Support 4122 26-12

My name is Ann Murray and I am a pharmacist from Heppner Oregon. I am here with my daughter, Laurie Murray a pharmacy intern. Our family own's Murray's Drug Inc. with stores in Heppner, Condon and Prairie City, Oregon. It is a family business serving Eastern Oregon since 1959 with 3 generations of pharmacists , 5 licensed pharmacists, one intern and one applying to pharmacy school. We serve Morrow, Gilliam and Wheeler counties as the only pharmacy in those counties and the eastern half of Grant County. This equates to over 5,000 square miles of rural eastern Oregon, involving a population of about 15,000.

Just over a week ago I spoke to an Assoc. Press reporter who was doing a story on why so many independent pharmacies have closed across the nation and Oregon in Particular. (On Feb. 1st Boardman pharmacy closed, leaving us as the sole Morrow county pharmacy) I will tell you now what I told him. The reason that access to pharmacies are decreasing especially in the rural areas, but will continue into the urban ones and why health care costs continue to skyrocket can be summed up into 3 large should I say "capital" and very powerful letters. PBM's!!

I urge you to read an article written in Sept. 2002 by Ed. Heckman called "Evolution of a Hurricane" explaining and predicting what would happen as PBM's became more powerful. He warned that PBM's would greatly increase the cost of healthcare by adding an expensive 'middle man" layer of beauracracy instead of insurers being able to directly contract with pharmacies that are actually doing the work of providing the health care services. Nationally, as we speak, 2 of the 3 giant PBM's Express Scripts and Medco are attempting to merge, creating an even greater monopoly. According to Forbes.com for highest paid CEO's, 2011, Express Scripts CEO ranked #4 bringing in $51.5 million in compensation.

Pharmacies and Dr.'s offices alike have had to add staff and expense to deal with PBM"S on a daily basis as they put increasing number of drugs under the status"Prior Authorization required" , or reject claims for any number of reasons. You may have personally experienced trying to fill a prescription that has been "blocked for coverage" by the pbm, or else "not on the formulary".. How certain drugs get on the formulary is a whole discussion in itself, and a reason that transparency regarding rebates etc. should be mandatory. Insurers need to know where the money is going. I would estimate that I have to call PBMS at least twice an hour to (with calls lasting from 5-20 min.) to resolve claim issues as we try to help patients fill their prescriptions.

The main reason that PBM's are driving pharmacies out of business is the "take it or leave it' contracts that offer below cost reimbursement. Last Thurs. when I worked in our Condon store (we drive an hour each way to staff that pharmacy) I dealt with a prescription for an elderly patient in the assisted living facility. The PBM was paying $27 below my cost. It cost me 224 but they reimbursed me $197. I called the "help desk" that we are instructed to call. They told me they only help with claim adjudication issues and for reimbursement issues I would have to call the plan. I called the plan. The plan directed me back to the PBM. They couldn't help me. I asked if they had a provider relations dept and waited a long time. . I was given a number to leave a message. I asked them what I should tell the patient who was rapidly running out of medication. They didn't have any answer for me. National dispensing studies have shown it costs about $10 per RX in overhead to dispense a prescription. This would have put my loss at $35 on that Rx. We do between 70-100 prescriptions per day in Condon. We sell mostly Rx's and don't have a

lot of other merchandise that can be cost shifted to cover those type of losses. We buy from a large national wholesaler, but PBM's do not understand that smaller stores do not get the same discounts as the larger volume stores and they do not respond to cost changes in the marketplace as drug supply availability issues surface which is becoming a big problem. PBM's are constantly faxing "new contracts" that keep dropping the reimbursement with "you will no longer be in our network" if you don't sign by such and such a date. We have had to refuse to sign many contracts, leaving many patients having to drive long distances or waiting for drugs in the mail from the PBM owned pharmacies. The help desk at the PBM's will say, "the patient can drive to the nearest participating pharmacy or it can be mailed to them from our mail order pharmacy." Do they care or could they even believe (calling from New Jersey) that many of our rural customers get mail delivery 3 days per week? We know that signing these contracts is just a slow death, as evidenced by so many small stores closing. Even if you can determine what your payment would be before signing a contract, the ability of the PBM to change the MAC reimbursement (maximum allowable cost per pill-on almost all generics) AT ANY TIME defies a traditional understanding of what a business contract is. If one party can change the rate agreed upon at any time, how is that a fair contract? Lack of access to pharmacy services is a direct result of PBM'S directing business away from where customers want to buy their medication. In rural Eastern Oregon this is showcased as a reduction in care as elderly or sick patients are unable to drive the 2 to 3 hour (at the minimum) round trip to go to Hermiston, Pendleton, The Dalles , or south to Central Oregon.

