STATE REPRESENTATIVE
DEBRA KOLSTE

44TH DISTRICT

WISCONSIN STATE ASSEMBLY

AB 621
Assembly Committee on Health
February 14, 2018

Thank you, Chairman Sanfelippo and fellow committee members, for holding a public hearing on AB 621. This legislation is an important first step in increasing transparency and accountability in the prescription drug marketplace.

The goal of the bill is to bring the operations of pharmacy benefit managers, also known as PBM's, under the purview of state regulators; specifically, in this case, OCI.

Although relatively unknown to consumers, PBM's influence:

1. Which drugs we have access to – PBM's create drug formularies for insurers, determining which drugs will get placed in the most preferential tiers;
2. Which drugs we take – PBM's are paid by drug manufacturers to give their medicine preferential placement in the formularies being designed for insurers;
3. Which pharmacies we can use – PBM's set up a network of pharmacies. These pharmacies gain network preference in return for discounted pricing; and
4. How much we pay for drugs – Higher drug prices mean higher rebates for PBM's

Pharmacy benefit managers are the connectors between employers, drug manufacturers, pharmacies, and the end consumer, managing prescription drug benefits for 266 million Americans. The 3 largest PBM's managed pharmacy benefits for over 80% of that total number, speaking to the lack of competition in the market.

Despite their ubiquity and importance to prescription drugs there is virtually no regulation of these businesses in Wisconsin. As it stands currently in our state, health care providers, plan sponsors, pharmacies, and the insured have no recourse against PBM's when they deny coverage, manipulate copayments, influence formulary design, mandate therapeutic substitutions, refuse to disclose financial transactions or relationships to their clients, or effectively deny access to prescription drugs at certain pharmacy locations.

Departments of Insurance have consistently found that their state laws do not provide them with sufficient licensing and enforcement authority over PBM's. We need to be confident that PBMs are not abusing their position in the marketplace as middlemen and are acting in the best interest of their clients and patients.

Pharmacy benefit managers enter into separate contracts with pharmacies, insurers, and manufacturers. Yet they are the only entity that has access to all 3 contracts giving them leverage in negotiations and an opportunity to increase their profits by charging insurance plans one price, reimbursing pharmacies a smaller price, and pocketing the spread.

Thank you for your consideration of AB 621 – an important consumer protection and first step in increasing transparency around prescription drug pricing. I, respectfully, ask for your support of this bill and would be happy to take any questions at this time.

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

Middlemen | The role of pharmacy-benefit managers

Individuals pay premiums to their employer/plan sponsor or health insurer.

Consumers

Individuals cover their prescription-drug copay, or pay cash to the pharmacy.

Pharmacy

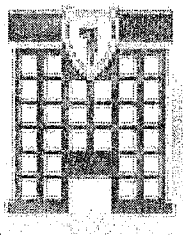
The pharmacy negotiates with the drug maker or a wholesaler for drug costs, as well as discounts and rebates based on the volume of drugs the pharmacy handles.

Pharmacy-benefit manager

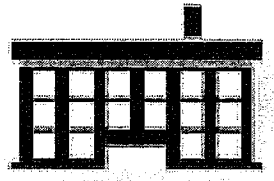
The PBM negotiates with the pharmacy over reimbursement for drugs and dispensing fees.

The PBM also negotiates prices with the manufacturer, which then pays rebates to the PBM for preferred placement on a plan's formulary.

The insurance company pays the PBM to manage its drug costs, and get rebates from manufacturers. (The PBM often retains a portion of the rebate.)



Insurance company



Manufacturer

Source: Avalere Health LLC

NAVITUS HEALTH SOLUTIONS

PO Box 999
Appleton, Wisconsin 54912-0999

[MAILING DATE] 11-1-17

[MEMBER NAME]
[ADDRESS LINE 1]
[ADDRESS LINE 2]
[CITY&ST&ZIP]

Dear [Member Name]:

Pharmacy Network Change Notice

This letter is to inform you that the pharmacy chains listed below will no longer participate in the State of Wisconsin and Wisconsin Public Employers group health insurance programs after December 31, 2017. We have implemented this change to help continually provide the best value for our members. These pharmacy chains will be considered out-of-network in 2018.

American Pharmacy Network Solutions	Bartell Drug Company	BI-LO	Brookshire Grocery
CVS Pharmacy	Food City	Food Lion	Giant Eagle
Hannaford Brothers	Harris Teeter	HEB Grocery	Ingles Market Pharmacy
Inserra Supermarket	Kinney Drugs	Klein Family Market	LML Supermarket
Longs Drug Store	Navarro Discount Pharmacy	Procare Pharmacy	Publix Super Market
Raleys Drug Center	Ronetco Supermarket	Saker Shoprite	Save Mart Supermarket
Shoprite	SRS Pharmacy	Target Pharmacy	Tops Markets
Village Supermarket	Wegman Food Market	Winn Dixie Pharmacy	Zallie Supermark

You are receiving this letter because you or a family member may have filled prescriptions at one of these pharmacies in 2017. If you have an existing prescription at one of these pharmacies, refills will be honored until December 31, 2017. We recommend you transfer prescriptions to another participating pharmacy by the end of December to ensure you receive uninterrupted prescription service.

How do I transfer a prescription?
There are several participating pharmacies available in your area. To locate a participating pharmacy, visit the Navi-Gate for Members web portal at www.navitus.com > Members > Member Login. After logging into the website, you can perform a pharmacy search using the pharmacy search function along the left-hand side menu. You can also call us for help locating a participating pharmacy.

NAVITUS
HEALTH SOLUTIONS

PO Box 999
Appleton, Wisconsin 54912-0999

To transfer an existing prescription, contact the new pharmacy and request they transfer the prescription to their location. When contacting the new pharmacy, you will need to have the drug name, prescription number, and the name of the current pharmacy that the prescription will be transferred from.

Another option is to take advantage of the convenient mail order service that will be offered by Serve You DirectRx Pharmacy Mail Service starting January 1, 2018. You can reach Serve You at 800-481-4940.

If you have questions about your prescriptions, please contact your health care provider or pharmacist. For questions about your pharmacy benefit, please call Navitus Health Solutions Customer Care at 866-333-2757.

Sincerely,
Navitus Health Solutions, LLC

The State of Wisconsin Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 45 C.F.R. § 92.8(b)(1) and (d)(1)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 1-800-833-7813).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (1-800-947-3529).

STATE LAWS REFORMING THE PRACTICES OF PHARMACY BENEFIT MANAGERS (PBMS)

The following provides a summary of those states which have enacted legislation to reform the business practices of the Pharmacy Benefit Manager (PBM) industry. The summaries provided below do not provide a detailed description for all the provisions enacted in each of these state laws, but instead provide a generalized review of the reforms made by these laws. Any individual wishing to review the exact wording for any of these laws is encouraged to pull the actual Act. To further discuss any of the specifics within these state reforms please contact NCPA State Government Affairs staff at 703-600-1223.

