Letter 59

[redacted]

April 9. 2017

Sarah Brockman
Group Insurance Liaison
PO BOX 7931
Madison WI 53707-7139

Dear Ms. Brockman

I am requesting a change to the Employee Trust Fund (ETF) drug coverage contract. Unless changes are made local independent pharmacies will not survive. Pharmacy Benefits Managers (PBM) have moved into the pharmacy market place, as an interface between insurance companies and pharmacies. While claiming to have reduced the cost of healthcare the three largest PBMs process over 80% of prescriptions and gross 15 billion dollars per year. Navitus, the PBM that manages claims for the Employee Trust Fund has grown immensely since they began in 2003, now making more than 5 million dollars annually. The average increase in healthcare costs attributed to PBMs is about 30% . (See accompany documentation, Middlemen drive up cost of Prescription Prices).

The first blow to local pharmacy was the offering of mail-order services by PBMS. In the case of ETF insurance plans Navitus took a huge number of local prescriptions to Lakeland Fl to the WelldyneRX mail-order service. In spite of costs and convenience many of the customers of Community Pharmacy Cooperative have preferred to keep Community Pharmacy as their pharmacy. The local pharmacy can offer same day service especially useful for antibiotic therapy or pain relievers and create a trusting and healthy partnership between patient and pharmacists resulting in continuity of care and improved outcomes.

Another ongoing issue is the poor reimbursement rate and lack of timeliness in payment. Any other business would expect payment upon providing a service or product. Why are pharmacies forced to be lenders while they wait several weeks for payment? It is now a very common occurrence for a pharmacy to have to draw on a line of credit to pay for a drug wholesaler's bill while waiting for payment. This is a costly practice for any retail business and one that pharmacies would not be forced into if payment were made on receipt of each prescription.

Of the 245 claims processed from Navitus Health Solutions from Oct 1 – Oct 31, 2016, 55% were paid at less than $2.00 per claim. The non-labor cost alone to fill any prescription before the drug cost is even added on is between $2.75 and $3.65. This includes space to fill, licensing, bottles, labels., computers, networks,

secure internets and telephone services, and holding almost $100,000 in drug inventories. Adding labor on top of that makes the cost between $11 -14. We have watched our net margin decline from a longtime independent pharmacy standard of approximately 23% to less than 16% , which is close to a breakeven number with no income. At the same time PBMs have been given the power to dictate what products can be used while paying the lowest possible prices for them based on cost systems they have devised, which often do not match the realities of actual purchase prices. Insurers have also not made any reimbursement to pharmacies for costs of audits, mail outs, medboxes, or transactions fees to securely submit claims via the internet.

The National Association of Community Pharmacies has documented how many independent pharmacies are in the US and what their margin have been over the last several years. There has been a decline of over 900 stores. While nationally the margin has held pretty strongly around 22.5%, this has not been the case for local pharmacies where gross margin percentage has plummeted and to a just breakeven number of approximately 16%.

I believe the contracts local insurers hold with PBMs have been a direct cause for the loss of several local pharmacies in Madison. In the last year alone six pharmacies have closed their doors. Most recently Mallatt's closed two Madison dispensaries, a store in Waunakee and in Lodi (leaving this town with no pharmacy). Two of the Madison SHOPKO stores removed their dispensaries. Target sold their dispensaries to CVS. The actual providers of prescriptions, those folks that are actually seeing the patients, talking to them and providing direct care are barely able to maintain a less than nonprofit business under current reimbursements, while an administrative middleman is showing high profitability and applauding their apparent reductions in the cost of healthcare.

When Navitus took over processing claims for Unity, Group Health Cooperative, Physician's Plus, and Dean Care, Community Pharmacy Cooperative had a decline in per prescription average payment from a high of $16.43 per prescription to a low of $7.94 on an average prescription cost of $78.12. (based on actual claims to these HMOs from Community Pharmacy from 2011-2015.

The workers at Community Pharmacy Coop have been struggling several years now to keep their dispensary open, but there is little left to cut since wages have been frozen with an base wage of $11.25 for workers and under $38.00 per hour for a pharmacists. These are not good wages in the first place, but Community Pharmacy has strived to serve the Madison Community and is making every effort to continue to do so trying to adhere to their motto Healthcare for the people not for profit. We are desperately in need of help. I firmly believe that the personal interactions between a Healthcare Provider and the patient are still the basis of a strong medical system. We must prioritize the real costs of medical care and separate it from a profit-motivated system.