We have a large elderly population that gets confused and upset when we say" we can't do your prescription because your PBM says you have to use their mail order pharmacy". Others ask us, "how can you stay in business when they tell us if we use mail order we can get a 90 day supply for the same co-pay as a 30 day supply limit imposed on those using a retail pharmacy?". They say they want to use our pharmacy as they value having a pharmacy in our small town. I say it isn't fair and I don't know how anti-trust or monopoly legislation doesn't apply to PBM's in this country. Many of our customers appreciate our presence in the community and we are proud to be there. We have a payroll of about 20 people between full and part time, which may not seem like a lot in urban areas, but in our hard hit economy it is important. To make our payroll and pay our state taxes we cannot operate in the red.

A long time ago only a certain percentage of people had insurance that had copays and used PBM's . However today with part D and all Medicare beneficiaries and others on state programs such as Medicaid and OPDP etc. , almost 100 percent of our prescriptions involve transmission to a PBM. This leaves us at the mercy of PBM's and their ability to dictate contracts and force our customers away from us and to their own OUT OF STATE PBM owned pharmacies.

I urge you to support HB 4122 and provide transparency for insurers, access and freedom of choice for patients in Oregon and a fair and competitive health care marketplace. Other states have already enacted PBM transparency legislation. Oregon aspires to be on the cutting edge of Health Care Reform. This legislation would be an important and worthwhile step towards that goal.

Sincerely,

Ann Marie Murray R.Ph.

Ann Marie Murray

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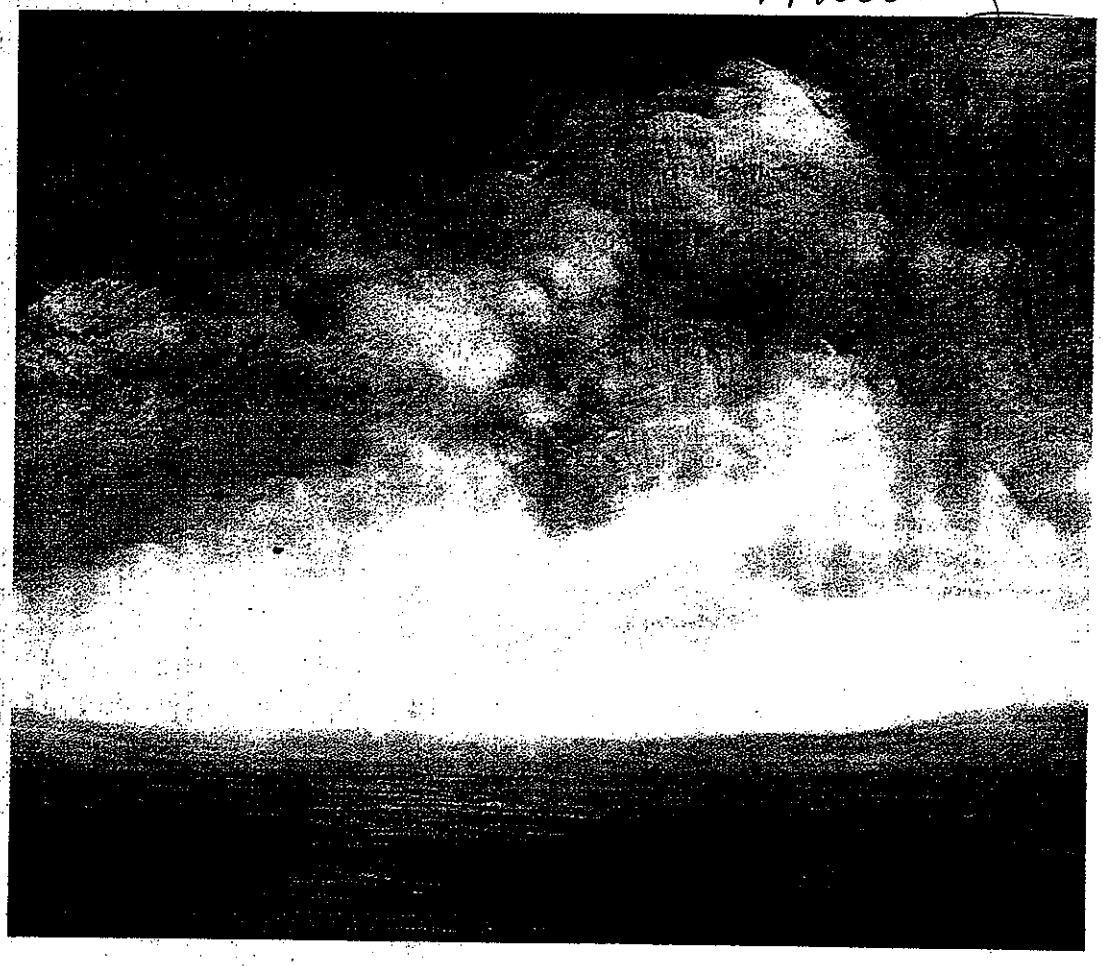


