COMMENTS OF GREGORY DREW, R. PH, TO THE SENATE HEALTH & HUMAN SERVICES COMMITTEE AND SENATE REPUBLICANS POLICY COMMITTEE.

OCTOBER 16, 2018

Good morning. My name is Greg Drew. I am a Pennsylvania registered pharmacist; however I appear before you today not as a practicing pharmacist, but as President of Value Drug Company, an Altoona based pharmaceutical wholesaler and distributor, organized under a co-operative corporation comprised of independent community pharmacy owners. I also serve as Board Chairman of the Wholesale Alliance, a consortium of wholesalers serving primarily independent community pharmacies across the country, and owners of Pharmacy First, an independent Pharmacy Services Administrative Organization, known as a PSAO. In addition to these positions, I have a deep professional history of management of Pharmacy Benefit Managers, or PBMs, both in a clinical capacity and in fact as General Manager of a PBM.

As you are likely aware, pharmacy benefit managers provide several services to its clients, which include commercial insurance plans, self-funded ERISA plans, Taft Hartley organized labor managed plans, state Medicaid programs, and federal Medicare programs. Based on published research, PBMs manage more than ninety percent of all the patients with prescription drug coverage. PBMs determine the levels at which pharmacies are reimbursed for the pharmaceuticals and services that they provide to their client's members. Not irrelevant is the fact that most PBMs additionally own and operate mail order or retail pharmacies, as well as specialty pharmacies, to whom which they direct business through benefit design. If this was a practice performed by physicians towards affiliated suppliers and services, these practices would be prohibited under the Stark Law, however PBMs are allowed to make this part of their business model, unregulated. In fact, PBMs remain unregulated in most aspects of their practices, even when state law addresses abuses, due to a federal pre-emption under ERISA law.

PSAOs are entities that provide numerous support services to primarily independent community pharmacies, such as group contract negotiation, financial reconciliation of PBM payments, credentialing services, and centralized payment services. PSAOs act as the umbrella organization for independent pharmacies that do not have the resources to do so on their own. Recently one major pharmacy benefit manager in fact reduced the number of PSAOs that they would recognize and do business with to only four organizations, leaving pharmacies contracted elsewhere with no choice but to abandon the PSAO that they were currently contracted with, move to an anointed PSAO, or contract directly with the PBM, without representation. Essentially removing the ability for the independent community pharmacy to exercise choice.

Even when represented by PSAOs, pharmacies are often presented with contacts that the PBMs will not negotiate, but rather the pharmacy is faced with the decision to accept the reimbursement offered or no longer be able to serve their long-standing patients. These reimbursement levels have continued to erode to the point at which a pharmacy often is reimbursed less that the cost of the drug, and may not receive any reimbursement for their professional services. There have been numerous studies performed to determine the cost to dispense a prescription, which is often more than twelve dollars. This does not include any profit margin whatsoever for the pharmacy, which is one of the small businesses upon which our country depends to drive our economy, nor does it recognize the clinical services that community pharmacists provide as health care providers, often in rural areas where they are a primary source of care. Recent state Medicaid investigations have determined that the difference

between what these pharmacies have been paid, and the higher costs charged to the state Medicaid programs, are in the hundreds of millions of dollars. The takeaway here is that the largest three PBMs, publicly traded companies, in conjunction with their parent companies, are all listed within the top 200 global Forbes companies. We would be hard pressed to find our independent community pharmacies on that list. Even more significant is that the combined companies, with the mergers and acquisitions of Express Scripts and Cigna, and CVS/Caremark and Aetna, will move even higher on the list. I would argue that a portion of this phenomenon is on the backs of, and at the detriment to, independent community pharmacy.

In recent actions, the reimbursement levels to pharmacy have been further reduced through two distinct methods. The first of which is the introduction of DIR fees, or direct and indirect remunerations. In the case of pharmacy, these are fees that are charged a pharmacy for the privilege of participating in a plan network, when in fact they even have the opportunity to participate. These fees are often determined based on metrics that are beyond the control of independent pharmacies, such as generic dispensing rates. If pharmacies were measured on their performance substituting generic drugs when possible, to contain healthcare costs, this might be acceptable, however when the mix of prescriptions is determined by prescribing physicians and their patients, it is beyond the pharmacy's control. These fees are often charged months after the pharmacy dispenses a prescription, without transparency or visibility to the ultimate reimbursement amount. A more recent reimbursement modifier introduced is the concept of Generic Equivalent Reimbursement, which measures the pharmacy's reimbursement amount to an irrelevant benchmark of Average Wholesale Price. It is not my intent to educate the Committee on reimbursement metrics, however it is important to recognize that the reimbursement amounts, which were originally set by the PBM, are modified to meet a metric which has no relevancy to the actual cost of a generic drug. When I was involved in the PBM business, these were guarantees made to a client by the PBM, and apparently now are a risk mitigation strategy by PBMs to eliminate their risk and transfer it to the pharmacy. I have to wonder if the reimbursement to their own pharmacies is subject to this methodology.

I want to be clear that I fully recognize the need for pharmacy benefit managers to be a part of prescription drug coverage management. They have the ability to negotiate drug cost with pharmaceutical manufacturers and provide very critical clinical services around drug utilization by patients. They also have significantly automated payment mechanisms associated with plan design and provide services that ensure the appropriate utilization of pharmaceuticals in many cases. Since price transparency and the gross to net pharmaceutical pricing methodology are not the topics of this hearing, I will refrain from opining on whether I believe that they are appropriate venues for PBM profitability. I also want to add that not all PBMs act in the fashion that I have described, however the largest do. There are several transparent pharmacy benefit managers that truly deliver these services, under a fixed fee system, that not only reflects the way they interact with pharmacy and pharmaceutical manufacturers but deliver true health care cost savings to our economy. One of these, Benecard PBF, has significant operations within Pennsylvania, and has been a leader in transparency. These entities would not be impacted by regulation, as their practices are clear and truly bring value to its clients while providing excellent service portfolios. However, regulation would bring honesty and transparency to an industry, which if we continue to allow to operate unchecked, will be the death knell to independent community pharmacy as we know it in the Commonwealth, and will be a disservice its residents.