In conclusion unless some change is brought about in how pharmacy reimbursement is determined, it seems inevitable that more local pharmacies will fail. What will remain are the giant mail order options and the strongest of the chains. Insurers have grabbed control of the economic factors that were once in the hands of local pharmacies. To insure protecting this valuable resource I would recommend that before agencies like ETF choose a PBM they consider having Health Plan Data Solutions do an audit.

Yours truly,

Jane M Greischar R. Ph.
Formerly and occasionally still associated with Community Pharmacy Cooperative INC since Sept 25, 1972

Gary Rutherford RPh
HealthPlan Data Solutions, LLC
Co-Founder & Chief Clinical Officer
[redacted]

Enc: Middleman Drive up prescription drug prices, critics say
Columbus Dispatch October 23, 2016

CC: Community Pharmacy Coop Inc.
David Sparer, Attorney
Pharmacy Society of Wisconsin
Gary Rutherford, Health Plan data Systems

Middlemen drive up prescription drug prices, critics say

By Encarnacion Pyle The Columbus Dispatch • Sunday October 23, 2016 11:53 AM

- A sampling of 41 prescriptions filled during September at one pharmacy found pharmacy benefit managers took back an average profit of $7 per prescription, while the pharmacy made an average of about $6.

The industry created to keep drug prices in check is capitalizing on a lack of government oversight to rake in huge profits — often at the expense of patients, health plans and pharmacies, critics say.

Drugmakers such as Mylan have been the target of much consumer wrath after the cost of its EpiPen, used to treat potentially deadly reactions to food allergies and bee stings, rose by more than 500 percent in just a few years.

But a lesser-known group of companies called pharmacy benefit managers, or PBMs, also play a critical role in driving up drug prices, said former state Rep. Tim Brown, a Bowling Green Republican. And not enough people know about it.

"There's capitalism and exploitative capitalism, which is no better than stealing," said Brown, who helped to push through a 2015 state law to hold pharmacy benefit managers more accountable. " These pharmacy benefit managers have created a real racket that's made them into multibillion (dollar) corporations. And we, as government, should be asking why."

He would like to see stronger regulation of pharmacy benefit managers and says the Ohio law passed last year needs to be reworked because the firms have found ways around the reforms that were intended to rein in dramatic underpayments to pharmacies.

The industry's trade group says the firms help keep down costs for health plans, while providing consumers access to medications and pharmacies at more affordable prices. Between now and 2025, pharmacy benefit managers are projected to save clients $654 billion nationwide.

"In Ohio, PBMs are projected to save the state's employers, unions, government programs and consumers $24.7 billion on drug benefit costs over the next decade," said Mark Merritt, president and CEO of the Pharmaceutical Management Association.

But that hasn't stopped a growing call for more scrutiny of the industry.

Since around the late 1960s, pharmacy benefit managers have served as third-party administrators of prescription drug programs for commercial, self-insured, Medicare Part D and state and federal employee health plans. Think of them as the middlemen between health insurance companies and pharmacies.

They originally were designed to process claims, oversee plan benefits and negotiate costs between pharmacies and insurance plans, said Antonio Ciaccia, director of government and public affairs at the Ohio Pharmacists Association.

Today, however, pharmacy benefit managers have become complex businesses that can manipulate prices and payments to their benefit, he said. They decide what medications insurers should cover, how much they'll cost and how much pharmacies will be reimbursed.

The three largest firms — Express Scripts, CVS Caremark and OptumRx — manage drugs for 180 million Americans, just under 80 percent of the market. Each company has annual revenue exceeding $15 billion.

"Not everything about PBMs are awful, but confusion and cloudiness has resulted in heavy profits for this industry," Ciaccia said.

One of the drug middlemen's most dubious practices is overcharging for medications, sometimes charging patients hundreds of dollars more than their cost, advocates say.

"People assume that their insurance card is their golden ticket to good prices, but that's not always true, and we're not allowed to tell them," said a central Ohio pharmacist.

Several pharmacists spoke to The Dispatch on condition of anonymity because they have confidentiality clauses in their contracts that could result in getting kicked out of their PBM networks.

Here's how the overcharging works:

At the pharmacy counter, patients pay a copay set by their pharmacy benefit manager and insurance plan. Later, the PBM takes back a portion of that patient payment after it determines what it will pay the pharmacy for the drug. It's a practice often referred to as a "clawback."