PBMs: The Evolution Of A Hurricane

by H. Edward Heckman, R.Ph.

Pharmacy benefit managers (PBMs) are sweeping through the pharmacy industry with gale force winds. They grew over the years from providing beneficial information services to pharmacies and drug plan sponsors into oligopsonistic market-controlling colossuses. They are also creating a whirlwind for the drug manufactures as the PBM demands for lower prices and larger rebates grow recklessly out of control. These are major reasons for the runaway inflation that our society experiences with drug expenditures. As costs continue to skyrocket, the PBMs line their pockets with lavish profits by controlling drug expenditures for the majority of Americans—nearly 90 percent of all prescriptions are covered by a third-party payor. The PBM model is unique to the United States. There is really nothing quite like it anywhere else in the world.

ILLUSTRATION COLLECTION: RUTH SORENSON

The Beginning—How It Started

Let's go back to the beginning when PBMs served a beneficial purpose. The original operating plan posed by Pharmaceutical Card System, Inc. (PCS) to the Antitrust Division of the Department of Justice in 1969 was to serve as an information clearinghouse for health plan payors and pharmacy providers. They legitimately initiated operation as an organized method to efficiently pass information about a plan sponsor's drug benefits to pharmacies across the country. And indeed that is how they operated for better than a decade.

Many pharmacists can recall receiving the plan specifications sheets sent to their pharmacy from PCS, PAID, and other third parties back in the 1970s. Pharmacists received three-hole punched information pages that listed a plan number in the upper corner with the details of the drugs covered, permitted days supply, allowable quantities, and payment information. We filed these informative plan profiles away in our three-ring PCS and PAID binders for future reference.

When a patient appeared in the pharmacy with a drug card listing a particular plan number that was unfamiliar, the pharmacist would look up the plan parameters and then make a decision to provide services under those terms or not. The PBMs provided a beneficial service that saved pharmacists and patients frustrations in attempting to verify eligibility and coverage.

Eventually, the PBMs agreed, along with pharmacies and plan sponsors, on

a standardized format to submit claims for services, the universal claim form. The universal claim was a great time saver. And, PBMs began administering drug plans by reviewing drug claims on behalf of plan sponsors. At the time, this was an excellent benefit helping pharmacists cut through the increasing mire of where and how to submit claims for payments.

