PHARMACY BENEFITS MANAGEMENT COMPANY REGULATION
STAKEHOLDER COMMENTS – SURVEY FINDINGS

North Carolina Department of Insurance

(in collaboration with the North Carolina Department of Commerce and the North Carolina Board of Pharmacy)

January 20, 2015

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AUTHORIZING LEGISLATION

Session Law 2014-120

SECTION 20.(b) The Department of Insurance, in collaboration with the Department of Commerce and the North Carolina Board of Pharmacy, shall study the issue of pharmacy benefits management company regulation. Specifically, the study shall include: (i) frequency of disclosure of and methodology for calculating maximum allowable cost prices by the pharmacy benefits management companies; (ii) appeals procedures for pharmacies relating to maximum allowable cost pricing; (iii) consumer protections and the disclosure of consumer health information by pharmacy benefits managers; (iv) regulation of the various forms of incentives offered to a consumer by pharmacy benefits managers and its effects on choice of pharmacy; and (v) any further industry regulation deemed necessary to study. The Department of Insurance shall report the collective findings and recommendations, including any proposed legislation, to the 2015 General Assembly on or before January 20, 2015.

METHODOLOGY

As directed by the North Carolina General Assembly in Section 20(b) of Session Law 2014-120 (*supra*), the North Carolina Department of Insurance, in collaboration with the Department of Commerce and the North Carolina Board of Pharmacy, conducted a preliminary study on the issue of pharmacy benefits management (PBM) company regulation. In light of logistical and financial constraints, and following consultation with the Department of Commerce and Board of Pharmacy, the Department conducted a survey of PBM stakeholders in our State to identify the range of responses and perspectives these stakeholder would have regarding the issues identified by the General Assembly in its authorizing legislation. It is the intention of the Department that any and all interested parties be given the opportunity to provide written comment to the Department. This summary report presents the full range of stakeholder perspectives on PBM regulation received, for receipt by the General Assembly to inform their consideration and possible action on the topic in coming legislative sessions.

The Department requested that recipients of the survey provide written responses to the questions included in the survey (which were drawn directly from the authorizing provision), as well as make written comment of topics that respondents feel are pertinent to discussion of issues relating to PBM that may not otherwise be included in the survey question responses. All recipients of the survey were asked to distribute the survey to any interested parties who may not have already received the survey and who may not otherwise have an opportunity to share their perspective with the General Assembly.

A total of five responses were received, representing the perspectives of the full range of stakeholders in the Pharmacy Benefits Management market in North Carolina, including Pharmacists, Pharmacy Benefits Management Companies, insurance carriers and stakeholder associations. Respondents are identified in Appendix B.

SURVEY QUESTION RESPONSES

QUESTION NUMBER ONE: Provide or comment upon the frequency of disclosure of and methodology for calculating maximum allowable cost prices by pharmacy benefits management companies.

- **Respondent 1 (Prime):**

  Prime regularly reviews and performs all necessary adjustments to MAC pricing and updates the MAC price list regularly in compliance with all applicable state and federal laws. Every pharmacy in a Prime pharmacy network has the ability to access up to date MAC prices by using the Prime website and passcode available to all network member pharmacies. http://www.primetherapeutics.com/pharmacistsmac.html

  Prime considers the methodology by which it sets MAC prices to be confidential and proprietary and does not disclose such information. However, Prime does provide the sources used to calculate our MAC prices. Our sourcing information is clearly identified on our website and available to all network member pharmacies. http://www.primetherapeutics.com/pharmacistsTools.html

  (For additional information see PRIME Survey Response Appendix C – Exhibit A)

- **Respondent 2 (PCMA):**

  The methodology for establishing contracted reimbursement rates for brand-name drugs is different from that used for generic drugs. Maximum allowable cost (MAC) is one of the most common methodologies used for reimbursing pharmacies for dispensing generic drugs. By definition, MAC pricing specifies the maximum allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices.

In terms of frequency of disclosure of MAC lists, PBMs routinely identify the sources used to obtain the data on which MAC prices are based, including the Food and Drug Administration's (FDA) Orange Book, average wholesale price (AWP) information, data on MAC pricing lists used in State Medicaid programs, and information from pharmaceutical wholesalers such as McKesson and AmerisourceBergen. PBMs update MAC lists frequently and make those lists available to their contracted pharmacies. Given that about 80% of prescriptions in the U.S. are dispensed as generic drugs, MAC lists are critical to containing drug costs and maximizing savings to both PBM clients like health plans and employers as well as consumers.

In terms of calculating MAC reimbursement levels, each PBM develops and maintains its own confidential MAC list derived from its proprietary methodologies. First, the PBM determines what types of drugs will be included on its MAC list, based on factors such as whether the drugs are approved by the FDA or listed in the FDA's Orange Book, whether the drugs have therapeutic equivalents and how many, whether there are multiple generic versions, and the number of manufacturers; and second, the PBM determines the appropriate costs of the drugs based on a survey of market drug costs, market share, inventory, and utilization.

- **Respondent 3 (ACP):**

Each Pharmacy Benefit Manager (PBM) treats Maximum Allowable Cost (MAC) pricing and the methodology to determine such pricing as strictly proprietary and confidential information. Pharmacies do not have access to this data at time of contracting or at any time until the drug is ultimately dispensed to the beneficiary. This is the case even though the pharmacy is the one purchasing the drug. In essence, the pharmacy is required to blindly dispense generic or "MAC'd" medications and simply hope they ultimately recoup the medication cost. It should also be noted that generics comprise the majority of medications dispensed (over 80%). So essentially, pharmacists are put in the untenable position of having to sign contracts without having any insight into the adequacy of their reimbursement. PBMs have the ability to determine and increase MACs at their sole discretion. This ability is clearly identified within their own contracts. Claims by the PBM industry stating that the MAC process is fair and transparent are simply inaccurate and misleading. Common PBM contracting language states:

MAC or "maximum allowable cost" means the unit price established by the PBM for a multisource drug included on PBM's MAC drug lists developed for PBM's clients, which may be amended from time to time by PBM, in its sole discretion.

MAC, the maximum allowable cost, consists of a list of off-patent drugs subject to maximum-allowable-cost payment schedules developed or selected by PBMs. The payment schedules specify the maximum unit ingredient cost payable by client for drugs on the MAC list.

- **Respondent 4 (OptumRx/United):**

OptumRx provides disclosure and access to the Maximum Allowable Cost (MAC) lists to each pharmacy upon request. OptumRx's methodology to assure MAC lists accurately reflect market pricing and the availability of generic drugs involves multiple sources to determine MAC pricing. The methodology sources include market pricing benchmark data such as AWP and WAC, wholesaler information on market availability and pharmacy information from inquiries. A synthesis of these and other sources helps create a market based MAC price for Generic Drugs on the MAC list. These sources are also monitored and updated to timely help manage market pricing fluctuations on the MAC list.

- **Respondent 5 (Drugco Pharmacies):**

It has been totally devastating how slowly the PBM's update prices, specifically price increases that we receive on drugs that we dispense every day. While the payers seem to update their files daily as drug prices decrease (rarely) they seem to take from 2 weeks to 2 months to correctly update prices as they increase to our pharmacies. This results in us being paid below cost routinely for drugs as they increase in price, and this has been a bad situation during the year 2014. Also, they seem to search high and low for maximum allowable costs to find prices that are not available in the market place, and actually use NDC's that are no longer available and subsequently not even updated.

QUESTION NUMBER TWO: Provide or comment upon appeals procedures for pharmacies relating to maximum allowable cost pricing.

- **Respondent 1 (Prime):**

For 2014, Prime received approximately 2,896 appeals from North Carolina network pharmacies – averaging around 250 per month. Each appeal was received using the required Prime process as outlined on our website available to all network member pharmacies.
http://www.primetherapeutics.com/pharmacistsmac.html
(For additional information see PRIME Survey Response Appendix C – Exhibit B)

The following selection is from the appeal process as outlined in our current Provider Manual available to all network pharmacy providers:

A pharmacy may submit a MAC pricing appeal via email at pharmacyops@primetherapeutics.com or via fax at 877-823-6373. If a fax is sent, an email address is required so a response may be provided. The following information needs to be provided in order to initiate the appeal process:

- A copy of the original invoice that contains the purchase price of the drug being appealed.
- Pharmacy NPI or NCPDP, member ID, Rx #, and date of fill.
- Generic drug name, and NDC #
- Brief explanation as to the nature of the appeal.

Once a MAC pricing appeal is submitted, the MAC Pricing Specialist will investigate the claim and proceed based on the following situations:

- ALL submitted and verified MAC related appeals will receive an email confirmation that the appeal has been entered into the database and will be reviewed for a MAC pricing change within 7 business days.
- Appeals submitted for drug NDC's that are not on the Prime Therapeutics MAC list or a claim that has been entered as usual and customary and/or submitted will be returned as a non-MAC related issue and appeal will be closed.

- MAC appeals submitted from a pharmacy in a state that has MAC regulations in place, will receive notification within 1 calendar week of the MAC price status decision.
- MAC appeals submitted from a pharmacy in all other states will receive notification of the MAC price status decision only if the MAC price is increased or removed. MAC pricing is reviewed and updated every week based on market acquisition costs from Prime's wholesaler sources. The appeal will remain on file for continual review for up to 90 days.