Consider a recent transaction at a local pharmacy for Raloxifene, an osteoporosis drug: The pharmacy benefit manager directed the pharmacist to charge the customer a copay of nearly $192. That's much more

than the $116 the PBM paid the pharmacy for the cost of the drug and to fill the prescription. And it is much more than the nearly $57 the pharmacy originally paid for the pills. In the end, the pharmacy made $59 in profit, and $76 stayed with the PBM.

On a purchase of the nasal spray Fluticasone, the pharmacy profited much less than the pharmacy benefit manager, a more common scenario, the pharmacist said. In this case, the pharmacist was told to ask for a copay of $35. The PBM later kept about $28 of the patient's payment, and the pharmacy was paid just over $7, for a $4 profit.

These examples came from a sampling of 41 prescriptions filled in the month of September at just one pharmacy. Of these, the pharmacy benefit managers took back an average profit of $7 (ranging from 30 cents to $75), while the pharmacy made an average of about $6 (ranging from a loss of $14.91 to an almost $60 profit). That's for both the cost of the drug and the cost to dispense it. But the pharmacist said it doesn't actually cover both — the actual cost to fill one prescription is between $10 and $15.

It's no different from "picking a customer's pocket," another pharmacist said.

Merritt said pharmacists could simply offer customers the cash price of drugs, bypassing insurance. The only reason for pharmacies to process the claim is to keep the copay for themselves, he said.

Patients can — and should — pay cash whenever it is to their benefit, the pharmacists said. But too often they don't know that is an option, they said. And when they do, the price they pay will not go toward the deductible on their insurance plans, so they need to weigh what will help them most.

In the case of the osteoporosis drug, the customer would have paid the same amount — just under $192 — whether they paid cash or not, the pharmacist said. The person buying the nasal spray would have paid $18 less — about $17 instead of $35 — with cash, the pharmacist said.

To make sure they're getting the best deal, people can comparison shop for their prescription drugs at sites such as GoodRx.com.

Pharmacy benefit managers have been criticized for several other practices including:

• Reimbursing pharmacies one rate for dispensing a medication, but charging a higher rate to the insurance plan sponsor, usually a company or employer, for the same medication — and pocketing the "spread" between the two prices. This charge is on top of any agreed-upon maintenance fee between the plan and the pharmacy benefit manager. Spread pricing generally averages $5 per prescription but can run as high as $200, according to a report by the Creighton University School of Pharmacy and Health Professions.

• Assessing fees to a pharmacy sometimes weeks or months after they've already been reimbursed. These fees might be so-called "pay to play" fees for preferred network participation, periodic reimbursement reconciliations or penalties for not meeting quality measures. Often poorly explained, the fees can cost thousands of dollars each month, turning modest profits into financial losses, pharmacists said.

• Tying pricing for generic medications to "Maximum Allowable Costs," or MAC, that can be changed at will. Pharmacy benefit managers can change the drugs it includes — or excludes — from the lists. They can select any price they want — and change the price whenever they want.

Last year, Ohio adopted several reforms, including those requiring pharmacy benefit managers to update their MAC pricing lists every seven days, provide where the drugs can be purchased at those prices, and disclose any discrepancy in reimbursements to pharmacies versus what is charged to plan sponsors.

The law also requires the firms to be licensed as "third-party administrators" by the Ohio Department of Insurance. However, advocates say the law needs to be tightened because the companies have found ways to skirt the regulations.

Merritt said instead of complaining about being reimbursed too little by pharmacy benefit managers, pharmacies should consider that the collective bargaining groups they use are paying too much for medications. "Drugstores are always going to want to get paid more like any business," he said. "But health plans want to pay less, and the reality is we don't represent the drugstores, we represent the health plans and their consumers, and our job is to save them money."

But even some health insurance companies are starting to express displeasure with pharmacy benefit managers.

In March, Anthem sued Express Scripts for more than $15 billion, arguing that it charged "above competitive pricing levels" in violation of the parties' agreement. A market analysis performed by a third party revealed that Anthem was overpaying Express Scripts $3 billion a year.

Express Scripts has denied the allegation.

Only about 40 percent of plan sponsors audit their pharmacy benefit managers, said Gary Rutherford, co-founder of HealthPlan Data Solutions, a pharmacy benefit analytics company in Columbus. But more should.

He said his company saved one state agency millions of dollars.

"The best way to improve this confusing and opaque system is by requiring more transparency," said Rutherford, a pharmacist for more than 36 years. "Otherwise, we'll continue to see higher prices."

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