States With Pharmacy Benefit Manager (PBM) Laws	
Fair & Uniform Pharmacy Audits	21 AL, AR, CA, FL, GA, IN, KS, KY, LA, MD, MN, MS, MO, NM, NC, ND, OK, SC, TN, UT, VT
PBM Regulation/Transparency	11 AR, IA, MD, MS, ND, RI, SD, TN, TX, UT, VT
Anti-Mandatory Mail Order	3 NY, PA and? (TX, CT, TN - AWP Legislation)
PBM Licensure (Insurance or Board of Pharmacy)	3 CT, GA, KS
Maximum Allowable Cost (MAC) Transparency	0
Total Laws Enacted	39

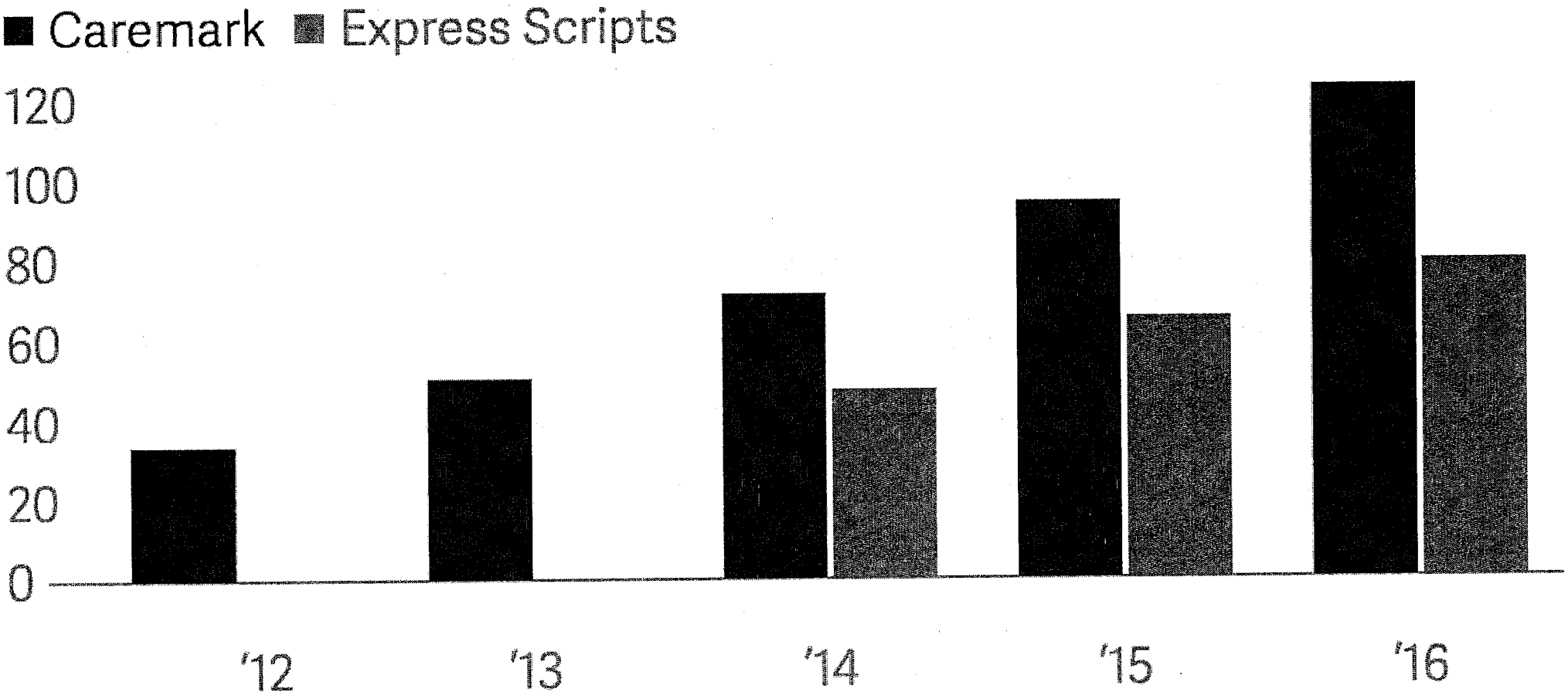
Table 3 PBM Litigation Involving P&T-Related Issues	
Case	Basis, Route of Complaint, and Allegations
Eli Lilly/PCS merger (1985)[28]	Federal Trade Commission. Vertical merger resulted in formulary preferences. Settled via consent order.
Mulder v PCS Health Systems, Inc. (1998)[29]	ERISA. Resolved against plaintiff. Self-dealing, including formulary practices and drug-switching practices.
Merck & Co. Inc./Medco merger (1999)[28]	Federal Trade Commission. Vertical merger resulted in formulary preferences. Settled via consent order.
United States v Merck-Medco Managed Care, LLC, et al. (1999 and 2000)[29]	False Claims Act. Settled for $184.1 million, cumulatively. Allegations of switching patients' prescriptions to different drugs without their knowledge/consent; false reporting of physician contacts for switching; secret rebates for increasing market share.
United States ex rel Parradoss v Caremark, Inc. (1999)[29]	False Claims Act. Settled in 2013. Alleged preauthorization requirements made reimbursement impossible.
Bickley v Caremark, Inc., et al. (2002)[29]	ERISA. Resolved against plaintiff. Alleged that PBM negotiated with manufacturers to favor more expensive (but equivalent) drugs in drug-switching program in exchange for compensation (i.e., kickbacks).
Medco Health Solutions, Inc., litigation (2003)[29]	ERISA. Settled for $42.5 million. Allegations of promoting more expensive Merck drugs over less costly alternatives. Breach of fiduciary duty in management of formulary and drug-switching programs.
Board of State Teachers Retirement System of Ohio v Medco Health Solutions, Inc. (2003)[29]	Breach of contract. Settled for $7.8 million. Allegations of steering of physicians, pharmacists, and patients to choose brand-name and higher-cost medications manufactured by Merck rather than generic equivalents; switching patients to different drugs without patient knowledge/consent; soliciting and receiving kickbacks.
Group Hospitalization and Medical Services v Merck-Medco Managed Care, LLP, et al. (2003)[29]	State law. Negligent misrepresentation, unjust enrichment. Settled July 31, 2008. Alleged failure to require generic substitution; choosing drugs for formulary based on rebates rather that cost-effectiveness/efficacy; engaging in drug switching to higher-cost drugs without medical justification.
Moeckel v Caremark, Inc., et al. (2004)[29]	ERISA. Resolved against plaintiff. Self-dealing, including formulary practices and drug-switching practices.
State of New York v Express Scripts, Inc., et al. (2004)[29]	Breach of contract. Settled for $27 million. Allegations of inducing physicians to switch patients, often to higher-cost drugs, based on PBM rebates.
State Attorneys General v Express Scripts, Inc. (2008)[29]	Consumer protection acts. Settled for $9.3 million, with up to $200,000 to affected patients. Numerous states alleged PBM illegally encouraged doctors to switch patients to different brand-name medications while profiting from same without passing savings on to plans.
State Attorneys General v Caremark, Inc. (2008)[29]	Consumer protection acts. Settled for $41 million. Twenty-nine attorneys general alleged deceptive trade practices and failure to inform of profits from drug switches. Patients were switched from originally prescribed brand drugs to different brand drugs.
United States v AstraZeneca (2015)[20]	Anti-Kickback Statute. Settled for $7.9 million. Allegations that PBM received kickbacks to maintain "sole and exclusive" formulary status for certain drugs.
United States ex rel Kester et al. v Novartis et al. (2015)[30]	Anti-Kickback Statute. Settled for $390 million; specialty pharmacy settled for $60 million. Allegations of inducement of specialty pharmacies to increase prescriptions for Novartis drugs by paying kickbacks in the form of rebates.

ERISA = Employee Retirement Income Security Act of 1974; PBM = pharmacy benefit manager.

of the Anti-Kickback Statute have led to large settlements by PBMs. The lawsuits, many of which are qui tam, or whistleblower suits, typically allege that the PBM negotiated rebates from pharmaceutical companies that it did not disclose to the government. Such hidden financial agreements are considered kickbacks, which can increase drug prices, influence formularies, and inappropriately guide pharmaceutical prescription decisions.