- **Respondent 2 (PCMA):**

The purpose of a MAC list is to incentivize pharmacies to negotiate more competitive rates for generic drugs with manufacturers and wholesalers in order to keep overall prices down. PBMs use MAC lists to balance fairly compensating pharmacies with being able to provide a cost-effective drug benefit plan to their health plan and employer clients. However, pricing in the pharmaceutical marketplace is volatile; in the event that market conditions (such as manufacturer drug shortages) create a situation where a pharmacy is dispensing a drug that is not profitable to the pharmacy based on current MAC lists, that pharmacy can often submit an appeal seeking review of the reimbursement level. The PBM can then readjust the standard reimbursement to meet those exigent market conditions and assure that the pharmacy is adequately compensated.

While different PBMs may have their own appeals procedures, the information regarding appeals is contained in the pharmacy services manual each pharmacist receives from the PBM it contracts with. The manual is distributed to pharmacists annually and outlines standard procedures and clinical and regulatory information. Many PBMs also provide pharmacists access to these manuals online. Additionally, many PBMs have Pbarmacist Resource Centers and Pharmacy Help Desks which pharmacists can access to communicate specific concerns.

- **Respondent 3 (ACP):**

It is true that PBMs provide a MAC appeals process for pharmacies but this process is often complicated and cumbersome to negotiate. Many pharmacies and small business owners feel that the PBMs are purposely creating roadblocks to overcome. Often times these appeals take

months to resolve. Often the revenue is taking from the pharmacy before the appeal decision is finalized. Pharmacists from North Carolina and across the nation see claims that are reimbursed below cost. With independent pharmacies on average producing over 90% of their revenue from prescription sales, these below cost reimbursements become a major problem.

- **Respondent 4 (OptumRx/United):**

To comply with applicable state laws, OptumRx has implemented an appeals process to allow a participating network pharmacy to dispute applicable and particular MAC pricing of a Covered Prescription Service Drug Product (i.e. MAC Appeal). This process also includes a timely review and investigation to resolve MAC disputes. For a MAC Appeal, the pharmacy must obtain, fully complete and submit the MAC Appeal form to OptumRx as defined in our pharmacy provider agreement, and adhering to state-specific requirements. Review requests will be reviewed to determine the appropriateness of pricing utilized by OptumRx for reimbursement. OptumRx will utilize available information to deduce the appropriateness of reimbursement. Participating pharmacies must submit their actual acquisition cost (including any rebates) for each item being reviewed. The information the Pharmacy provides through the appeal process will factor into the decision to accept or reject the appeal request.

- **Respondent 5 (Drugco Pharmacies):**

"...when we do question the PBM's on maximum allowable costs, we rarely are able to find anyone who can truly respond, but typically the answer is you need to buy it someplace else at a cheaper price, which generally is not possible."

QUESTION NUMBER THREE: Comment upon the existence, adequacy or shortcomings of consumer protections and issues relating to the disclosure of consumer health information by pharmacy benefits managers.

- **Respondent 1 (Prime):**

  Prime is fully compliant with all Health Insurance Portability and Accountability Act (HIPAA) requirements as well as all state privacy laws.

  In addition, Prime is registered as an LLC with the North Carolina Secretary of State and holds the following licenses, as required by North Carolina state law:

  - Non-resident Pharmacy License – Accountable to the North Carolina Board of Pharmacy
  - Third Party Administrator License – Accountable to the North Carolina Department of Insurance

- **Respondent 2 (PCMA):**

  PBMs are fully compliant with all Health Insurance Portability and Accountability Act (HIPAA) requirements and state regulations regarding the protection of consumer health information. The HIPAA Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. At the same time, the Privacy Rule recognizes that circumstances arise where health information may need to be shared to ensure the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others. The Rule is carefully balanced to allow uses and disclosures of information for treatment (such as prescription refill reminders) and other purposes with appropriate protections.

  Additionally, all PCMA member companies have been, or are currently undergoing examinations to be, accredited by URAC, a prestigious, independent accrediting body. URAC sets national standards for PBMs and other entities, focusing on key benchmarks in service

quality, and processes that enhance operations and compliance, including a specific measure for confidentiality of individually-identifiable health information.

- **Respondent 3 (ACP):**

Due to the notable lack of regulation or patient protections in place at the state or federal levels, PBMs can influence virtually every aspect of a beneficiary's access to their needed medications. A PBM plays a critical role in both gathering patient eligibility information from the payer and providing this information to the pharmacy to allow for online processing of prescription claims. However, as part of these administrative transactions, and due to the lack of oversight in place the PBM is able to make critical decisions about the patient's health care including having free reign to determine the benefit plan design (what medication and pricing the beneficiary has access to through their plan formulary) and determining the amount the beneficiary is responsible for paying under the plan formulary (which often influences a patients decision as to what medication to take) commonly referred to as the copay. Also, as stated above, a PBM can significantly coerce a patient to only access medications at the pharmacy of the PBMs choice thorough supposedly driving prices up to access medications at the beneficiaries retail pharmacy but hiding many costs so the it appears a medication would cost much less at as PBM operated or preferred pharmacy.

The issue of disclosure of patient specific information has arisen particularly with regard to the existence in the marketplace of the common ownership of a major PBM and a large pharmacy chain. We have seen instances in which the PBM gains access to patient data as well as access to where patients are filing their prescriptions. The PBM has then contacted patients by phone and/or mail naming their medications and requiring, from a practical standpoint, them to fill their prescriptions instead at the PBM-owned retail or mail order pharmacy.

- **Respondent 4 (OptumRx/United):**

Pharmacy benefits managers are business associates under HIPAA Privacy and Security Rules. In 2013, the U.S. Department of Health & Human Services expanded most of the requirements that covered entities must comply with to business associates. These requirements are comprehensive

and were created to ensure that disclosures of consumer health information are secure, transparent, and consistent with fair information practices. These rules, along with other federal consumer protection rules by FTC and FCC, are adequate to protect consumer health information from unwanted or unsecure disclosure.

- **Respondent 5 (Drugco Pharmacies):**

We believe that protected patient information is used routinely by PBM's to steer patients to their mail order programs and often to competitor pharmacies. I routinely have patients come in with a letter that details what medications they are taking, and asks them to use a certain mail order house or preferred pharmacy to supposedly get a better price or lower copay. This is inappropriate use of patient information, and undermines our ability to care for the patients that we serve in our pharmacy area of the patient medical home. It also breaks the chain of patient care as we are unable to monitor and maintain patient compliance, relate to the prescribers, and make decisions about optimum therapies.

QUESTIONS NUMBER FOUR: Comment upon the existence, adequacy or shortcomings of regulation of the various forms of incentives offered to consumers by pharmacy benefits managers and any effects that such incentives may have on consumers' choice of pharmacy.

- **Respondent 1 (Prime):**

  Prime is owned by more than a dozen Blue Cross and Blue Shield health plans, of which North Carolina Blue Cross and Blue Shield is one. We collaborate with these plans to get a more comprehensive picture of every member's care. This unique connection allows Prime to coordinate our programs and manage drug costs with respect to overall health care spending. This close collaborative relationship helps us work better with consumers, their doctors and pharmacists to help patients make the decisions right for them. In turn helping to keep consumer health costs lower overall and create better health outcomes for North Carolina members. By connecting across the health care system, we work to improve the safety and quality of North Carolina member's health care.

  Through this unique collaborative effort with the health plan, Prime's pharmacy programs and services are in complete alignment with the goals of North Carolina Blue Cross and Blue Shield member health objectives.

- **Respondent 2 (PCMA):**

  Working with health plan and employer clients, PBMs use advanced tools and strategies to manage drug benefit programs that give consumers more efficient and affordable access to medications. One of these cost-saving tools offered to clients by PBMs is preferred pharmacy networks. PBMs can create plans that have a select group of preferred pharmacies within a broader network of non-preferred drugstores. These preferred pharmacies offer better discounts than the non-preferred drugstores, and, in turn, offer lower copays/cost sharing for enrollees who choose them. Use of preferred networks can lower prescription costs by an estimated 5% and save health plans and employers $54 billion over the next ten years. PBMs also incentivize preferred brands and generics by offering lower copays on these drugs.

Health plan and employers also frequently choose to provide their members and employees with the option of a lower co-payment on a 90-day supply of their medications through use of mail-service pharmacies. This provides significant cost savings, particularly for medications prescribed for chronic conditions.

Normally, when an employer or health plan elects to require the use of mail service for maintenance medications, the patient first goes to a brick-and-mortar pharmacy to make sure the prescribed regimen is effective. Then the patient transitions to a mail-service system. Mail-service pharmacies are more technologically advanced, efficient, and have lower dispensing error rates than brick-and-mortar drugstores. Mail-services pharmacies are expected to save consumers, employers and other payers in North Carolina $1.94 billion over the next ten years.

- **Respondent 3 (ACP):**

Community pharmacies represent the most accessible point in patient-centered health care. However, patients are often limited from accessing their pharmacy of choice or are financially punished for having their prescription filled at a community pharmacy rather than a "preferred pharmacy" or mail-order pharmacy such as one owned by their health plan's pharmacy benefit manager (PBM). Financial incentives may come in the form of health plans subsidizing patient co-payments for drugs purchased from a preferred pharmacy or PBM-owned mail order pharmacy instead of their long trusted retail community pharmacy of choice. Therefore, requiring higher co-payments for beneficiaries who continue to visit their community pharmacy of choice even if a trip to a preferred pharmacy involves 20+ miles of travel—likely passing many excluded community pharmacies along the way. It should be noted that studies have concluded that such plans are actually paying more for drugs dispensed through these restricted options in comparison to a community retail pharmacy. The local community pharmacy is rarely, if ever offered an opportunity to participate "in the network" with the same access to those patients—no matter what the patients preference may be.