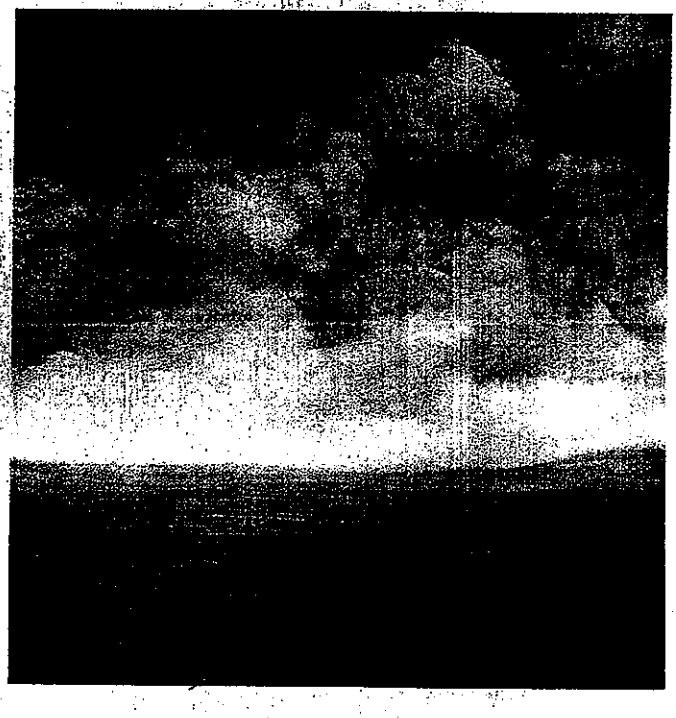
The PBM was more like a breath of fresh air in those days—providing a beneficial service to pharmacists. Life was simple. Business was good. These were elementary statements of fact during an era when the average prescription price was less than $5. At that time, third parties were a small part of a pharmacy's business with minimal impact on the bottom line. Pharmacists didn't pay a lot of attention to PBMs back in those days.

Where It Went Wrong

Over time, the PBMs became more and more aware that pharmacists really didn't closely watch how much or how little a particular plan reimbursed. Pharmacists would fill anything for any plan for any price because after all, "it didn't cost any more to fill another prescription." The PBMs learned that they could do more than just act as an information pass-through from plan sponsor to provider pharmacy. The PBMs turned the corner from bona fide ancillary service organizations to become opportunistic.

They began coaching their plan sponsors on pharmacy reimbursement offers to help them "control their expenditures" for drug benefits. Their advice of "offer the pharmacies less, they'll take anything!" became the operating standard and indeed for a number of years pharmacists accepted anything offered. The PBMs took it a step further by creating their own networks with reimbursements so they could potentially sell services to plan sponsors at one price and then reimburse pharmacies at another.

And so, what once seemed a gentle breeze, the PBM, matured into the hurricane of the drug industry whose behavior careened out of control. The plan sponsors didn't attempt to control them because after all, the PBM controlled a huge network of pharmacies and could obtain services on their behalf at rates lower than they believed could be obtained on their own. And pharmacists weren't about to take restrictive measures against PBMs, else a customer might go down the street to another pharmacy. And pharmacists could never let that happen. The PBMs grew from minor tropical depressions to the devastating hurricanes they are today.



Pharmacists Fight Back

It has only been in the past few years that pharmacists have become more aggressive in taking steps to stem these storms and make amends. Pharmacists are now drawing profit lines and turning down programs and networks that fall below them. In fact, the 2001 edition of the *Takeda and Lilly Prescription Drug Benefit Cost and Plan Design Survey Report* focuses on just that stating,

> "The PBMs negotiate (sic) with the pharmacies for discounts to AWP... Although we expect respondents (PBMs) to continuously negotiate for greater discounts, there are limits as to how far they can go. Many retail pharmacies, particularly large national chains, have drawn the line in the sand at AWP-13%."