In 2015, under the HEAT initiative, DOJ allegations of potential kickback arrangements in which pharmaceutical companies provided price concessions on other products in exchange for sole and exclusive formulary status in violation of the False Claims Act resulted in very large settlements and judgments. In two cases, the price concessions or discounts were not disclosed to Medicaid as required under the Medicaid Drug Rebate Statute's "best price" reporting requirements. The companies settled for

Number of products on formulary exclusion lists of...



△ T L △ S | Data: drugchannels.net | No list published by Express Scripts in 2012-13

The Role of Pharmacy Benefit Managers in American Health Care: Pharmacy Concerns and Perspectives: Part 1

November 14, 2017
Brittany Hoffman-Eubanks

Rising health care expenditures within the United States has been a major focus of policy makers, business owners, and individuals for years.

According to the Centers for Disease Control and Prevention (CDC), the per capita national health expenditures in 2015 US dollars was $9,990, total national health expenditures were $3.2 trillion, and the percent of Gross Domestic Product (GDP) was 17.8% [1] Furthermore, prescription drug treatment accounted for 10% of the overall costs associated with national health expenditures in the US (2015 US $).[1]

A 2013 report by Moses III et al, identified the top 4 drivers of health care costs in the US since 2000 as: 1) administrative costs (5.6% per year); 2) price of health care services (4.2% per year); 3) price of drugs and medical devices (4% per year), and 4) price of professional services (3.6% per year)[2] Interestingly, this report did not find demand for health care services or aging of the population to significantly contribute to this increase in health care costs. Thus, the price of health care itself seems to be driving the increase in costs. [2]

To address these increases in costs related to prescription drugs, private employer groups, individual States, and the federal government, have utilized the services of pharmacy benefit managers (PBMs). Historically, PBMs were "middlemen" entities designed to process prescription medication claims (for a small fee per claim) for insurance companies and plan sponsors (ex. private employers). [3]

Today, PBMs have leveraged their position as the "middlemen" and now impact almost every aspect of the prescription drug marketplace.[3] For example, the top 3 PBMs within the country manage the drug benefits for approximately 95% of the US population or 253 million American lives.[4] Beyond their traditional claims processing, PBMs are now involved in drug utilization review, drug plan formulary development, determining which pharmacies are included in the prescription drug plan's network, deciding how much network pharmacies will be reimbursed for their services, and operating mail order and specialty pharmacies themselves.[4]

A 2015 report from *Applied Policy* states: "over the past decade, the role of PBMs in the delivery of health care has increased, due to a confluence of factors: coverage expansions under both the Medicare Part D prescription drug benefit and the Affordable Care Act, combined with an increase in prescription drug spending that has motivated commercial health plans and self-insured employers to outsource the management of their spending on outpatient prescription drugs."[5] As a result of this increased involvement, PBMs today have multiple, extremely profitable, revenue streams with the top 3 PBMs each exceeding 15 billion in revenue yearly.

PBMs are compensated in 3 main ways: 1) rebates; 2) administrative fees; and 3) pharmacy spread.

A rebate is a discount on a mediation a drug manufacturer provides to the PBM in return for the PBM covering the manufacturer's drug product. Since PBMs make the formularies that the plan sponsor will cover they can negotiate better prices for certain drugs (often name brand) when there are other less expensive equivalent medications that could be utilized. This process is concerning since, typically only a portion of those rebates are shared back with the plan sponsor while the PBM pockets the rest creating a major conflict of interest.[6] It is estimated that approximately one-third of the net price paid for prescription drugs is traceable to these rebates and, as a result, consumers may already be paying one-third more from rebates alone.[6] In addition, patients are often forced to switch their drug therapy based upon these rebates that dictate the plan's formulary regardless of their efficacy. If patients or their providers want the patient to stay on the original drug therapy, then they are forced to obtain a prior authorization before the PBM will authorize coverage for the drug product. This practice is alarming since a patient's drug therapy may be interrupted as a result and can lead to patient harm. For example, the novel factor-Xa direct oral anticoagulants (apixaban, rivaroxaban, and edoxaban) are not necessarily interchangeable and evidenced based guidelines, pharmacologic properties, renal/hepatic impairment, adherence, and patient preference should be taken into account when deciding which agent is appropriate. Furthermore, these agents have very short durations of action and even missing one dose as a result of a prior authorization request can put a patient at risk of a negative outcome.

Data from 151 Fellows of the American College of Cardiology (FACC) surveyed by the American College of Cardiology (ACC) revealed that 71% thought formulary restrictions lead to disparities in care related to income, elderly age, and underserved populations.[7]

Administration fees are another source of revenue for PBMs where they often charge plan sponsors and manufacturers additional fees and payments that the PBM pockets. Due to the lack of transparency and the highly complicated nature of drug pricing, it is incredibly difficult for plan

sponsors to identify all charges outlined in their contracts with the PBMs.[6]

The third, and arguably, most controversial source of revenue of the PBMs comes from the "pharmacy spread."The pharmacy spread is a PBM practice where the network pharmacy is reimbursed one price and the plan sponsor is charged a higher price for the same drug product and the PBM pockets the difference (otherwise known as a "clawback").[6] PBMs are able to do this because they negotiate separate contracts with the network pharmacy and the plan sponsor with neither typically being privy to the other's contract. Furthermore, the contracts created with the network pharmacies frequently forbid the pharmacy from informing the patient of this price difference who might otherwise choose to pay out-of-pocket if the cost was lower than their plan.[8] Thus, this practice leads to increased costs for the plan sponsor and the patient while the PBM increases their profit. In fact, PBMs are estimated to profit by hundreds of millions of dollars annually from clawbacks and this has led to at least 16 lawsuits over the past year to address this conflict of interest.[8]

As a result of these revenue sources, PBMs are making billions of dollars a year with little to no federal regulation or oversight.[3] The lack of transparency and regulation is alarming given they manage numerous prescription plans that are funded by American tax dollars with the intended goal of reducing costs. Meanwhile, health care costs continue to rise within the US and drug costs are an important component of total aggregate costs. In part 2 of this article series, the specific impact of PBMs on American pharmacies will be discussed in detail.

References

1. Centers for Disease and Control Prevention. National Center for Health Statistics: Health Expenditures. [Internet] Accessed October 10, 2017 at: https://www.cdc.gov/nchs/fastats/health-expenditures.htm
2. Moses H 3rd, Matheson DH, Dorsey ER, George BP, Sadoff D, Yoshimura S. The anatomy of health care in the United States. *J Am Med Assoc*. 2013;; 310(18)1947-1963.
3. National Community Pharmacists Association. Pharmacy benefit managers (PBMs) 101. [Internet] Accessed October 10, 2017. Accessed at: http://www.ncpa.co/pdf/leg/nov12/pbm_one_pager.pdf
4. National Community Pharmacists Association. PBMs. [Internet] Accessed October 10, 2017. Available from: http://www.ncpanet.org/advocacy/pbm-resources/what-is-a-pbm-
5. Concerns regarding the pharmacy benefit management industry. [Internet] November 2016. *Applied Policy*. Accessed October 10, 2017. Available from: http://www.ncpa.co/pdf/applied-policy-issue-brief.pdf

6. National Community Pharmacists Association. The PBM Story. [Internet] Accessed October 10, 2017. Available from: http://www.ncpanet.org/advocacy/pbm-storybook

February 12, 2018

The Honorable Joe Sanfelippo
Wisconsin State Legislature
Assembly Committee on Health
2 E Main Street
Madison, Wisconsin 53703

RE: NATIONAL COMMUNITY PHARMACISTS ASSOCIATION SUPPORTS ASSEMBLY BILL 621

Dear Representative Sanfelippo,

I am writing to you today on behalf of the National Community Pharmacists Association (NCPA) in support of AB 621. This bill would take a necessary step toward oversight of the massive, predominately unregulated pharmacy benefit manager (PBM) industry.

