PSSNY

Pharmacists Society of the State of New York, Inc.

PHARMACISTS SOCIETY OF THE STATE OF NEW YORK

TESTIMONY

JOINT LEGISLATIVE BUDGET HEARING
HEALTH AND MEDICAID

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Honorable Finance Chair Senator Krueger, Honorable Ways & Means Chair Assembly Member Weinstein, Senator Rivera, Assemblyman Gottfried and distinguished members,

My name is Debbi Barber. I am a licensed pharmacist from Malone, New York and currently serve as President of the Pharmacists Society of the State of New York. With me today is PSSNY's President-Elect Steve Moore, a licensed pharmacist and co-owner of an independent pharmacy in Plattsburgh.

PSSNY is a 140 year-old statewide organization with regional affiliates that represents the interests of more than 25,000 pharmacists who practice in a variety of settings. Most members practice in community pharmacies. Many are independent owners who will be in Albany on March 5th.

Thank you

It is important to recognize the support that the leaders and members of both houses have shown for the issues that PSSNY has brought to you in the past. Thank you for recognizing the value that local pharmacies bring to your communities. Many of your constituents rely on pharmacists they know for medications as well as the additional support and extra services they provide. With that being said, we are here today calling on you again with an even greater sense of urgency.

Support DFS Oversight of Pharmacy Benefit Management Services

The Society strongly supports the Governor's proposal (Part I of S1507/A2007) to add Article 29 to State Insurance Law. This is a robust licensure and regulatory program that will for the first time give the Department of Financial Services (DFS) authority to hold large and currently unregulated business to account. Over time Pharmacy Benefit Managers (PBMs) have come to wield tremendous power over the healthcare industry and the pharmacy market in particular. The business practices of these entities impact patients, physicians, health plans, pharmaceutical manufacturers, pharmacies and taxpayers to a significant degree behind the scenes and without any regulatory oversight. We urge the legislature to accept the Executive's proposal as presented. It is much needed and long overdue.

PBMs do not hold down prescription drug costs. The Health Care Cost Institute reported that over the recent five-year period, prescription drug spending had a cumulative growth of 27%, despite a flat or decreasing trend in generic drug prices and despite a decline in utilization of brand prescription drugs. The spending increase was driven by double-digit price increases from 2012 to 2016 for brand drugs.[1]

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[1] Moore, Tamara. "Rising Prices Drive Pace of Health Spending Increase." January 23, 2018. https://healthcostinstitute.org.

Three large PBMs dominate the managed care market. According to recent published reports CVS/Caremark, ExpressScripts (ESI) and Optum Rx collectively control 75% to 85% of prescriptions dispensed in the United States, including prescriptions covered by Medicare Part D Plans and Medicaid managed care plans. Their profitability parallels increased drug costs. The big three generated net profits totaling $12.3 billion in 2017 according to their 10-K SEC filings.

Formulary control makes pharmacy benefit managers the major player in the prescription drug market. Formularies provide leverage in rebate negotiations with pharmaceutical manufacturers and prescription drugs with "preferred" status bring higher rebates that do not always make it back to the patient or payer. PBMs are increasingly adopting drug exclusion lists and both of these aspects of coverage affect which medications are available to patients. [2],[3] It is important to note here that current state law has no external appeals procedure for patients/caregivers or prescribers to appeal a drug coverage decision by a health plan or its PBM sub-contractor.

The pharmacy market is broken. Large PBMs own and operate mail order and "specialty" pharmacies. They also "manage" pharmacy networks, an arrangement is fundamentally anti-competitive. It is not a surprise that PBMs steer prescription volume to themselves and mandate that patients receive prescription refills or "specialty" medications exclusively from the mail order or specialty pharmacies they own. In addition to steering which is perfectly legal under the current law, PBMs have unfettered control over how much they pay their network pharmacies, their competitors in the pharmacy marketplace. Community pharmacies of all sizes, from the single store independent to chains as large as Walmart, are victims of this broken market.[4] **The Governor's PBM licensing proposal shines light on the routinely unfair business practices that are bringing New York's pharmacies to their knees.**

In a particularly egregious example of unfair predatory behavior, in the fall of 2017 a large PBM that dominates state's managed care pharmacy market (both private insurance and Medicaid managed care) drastically cut payments to pharmacies significantly below acquisition cost for a substantial number of prescription drugs across many therapeutic categories. Pharmacies then received buy-out offers from the same corporation citing market pressures such as low reimbursements and reduced profitability.[5]

PSSNY members throughout the state are reporting that they are running out of belt-tightening options as they wrestle with PBM reimbursements that are below cost, patients who are required to use mail order or specialty pharmacies in order to access their

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[2] The Doctor Patient Rights Project. "The De-List: How Formulary Exclusion Lists Deny Patients Access to Essential Care. December, 2017.

[3] Ne'eman, Ari. "Formulary Restrictions Devalue And Endanger The Lives Of Disabled People." October 29, 2018. Health Affairs blog. https://healthaffairs.org.