This annual study is sponsored by Takeda Pharmaceuticals and Eli Lilly and Company for the Pharmacy Benefit Management Institute, Inc. in Tempe, Arizona. Many independent pharmacists have also drawn their own line in the sand. More and more pharmacists are individually turning down subpar, often predatory, plan offerings.

In addition, community pharmacists have initiated attempts to negotiate more favorable terms. Even the smallest pharmacies are charting strategies and approaching PBMs to negotiate more favorable terms. If you have not attempted to improve contract terms you should start. You may be pleasantly surprised.

PBMs hate to admit it but they need community pharmacies. Yes, PBMs push their very profitable unregulated mail order operations as the pancea to high drug costs, but this mode of prescription delivery is not well accepted by patients. The Takeda/Lilly study states that 87 percent of employers offer mail order to their employees but only 14.2 percent of prescriptions are dispensed through it.

If a community pharmacy is in an underserved location, performs services not readily available elsewhere, or has developed a niche, they may have an opportunity to improve reimbursements with third party payors.

PBM Legislation And Regulation

PBMs have evolved in an unregulated environment. The lack of regulation allowed PBMs to become bolder in their actions. PBMs claim that they are not insurance companies and therefore do not fall under state insurance laws, although some argue they should as they act as an agent of the insurance companies. The real question is whether or not it is too late to make amends for the devastation and destruction PBMs have wreaked upon unsuspecting patients, our economy, and community pharmacies. One thing is certain; left unbridled, PBMs will continue gain strength and control in the pharmacy market.

Pharmacists in every state must come to the forefront to push state legislation to place PBMs under some form of regu-

lation. NCPA assists states by providing Model PBM Regulation Legislation to be used to initiate such legislation. Georgia recently was the first state to enact legislation to regulate PBMs. Many other states are beginning to address this issue, and some members of Congress are beginning to scrutinize the unwieldy and expensive control of PBMs on the drug industry.

Enough For The Manufacturers

Pharmacists were the first to learn these lessons. Now the manufacturers are being tossed about by the PBMs. What was originally a low-stakes game for a manufacturer to pay a PBM for the preferential treatment of their products has become a PBM entitlement of gigantic proportion. While it is unclear the exact magnitude of these arrangements, the recent lawsuit between AARP and AdvancePCS might provide a clue.

AARP is suing AdvancePCS because it claims that AdvancePCS illegitimately kept their Cash Discount Card (100 percent copay) business after AARP moved to Express Scripts as their claims processor. AARP is asking for damages of $18 per prescription in this suit. Keep in mind that the patient pays the entire cost of the prescription (100 percent copay card) so the $18 claimed in damages must come from somewhere. The likely source is from the sale of the data to the manufacturers and by dipping into their rebate pockets.

So huge is the PBM influence that a manufacturer may employ a marketing representative whose sole job is to service one customer, a single PBM, and to stay on top of what they are doing. Their jobs are to promote positive relationships with the PBMs lest some other manufacturer capture a more favored position. They bend over backwards to do whatever it takes to please the PBM and maintain or increase their share of the market.

Unregulated Mail Order Pharmacies And Pharmacists

After opening the money tap with preferred products in formularies, the PBMs realized that they could exert more control and extract deeper discounts from manufacturers on brand name drugs if the PBM owned the pharmacy. Thus the introduction and evolution of mail order pharmacies owned by the PBMs.

Apparently, the Federal Trade Commission (FTC) viewed these new PBM business ventures into mail order pharmacies with blinders. How could they sit in ambivalence with such a huge conflict of interest looking them straight between the eyes? The PBM that was once limited to being an information conduit now created the opportunity to vertically integrate the marketplace at the demise of others.