- **Respondent 4 (OptumRx/United):**

Requiring prescription drug plans to contract with any willing pharmacy would reduce the ability of plans to obtain price discounts based on the prospect of increased patient volume and thus impair the ability of prescription drug plans to negotiate the best prices with pharmacies. Evidence suggests that prescription drug prices are likely to rise if Prescription Drug Plans ("PDPs") are less able to assemble selective pharmacy networks. These forms of restrictions may also hinder the ability of plans to steer beneficiaries to lower-cost, preferred pharmacies and preferred mail order vendors through financial incentives or other terms.

Plan sponsors hire pharmacy benefit managers (PBMs) to manage pharmacy benefits on their behalf. As part of the management of these benefits, PBMs assemble networks of retail and mail pharmacies so that the plan sponsor's members can fill prescriptions easily in multiple locations.

PBMs lower costs and encourage quality care by developing a network of retail pharmacies willing to accept discounted pricing in exchange for access to a plan's members. A PBM must establish a network of retail pharmacies so that consumers with prescription drug insurance can fill their prescriptions. Plan sponsors want members to have convenient access to pharmacies providing high quality service. A consumer with a prescription drug benefit plan must utilize a pharmacy that accepts payment for that plan. Therefore, retail pharmacies must compete to be part of the retail pharmacy network for a particular PBM or risk losing access to the consumer. Store-based retail pharmacies enter into contracts with a PBM to participate in the PBM's retail network and provide prescriptions to a plan's beneficiaries.

A consumer's out-of-pocket costs and co-payments are typically identical regardless of which pharmacy in the network dispenses the prescription. Therefore, network pharmacies compete on service, convenience, and quality to attract consumers within a particular plan. PBMs offer their clients a choice of more selective networks as a way to reduce costs further. A more selective network provides the plan sponsor with the greatest degree of economic control over prescription fulfillment. A pharmacy will offer bigger discounts or a lower dispensing fee to be in a more exclusive network because each pharmacy in the network will fill a larger percentage of prescriptions for the plan.

Plan sponsors must balance the access and availability of pharmacies against a higher level of discounts achieved by a smaller network. The network must be sufficient to maintain access but selective enough to garner the necessary discounts.

PBMs are often the only entity with complete information on a patient's medications—particularly when enrollees are prescribed medication by more than one physician or fill prescriptions at different pharmacies. Pharmacy networks can also reduce costs because PBMs can screen pharmacy claims for fraud, waste, and abuse. Typical fraud, waste, and abuse detected prior to a claim being paid include prescription claims submitted with the improper quantity, improper day supply, improper coding, duplicative claims, and other irregularities. PBMs detect pharmacy fraud, waste, and abuse by screening and auditing prescription claims for common errors, irregular information, and suspicious patterns over time within their pharmacy networks.

QUESTIONS NUMBER FIVE: Provide examples of additional regulation of PBMs about which policymakers should be made aware. Provide any relevant detail supporting or opposing implementation of such regulation, and comment sufficient to explain your particular perspective on the regulatory action in question.

- **Respondent 1 (Prime):**

  The best way to answer this question is to focus on the depth of scrutiny that has already been undertaken. Over the years, PBMs and the activities in which they are engaged have been reviewed and studied by many major Federal agencies including but not limited to; Federal Trade Commission (FTC), Centers for Medicare and Medicaid Services (CMS), US General Accounting Office (GAO), Congressional Budget Office (CBO) and any number of state agencies across the country, including State Departments of Insurance, State Attorney Generals, and other oversight agencies.

  PBMs already fall under significant State and Federal regulation (see attached appendix exhibit C). PBMs that operate mail order or specialty pharmacies are regulated as pharmacies by the Board of Pharmacy in both the state they are physically located and the various states they mail into. Additionally, PBMs are regulated by the various State Insurance Commissions directly through requirements to hold permits such as Third Party Administrators (TPA) along with other licensees and indirectly through contracts with Health Benefit Plans who are already regulated by the State.

  As demonstrated above, the depth of the existing scrutiny into PBMs and their activities has not been limited to only one aspect of PBM operations. Much of the focus of these studies has been centered on comparison of PBM mail operations to those of retail pharmacy, including generic dispensing rates and consumer drug cost, and the value add PBMs bring to various federal health programs.

  (For additional information see PRIME Survey Response Appendix C – Exhibit D)

Respondent 2 (PCMA):

PBMs provide tremendous advantages to consumers by holding down the cost of prescription drugs, helping pharmacists to monitor potential adverse drug events, and providing consumers with wide access to medications and pharmacies. PBM activities are already extensively regulated, directly, and indirectly, at both the state and federal levels. PBMs comply with numerous existing regulatory requirements as third party administrators, preferred provider organizations, utilization review organizations, resident and non-resident pharmacies, where required by law. Through contracts with health plans and insurers, PBMs are required to comply with the same consumer protection laws and regulations governing utilization review and prior approval, timely claims payment, and dispute resolution systems, among others. State boards of pharmacy already regulate PBM activities in the mail-order arena in several different areas of pharmacy services, including prescription drug dispensing and labeling, patient counseling, generic substitutions, and controlled substances.

Further, numerous analyses have been conducted by government agencies including the Federal Trade Commission (FTC), the Department of Justice (DOJ), the General Accounting Office (GAO), the Congressional Budget Office (CBO), and the Office of Inspector General for both Health and Human Services and Department of Defense on PBM activities. The 2004 report by the FTC and DOJ concluded that "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms."

PBMs' clients, such as health plans, insurers, major employers, unions, and state and local governments are sophisticated purchasers of health care that rely on PBMs to manage their drug benefit programs. Many of these clients have consistently stood up in opposition to unnecessary PBM regulation in state legislatures around the country. Additionally, the FTC has opined on PBM legislation, stating that it is anti-competitive and will reduce efficiency and raise costs. Further regulation is unnecessary and would only result in increased costs for consumers without any benefit.

(For additional information see PCMA Survey Response Appendix C – Appendix and Chart)

- **Respondent 3 (ACP):**

  PBMs demand burdensome non-negotiated contracts that contain onerous requirements of the pharmacy such as requirements to continue to serve the patient even if the PBM goes out of business and in some cases attempting to dictate the pharmacy's hours of operation. The contract also prevents the pharmacy from charging the patient for other services such as delivery even if it is requested as a special service by that patient. Federal anti-trust laws prohibit two or more pharmacies from having the right to band together to negotiate their contract with the PBM, which in itself nullifies strength of negotiation.

- **Respondent 4 (OptumRx/United):**

  Mail service consistently shows that it increases patient adherence, especially with chronic medical conditions such as Diabetes, Hypertension and Hypercholesterolemia. A recent study found that consumers who receive their prescription medications for chronic conditions through a mail-service pharmacy "were more likely to take them as prescribed by their doctors than did patients who obtained them from a local pharmacy." In fact the same study showed that 84.7% of patients who received their medications by mail at least two-thirds of the time stuck to their physician-prescribed regimen, compared to 76.9% of patients who picked up their medications at "brick and mortar" Kaiser Permanente pharmacies.[1] Other studies have shown that the use of a mail order pharmacy may even improve clinical outcomes because of better adherence rates. A published study by OptumRx, showed that Rheumatoid Arthritis (RA) patients who were taking specialty medications via mail had significantly higher medication adherence with their (RA) injection therapies compared to patients who relied on community pharmacies to receive their medications. Outcomes were improved because our specialty pharmacy disease therapy

[1] The American Journal of Managed Care, Volume 16, No. 1, 2010, Mail Order Pharmacy Use and Adherence to Diabetes-Related Medications.

management programs are designed to empower patients and increase their knowledge of often complex clinical conditions compared to other pharmacies.[2]

Mail service utilization also has the additional benefit of cost savings in the form of leveraged buying power. This is particularly critical in today's specialty marketplace where products are not getting any cheaper, and patients who rely on these products require vigilant monitoring. Many local pharmacies simply do not have the ability to keep specialty products on their shelves. Further, accredited specialty mail service pharmacies like our own, have the benefit of utilizing large data pools, and through the use of skilled case managers and clinical pharmacy experts we provide clinical consultations by a pharmacist 24 hours a day 7 days a week. In order for any pharmacy to promote adherence they must be maintain a clinical presence." We are ready willing and able to answer clinical questions related our patient's medications at all times. Our clinical doors do not close like those of a community pharmacy. This is particularly important in patients taking specialty products who often have multiple comorbid conditions. The ability to speak to a clinical pharmacist at any time would undoubtedly enhance medication adherence. The importance of medication adherence cannot be emphasized enough. With the ever increasing costs of medication therapy and with the clinical dangers of not having timely use of prescription medications, OptumRx has invested heavily in an efficient, cost effective mail-order pharmacy system designed to provide patients with consistent access to low-cost medicine while ensuring that our patients take their medications.

Normally, when an employer or health plan elects to require the use of mail service for maintenance medications, the patient first goes to a brick-and-mortar pharmacy to make sure the prescribed regimen is effective. Then the patient transitions to a mail-service system where co-payments are generally lower. Regulations and state policy decisions that do not allow for these types of co-payment differentials take choices away from North Carolina consumers. Mail-service pharmacies are able to keep prescription drug costs down because they have greater efficiency and lower overhead costs than retail pharmacies. Utilizing this option provides significant cost

[2] Journal of Managed Care Pharmacy, Volume 16, No. 8, October 2010, Outcomes of Rheumatoid Arthritis Disease Therapy Management Program Focusing on Medication Adherence.

savings, particularly for medications prescribed for chronic conditions. Anti-mail legislation that restricts the appropriate use of mail-service for long-term prescriptions amounts to nothing more than special-interest legislation that will raise costs for consumers.

