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M E M O R A N D U M

TO: Members of the Senate Health & Welfare Committee

FROM: Charles ("Chuck") Storrow, KSE Partners, LLP, on behalf of Express Scripts, Inc.

DATE: March 9, 2015

SUBJECT: Draft Committee Health Care Bill/Pharmacy Benefit Managers

The purpose of this memorandum is to follow up on my testimony on behalf of this firm's client Express Scripts, Inc. ("ESI") on February 26 concerning the provisions in the draft committee health care bill (drafting request 15-1145—draft 1.2) regarding pharmacy benefit managers ("PBMs"). ESI is a PBM and it helps the Vermont State Employees Health Plan and Blue Cross/Blue Shield of VT manage their respective prescription drug benefits.

By way of background, ESI is a national company that helps health insurers, self-insured employers, union sponsored health plans, and public health plans manage their prescription benefits. ESI helps manage the prescription drug benefits provided to over 140 million Americans. Reference is made to the "Pharmacy Benefit Manager (PBM) 101" document I provided to the Committee in connection with my testimony on February 26 for a more detailed description of the services, strategies and tools PBMs provide to manage prescription drug benefits and reduce prescription drug costs. An example of the value ESI can provide in reducing prescription drug costs reference is illustrated by the December 22, 2014 *New York Times* article about an agreement ESI reached with a drug manufacturer which I provided to the Committee in connection with my testimony. Finally, reference is made to the document entitled "Purchasing Pharmacy Benefits: A Request for Proposal Overview" I also provided to the Committee.

It should be noted that while ESI is a large company, in 2013 its profit margin was 1.76%.

ESI has significant concerns with section 1 of the draft committee bill. In ESI's view the provisions in section 1 will put upward pressure on the cost of providing prescription drug benefits. The reasons for this conclusion are as follows:

- On page 5 of the bill a new subchapter dealing with the so-called "maximum allowable cost" ("MAC") pricing tool utilized by PBMs is proposed.

- The MAC pricing tool was developed by state Medicaid agencies and relates to the fact that there can be widely differing wholesale prices for any given generic drug depending on the

particular wholesaler.

- PBMs like ESI analyze the wholesale market on a continuous basis and determine the prices available to pharmacies (or groups of pharmacies acting together in purchasing drugs) in purchasing, at wholesale, various generic drugs.

- In reimbursing pharmacies for the generic drugs they purchase and dispense PBMs like ESI pay the pharmacy an amount—"maximum allowable cost"-- that is based on the reasonable wholesale cost of a given generic drug.

- The amount the PBM pays the pharmacy may or may not reflect the pharmacy's actual cost. In some cases the amount paid to the pharmacy is more than the pharmacy's actual cost and in some cases it may be less than the pharmacy's actual cost.

- PBMs use the MAC pricing tool in reimbursing pharmacies in order to normalize the widely differing wholesale prices for many generic drugs.

- If PBMs just reimbursed pharmacies based on the actual price a pharmacy paid it would remove the incentive for pharmacies to "shop around" for the best price.

- The draft committee bill would impose a number of requirements and restrictions on the use of the MAC pricing tool by PBMs.

- Of particular concern to ESI is subdivision (B) beginning on line 7 on page 7 of draft 1.2. Under this provision a PBM would have to retroactively adjust the MAC based amount it paid a pharmacy and pay an additional amount to the pharmacy if the pharmacy's actual acquisition cost is more than the MAC based amount. This would reduce a pharmacy's incentive to obtain the best wholesale price possible for a generic drug.

- It should also be noted that there is no provision for a retroactive, downward adjustment if the MAC based amount paid to the pharmacy is more than the pharmacy's actual acquisition cost.

