Committee on Health and Human Services,

I am writing to you about what I talked about last week at the Assembly Committee on Health regarding how PBMs have affected my life.

I've got a different health plan, and everything has to come through the mail now. No go. No way! I talked to one person on the phone who didn't know what was going on with my meds, then I asked for another person to talk to, and they also didn't know what was going on!. They said everything had to go through the mail, and I said no. I had in my plan the option to opt out of the mail order, which is what I wanted to do, and go back to my pharmacy. It felt like no one I spoke to would let me! I had to talk to 5 people to try to opt out, and still was told I was not allowed to leave their mail order pharmacy. Their pharmacy is OptumRx.

Pharmacy should be seeing your pharmacist, and the pharmacist you want! They talk to me, tell me about the important things regarding my medications, and make sure they aren't sending me medications that I'm not on. They know me. Abbi, my pharmacist, knows me!

It's so different when you get the mail order pharmacy on the other hand, where they did not listen to me or understand me. I told this lady on the phone that there were some medications I didn't need filled yet. If I say I don't want this medication, I don't want them sending it to me. Well one week after that call I wound up with 6 months of medications, including another prescription I haven't taken in over a year! I shouldn't be receiving medications that I'm not taking – that is wrong. Abbi thankfully took them back and destroyed them for me, but I still had to pay for them.

I reached the point where I wanted to cancel my plan and find one that allowed me to go to my pharmacy. They just kept repeating on the phone that I had to do this, or follow their instructions, or they can't opt me out, which upset me enough to hang up. I'm an independent human being, and no one is going to tell me I have to take this medication when I know I wasn't supposed to. I mean, my plan charges me so much through the plan to get my meds mailed, then I go to my pharmacy and find out I could get it cheaper. I'm on a fixed income and disabled, it's not like I can get a part time job in order to pay for these medications.

I'm frustrated! This shouldn't happen. I should be allowed to opt out and go back to Hometown for everything. Thankfully, the 6th person I talked to finally opted me out, so I can go back to Abbi. But this is why I wanted to write to you guys to pass SB100. I'm unable to come and tell you my story in person, so I hope this letter helps you see what I've gone through thanks to PBMs forcing me go to mail order. You guys are going in the right direction with this bill. Let's get this passed and push it through! People shouldn't have stuff like this happen to them and be forced to leave their pharmacy or do what they don't want to do.

From,

Larry D. Krueger

Larry Krueger