<u>QUESTIONS NUMBER SIX;</u> Provide additional comment on issues related to PBM that may not otherwise be represented in responses to previous questions.

- **Respondent 1 (Prime):**

  Prime believes that additional regulation over the PBM industry at this time would not be in the best interest of those who offer health benefits nor the consumers who enjoy those benefits. Time and time again, it has been shown that PBMs are effective at helping health benefit plans create sustainable, affordable benefits that enable consumers affordable access to life saving drug therapies.

  PBMs are engaged in competitive negotiations with retail pharmacies and drug manufacturers in order to fulfill specific contract requirements of health benefit plans. Regulations or legislation that attempts to intervene in those business to business relationships only serves to add additional costs on consumers who use the benefit and those employers who provide the benefit.

- **Respondent 2 (PCMA):**

  PBMs save plan sponsors and consumers an average 35% compared to expenditures made without pharmacy benefit management. In North Carolina, PBMs will save $65.6 billion over the next ten years, including $42.6 billion for consumers, employers, unions, and the state government and $22.9 billion for Medicare and its beneficiaries. If enacted, anti-payer, anti-consumer state laws restricting how health plan sponsors employers can use PBM tools could decrease PBM savings in North Carolina by more than $4.8 billion over the next ten years for fully-insured plan sponsors. Any state regulation of PBMs could serve to unwisely limit the use of their tools, decrease competition, and increase drug costs in North Carolina. We suggest North Carolina ensure current regulations are working properly, including the recently enacted law on MAC pricing, before considering imposing any additional regulations on PBMs.

- **Respondent 3 (ACP):**

More and more every day PBMs are harassing physicians about their drug of choice for patient's medication needs. The PBM is refusing to honor the physician's medication requirement for the patient and refusing to process the medication even when the physician says it is a necessary medication. The PBM simply tells the physician to use the medication preferred by the PBM. So is this the PBM practicing medicine? PBMs are also calling patients inferring they are representing the patient's pharmacy---telling the patient which medications are due to be filled and asking if the patient wants them to go ahead and fill the prescriptions. When the patient answers "yes" the prescriptions are immediately switched to the mail-order pharmacy of the PBM and blocked out by the PBM so the prescriptions cannot be filled at the patient's local pharmacy.

It is a given that physicians are the gatekeepers of the patient. Pharmacists are, in fact, the "SAFE-KEEPERS" of the patients' health. Once the doctor has diagnosed and facilitated a treatment, it is up to the pharmacist, on a day-to-day basis, to make sure that patients maintain their medicine regiment. This substantially decreases further physician, emergency room and hospital visits and costs. The PBM business model is set 180 degrees in opposition to this needed outcome and there is no oversight at state or federal level to define "patient care" best practices into the system.

Appendix A: Survey

Pharmacy Benefits Management Survey

(per Section 20(b) of Session Law 2014-120)

1) Provide or comment upon the frequency of disclosure of and methodology for calculating maximum allowable cost prices by pharmacy benefits management companies.

2) Provide or comment upon appeals procedures for pharmacies relating to maximum allowable cost pricing.

3) Comment upon the existence, adequacy or shortcomings of consumer protections and issues relating to the disclosure of consumer health information by pharmacy benefits managers.

4) Comment upon the existence, adequacy or shortcomings of regulation of the various forms of incentives offered to consumers by pharmacy benefits managers and any effects that such incentives may have on consumers' choice of pharmacy.

5) Provide examples of additional regulation of pharmacy benefits management companies about which policymakers should be made aware. Provide any relevant detail supporting or opposing implementation of such regulation, and comment sufficient to explain your particular perspective on the regulatory action in question.

6) Provide additional comment on issues related to pharmacy benefits management that may not otherwise be represented in responses to previous questions.

Appendix B: Respondents

1) David Root
   Prime Therapeutics

2) Clement Cypra, State Affairs
   Barbara A. Levy, Vice President and General Counsel
   Pharmaceutical Care Management Association

3) Mike James, RPh
   Association of Community Pharmacists

4) Elizabeth F. Crabill
   Director, Regulatory Affairs
   UnitedHealthcare of the Carolinas

5) Gene Minton, RPh, CEO
   Drugco Pharmacies

Appendix C: Surveys, by Respondent

1305 Corporate Center Drive
Eagan, MN 55121
PrimeTherapeutics.com

PRIME THERAPEUTICS®

tel 804.834.2626
fax 866.470.8807
800.858.0723

December 29, 2014

Wayne Goodwin, Insurance Commissioner
North Carolina Department of Insurance
401 Glenwood Ave.
Raleigh, NC 27603

Re: Comments on the Pharmacy Benefits Management Survey per Section 20(b) of Session Law 2014-120

Dear Mr. Goodwin

Prime Therapeuties ("Prime") is an independent pharmacy benefit manager owned by 13 not-for profit Blue Cross and Blue Shield plans. Prime serves more than 25 million pharmacy members across the United States including more than one million North Carolina residents.

Prime's purpose is to help patients get the medicine they need to feel better and live well. To help fulfill that purpose, Prime strives to keep drug spending growth low so that drugs are more affordable. Together with our Blue Cross Blue Shield clients, we lead the industry in keeping drug spending growth in the low single digits. In 2013, Prime held drug spending growth to just 3.3 percent. We attribute our success to innovative management of high-cost specialty drugs, which are used to treat complex and chronic conditions; encouraging greater use of lower-cost generic medications; negotiating improved discounts with drug manufacturers and retail pharmacies; and effective outreach to boost members' adherence to regimens of clinically proven, cost-effective medication.

You have asked us to participate in the above referenced survey. We are happy to participate with our responses below.

1. Frequency of MAC List Disclosure and Methodology

Prime regularly reviews and performs all necessary adjustments to MAC pricing and updates the MAC price list regularly in compliance with all applicable state and federal laws. Every pharmacy in a Prime pharmacy network has the ability to access up to date MAC prices by using the Prime website and passcode available to all network member pharmacies.

http://www.primetherapeutics.com/pharmacistsmac.html

Prime considers the methodology by which it sets MAC prices to be confidential and proprietary and does not disclose such information. However, Prime does provide the sources used to calculate our MAC prices. Our sourcing information is clearly identified on our website and available to all network member pharmacies.
http://www.primetherapeutics.com/pharmacistsTools.html
(for additional detail see appendix exhibit A)

2. MAC Appeals Procedure for Pharmacies

For 2014, Prime received approximately 2,896 appeals from North Carolina network pharmacies – averaging around 250 per month. Each appeal was received using the required Prime process as outlined on our website available to all network member pharmacies.
http://www.primetherapeutics.com/pharmacistsmac.html
(for additional detail see appendix exhibit B)

The following selection is from the appeal process as outlined in our current Provider Manual available to all network pharmacy providers:

A pharmacy may submit a MAC pricing appeal via email at pharmacyops@primetherapeutics.com or via fax at 877-823-6373. If a fax is sent, an email address is required so a response may be provided. The following information needs to be provided in order to initiate the appeal process:

- A copy of the original invoice that contains the purchase price of the drug being appealed.
- Pharmacy NPI or NCPDP, member ID, Rx #, and date of fill.
- Generic drug name, and NDC #
- Brief explanation as to the nature of the appeal.

Once a MAC pricing appeal is submitted, the MAC Pricing Specialist will investigate the claim and proceed based on the following situations:

- ALL submitted and verified MAC related appeals will receive an email confirmation that the appeal has been entered into the database and will be reviewed for a MAC pricing change within 7 business days.
- Appeals submitted for drug NDC's that are not on the Prime Therapeutics MAC list or a claim that has been entered as usual and customary and/or submitted will be returned as a non-MAC related issue and appeal will be closed.
- MAC appeals submitted from a pharmacy in a state that has MAC regulations in place, will receive notification within 1 calendar week of the MAC price status decision.
- MAC appeals submitted from a pharmacy in all other states will receive notification of the MAC price status decision only if the MAC price is increased or removed. MAC pricing is reviewed

and updated every week based on market acquisition costs from Prime's wholesaler sources. The appeal will remain on file for continual review for up to 90 days.

3. Consumer Protections

Prime is fully compliant with all Health Insurance Portability and Accountability Act (HIPAA) requirements as well as all state privacy laws.

In addition, Prime is registered as an LLC with the North Carolina Secretary of State and holds the following licenses, as required by North Carolina state law:

- Non-resident Pharmacy License – Accountable to the North Carolina Board of Pharmacy
- Third Party Administrator License – Accountable to the North Carolina Department of Insurance

4. Incentives Offered by PBMs and Their Effect on Consumer Choice of Pharmacy

Prime is owned by more than a dozen Blue Cross and Blue Shield health plans, of which North Carolina Blue Cross and Blue Shield is one. We collaborate with these plans to get a more comprehensive picture of every member's care. This unique connection allows Prime to coordinate our programs and manage drug costs with respect to overall health care spending.

This close collaborative relationship helps us work better with consumers, their doctors and pharmacists to help patients make the decisions right for them. In turn helping to keep consumer health costs lower overall and create better health outcomes for North Carolina members. By connecting across the health care system, we work to improve the safety and quality of North Carolina member's health care.