NCPA represents the interest of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies across the United States and 273 independent community pharmacies in Wisconsin. These Wisconsin pharmacies filled over 16.3 million prescriptions last year, impacting the lives of thousands of patients in your state.

NCPA has long championed the need for greater oversight and enforcement of the PBM industry and believes the Wisconsin Office of the Commissioner of Insurance is an appropriate regulating entity for PBM operations within the state of Wisconsin. We believe any corporate entity exerting virtually exclusive control over a health care benefit system should have a clearly defined oversight entity whom beneficiaries, plan sponsors, and providers can contact when issues arise.

PBMs originated in the 1970s simply to process claims, validate patient eligibility, and administer plan benefits. Over time, however, PBMs have taken advantage of their strategic position as an intermediary between the insurer, payer, beneficiary, and health care provider to assert nearly total control over of an insured's prescription drug transaction, from manufacturing to dispensing. This includes creating pharmacy networks and defining terms and conditions of network participation; determining generic drug costs to the plan and reimbursement rates to the provider; acting as pharmacy providers through the operation of massive mail-order pharmacy operations; creating and managing drug formularies, thereby defining what medications can ultimately be dispensed to a patient as well as other pharmacy benefit management activities. Despite their ubiquitous role, PBMs operate with extremely limited oversight or regulation of any kind. As a result, the PBM business has proven to be extremely profitable with limited corresponding risk.

Essentially, pharmacy providers, plan sponsors and insured Americans have no recourse against these corporations when they deny coverage, manipulate copayments, mandate therapeutic

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(703) 683-8200 PHONE
(703) 683-3619 FAX

substitutions, refuse to disclose financial transactions or relationships to their clients, or effectively deny access to prescription drugs at certain pharmacy locations. PBMs have regularly argued that they owe no legally binding ethical duty to act in the best financial interests of their clients—the public and private payors, and insured beneficiaries that they are hired to serve. This lack of oversight and protection for the citizens of a state has been permitted to continue, all while legal actions have been filed by both state government and private entities against PBMs for questionable business practices. These business practices have impeded prescription drug access and increased medication costs.

More than twenty-five states require PBMs to register to do business within their state, and most of those states require that PBMs register with the state's commissioner of insurance. The mission of the Wisconsin Office of the Commissioner of Insurance is "to lead the way in informing and protecting the public and responding to its insurance needs," yet they currently have little defined oversight or authority over a massive industry that controls virtually every aspect of one of the most critical and costly aspects of health insurance – prescription drug benefits. NCPA urges you to support AB 621 because it is a step towards much needed oversight for a massive, predominately unregulated industry.

If you have any questions about the information contained in this letter or wish to discuss the issue in greater detail, please do not hesitate to contact me at alliejo.shipman@ncpanet.org or (703) 600-1179.

Sincerely,

Allie Jo Shipman

Allie Jo Shipman, PharmD
Associate Director, State Government Affairs

cc: Members of the Assembly Committee on Health

Pharmacy Society of Wisconsin

One Voice. One Vision.

TO: Assembly Committee on Health

FROM: Matthew Mabie, RPh
Owner, Forward Pharmacy
President-Elect, Pharmacy Society of Wisconsin

DATE: February 14, 2018

SUBJECT: **Testimony in Favor of Assembly Bill 621 – PBM Registration Legislation**

Thank you, members of the Assembly Committee on Health, for the opportunity to provide testimony in support of Assembly Bill 621. 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 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, they are virtually unregulated at the state or federal level. In response, over 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. In an effort to drive savings to their health plan customers, PBMs have implemented business practices that are unfair to the community pharmacy. In addition, savings promised through narrow preferred pharmacy networks and mail order incentives may not be realized by the PBM's customers.

In the 2015-2016 Wisconsin State Budget, a law change was passed that requires PBMs update maximum allowable cost (MAC) pricing information for prescription drugs every seven business days, reimburse pharmacists subject to this updated MAC information, investigate all appeals

[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.

regarding MAC pricing brought forth by a pharmacy and provide a reason for denying any appeal. This law change collectively is often referred to as the *MAC Transparency Law*.

The Pharmacy Society of Wisconsin has been informed by numerous pharmacists across the state that pharmacies have difficulty with enforcement of the MAC Transparency Law. The most common issue reported by members is that PBMs are either not investigating claims, or are investigating and denying claims, but not providing a reason for denial. Each time this occurs, members or PSW staff on behalf of members is told by the Office of the Commissioner of Insurance that they cannot enforce the MAC Transparency Law because they, nor any other Wisconsin state agency, has regulatory oversight of PBMs.

While PBMs are typically not insurers, they influence many aspects of prescription-drug coverage. The goal of this legislation is to regulate PBMs in Wisconsin and would provide OCI the legal authority to enforce the MAC Transparency Law and would give OCI oversight and enforcement of these entities.

For the following points, lets use the following real-life reimbursement I experienced in my pharmacy yesterday:

Drug A: 90 tablets reimbursed at Maximum Allowable Cost (MAC) for $90, plus dispensing fee of $1. The patient paid a copay of $10 and the PBM paid the pharmacy $81.

Seven ways PBMs have tilted the table in their favor:

1. **MAC Pricing**: PBMs set a list of maximum reimbursable costs, called MAC lists. Due to the secretive nature of each PBM MAC pricing list, the pharmacy has no idea what the reimbursement of Drug A will be until time of submission. A recent price increase has resulted in Drug A now costing $180 to purchase. The pharmacy has just lost $89 on this prescription. The pharmacy has no choice but to dispense drug to the patient and cannot recoup the loss from the patient. All efforts to ask the PBM for reconsideration of MAC pricing have been returned with a statement from PBM of "pricing per contract."
2. **DIR Fee**: At end of the quarter, the PBM has analyzed claims data and reported to the pharmacy that they have not met the targets that they have recently changed and set. This results in a $1 recoupment. We are now up to a $90 loss on this prescription.
3. **Audit**: Several weeks later, the insurer audits the pharmacy and asks to see above referenced prescription order. Due to a clerical error (missing date, DEA number, item PBM recently added to contract, etc.) the PBM recoups money for the prescription, $81. Total loss is now $170.
4. **Mail Order**: After that first fill at my pharmacy, the PBM mails the patient a letter claiming significant savings if the patient switches their prescription to the mail order pharmacy that the PBM owns. Offers to the patient include reduced copays and automatic enrollment in an auto-ship program. Often, this creates a huge surplus of medications in the patient's home due to ever changing and discontinued medications that rarely are stopped by mail order. I have worked drug take back events for the past five years and have seen the mail order waste coming into our pharmacy. Several years ago, a guardian of a patient walked into my pharmacy carrying a box. Often this could have been prevented had a pharmacist talked with the patient prior to dispensing, something required by WI pharmacy regulations[2].