- Due to advocacy by the pharmacy community the issue of MAC pricing came up during the 2014 legislative session. The House Health Care Committee considered language providing for transparency in MAC pricing in an amendment to S.252 proposed by Representative Copeland-Hanzas. I provided that language to the Senate Health & Welfare Committee in connection with my testimony on February 26. The language in question is set forth as proposed subsection (b) to 18 V.S.A. § 9473. ESI did not oppose that language then and does not oppose it now. It is respectfully requested that if the Committee wants to address the issue of MAC pricing it adopt the language in last year's proposed amendment to S.252 instead of the provisions in the proposed subchapter 3 in the draft committee bill under consideration.

- In addition to the provisions concerning MAC pricing the draft committee bill contains a new, proposed subchapter 4 beginning on page 7. ESI has serious concerns about the

provisions in the proposed subchapter 4 as they would increase the cost of a health plan's prescription drug benefits.

- Subsection (a) beginning on line 16 on page 7 provides that a health plan and/or a PBM must allow a plan beneficiary to fill his or her prescription at any pharmacy and cannot impose a differential cost sharing requirement (such as a copy or co-insurance amount) based on the plan beneficiary's choice of pharmacy.

- Health plans/PBMs often provide an incentive for plan beneficiaries to obtain a 90 day supply of drugs from a cost effective mail order pharmacy by reducing the co-pay or co-insurance amount the plan beneficiary has to pay if they do so.

- Subsection (a) would increase prescription drug costs because it would prohibit a health plan/PBM from providing an incentive to have a prescription filled by a cost effective mail order pharmacy.

- Importantly, under existing law (8 V.S.A. § 4089j) a health insurer and/or PBM must allow a retail pharmacy to fill a prescription that would otherwise be filled by a mail order pharmacy if the retail pharmacy is willing to do so on the same terms and conditions as the mail order pharmacy. In other words, a plan beneficiary already has the ability to have a retail pharmacy fill a prescription that would otherwise be filled by a mail order pharmacy if the retail pharmacy can match the terms and conditions of a mail order pharmacy.

- Subsection (a) would undermine the level playing field created by existing law (8 V.S.A. § 4089j), and would put upward pressure on the cost of prescription drug benefits because it would force a health plan/PBM to reimburse a pharmacy even if cannot match the terms and conditions of a mail order pharmacy.

- Subsection (b) beginning on line 20 of page 7 prohibits a health plan and/or a PBM from conditioning its reimbursement of a pharmacy on the pharmacy being in the health insurer's/PBM's "network."

- Health insurers enter into contracts with health care providers whereby the provider agrees to provide its services at a discount in exchange for being in the health insurer's "network" of providers. The health insurer then requires its beneficiaries to use a network provider (or provides an incentive to use a network provider). As a result, the health care provider gets the benefit of having a volume of patients that it otherwise might not have if it were not in the health insurer's network. Creating such a "network" is a commonly used and effective way of having health care services provided at a lower cost than they otherwise would be.

- In addition to medical health care providers the above described concept is applied in the context of prescription drug benefits and pharmacies. Health insurers and PBMs will enter into agreements with pharmacies whereby the pharmacy will agree to provide a discount on their dispensing fee in exchange for the volume of business they receive from being in the health insurer's/PBM's "network."

- Subsection (b) would negate the basis for having a "network" and thus increase the cost of prescription drug benefits.

- Federal and state law requires health insurers to have adequate networks of health care providers i.e., enough approved providers so that people have adequate access to health care providers. As a result, in order to create a legally adequate network of pharmacies a health insurer/PBM has to do what is needed in terms of financial agreements to entice an adequate number of pharmacies to be in its network.

- Finally, it should be noted that PBMs need pharmacies. PBMs help health plans manage prescription drug benefits. Retail pharmacies are obviously a necessary component in a system involving the provision of prescription drug benefits. Accordingly, it is in the interests of PBMs that their financial arrangements with pharmacies are such that an adequate number of pharmacies have the ability to be in business.

- On the other hand, PBMs help health plans reduce the cost of providing prescription drug benefits. To do that they utilize strategies that are designed to eliminate unnecessary costs. MAC pricing, the use of mail order pharmacies and provider networks are examples of such strategies. Section 1 in the draft committee bill would undermine all three strategies.