Through this unique collaborative effort with the health plan, Prime's pharmacy programs and services are in complete alignment with the goals of North Carolina Blue Cross and Blue Shield member health objectives

5. Examples of Additional PBM Regulation

The best way to answer this question is to focus on the depth of scrutiny that has already been undertaken. Over the years, PBMs and the activities in which they are engaged have been reviewed and studied by many major Federal agencies including but not limited to; Federal Trade Commission (FTC), Centers for Medicare and Medicaid Services (CMS), US General Accounting Office (GAO), Congressional Budget Office (CBO) and any number of state agencies across the country, including State Departments of Insurance, State Attorney Generals, and other oversight agencies.

PBMs already fall under significant State and Federal regulation (see attached appendix exhibit C). PBMs that operate mail order or specialty pharmacies are regulated as pharmacies by the Board of

Pharmacy in both the state they are physically located and the various states they mail into. Additionally, PBMs are regulated by the various State Insurance Commissions directly through requirements to hold permits such as Third Party Administrators (TPA) along with other licensees and indirectly through contracts with Health Benefit Plans who are already regulated by the State.

As demonstrated above, the depth of the existing scrutiny into PBMs and their activities has not been limited to only one aspect of PBM operations. Much of the focus of these studies has been centered on comparison of PBM mail operations to those of retail pharmacy, including generic dispensing rates and consumer drug cost, and the value add PBMs bring to various federal health programs (see appendix exhibit D).

6. Additional Comments

Prime believes that additional regulation over the PBM industry at this time would not be in the best interest of those who offer health benefits nor the consumers who enjoy those benefits. Time and time again, it has been shown that PBMs are effective at helping health benefit plans create sustainable, affordable benefits that enable consumers affordable access to life saving drug therapies.

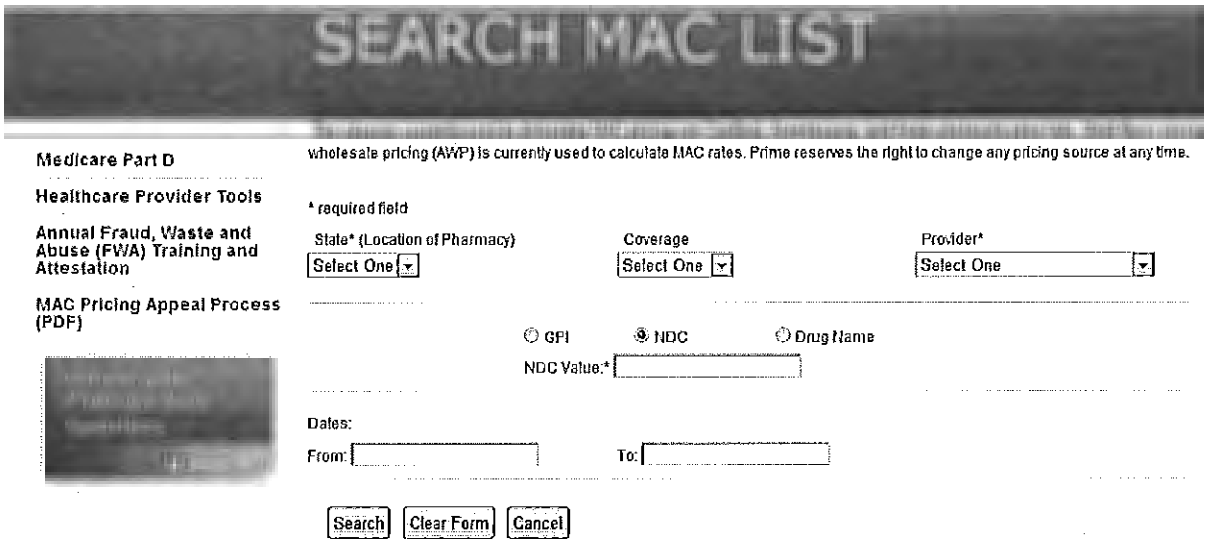
PBMs are engaged in competitive negotiations with retail pharmacies and drug manufacturers in order to fulfill specific contract requirements of health benefit plans. Regulations or legislation that attempts to intervene in those business to business relationships only serves to add additional costs on consumers who use the benefit and those employers who provide the benefit.

Sincerely,

David G. Root
Director, State Government Affairs

Survey Question 1

Appendix exhibit A



Survey Question 2

Appendix exhibit B

July 1, 2014

PRIME THERAPEUTICS

Overview MAC APPEALS PROCESS

A pharmacy may submit a MAC pricing appeal via email at pharmacyops@primetherapeutics.com or via fax at 877-823-6373. If a fax is sent, an email address is required so a response may be provided. The following information needs to be provided in order to initiate the appeal process:

- A copy of the original invoice that contains the purchase price of the drug being appealed.
- Pharmacy NPI or NCPDP, member ID, Rx #, and date of fill.
- Generic drug name, and NDC #
- Brief explanation as to the nature of the appeal.

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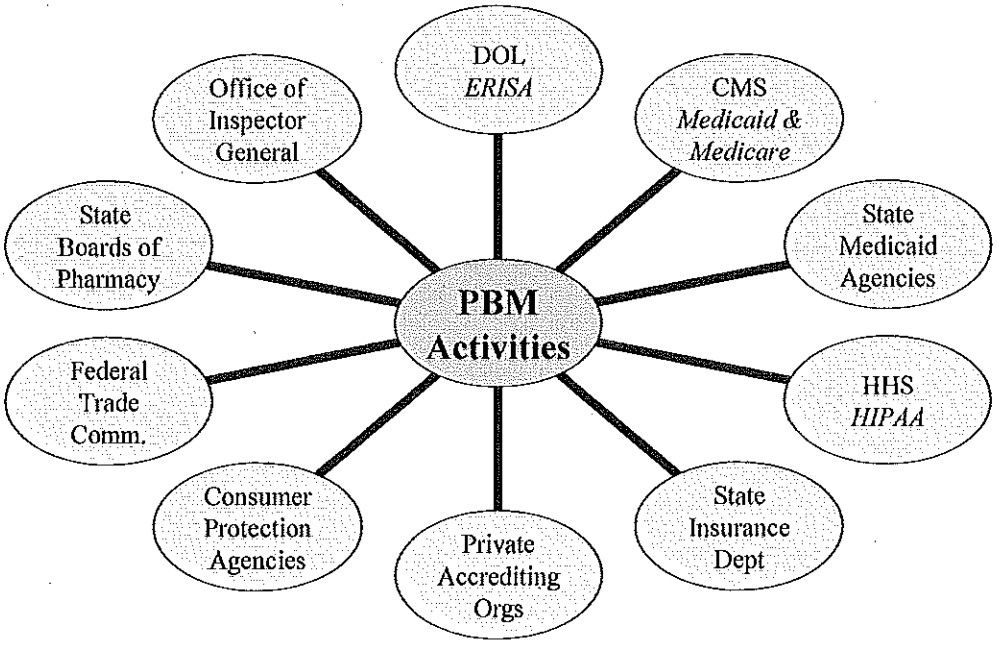
- ALL submitted and verified MAC related appeals will receive an email confirmation that the appeal has been entered into the database and will be reviewed for a MAC pricing change within 7 business days.
- Appeals submitted for drug NDC's that are not on the Prime Therapeutics MAC list or a claim that has been entered as usual and customary and/or submitted will be returned as a non-MAC related issue and appeal will be closed.
- MAC appeals submitted from a pharmacy in a state that has MAC regulations in place, will receive notification within 1 calendar week of the MAC price status decision.
- MAC appeals submitted from a pharmacy in all other states will receive notification of the MAC price status decision only if the MAC price is increased or removed. MAC pricing is reviewed and updated every week based on market acquisition costs from Prime's wholesaler sources. The appeal will remain on file for continual review for up to 90 days.

Survey Question 5

Appendix exhibit C

PBM Activities Heavily Regulated



Survey Question 5

Appendix exhibit D

What the Research Says About PBMs' Value to the Health Care System

- **Federal Trade Commission (FTC):** During the debate leading up to the passage of the Medicare Modernization Act of 2003, the retail pharmacy lobby sought to convince Congress that the use of PBM-owned mail-order pharmacies could result in higher costs. In response to these allegations, the FTC was charged with answering a number of very specific questions about the effects that PBM ownership of a mail-order pharmacy can have on overall prescription drug costs. The results of the FTC report were released in August 2005. In short, the FTC determined that allegations of PBMs' conflict of interest were "without merit,; and that PBM-owned mail-order pharmacies:
  - ✓ *Offer lower prices on prescription drugs than retail pharmacies and non-PBM owned mail pharmacies;*
  - ✓ *Are very effective at capitalizing on opportunities to dispense generic medications; and*
  - ✓ *Have incentives closely aligned with their customers: the third-party payors who fund prescription drug care.*[1]

- **Federal Trade Commission (FTC)-Department of Justice (DOJ):** A July 2004 analysis by the FTC and the Antitrust Division of DOJ concluded that the pharmacy benefit management industry is a competitive and diverse marketplace that is driving cost savings and quality improvements for health care consumers and purchasers and suggested that competition—not further government regulation—is the better avenue to ensuring appropriate PBM disclosure and transparency.[2]

- **Centers for Medicare and Medicaid Services (CMS):** Pharmacy benefit management tools helped slow prescription drug spending growth from 5.3% in 2009 to 3.5% in 2010, according to a new study by the Centers for Medicare and Medicaid Services. One PBM tool that helped was tiered co-pays that shifted medication use toward lower-cost generic drugs.[3]