[2] See Example: http://www.ncpanet.org/docs/default-source/default-document-library/waste-not-want-not---examples-of-mail-order-pharmacy-waste.pdf

5. **"Take It or Leave It" Contracting**: Recently, I have gone through re-contracting our pharmacy with several PBMs. At no point during any of the contracting was I allowed to strike, challenge, or otherwise negotiate the given contract. These contracts are in essence, "take it or leave it" contracting.
6. **Transparency**: For Drug A, the PBM has negotiated a rebate of $60 for every prescription that is dispensed. All told, the PBM has now made $142 ($60 rebate + $1 DIR fee + $81 audit recoupment) on a drug it didn't even dispense. In addition, the PBM charges the employer a $5 per claim administration fee. Total of $147 in revenue for the PBM.
7. **Any Willing Provider**: Wisconsin is an any willing provider state, which requires health insurers to allow pharmacies to be members of the insurer's network if certain conditions are met. If pharmacy is willing and able to meet the conditions set by the insurer, 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."

Summary:

- My pharmacy provided consultation of life-maving medication and provided the medication: Loss of $170
- PBM handles administrative duties: Gain of $146

In all examples, there is no governing body to ask for help. The playing field is completely tilted to the favor of the PBMs.

My father is a pharmacist who began experiencing the effects of PBMs in their earliest form in the early 1970s. Since then, the problems have only escalated, as PBMs have been creating new methods to tilt the table in their favor. Over the years, the aggressiveness of each of these methods has increased.

The ultimate issue is that there is no enforcement to address these problems when they occur. Because PBMs are unregulated, when they undertake coercive or illegal practices there is no method to address the problem for pharmacies. This bill attempts to solve that problem by putting a responsible regulating body in charge of registering and regulating PBMs.

At the end of the day who is responsible for auditing PBMs and keeping them honest? In our state, at present time, that answer is nobody. Join me and other pharmacists in leveling the playing field in Wisconsin with support of this much needed and long overdue legislation.

American Diabetes Association®

Assembly Bill 621
Proponent Testimony

Gary Dougherty
Director, State Government Affairs and Advocacy
American Diabetes Association
Assembly Committee on Health – February 14, 2018

Chairman Sanfelippo and Members of the Committee:

My name is Gary Dougherty and I am the Director of State Government Affairs and Advocacy for the American Diabetes Association.

On behalf of the nearly 542,000 Wisconsinites who have diabetes as well as the 1.55 million with prediabetes, I share with you the support of the American Diabetes Association for AB 621.

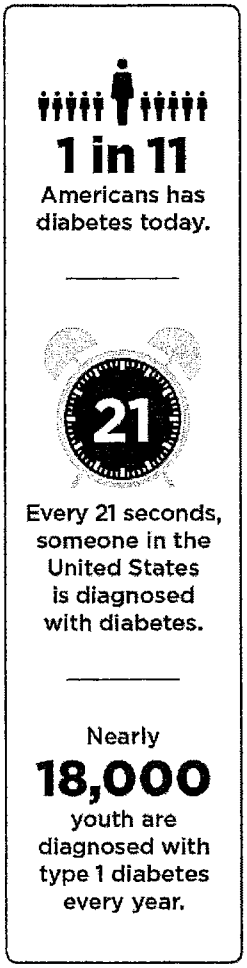
While there are many entities in the insulin supply chain, pharmacy benefit managers (PBMs) play a very large role in determining how much patients pay for their medications, including insulin. PBMs work on behalf of health plans and large employers to negotiate drug discounts with manufacturers; to determine which pharmacies to include in its network; to develop formularies; and determine which drugs are covered, on which tier to place covered drugs, and which drugs are subject to utilization management (like prior authorization or step therapy). Despite the significant role PBMs play in the drug supply chain, there is little public information about their dealings. In addition, PBMs are not highly regulated at the federal or state level.

AB 621 is an important step toward applying standards to PBMs, such as transparency and conflict of interest requirements. It also lays the groundwork for increased oversight and empowers the Commissioner of Insurance to conduct examinations of and reporting by PBMs.

The American Diabetes Association supports efforts to make insulin affordable for all who need it and to increase transparency throughout the insulin supply chain. AB 621 paves the way for increased oversight of PBMs. Such oversight could help improve transparency into how PBMs do business and/or impose additional standards for how PBMs conduct business.

On behalf of Wisconsinites living with or caring for someone with diabetes as well as those at risk for developing the disease, I encourage you to support AB 621.

Thank you very much for your consideration.



Gary Dougherty
Director, State Government Affairs & Advocacy
1-800-676-4065 x4832
gdougherty@diabetes.org

Assembly Committee on Health
Assembly Bill 621: Registration of Pharmacy Benefit Managers

February 14, 2018

Chairman Sanfelippo and Committee Members:

For the record, my name is Gary Boehler. Thank you for allowing me to send this written testimony with respect to the registration of pharmacy benefit managers.

I am a registered pharmacist living in Minnesota and have been licensed since 1970. My career has been spent in the retail sector, and for the past 35 years or so, I have worked on the business side of pharmacy, including contracting with pharmacy benefit managers (PBMs).

PBMs first came onto the scene in pharmacy during the late 1960s and early 1970s. Their primary function was to process prescription drug claims for plan sponsors as more of those sponsors began offering prescription drug coverage as a part of employees' benefit packages. Then in the early 1990s, PBM began taking on a much different role, becoming a "middleman" between the plan sponsors they represented and the pharmacies PBMs contracted with to fill those prescriptions on behalf of the plan sponsor.

Pharmacy benefit managers seized on an opportunity back then with a model, unchanged today, that does not allow one side to know what is happening on the other side! That is to say, an employer who contracts with a PBM has no idea what the pharmacy is being paid for dispensing those prescriptions, nor does the pharmacy know what the employer is being charged for that prescription in what is known in the industry as "spread pricing." Spread pricing is only one way the PBMs of today have figured out how to profit at someone else's expense. So, as a brief summary of what I see going on daily with PBMs, I will highlight some of the egregious practices that are most common.

1. **Spread Pricing** – as I explain above, this is a very common practice where the employer or plan sponsor is billed more for a prescription than the dispensing pharmacy is paid. Rumor says the average spread is $8.00 or thereabouts; however, I have also seen examples of spread pricing as high as several hundred dollars, and now with the high cost of specialty medications, far more than several hundred dollars.

2. **Patient Clawbacks**- although a newer phenomenon in the past two or so years, this is a practice whereby a PBM will process (adjudicate) a submitted claim by a pharmacy, pay an inordinately high amount for what has been submitted, and then charge the patient a very high copay at the cash register. Patients are clueless as to what is happening, but it becomes very obvious when assessing a claim. There are one or two PBMs who do this extensively, and at your request I will provide that information. I believe this is an illegal charge made by the PBMs that resort to these tactics; patients have already paid an annual premium to be a part of the prescription drug plan, and to force these patient clawbacks is nothing more than an additional premium. It should be banned completely.
3. **Gag Orders** – a pharmacist today is forbidden by PBM contracts pretty much universally from telling a patient there may be a less costly cash option than the patient copay or co-insurance that the patient has for a benefit. In an effort to save patients money where possible, if the

pharmacist suggests a cheaper cash version, that pharmacy can be terminated from the network.

4. **Mail Order/Delivery** – I have actual copies of letters pharmacies have received from PBMs warning them if mail order or delivery persists in their pharmacy for that specific plan the PBM represents, they can be removed from the network at the PBMs behest. Pharmacists have been mailing or delivering their patients' prescriptions since the advent of pharmacy as a service. Yet another PBM very close to home says that any deliveries a pharmacy makes MUST be done at no cost to the patient. Many snowbirds in this part of the country go south for winter, and at a patient's request ask for their prescriptions to be mailed and are fine paying the postage. Many elderly shut-ins cannot get out and in a small community it is a common practice to stop by on the way home after work and drop off a prescription. I did it myself many times! These tactics are merely put into place in an effort to push mail order to their own vertically integrated mail order pharmacies and specialty pharmacies. No regard is given to the patient, but only the PBM.