[4] Schladen, M. and Candisky, C. "Report: CVS Shorted Some Rivals: Undercutting the Competition." The Columbus Dispatch January 20, 2019

[5] "CVS/Aetna: State Regulators Urged to Investigate CVS Caremark Reimbursement Cuts, Solicitation Letters, as Part of Aetna Review. The Capitol Forum. January 12, 2018

medications, and PBMs that are shrinking local pharmacy networks. Our members are reporting reduction in hours of operation, reducing staff and depleting reserves to stay afloat.

To pharmacies and to patients, the need for PBM oversight is clear and urgent. **Please retain the Governor's PBM licensing and regulatory proposal in the one-house budget documents and in the final New York State budget.**

It is also important to note briefly that the Justice Department has approved the mergers of two large PBMs with health plans (CVS-Aetna and Cigna-ExpressScripts). OptumRx is owned by United Healthcare. These vertically integrated healthcare entities will change healthcare coverage that will in turn change how healthcare is delivered and accessed. The impact of these mergers is likely to be felt across the whole healthcare delivery system including physicians, pharmacists and hospitals.[6] Inherent in vertically integrated entities is the risk of further market manipulation, disruption and less transparency, making the Executive Budget PBM licensing proposal even more timely and necessary.

PBMs and Spread Pricing in Medicaid Managed Care

The Pharmacists Society supports the Executive Budget proposal to eliminate spread pricing in Medicaid managed care. DFS oversight of PBMs is needed to make it effective.

Prescription drug coverage became part of Medicaid managed care in 2011. Because Medicaid is funded with taxpayer dollars (state as well as federal), costs and cost efficiencies are of interest to public authorities. In 2011 managed care organizations and the Health Department argued that integrating pharmacy benefits would improve quality of care and therapeutic outcomes and control costs. PBMs gained complete, non-transparent control of the pharmacy program as subcontractors to health plans. PBMs formed networks and contracted with local pharmacies and to this day state officials have no way to see what PBMs pay pharmacies for prescriptions they dispense. The state does know what health plans pay PBMs for prescription drugs dispensed to Medicaid patients. **The difference between what the plans pay the PBM and what the PBM pays the pharmacy is the spread**. The Governor's proposal is to eliminate spread pricing by enforcing transparent pass-through pricing. The PBM would be paid a fee for processing the claim. The amount of the claim processing fee would be determined by the Health Department. The pharmacy would be paid a reasonable professional dispensing fee and would be reimbursed for the cost of the drug. The state expects to receive all associated rebates. In order to work as intended, DFS must have new authority to license and regulate pharmacy benefit management services.

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[6] Japsen, B. "Threats to Hospitals Emerging Already from CVS-Aetna Combination." Health Leaders Analysis. January 30, 2019. https://www.healthleadersmedia.com/strategy/threats-hospitals-emerging-a;ready-cvs-aetna-combination

A report by the Ohio State auditor from August, 2018 documented the dollar value of spread pricing in the Ohio Medicaid managed care program.[7] **Spread pricing in Medicaid managed care in Ohio amounted to $208 million a year.** Medicaid officials quickly directed the state's five managed care plans to eliminate all contracts with pharmacy benefit managers based on secretive spread pricing and to move to a more transparent pass-through pricing model effective January 1, 2019. This is what the Governor's Executive Budget proposes and what PSSNY knows needs to happen in New York.

"The more we learn, the more troubling this becomes," said Ohio State Auditor Dave Yost in releasing audit results in August. Ohio's official state audit began as a direct result of an independent analysis from data collected from a number of independent pharmacies. The analysis captured the amount pharmacies were paid for selected drugs under fee for service and the amount they were paid for the same drug by PBMs servicing Medicaid managed care plans (MCP) for the same drug. This data was posted on the CMS website where states reported their drug costs. It is publicly available prescription cost data. The difference between what plans were paying and what pharmacies were paid for generic drugs was significant. Legislators were briefed on the findings. Medicaid officials asked questions. When the Ohio State auditor compared what pharmacies were paid by PBMs to what plans were charged, he found that PBMs had pocketed $208 million of taxpayer dollars because of spread pricing. His findings validated the results of the initial private study.

Spread pricing: The PBM bills the managed care plan (MCP) one amount for a patient's medication, and pays the pharmacy a different (smaller) amount to dispense it. It keeps the difference as profit – along with any rebate it receives from the manufacturer. That means PBMs have an incentive to bill the MCP (i.e. the taxpayers) as much as possible while paying the pharmacy as little as possible. Until recently, the amount of a PBM's spread, and how much it received in rebates, has been a closely guarded secret.