Once in operation, the mail order Goliaths honed their operations over time. Today, for those manufacturers who ante the most, personnel at mail pharmacies will contact doctor after doctor to make therapeutic switches to

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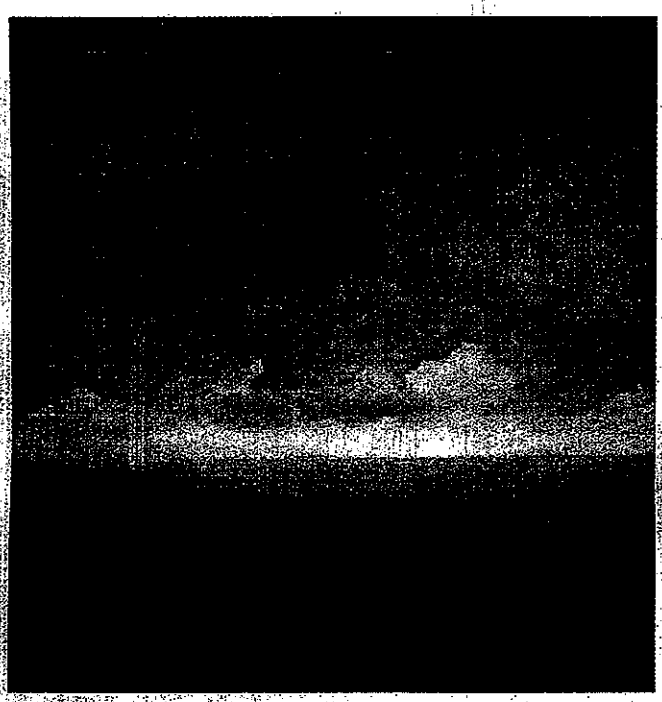
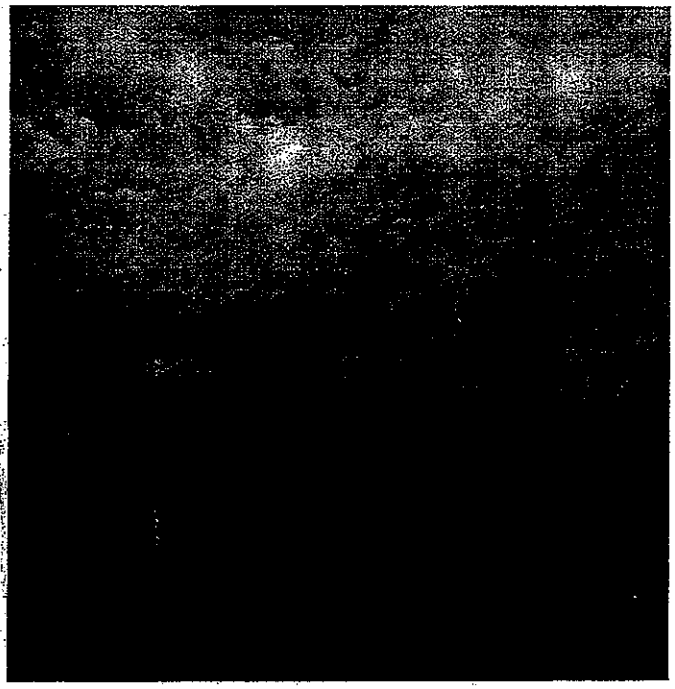
the profitable formulary product. PBM spin doctors state these switches are for better medication therapy for the patient or to benefit cost containment for the plan sponsor. But indeed, the Takeda/Lilly study alludes to the fact that mail order for sponsors is more expensive unless plan sponsors shift enough of the cost sharing to the patient.

The study states that mail order copayments must be at least two times the retail copayment before the sponsor can expect any savings. And when it comes to mail order the PBMs appear to have conveniently forgotten MAC prices on generic drugs. The study states,

> "Most PBMs no longer offer maximum allowable cost (MAC) pricing for mail service prescriptions. This is important as deep discounts offered in mail for generic drugs are not as deep as MAC prices in the retail environment."

The PBMs know that the real money is in brand name drug rebates and that is





the likely reason that mail operations only dispense generics 28 percent of the time versus independent community pharmacies at a nearly 50 percent rate.