5. **PBM Steering** – this is a common practice used by PBMs to coerce or force patients into their own preferred (I like the word restricted) networks. As an example most recently in Wisconsin, the PBM that represents Network Health Providers sent letters out to patients prior to the end of 2017 telling them that many of the stores were not in the network for their Medicare Part D plan or if they chose to fill at the local pharmacy, their copays would be higher. Much of this was a pure diversionary tactic (lie) on this PBMs part; as I checked with stores whose patients brought in letters, these stores were indeed in the preferred network and the rate structure was identical to what the big chain stores were receiving. This is a perfect example of a PBM exploiting the elderly population, causing anger, frustration, confusion and only unanswered questions in the minds of many patients. How many patients left their hometown pharmacy is an unknown; but it certainly what the PBM intended. To add fuel to the fire, this is at least the second year in a row that this PBM did the same ploy – a scheme to move patients to their preferred pharmacies. Green Bay TV station did a news piece on this, but was told by the PBM the letters were sent in error. We all know better. Without naming names, it is one of the big three and can easily be found out by just speaking to any independent pharmacy owner across the state.

6. **Direct and Indirect Remuneration Fees (DIRs)** – these are fees that are taken retrospectively by PBMs months after a prescription drug claim has been adjudicated and paid for. One might ask how that impacts our patients at the counter, and primarily those on Medicare Part D plans. The answer is very simple and straightforward. When a claim is submitted to a PBM and no DIR is taken at that point of sale, the patient is forced to pay a copay or co-insurance on that overinflated amount that appears in the paid amount at the local pharmacy. Then months later, when the DIR fee is taken by the PBM, the net amount on that drug claim can be many dollars less than when it was filled; as an example I see many DIR fees well in excess of $30 to $50 and more; those excess copays or co-insurance payments by the patient are indeed overstated and ultimately push those patients into the Medicare donut hole sooner, and then into catastrophic coverage much sooner than would be normal. This is ALL done at the expense of the patient and the taxpayer and all for the benefit of the PBM. We are told this money is given back to CMS,

but no proof is ever offered, and by the time it is sliced and diced by the PBM, one has no realization of how these DIR fees are accounted for, how they are classified, and if in fact there is a clean, concise reconciliation method in place. Since PBM true-ups may happen up to several years later, the PBM has the benefit of "floating" all this cash for a long period of time, and again, all at the expense of patients, CMS, and pharmacy provides across the country.

7. **Rebates from Drug Manufacturers –** among the many sources of revenue for PBMs, manufacturer drug rebates are certainly among their highest revenue sources. One only needs to go back six months to the revelations about Epi-Pen and the CEO of Mylan testifying in Washington, D.C. about the high rebates paid to PBMs just so Mylan could have Epi-Pen on their drug formularies. The estimated rebate on a drug that has a list price of $608 was around 60%, or more than $360 per Epi-Pen dispensed! As all of us do, I believe drug prices are too high; I also believe the biggest cost drivers behind high drug prices are rebates extorted by PBMs from these drug manufacturers that are being forced into the game by "pay to play" models PBMs exercise. All of these costs trickle down to the consumer as higher costs in the form of insurance premiums, higher copays at the point of sale, and higher plan sponsor costs. It is a model that is long broken and needs fixing.

8. **Lack of Transparency –** the shell games I list above are only a few, but directly impact the pocketbooks of every person who stands at the prescription counter waiting to have a prescription filled, his/her employer who offers the prescription drug benefit, and the struggling independent pharmacist who in trying to take care of his patients, is constantly hampered by every egregious act that PBMs can think of to make life tougher, but for themselves. It is all about follow the money trail (FTMT) and it leads directly to their doorsteps.

There are many more issues that can be addressed, but what I mention above are commanding high focus and attention across the country. Wisconsin is no different and is being impacted the same way as all other states. Time is long past for swift and curative PBM legislation that must begin at the state level with the input of all the major stakeholders that have endured enough, namely, patients, plan sponsors and employers, and all pharmacy providers who are having their pockets emptied daily by one ruse or another.

Three of the biggest PBMs today control 80% of all the prescriptions filled in our country; it may not be a monopoly, but it is certainly an oligopoly that is taking the prescription drug model in the wrong direction and costing all the players money, and I believe most of that money falling into the hands of the PBMs administering these plans. PBMs can certainly help provide a service of helping control drug costs, but at the other end of the spectrum those costs imposed by PBMs are doing far more than eating up those savings. It is indeed time for major reform.

Sincerely,

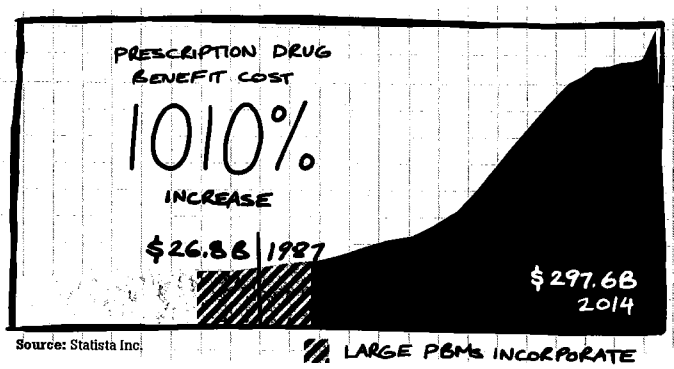
Gary W. Boehler, R.Ph.

pilrlr@comcast.net

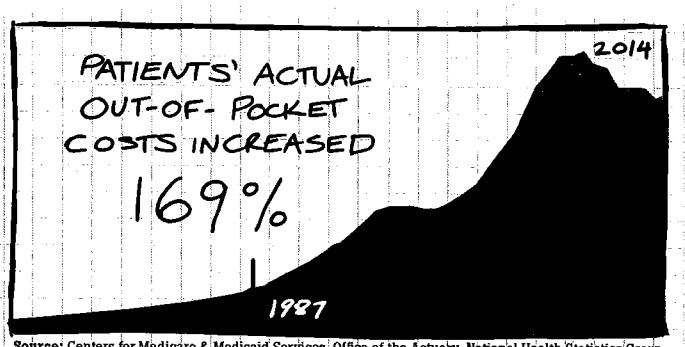
(763) 354-4875

Want to reduce prescription drug costs?

PAY ATTENTION TO THE MIDDLEMEN.



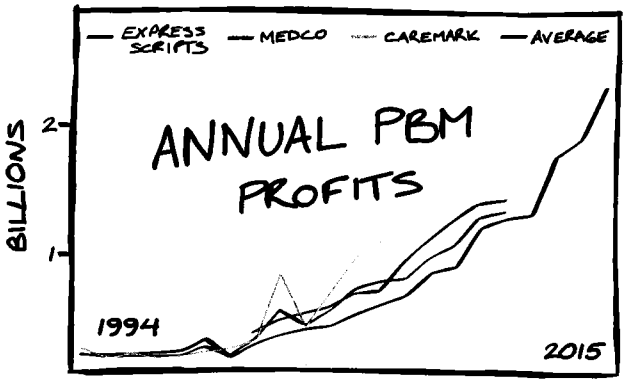
Source: Statista Inc.



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

"According to one estimate, PBMs fail to pass $120 billion back to consumers, and retain another $30 billion in additional out-of-pocket costs."