- **US General Accounting Office (GAO):** In January 2003, the GAO examined the value provided by PBMs participating in the federal employees' health plan. For prescription drugs dispensed through mail-order pharmacies, the average mail-order price was about 27 percent below the average cash-price paid by consumers for a brand name at a retail pharmacy and 53 percent below the average cash-price paid for generic drugs. For drugs dispensed at the retail pharmacy counter, PBMs negotiated discounts of 18 percent below what consumers would pay in cash at a retail pharmacy counter for 14 brand name drugs and 47 percent below what consumers would pay for 4 select generic drugs.[4]

- **Congressional Budget Office (CBO):** In October 2002, the non-partisan CBO estimated that PBMs have the potential to save as much as 30 percent in total drug spending relative to unmanaged purchases of prescription drugs where PBMs can use their full range of price discounts and rebates, utilization control tools, and other tools for encouraging appropriate utilization.[5]

- **American Journal of Managed Care:** Consumers receiving their prescription medications for chronic conditions through a mail-service pharmacy "were more likely to take them as prescribed by their doctors than did patients who obtained them from a local pharmacy." Key findings from the study include:
  - ✓ Mail-order pharmacy users were more likely than local pharmacy users to have a financial incentive to fill their prescriptions by mail (49.6 percent vs. 23.0 percent), and to live a greater distance away from a local pharmacy (8.0 miles vs. 6.7 miles).
  - ✓ 84.7 percent of patients who received their medications by mail at least two-thirds of the time stuck to their physician-prescribed regimen, versus 76.9 percent who picked up their medications at "brick and mortar" Kaiser Permanente pharmacies.[6]

---

[1] Federal Trade Commission, "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," August 2005, available at http://ftc.gov/reports/index.htm#2005.
[2] Federal Trade Commission and Department of Justice, "Improving Health Care: A Dose of Competition," July 2004, available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf
[3] Sean P. Keehan et al., "National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth," *Health Affairs*, Volume 30, No. 8 (2011).
[4] US General Accounting Office, "Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees and Pharmacies," GAO-03-196, January 2003.
[5] Congressional Budget Office, "Issue in Designing a Prescription Drug Benefit for Medicare," October 2002.
[6] O. Kenrik Duru et al., "Mail-Order Pharmacy Use and Adherence to Diabetes-Related Medications," The American Journal of Managed Care, Volume 16, No. 1, pgs. 33-40 (2010).

Appendix E

Full text of specific studies referenced in comments:

FTC: http://www.ftc.gov/sites/default/files/documents/reports/pharmacy-benefit-managers-ownership-mail-order-pharmacies-federal-trade-commission-report/050906pharmbenefitrpt_0.pdf

DOD OIG MAIL: http://www.dodig.mil/pubs/documents/DODIG-2013-108.pdf

HHS OIG MAC: http://oig.hhs.gov/oei/reports/oei-03-11-00640.pdf

FTC letters:
http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-mark-formby-mississippi-house-representatives-concerning-mississippi/110322mississippipbm.pdf

http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-comment-hon.greg-aghazarian-concerning-ca.b.1960-requiring-pharmacy-benefit-managers-make-disclosures-purchasers-and-prospective-purchasers/v040027.pdf

http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.nelie-pou-concerning-new-jersey.b.310-regulate-contractual-relationships-between-pharmacy-benefit-managers-and-health-benefit-plans/v060019.pdf

http://www.ftc.gov/news-events/press-releases/2004/04/ftc-staff-rhode-island-bills-would-raise-prices-pharmaceuticals

PCMA
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

December 22, 2014

Submitted via email to: ben.popkin@ncdoi.gov

Wayne Goodwin, Insurance Commissioner
North Carolina Department of Insurance
401 Glenwood Ave.
Raleigh, NC 27603

Re: Comments on Pharmacy Benefits Management Survey per Section 20(b) of Session Law 2014-120

Dear Mr. Goodwin:

The Pharmaceutical Care Management Association (PCMA) is submitting the following comments on behalf of our members regarding the Pharmacy Benefits Management Survey required per Section 20(b) of Session law 2014-120. PCMA is the national trade association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 216 million Americans with health coverage provided through Fortune 500 employers, health insurance plans, labor unions, and Medicare Part D.

1. Frequency of MAC List Disclosure and Methodology

The methodology for establishing contracted reimbursement rates for brand-name drugs is different from that used for generic drugs. Maximum allowable cost (MAC) is one of the most common methodologies used for reimbursing pharmacies for dispensing generic drugs. By definition, MAC pricing specifies the maximum allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices.

In terms of frequency of disclosure of MAC lists, PBMs routinely identify the sources used to obtain the data on which MAC prices are based, including the Food and Drug Administration's (FDA) Orange Book, average wholesale price (AWP) information, data on MAC pricing lists used in State Medicaid programs, and information from pharmaceutical wholesalers such as McKesson and AmerisourceBergen. PBMs update MAC lists frequently and make those lists available to their contracted pharmacies. Given that about 80% of prescriptions in the U.S. are dispensed as generic drugs, MAC lists are critical to containing drug costs and maximizing savings to both PBM clients like health plans and employers as well as consumers.

In terms of calculating MAC reimbursement levels, each PBM develops and maintains its own confidential MAC list derived from its proprietary methodologies. First, the PBM determines what types of drugs will be included on its MAC list, based on factors such as whether the drugs are approved by the FDA or listed in the FDA's Orange Book, whether the drugs have therapeutic equivalents and how many, whether there are multiple generic versions, and the number of manufacturers; and second, the PBM determines the appropriate costs of the drugs based on a survey of market drug costs, market share, inventory, and utilization.

2. MAC Appeals Procedure for Pharmacies

The purpose of a MAC list is to incentivize pharmacies to negotiate more competitive rates for generic drugs with manufacturers and wholesalers in order to keep overall prices down. PBMs use MAC lists to balance fairly compensating pharmacies with being able to provide a cost-effective drug benefit plan to their health plan and employer clients. However, pricing in the pharmaceutical marketplace is volatile; in the event that market conditions (such as manufacturer drug shortages) create a situation where a pharmacy is dispensing a drug that is not profitable to the pharmacy based on current MAC lists, that pharmacy can often submit an appeal seeking review of the reimbursement level. The PBM can then readjust the standard reimbursement to meet those exigent market conditions and assure that the pharmacy is adequately compensated.

While different PBMs may have their own appeals procedures, the information regarding appeals is contained in the pharmacy services manual each pharmacist receives from the PBM it contracts with. The manual is distributed to pharmacists annually and outlines standard procedures and clinical and regulatory information. Many PBMs also provide pharmacists access to these manuals online. Additionally, many PBMs have Pharmacist Resource Centers and Pharmacy Help Desks which pharmacists can access to communicate specific concerns.

3. Consumer Protections

PBMs are fully compliant with all Health Insurance Portability and Accountability Act (HIPAA) requirements and state regulations regarding the protection of consumer health information. The HIPAA Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. At the same time, the Privacy Rule recognizes that circumstances arise where health information may need to be shared to ensure the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others. The Rule is carefully balanced to allow uses and disclosures of information for treatment (such as prescription refill reminders) and other purposes with appropriate protections.

Additionally, all PCMA member companies have been, or are currently undergoing examinations to be, accredited by URAC, a prestigious, independent accrediting body. URAC sets national standards for PBMs and other entities, focusing on key benchmarks in service quality, and processes that enhance operations and compliance, including a specific measure for confidentiality of individually-identifiable health information.

4. Incentives Offered by PBMs and Their Effect on Consumer Choice of Pharmacy

Working with health plan and employer clients, PBMs use advanced tools and strategies to manage drug benefit programs that give consumers more efficient and affordable access to medications. One of these cost-saving tools offered to clients by PBMs is preferred pharmacy networks. PBMs can create plans that have a select group of preferred pharmacies within a broader network of non-preferred drugstores. These preferred pharmacies offer better discounts than the non-preferred drugstores, and, in turn, offer lower copays/cost sharing for enrollees who choose them. Use of preferred networks can lower prescription costs by an estimated 5% and save health plans and employers $54 billion over the next ten years. PBMs also incentivize preferred brands and generics by offering lower copays on these drugs.

Health plan and employers also frequently choose to provide their members and employees with the option of a lower co-payment on a 90-day supply of their medications through use of mail-service pharmacies. This provides significant cost savings, particularly for medications prescribed for chronic conditions. Normally, when an employer or health plan elects to require the use of mail service for maintenance medications, the patient first goes to a brick-and-mortar pharmacy to make sure the prescribed regimen is effective. Then the patient transitions to a mail-service system. Mail-service pharmacies are more technologically advanced, efficient, and have lower dispensing error rates than brick-and-mortar drugstores. Mail-services pharmacies are expected to save consumers, employers and other payers in North Carolina $1.94 billion over the next ten years.

5. Examples of Additional PBM Regulation

PBMs provide tremendous advantages to consumers by holding down the cost of prescription drugs, helping pharmacists to monitor potential adverse drug events, and providing consumers with wide access to medications and pharmacies. PBM activities are already extensively regulated, directly, and indirectly, at both the state and federal levels. PBMs comply with numerous existing regulatory requirements as third party administrators, preferred provider organizations, utilization review organizations, resident and non-resident pharmacies, where required by law. Through contracts with health plans and insurers, PBMs are required to comply with the same

consumer protection laws and regulations governing utilization review and prior approval, timely claims payment, and dispute resolution systems, among others. State boards of pharmacy already regulate PBM activities in the mail-order arena in several different areas of pharmacy services, including prescription drug dispensing and labeling, patient counseling, generic substitutions, and controlled substances.

