

# **MEANS LAUF SUPER DRUG**

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Senator Don White, Majority Chair  
PA Senate Banking and Insurance Committee  
Harrisburg, PA

Dear Committee Members,

Thank you for this opportunity to provide testimony in support of SB616 (PN665). As an independent retail pharmacy owner, I am confronted daily by my patients who are forced to choose between their trusted local pharmacist and the limitations imposed upon our retail pharmacies vs using a mail order pharmacy owned by their Pharmacy Benefit Manager (PBM). PBMs allow a larger day's supply in mail order (typically 90 days vs 30 days retail) and generally for a lower co-payment (not necessarily a lower overall cost for a prescription). This incentivizes the patient to use the mail order option.

Hardly a day goes by that I don't have to supply an emergency prescription to a patient who didn't receive their mail order supply in a timely fashion. Often the emergency supply isn't covered by their insurance, since mail order has already processed the claim. Patients either have to pay cash or ask for an emergency authorization from the PBM (often with limitations and higher co-pays for a lesser day supply). Patients often don't understand why this occurs. Why can't the retail pharmacy fill 90 day supplies? (We could, but the PBM won't let us). Why can the retail pharmacy fill their prescription in 15 minutes, but mail order takes more than 15 days? (Is this efficiency?). Why are they forced to use mail order when they prefer their local pharmacist? (some plans limit the patients to 21 day supplies and two refills on maintenance medications at retail pharmacies) Why, if their company is saving so much money by using mail order, do their co-pays and cost sharing keep increasing every year? Why can the local CVS pharmacy fill 90 days, but no other retail pharmacy can? If a PBM manages prescription drug costs, why are drug costs being blamed for the runaway cost of healthcare? Let's explore these questions in the context of SB616.

I have patients who use mail order. They still use my pharmacy for acute medications, new prescriptions, and emergency supplies, but the lower co-pays for mail prescriptions saves them money. If we could fill prescriptions under the same terms, they would prefer to get them all locally. I also have patients who tried mail order and came

back to my pharmacy despite higher out of pocket costs due to problems with mail order (meds don't arrive on time, errors were made, packages shipped in extreme temperatures (both hot and cold), etc. They trust their local pharmacist, seek our counsel, and value the services we provide. I have a couple whose prescription plan limits their chronic medications to a 21 day supply at retail pharmacies with a maximum of two refills yearly (63 days of medicine at retail). After that is exhausted, they get no benefit other than mail order for the medication. This creates a problem for them: they don't have credit cards and they don't have enough cash for the 90 day co-pays for as many medications as they need. They end up going without their medications and end up hospitalized (six times in 2009 and she is currently in a local nursing home for IV Therapy) which costs their insurance company much more money than the prescriptions would (not to mention the poor quality of life they endure and worry over how to get their medications). I have another elderly patient who doesn't have credit cards, and when mail order lost her check she sent with her order, now refuses to accept checks from her. She would appreciate passage of SB616 so she can receive the same cost savings from her local pharmacy!

We have fought back against this mail order push by PBM's. In order to save prescription costs, we get the physician's approval to change to a generic or other less expensive drug. This is especially valuable for our Medicare Part D recipients. We now fill over 70% of our prescriptions with generic drugs (the average generic price is approximately \$20 vs \$150 for brand drugs). Also with generic drugs, although the PBM may limit us to a 30 day supply, we can sometimes match the mail order co-pay for 90 days supply and just fill the prescription on a cash basis.

Although much of this report has focused on cost, I caution you against considering the dispensing of drugs as a simple commodity. Prescription medications have good and bad effects. We monitor and counsel patients on what the medication is for and what to expect. We follow up further to see if the medication improved the person's health vs any side effects experienced. We check the prescription order for accuracy, appropriate dose and directions, and will consult with their physician on any inconsistencies (which occur daily despite electronic prescribing systems) or formulary compliance issues. This is the professional service a pharmacist provides and is included as part of the prescription filling process. When a patient gets some prescriptions by mail and some at a retail pharmacy, as well as their vitamins and other OTC products, there is a gap in this monitoring and adverse drug reactions can occur. It is estimated that in the United States, we are currently spending \$1 on treating adverse drug reactions for each \$1 we spend on drugs. It's time to value and reward good pharmacist care, and not just who can fill the most or biggest prescriptions.

Prescription costs have sky rocketed while the pharmacist's payment rates have been steadily reduced. Granted, our population is aging and we use more drugs as we get older, but a greater cause is how PBM's have used co-pays to isolate the patient from the total prescription cost and use co-pays to drive business to their mail order units and to drugs that earn the PBM a higher profit (i.e. the formulary). Drug manufacturers give PBM's rebates for preferred formulary status; however manufacturers have no price controls and can raise the price retail pharmacies pay for drugs at any time. I feel this rebate system (after the patient is dispensed the prescription) has escalated the cost of medicines much faster than appropriate.

On generic prescriptions, PBM's use "spread pricing" where they pay pharmacies at a low MAC (maximum allowable cost) rate and still bill plan sponsors and insurers at much higher rates. It's very frustrating as a small business person to have no negotiating power with a PBM (its take it or leave it with them as far as your contract is concerned) and know that you do all of the professional service and provide the medication and get paid a very small price, but the PBM doesn't pass it on to the company and often times makes more than we do for sitting in the middle of the transaction and keeping the payer in the dark about what they actually pay pharmacies. This is especially addressed in SB616 in section 15 (IV) which tries to create transparency in the prescription payment process. This problem (the lack of transparency) is probably the greatest area of potential savings in the prescription drug market (adverse drug reactions is greater, but doesn't necessarily change prescription costs). This lack of transparency is proven to me every day by: 1. contract clauses that forbid me to share what the PBM pays me for prescriptions with patients or plan sponsors (i.e. employers); 2. The proliferation of discount cards (where the patient pays 100% of the prescription cost (and the PBM gets the rebates and or a pharmacy administrative fee); 3. Fixed percentage based co-pays where the co-pay amount (i.e. 30% doesn't match the amount paid to my pharmacy); 4. The introduction of Health Savings Accounts (HSA) with high deductible health plans (generic drugs that were paid at \$12 minus a \$10 patient co-pay (\$2 payment from the PBM) are now priced at \$30 in the HSA plan to keep the PBM from looking bad to the employer; 5. Formularies that require patients to stay on a brand medication (i.e. Protonix) at a higher co-pay when a generic is available and should be a lower co-pay; 6. The advantage of cost savings for "formulary" drugs isn't passed back to the patient particularly in Part D plans. (The patient may have a lower co-pay, but the full cost of the medication counts toward their annual limits – not minus the rebates).

I have strayed from SB616 and its prohibitions on mail order prescription discrimination but I feel educating you on the problems in pharmacy payment methodologies can only enlighten you as you move forward in deciding how to continue to provide pharmacy benefits at an affordable cost for state employees, and those you are entrusted and required to care for as The Commonwealth of Pennsylvania.

Giving consumers a choice in selecting their pharmacy without punishing them financially removes a monopoly the PBM's have enjoyed for too long and has cost employers and the Commonwealth more for prescription drugs than would have occurred in a transparent system!

I would be happy to answer your questions on this complicated subject.

Sincerely,

David M. Smith RPh.  
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