– "YOU CAN BLAME PHARMACY BENEFIT MANAGERS FOR HIGHER DRUG PRICES," *REAL CLEAR HEALTH*, MARCH 28, 2017



Source: Medco was owned by Merck from 1994–2003 and purchased by Express Scripts in 2012. Publicly available income statements are reported from 2001–2011. Caremark was purchased by CVS in 2006. Net income from publicly reported statements are reported from 1994–2006. Reported net income excludes negative values from discontinued operations reported on 10-K forms from 1995–2000. Express Scripts has been the sole independent major PBM with publicly available income statements since 2012.

PBMs control the pharmacy benefits of more than

Americans.

After numerous acquisitions ***and consolidations,***

Just 3 PBMs

of prescription drug benefit *transactions in the U.S.*[1]

[1] Health Strategies Group, "Research Agenda 2015: Pharmacy Benefit Managers," http://www.healthstrategies.com/sites.default.files:PBM_Research_Agenda_PBM_RA101513.pdf. Similar figures come from "Prescription Medicines: Costs in Context," August 2016, available at http://phrma-docs.phrma.org/sites/default/files/pdf/prescription-medicines-costs-in-context-extended.pdf.

A few prescriptions for what's ailing health care costs:

- **Plan sponsors and policy makers must demand transparency from PBMs.** It is in their interest to do so.
- **Help ensure PBM accountability by supporting the following legislation:**
  - S. 413 and H.R. 1038, the "Improving Transparency and Accuracy in Medicare Part D Drug Spending Act."
  - H.R. 1316, the "Prescription Drug Price Transparency Act."
  - H.R. 1939, the "Ensuring Seniors Access to Local Pharmacies Act."
- **Change the model:** Plan sponsors should insist on a flat fee system that eliminates hidden asks.
- **Leverage the expertise of community pharmacists.** We can help reduce prescription drug spend and improve patient health outcomes.

READ MORE AT WWW.NCPANET.ORG/ADVOCACY

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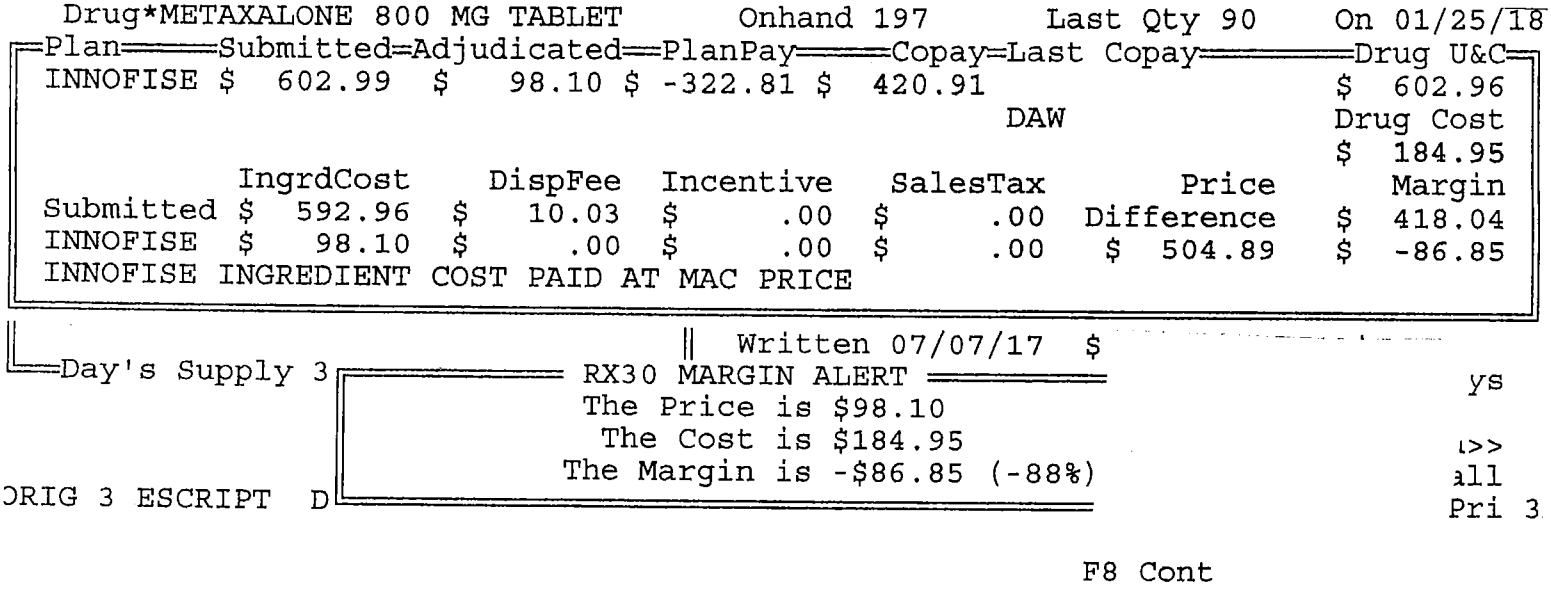

Drug*METAXALONE 800 MG TABLET Onhand 197 Last Qty 90 On 01/25/18
Plan Submitted Adjudicated PlanPay Copay Last Copay Drug U&C
INNOFISE $ 602.99 $ 98.10 $ -322.81 $ 420.91 $ 602.96
DAW
Drug Cost
$ 184.95
IngrdCost DispFee Incentive SalesTax Price Margin
Submitted $ 592.96 $ 10.03 $ .00 $ .00 Difference $ 418.04
INNOFISE $ 98.10 $ .00 $ .00 $ .00 $ 504.89 $ -86.85
INNOFISE INGREDIENT COST PAID AT MAC PRICE
Written 07/07/17 $
Day's Supply 3
RX30 MARGIN ALERT
The Price is $98.10
The Cost is $184.95
The Margin is -$86.85 (-88%)
ys
>>
all
Pri 3
ORIG 3 ESCRIPT D
F8 Cont

EXAmple A

Drug*CELECOXIB 200 MG CAPSULE Onhand 149 Last Qty 30 On 01/25/18

Plan	Submitted	Adjudicated	PlanPay	Copay	Last Copay	Drug U&C
INNOFISE	$ 259.99	$ 8.10	$ -129.83	$ 137.93		$ 259.81

DAW

Drug Cost $ 3.86

	IngrdCost	DispFee	Incentive	SalesTax	Price	Margin
Submitted	$ 249.81	$ 10.18	$ .00	$ .00	Difference	$ 256.13
INNOFISE	$ 8.10	$ .00	$ .00	$ .00	$ 251.89	$ 4.24