Further, numerous analyses have been conducted by government agencies including the Federal Trade Commission (FTC), the Department of Justice (DOJ), the General Accounting Office (GAO), the Congressional Budget Office (CBO), and the Office of Inspector General for both Health and Human Services and Department of Defense on PBM activities. The 2004 report by the FTC and DOJ concluded that "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms."

PBMs' clients, such as health plans, insurers, major employers, unions, and state and local governments are sophisticated purchasers of health care that rely on PBMs to manage their drug benefit programs. Many of these clients have consistently stood up in opposition to unnecessary PBM regulation in state legislatures around the country. Additionally, the FTC has opined on PBM legislation, stating that it is anti-competitive and will reduce efficiency and raise costs. Further regulation is unnecessary and would only result in increased costs for consumers without any benefit.

Please see the appendix and attached chart for more information.

6. Additional Comments

PBMs save plan sponsors and consumers an average 35% compared to expenditures made without pharmacy benefit management. In North Carolina, PBMs will save $65.6 billion over the next ten years, including $42.6 billion for consumers, employers, unions, and the state government and $22.9 billion for Medicare and its beneficiaries. If enacted, anti-payer, anti-consumer state laws restricting how health plan sponsors employers can use PBM tools could decrease PBM savings in North Carolina by more than $4.8 billion over the next ten years for fully-insured plan sponsors. Any state regulation of PBMs could serve to unwisely limit the use of their tools, decrease competition, and increase drug costs in North Carolina. We suggest North Carolina ensure current regulations are working properly, including the recently enacted law on MAC pricing, before considering imposing any additional regulations on PBMs.

We appreciate your consideration of our comments. If you should have any questions, please do not hesitate to contact me.

Sincerely,

Barbara A. Levy
Vice President and General Counsel

Appendix

Studies

FTC: http://www.ftc.gov/sites/default/files/documents/reports/pharmacy-benefit-managers-ownership-mail-order-pharmacies-federal-trade-commission-report/050906pharmbenefitrpt_0.pdf

FTC/DOJ: http://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf

GAO: http://www.gao.gov/assets/240/236828.pdf

CBO: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/39xx/doc3960/10-30-prescriptiondrug.pdf

HHS OIG: http://oig.hhs.gov/oei/reports/oei-03-11-00640.pdf

DOD OIG: http://www.dodig.mil/pubs/documents/DODIG-2013-108.pdf

FTC Letters

CA: http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-comment-hon.greg-aghazarian-concerning-ca.b.1960-requiring-pharmacy-benefit-managers-make-disclosures-purchasers-and-prospective-purchasers/v040027.pdf

MS: http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-mark-formby-mississippi-house-representatives-concerning-mississippi/110322mississippipbm.pdf

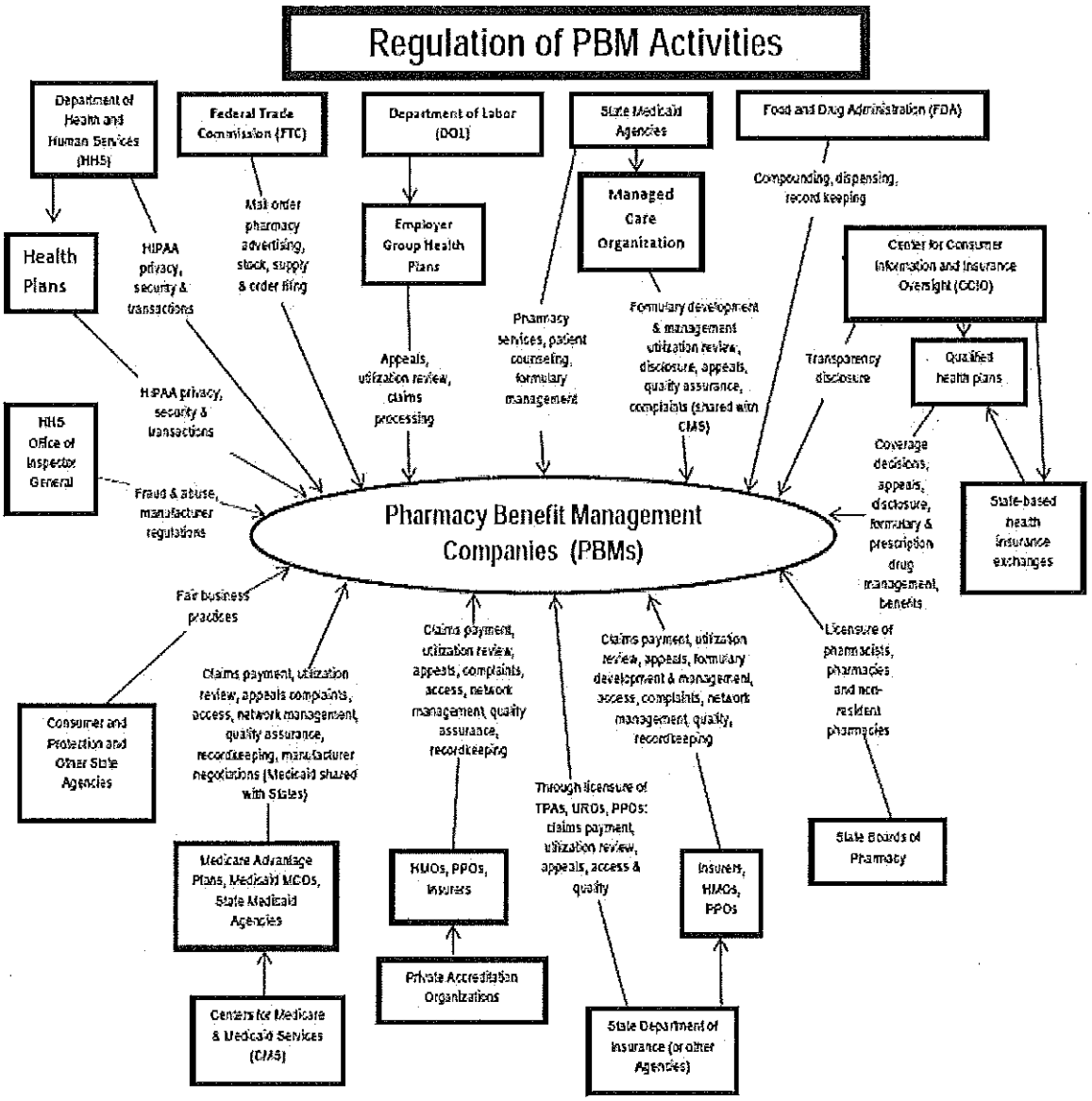
NJ: http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.nelie-pou-concerning-new-jersey.b.310-regulate-contractual-relationships-between-pharmacy-benefit-managers-and-health-benefit-plans/v060019.pdf

NY: http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-james-l.seward-concerning-new-york-senate-bill-58-pharmacy-benefit-managers-pbms/v090006newyorkpbm.pd

RI: http://www.ftc.gov/news-events/press-releases/2004/04/ftc-staff-rhode-island-bills-would-raise-prices-pharmaceuticals

Miscellaneous

URAC Pharmacy Benefit Management Accreditation Measures: https://www.urac.org/wp-content/uploads/STDGlance_PharmBen1.pdf


Regulation of PBM Activities
Department of Health and Human Services (HHS)
Federal Trade Commission (FTC)
Department of Labor (DOL)
State Medicaid Agencies
Food and Drug Administration (FDA)
Health Plans
HIPAA privacy, security & transactions
Mail order pharmacy advertising, stock, supply & order filing
Employer Group Health Plans
Managed Care Organization
Compounding, dispensing, record keeping
Center for Consumer Information and Insurance Oversight (CCIO)
Qualified health plans
HHS Office of Inspector General
HIPAA privacy, security & transactions
Appeals, utilization review, claims processing
Pharmacy services, patient counseling, formulary management
Formulary development & management utilization review, disclosure, appeals, quality assurance, complaints (shared with CMS)
Transparency disclosure
Fraud & abuse, manufacturer regulations
Pharmacy Benefit Management Companies (PBMs)
Coverage decisions, appeals, disclosure, formulary & prescription drug management, benefits
State-based health insurance exchanges
Fair business practices
Claims payment, utilization review, appeals, complaints, access, network management, quality assurance, recordkeeping
Claims payment, utilization review, appeals, formulary development & management, access, complaints, network management, quality, recordkeeping
Licensure of pharmacists, pharmacies and non-resident pharmacies
Consumer and Protection and Other State Agencies
Claims payment, utilization review, appeals complaints, access, network management, quality assurance, recordkeeping, manufacturer negotiations (Medicaid shared with States)
Through licensure of TPAs, UROs, PPOs: claims payment, utilization review, appeals, access & quality
Medicare Advantage Plans, Medicaid MCOs, State Medicaid Agencies
HMOs, PPOs, insurers
Insurers, HMOs, PPOs
State Boards of Pharmacy
Private Accreditation Organizations
Centers for Medicare & Medicaid Services (CMS)
State Department of Insurance (or other Agencies)

Association of Community Pharmacists
816 Ellis Road
Durham, N. C. 27703

Mr. Benjamin Popkin, JD, MPH
Senior Health Policy Counsel
North Carolina Department of Insurance

Dear Mr. Popkin:

The Association of Community Pharmacists was asked by you to respond to the Pharmacy Benefit Mangers survey directed by the General Assembly. Below is our contribution to that survey.

1) Provide or comment upon the frequency of disclosure of and methodology for calculating maximum allowable cost prices by pharmacy benefits management companies.

