Testimony

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1. Possible Revenue for Vermont

When the Vermont Retail Druggists and Otis & Kennedy, LLC. began our campaign to bring a measure of transparency to Healthcare, we understood that many Healthcare dollars and opportunities were leaving the State at the cost of Vermont citizens. In our MAC drug pricing proposal we introduced some language, later passed, that we feel can serve to bring some of those dollars back into the State.

Ttle 18: Chapter 221: Subchapter 009 § 9472

(d) At least annually, a pharmacy benefit manager that provides pharmacy benefit management for a health plan shall disclose to the health insurer, the Department of Financial Regulation, and the Green Mountain Care Board the aggregate amount the pharmacy benefit manager retained on all claims charged to the health insurer for prescriptions filled during the preceding calendar year in excess of the amount the pharmacy benefit manager reimbursed pharmacies.

Presumably, the State is now seeing the amount of money that some pharmacy benefit managers (PBMs) are up-charging the Health Insurers. Since I have yet to see any numbers let us for purpose of this conversation call it 3% increase from the retail claim amount. The question then becomes, "What does this money represent?" To the VRD it represents another layer of confusion on the true cost of pharmaceuticals. How are we ever to fully understand what the drivers are in pharmaceutical price changes if "Real" costs are not transparent? When a local insurer like BCBS of VT goes to evaluate the cost of its pharmaceutical expenses and make formulary decisions, are they basing that evaluation on the price that the local pharmacy accepts for the product or are they basing it on the inflated price from the PBM. Do they ever see the "Real" claim amount? Now I can understand administrative/operational costs that the PBM should seek to recoup. However, changing or rather concealing the cost of medications seems a bit of a stretch. The model should, and in many cases does, separate those expenses. The cost of the drug is the cost of the drug; and admin fees are admin fees. That being said, should a PBM decide to "mark up" the price of a pharmaceutical product dispensed in Vermont, it could be argued that they are "retailing" the product and should therefore be subject to the same taxation of revenue as all Vermont retail pharmacies. Distinction needs to be made between the "product" costs and "admin" costs because should such a taxation exists the PBMs would undoubtedly pass such a burden onto the Health Insurer who in turn would only pass it on to the constituents at the premium level. Imposing a tax on the "product" and not the "admin" would offer the PBMs an out that would encourage more transparent practices. Transparency remains at this point, the only reasonably attainable goal until such a time as we are ready to embrace more fundamental changes to our health system. However, that too is a losing battle.

2. DIR (Direct Indirect Renumeration)

Last Year Pharmacy saw the beginning the "new era" in Healthcare payment with the widespread launch of "fee for performance" across all facets of the industry including pharmacy. Despite the fact that the sector has remained hopeless entrenched in an exceedingly vailed "fee for product" construct, insurers took the quantum leap forward to pay based on performance of services. The VRD certainly agrees with the establishment of a performance based system; IF THAT SYSTEM WERE FAIR. All one needs to do is simply ask the question of "Who" is doing the evaluating; Answer: the same monopolies that compete within the market. What is even more enlightening in the DIR scenario is the actual "payment" or rather RECOUPMENTS for performance. The evaluation period is 6 months to a year. If a pharmacy does exceedingly well in its evaluation, that pharmacy will get a notice that money will held back from future payments to adjust for its "job well done." No matter how well they perform, money is always recouped. Furthermore, the offset from each individual claim is not identified. Instead only the aggregate amount to be withheld is reported. One local pharmacy in Vermont scored top marks in its evaluation and was handed an $18K bill.

I bring up the subject of DIR fees not for the purpose of action, as this exists within Medicare D and is out of our hands; but rather to highlight the misdirection and the continual addition of confusion to the cost of pharmaceuticals.

3. Patient Choice

All this time, government bodies have scrutinized the misdeeds of the drug manufacturers; and justly, for they do commit offenses to our citizenship. However, we have become so focused on them and so desperate for a solution that we have allowed and help create other monsters. All we were asking for was lower costs and fair pricing standards. Our singular focus on that paved the way for these other entities, giant vertical monopoly-like partnerships such as CVSHealth and Walgreens Alliance/OptumRx. These companies have done an exceptional job at owning almost every aspect of your care. They claim to save money and help drive competitive pricing, but have prices dropped? More importantly has "ACCESS" to care increased? What we have done is chase to dollar to such an extent that we are literally handing our souls to these conglomerates. We have destroyed any hope of creating a competitive market to help control healthcare costs and may soon find ourselves without any ability to negotiate. Prepare yourselves, prices will go up as your choices go down.

Then again there is always…

08 VSA § 4089j

(b) A health insurer and pharmacy benefit manager doing business in Vermont shall permit a retail pharmacist licensed under 26 V.S.A. chapter 36 to fill prescriptions in the same manner and at the same level of reimbursement as they are filled by mail order pharmacies with respect to the quantity of drugs or days' supply of drugs dispensed under each prescription.

… but no one seems to push this.

Cigna Health is currently offering a "cheaper" plan to many Vermont companies that forces a patient to get their pharmaceuticals from an "associated" pharmacy. Being a "Network" pharmacy means nothing in these cases. (see attached testimony from Emily Marchinkowski).

There are many examples of these closed networks within our healthcare system despite what is a pretty clear statute against such practices.

Access is further restricted in the availability of product. Take CVS's claim for a less expensive alternative to the Epipen (now, it is NOT a generic for the Epipen autoinjector). This product is not available to most retail pharmacies even if that pharmacy works with the same Wholesaler as CVS. Probably has something to do with the fact that the Wholesaler, Cardinal Health, pays more than $20 million annually to participate in CVSHealth's buying group.

Other companies simple feel that the law does not apply to them. They create private preferred networks that steer patients. If they are fortunate to be allowed to choose providers, those patients typically are forced to pay $$$ to exercise their rights.

4. Enforcement

EVERYTHING that has been achieved thus far to attempt to add a minimal level of transparency to pharmacy has failed simply because there is no enforcement. Violations are rampant, ranging from negative or pass thru reimbursements to illegal recoupments; and the violators range from the supposedly transparent PBAs to the great monopolies of our time.