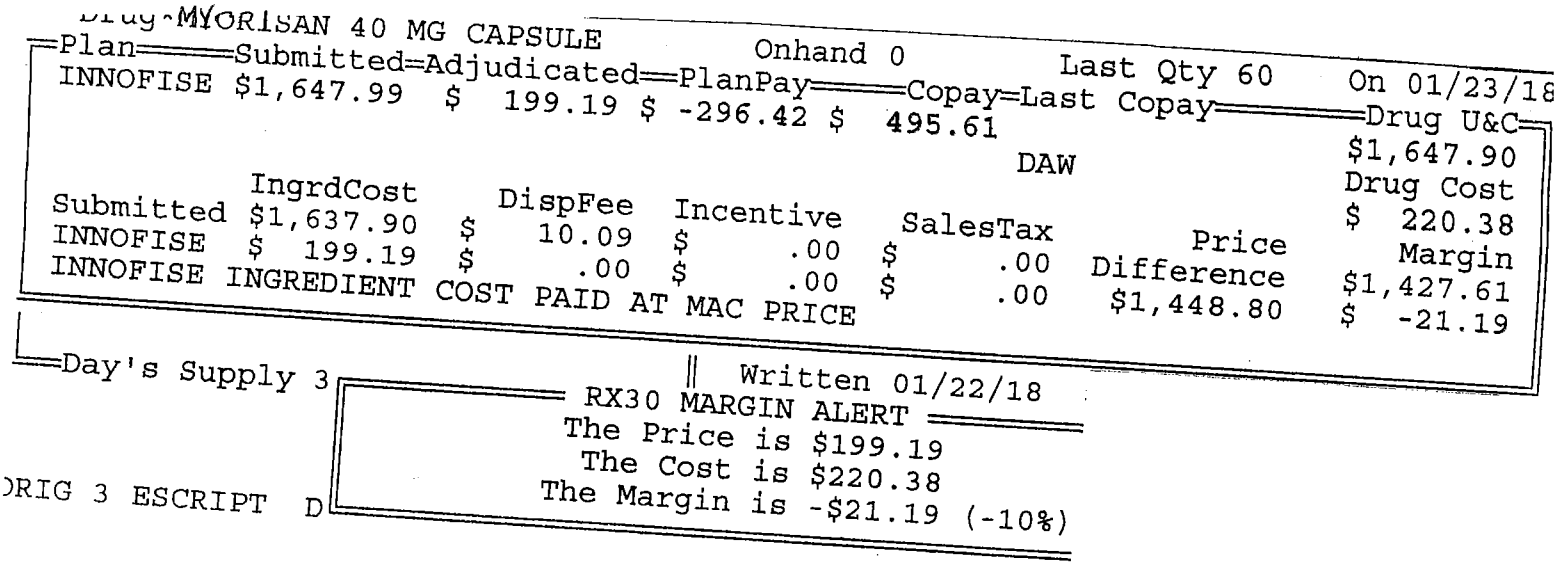
INNOFISE INGREDIENT COST PAID AT MAC PRICE

ADDITIONAL MESSAGES

(Authorization 180252579592054999).

F1 Cont F3FinishF4Copay F5FaxPrtF6Trace F7DetailF8Revers Plan Paid

Example B



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F8 Cont

Example C

network health

EXPRESS SCRIPTS®

)2

Starting January 1, 2018, please use a preferred pharmacy to avoid paying more for your medicine.

Starting January 1, 2018, your Medicare prescription plan will help you **pay less if you fill your Part D prescriptions at a preferred pharmacy.**

You can keep filling prescriptions at WATERTOWN HOMETOWN PHCY, but you'll pay more for them. So before you refill, please consider using home delivery or a preferred retail pharmacy* below for your medicine:

Home delivery from the Express Scripts Pharmacy℠ OR Preferred retail pharmacy

For **long-term medicine,** home delivery may be your best option:

- Call **1.800.316.3107** (TTY users: **1.800.716.3231**) or visit **NetworkHealthMedicare.com** to get started.
- Express Scripts will contact your doctor for you to get a new prescription for up to a 90-day supply.
- We'll send your medicine straight to your door with **free standard shipping.**†
- Get 24/7 access to a pharmacist from the privacy of your home for questions about your medicine.

Ask your doctor to send a new prescription to a preferred retail pharmacy:

WALGREENS #05136
301 W MAIN ST
WATERTOWN, WI 53094
1.920.206.9588

PICK N SAVE PHARMACY #6854
607 S CHURCH ST
WATERTOWN, WI 53094
1.920.261.7140

SHOPKO PHARMACY #2019
701 S CHURCH ST
WATERTOWN, WI 53094
1.920.261.1920

Or ask your new preferred pharmacy to call your current pharmacy for the prescription.

H4656OU

For long-term medicine (the kind you take regularly), you can get up to a **90-day supply instead of the typical 30-day supply.** You'll refill less often and are less likely to miss a dose. It's easy to do - your doctor can send a prescription for up to 90 days to the Express Scripts Pharmacy for home delivery or to a preferred retail pharmacy. For short-term medicine like antibiotics, a preferred retail pharmacy is your best option.

Don't pay more than you need to for your medicine. If you have any questions, we're here to help. Just give us a call at **1.800.316.3107** 24 hours a day/seven days a week. TTY users, call **1.800.716.3231.**

Sincerely,

Kris D. Ramsey
Senior Director, Member Services
Express Scripts

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*Other pharmacies are available in our network. To find other preferred pharmacies in your area, log in at **NetworkHealthMedicare.com**

† Standard shipping costs are included as part of your prescription plan.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/ coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

ATTENTION: if you speak a language other than English, language assistance services, free of charge are available to you. Call **1.800.316.3107** (TTY: **1.800.716.3231**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.316.3107** (TTY: **1.800.716.3231**).

As an enrollee of our plan, you can get a long-term supply (up to 90 days) of drugs shipped to your home using our plan's network mail order delivery program. Usually you will receive your mail order prescriptions within 14 calendar days. If your order does not arrive within the estimated timeframe, call Express Scripts Customer Service at 800-316-3107 (TTY 800-899-2114), 24 hours a day/7 days a week.

Network Health Medicare Advantage plans include MSA and PPO plans with a Medicare contract. NetworkCares is a PPO SNP plan with a Medicare contract and a contract with the Wisconsin Medicaid program. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal.

To: The Honorable State Representative Joe Sanfelippo
Members, Assembly Committee on Health

From: Janet Fritsch, RPh
Owner, Corner Drug Hometown Pharmacy

Date: February 14, 2018

Re: **Support of Assembly Bill 621 (PBM Registration)**

Thank you, Chairman Sanfelippo, for the opportunity to provide testimony on Assembly Bill 621. I would also like to express thanks to Representative Kolste for introducing this important legislation.

Many people do not realize that their insurance company often does not directly manage their prescription drug benefits. Rather, the vast majority of Americans with prescription drug coverage have their plans managed by a Pharmacy Benefit Manager. PBMs create formularies, negotiate drug discounts and rebates, establish pharmacy networks, and process prescription drug claims.

As a community pharmacist in Baraboo, I support this legislation because it would give oversight of PBM practices to the Office of the Commissioner of Insurance (OCI). PBMs operate as quasi-insurance companies, yet are unregulated at the state level – this bill would give OCI the authority to ensure PBMs were not operating in a coercive or dishonest manner. Nearly 20 other states require PBMs to be registered with their equivalent state agency.

I have many patients who have been required to receive a brand name medication even when there is a generic available, the patient would like the generic equivalent and the patient has sometimes had the generic in the past. These patients are also required to pay a brand copay even though there is a generic available. Examples of these drugs are Epi-pen, Adderall XR, Synthroid, and Nexium. Why do PBMs do this when the generic should be cheaper? How can they require the patients to pay for brand name when there is a generic available? Not only does this increase the cost that the patient has to pay, increases overall costs to the healthcare system, but it also increases the pharmacy's inventory costs.

Additionally, there have been PBMs that have sent letters to my patients saying that they would no longer be able to go to my pharmacy and would have to go to Walgreens or Walmart. This was untrue. There was nothing I could do except advertise locally that it was not correct information. Unfortunately, there was no oversight over these practices, so the PBM got away with it.

PBMs operate very similarly to insurers and influence nearly every aspect of prescription drug coverage for more than 200 million Americans. Please join me in supporting this legislation which would regulate PBMs in Wisconsin and would give pharmacists and patients in Wisconsin confidence that their prescription drug benefit managers are operating in an ethical manner.