The manufacturer-PBM scenario was complicated by drug companies who purchased PBMs. It is unclear how the FTC could be convinced that firewalls would prevent conflicts of interest between the manufacturer and the PBM they owned. This is worse than the case of the fox in the hen house. Given the fact that the entire existence of PBMs focuses upon the passing of transactions between pharmacies and payors for prescription drugs, firewalls are not realistic possibilities. The only firewalls set up by manufacturer-owned PBMs were those against other manufacturer's competitive products. Indeed, Merck has increased the percentage of its products moved through Medco-PAID by nearly 50 percent over the past few years.

The Manufacturers Fight Back

Yes, PBMs—the growing hurricane of the drug industry—have exploited the manufacturers to the maximum. Evidence is surfacing that the stakes have grown out of proportion and manufacturers are fighting back. Their direct-to-consumer marketing campaigns reach potential patients by television, radio, the Internet, and printed media. These manufacturer advertisements project desirable outcomes and positive lifestyle changes, thereby motivating and empowering a potential patient to vigorously advocate for a particular prescription drug. If patients scream long enough or relentlessly push enough buttons, they can usually gain approval for drugs that otherwise wouldn't be covered.

Manufacturers are lamenting off-the-record of their "Catch-22" situations with the PBMs. While they won't say it in public, they really wish the PBM would become someone else's problem, or better yet, drift out to sea.

The Senior Discount Strategy

The most interesting twist focuses on senior citizens and the political initiative to provide a Medicare prescription drug benefit. The Bush administration substituted for a real Medicare prescription drug benefit their cash discount cards, to which the manufacturers initiated an unique strategy after the Bush card was stopped by a federal court. They created their own discount programs for low-income seniors covering select products. There is no question that the manufacturers were using this opportunity to bolster their images with some positive public relations. But that may not have been their only motivation.

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The Bush Medicare-Endorsed Discount Card for seniors exposed the PBMs greed as they hungrily attended the July 2001 unveiling of the program in the White House Rose Garden. The manufacturers envisioned even greater financial doom and demands from the large PBMs to keep their products on the favored side of the senior discount program. Rather than sitting still for the onslaught, they had finally learned their PBM lesson.

Drug companies created their own programs. This may well have been a planned effort to avoid the high stakes required by the big three PBMs-AdvancePCS, PAID, and Express Scripts. By selecting much smaller pharmacy benefit companies, Argus and McKesson Health Systems, to administer their programs, the manufacturers side-stepped biting the bullet with the big three. To encourage participation in their programs instead of a Medicare-endorsed plan administered by the big three, they are offering pharmacists comparably high rates of reimbursement and at the same time large discounts to low-income seniors.

It is likely that the manufacturers feel they are less encumbered and further ahead selling a month's supply of medication for $12 or $15 and reimbursing pharmacists the difference. From a manufacturer's perspective, this really works out to be inexpensive advertising. The return on investment under this scenario has to be more appealing than dealing with the big three PBMs.

The Future

While PBMs will certainly disagree, their usefulness and future may be in question. In other words, this storm may be losing its steam. PBMs may have outlived their benefit and purpose.

Pharmacists do not really need the PBMs as much as the PBMs need pharmacists. That's right, the PBMs need pharmacists. Pharmacists can certainly live without their predatory audit tactics or unilateral contracts. The chains woke up in the mid-1990s and independent pharmacies are starting to do the same. The technologies now at our disposal and the Internet place direct dealings with plan sponsors for even the smallest pharmacies within the range of possibilities. Computer software can be aimed to send a claim in any electronic direction we choose. There is no question that a pharmacy or group of pharmacies administering a drug program for a local employer could with close personal involvement produce substantial savings, especially if the pharmacies share some of the risk and assume a degree of responsibility for outcomes management. These scenarios are evolving on a limited basis at this time, but are picking up more speed and interest. As these opportunities evolve for community pharmacies, the drug companies won't shed tears.

As concerns for spiraling drug costs heighten, expect more and more of the tactics of PBMs to be revealed and questioned by the public. Expect representatives and senators in Congress to embark upon fact-finding missions to help all Americans understand the expensive economics of PBM-controlled drug benefits. Keep in mind that the rest of the world functions without pharmacy benefit managers, so why do American pharmacists need them? Maybe pharmacists don't! ■

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