The Ohio Pharmacists Association reported that pharmacies in Ohio were netting $1.15 per Medicaid prescription on generic drug prescriptions while pharmacies owned by PBMs were pocketing $6.15 per prescription. Pharmacies were paid more than $350 million below typical market rates, a finding that helps to explain the number of pharmacy closures that alarmed Ohio legislators and prompted the administration to move to a pass-through pricing model such as is being proposed by Governor Cuomo.
Pass-through pricing: The PBM receives a flat fee for each prescription it processes, on top of the actual cost of the medication. Pharmacies are paid a set amount per prescription as a professional dispensing fee.

PSSNY Commissioned a White Paper to examine spread pricing in Medicaid managed care in New York which was completed in January. A copy of the study is included with this testimony.

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[7] http://gatehousenews.com/sideeffects/ohio-medicaid-drug-audit-calls-transparency-highlights-pharmacy-closures/site/dispatch.com/

The data analysis conducted by 3Axis Advisors confirms the theory that PBM payments to pharmacies were significantly reduced without a corresponding reduction in Medicaid spending for prescription drugs.

The analysis is not a claim by claim analysis of New York's Medicaid managed care program. Only the state has access to the full dataset needed to perform that analysis, as happened in Ohio.

The data analysis included a sample of prescription claims paid and processed by PBMs for all of the Medicaid managed care plans in New York. The eleven independent pharmacies in the sample are representative of all regions of the state.

Although 19 managed care plans participate in the NYS Medicaid program, the majority of prescription claims are processed by three large PBMs:

CVS processes 72% of NY Medicaid MCP prescription drug claims.
OptumRx processes 12% of NY Medicaid MCP prescription claims.
ExpressScripts processes 15% of NY Medicaid MCP prescription claims

The distribution of PBM paid claims analyzed in the sample reflects this same pattern, an important validation for study results.

As previously mentioned, a data set that was a key element in the preliminary independent analysis of paid claims in Ohio was the state-specific costs reported to CMS and available from the CMS website. Unfortunately, the cost data from New York was only available for the first quarter of 2018 as New York changed the way it reports data to CMS. For the most recent twelve months for which New York's Medicaid prescription cost data was publicly available, the average spread per prescription in the analysis was $5.62. When the spread is applied as a percentage of total generic spending by NYS Medicaid in 2017, the study suggests that the value of the spread in New York is more than $300 million.

PSSNY has concerns about the potential for anti-competitive business practices when one pharmacy/PBM is allowed to determine the reimbursement of another pharmacy as demonstrated by data from the Ohio Medicaid program. The Society is confident that an analysis by the Department of Health will confirm that what is happening in New York is the same as what has happened to pharmacies and taxpayers in Ohio. Safety net programs such as Medicaid should not be manipulated by PBM business entities for their own financial benefit. PSSNY stands ready to work with the Health Department and other stakeholders as our pharmacists can offer real solutions and services as part of a value-based care model. Pharmacies throughout the country have formed enhanced service networks, and one is active right here in Albany, working with a Preferred Performing System under the DSRIP program to improve outcomes and lower healthcare costs.

Solving the Spread Pricing Problem

Eliminating spread pricing in Medicaid managed care as the Governor has proposed, together with effective DFS regulatory oversight of businesses that provide pharmacy benefit management services as stand-alone companies or as part of a vertically integrated healthcare corporation is a good start. However, eliminating spread pricing does not ensure that pharmacies are compensated at fair and reasonable rates that allow them to remain financially viable over time. PSSNY therefore makes the following recommendations:

- Return to Fee for Service for the Pharmacy Benefit to give the state control over every rebate dollar generated by the Medicaid program. When PBMs control drug formularies they have incentives for manipulating and retaining rebates from pharmaceutical manufacturers. A uniform Medicaid formulary for every beneficiary ensures fair treatment and consistent prior authorization and appeals procedures. Predictable reimbursement policies would be a marked improvement over the current inconsistent, often incomprehensible reimbursement pharmacies receive from PBMs.

- Establish a pharmacy reimbursement floor in Medicaid managed care. Consider current Fee for Service benchmarks as the floor: Actual acquisition cost as represented by the National Average Drug Acquisition Cost (NADAC) and the $10.08 professional fee. While this fee is lower than the fees of neighboring states such as New Jersey, Vermont and Connecticut, and is not reflective of the cost of operating a pharmacy in New York State, it does represent a starting point for discussions.

- Conduct a statewide comprehensive analysis of spread pricing in Medicaid managed care to determine the full extent of spread pricing in the state Medicaid program and use a portion of the savings to provide pharmacies with fair and reasonable compensation for their professional services and the medications they dispense.

PSSNY pledges to continue to work with members of the legislature, state agencies, administration officials and other stakeholders to develop and provide progressive policies that promote healthy communities where community pharmacies thrive and pharmacists are rewarded for the important services they are uniquely well-equipped to provide. Please help the pharmacists in the state of New York continue their commitment to patient care. Pharmacists are part of the solution to the problem of rising healthcare costs as we are the most accessible healthcare providers capable of influencing outcomes. Without immediate and comprehensive reform in the current PBM dominated model, this ability will be irrevocably compromised.

Our members need relief to remain viable and we need relief now.