Each Pharmacy Benefit Manager (PBM) treats Maximum Allowable Cost (MAC) pricing and the methodology to determine such pricing as strictly proprietary and confidential information. Pharmacies do not have access to this data at time of contracting or at any time until the drug is ultimately dispensed to the beneficiary. This is the case even though the pharmacy is the one purchasing the drug. In essence, the pharmacy is required to blindly dispense generic or "MAC'd" medications and simply hope they ultimately recoup the medication cost. It should also be noted that generics comprise the majority of medications dispensed (over 80%). So essentially, pharmacists are put in the untenable position of having to sign contracts without having any insight into the adequacy of their reimbursement. PBMs have the ability to determine and increase MACs at their sole discretion. This ability is clearly identified within their own contracts. Claims by the PBM industry stating that the MAC process is fair and transparent are simply inaccurate and misleading. Common PBM contracting language states:

MAC or "maximum allowable cost" means the unit price established by the PBM for a multisource drug included on PBM's MAC drug lists developed for PBM's clients, which may be amended from time to time by PBM, in its sole discretion.

MAC, the maximum allowable cost, consists of a list of off-patent drugs subject to maximum-allowable-cost payment schedules developed or selected by PBMs. The payment schedules specify the maximum unit ingredient cost payable by client for drugs on the MAC list.

2) Provide or comment upon appeals procedures for pharmacies relating to maximum allowable cost pricing.

It is true that PBMs provide a MAC appeals process for pharmacies but this process is often complicated and cumbersome to negotiate. Many pharmacies and small business owners feel that the PBMs are purposely creating roadblocks to overcome. Often times these appeals take months to resolve. Often the revenue is taking from the pharmacy before the appeal decision is finalized. Pharmacists from North Carolina and across the nation see claims that are reimbursed below cost. With independent pharmacies on average producing over 90% of their revenue from prescription sales, these below cost reimbursements become a major problem.

3) Comment upon the existence, adequacy or shortcomings of consumer protections and issues relating to the disclosure of consumer health information by pharmacy benefit managers.

Due to the notable lack of regulation or patient protections in place at the state or federal levels, PBMs can influence virtually every aspect of a beneficiary's access to their needed medications. A PBM plays a critical role in both gathering patient eligibility information from the payer and providing this information to the pharmacy to allow for online processing of prescription claims. However, as part of these administrative transactions, and due to the lack of oversight in place the PBM is able to make critical decisions about the patient's health care including having free reign to determine the benefit plan design (what medication and pricing the beneficiary has access to through their plan formulary) and determining the amount the beneficiary is responsible for paying under the plan formulary (which often influences a patients decision as to what medication to take) commonly referred to as the copay. Also, as stated above, a PBM can significantly coerce a patient to only access medications at the pharmacy of the PBMs choice thorough supposedly driving prices up to access medications at the beneficiaries retail pharmacy but hiding many costs so the it appears a medication would cost much less at as PBM operated or preferred pharmacy.

The issue of disclosure of patient specific information has arisen particularly with regard to the existence in the marketplace of the common ownership of a major PBM and a large pharmacy chain. We have seen instances in which the PBM gains access to patient data as well as access to where patients are filing their prescriptions. The PBM has then contacted patients by phone and/or mail naming their medications and requiring, from a practical standpoint, them to fill their prescriptions instead at the PBM-owned retail or mail order pharmacy.

4) Comment upon the existence, adequacy or shortcomings of regulation of the various forms of incentives offered to consumers by pharmacy benefits managers and any effects that such incentives may have on consumers' choice of pharmacy.

Community pharmacies represent the most accessible point in patient-centered health care. However, patients are often limited from accessing their pharmacy of choice or are financially punished for having their prescription filled at a community pharmacy rather than a "preferred pharmacy" or mail-order pharmacy such as one owned by their health plan's pharmacy benefit manager (PBM). Financial incentives may come in the form of health plans subsidizing patient co-payments for drugs purchased from a preferred pharmacy or PBM-owned mail order pharmacy instead of their long trusted retail community pharmacy of choice. Therefore, requiring higher co-payments for beneficiaries who continue to visit their community pharmacy of choice even if a trip to a preferred pharmacy involves 20+ miles of travel—likely passing many excluded community pharmacies along the way. It should be noted that studies have concluded that such plans are actually paying more for drugs dispensed through these restricted options in comparison to a community retail pharmacy. The local community pharmacy is rarely, if ever offered an opportunity to participate "in the network" with the same access to those patients—no matter what the patients preference may be.

5) Provide examples of additional regulation of pharmacy benefit management companies about which policymakers should be made aware.

PBMs demand burdensome non-negotiated contracts that contain onerous requirements of the pharmacy such as requirements to continue to serve the patient even if the PBM goes out of

business and in some cases attempting to dictate the pharmacy's hours of operation. The contract also prevents the pharmacy from charging the patient for other services such as delivery even if it is requested as a special service by that patient. Federal anti-trust laws prohibit two or more pharmacies from having the right to band together to negotiate their contract with the PBM, which in itself nullifies strength of negotiation.

6) Provide additional comment on issues related to pharmacy benefits management that may not otherwise be represented in responses to previous questions.

More and more every day PBMs are harassing physicians about their drug of choice for patient's medication needs. The PBM is refusing to honor the physician's medication requirement for the patient and refusing to process the medication even when the physician says it is a necessary medication. The PBM simply tells the physician to use the medication preferred by the PBM. So is this the PBM practicing medicine? PBMs are also calling patients inferring they are representing the patient's pharmacy---telling the patient which medications are due to be filled and asking if the patient wants them to go ahead and fill the prescriptions. When the patient answers "yes" the prescriptions are immediately switched to the mail-order pharmacy of the PBM and blocked out by the PBM so the prescriptions cannot be filled at the patients local pharmacy.

It is a given that physicians are the gatekeepers of the patient. Pharmacists are, in fact, the "SAFE-KEEPERS" of the patients' health. Once the doctor has diagnosed and facilitated a treatment, it is up to the pharmacist, on a day-to-day basis, to make sure that patients maintain their medicine regiment. This substantially decreases further physician, emergency room and hospital visits and costs. The PBM business model is set 180 degrees in opposition to this needed outcome and there is no oversight at state or federal level to define "patient care" best practices into the system.

Thank you for your work with pharmacy on this survey. If there is anything we can help you with as you compile your report, we will be happy to do so.

Best regards,

Mike James RPh
Association of Community Pharmacists
919-272-4256 (c)

Pharmacy Benefits Management Survey

(per Section 20(b) of Session Law 2014-120)

1) Provide or comment upon the frequency of disclosure of and methodology for calculating maximum allowable cost prices by pharmacy benefits management companies.

   OptumRx provides disclosure and access to the Maximum Allowable Cost (MAC) lists to each pharmacy upon request. OptumRx's methodology to assure MAC lists accurately reflect market pricing and the availability of generic drugs involves multiple sources to determine MAC pricing. The methodology sources include market pricing benchmark data such as AWP and WAC, wholesaler information on market availability and pharmacy information from inquiries. A synthesis of these and other sources helps create a market based MAC price for Generic Drugs on the MAC list. These sources are also monitored and updated to timely help manage market pricing fluctuations on the MAC list.

2) Provide or comment upon appeals procedures for pharmacies relating to maximum allowable cost pricing.

   To comply with applicable state laws, OptumRx has implemented an appeals process to allow a participating network pharmacy to dispute applicable and particular MAC pricing of a Covered Prescription Service Drug Product (i.e. MAC Appeal). This process also includes a timely review and investigation to resolve MAC disputes. For a MAC Appeal, the pharmacy must obtain, fully complete and submit the MAC Appeal form to OptumRx as defined in our pharmacy provider agreement, and adhering to state-specific requirements. Review requests will be reviewed to determine the appropriateness of pricing utilized by OptumRx for reimbursement. OptumRx will utilize available information to deduce the appropriateness of reimbursement. Participating pharmacies must submit their actual acquisition cost (including any rebates) for each item being reviewed. The information the Pharmacy provides through the appeal process will factor into the decision to accept or reject the appeal request.

3) Comment upon the existence, adequacy or shortcomings of consumer protections and issues relating to the disclosure of consumer health information by pharmacy benefits managers.

Pharmacy benefits managers are business associates under HIPAA Privacy and Security Rules. In 2013, the U.S. Department of Health & Human Services expanded most of the requirements that covered entities must comply with to business associates. These requirements are comprehensive and were created to ensure that disclosures of consumer health information are secure, transparent, and consistent with fair information practices. These rules, along with other federal consumer protection rules by FTC and FCC, are adequate to protect consumer health information from unwanted or unsecure disclosure.

4) Comment upon the existence, adequacy or shortcomings of regulation of the various forms of incentives offered to consumers by pharmacy benefits managers and any effects that such incentives may have on consumers' choice of pharmacy.

Requiring prescription drug plans to contract with any willing pharmacy would reduce the ability of plans to obtain price discounts based on the prospect of increased patient volume and thus impair the ability of prescription drug plans to negotiate the best prices with pharmacies. Evidence suggests that prescription drug prices are likely to rise if Prescription Drug Plans ("PDPs") are less able to assemble selective pharmacy networks. These forms of restrictions may also hinder the ability of plans to steer beneficiaries to lower-cost, preferred pharmacies and preferred mail order vendors through financial incentives or other terms.

Plan sponsors hire pharmacy benefit managers (PBMs) to manage pharmacy benefits on their behalf. As part of the management of these benefits, PBMs assemble networks of retail and mail pharmacies so that the plan sponsor's members can fill prescriptions easily in multiple locations.

PBMs lower costs and encourage quality care by developing a network of retail pharmacies willing to accept discounted pricing in exchange for access to a plan's members. A PBM must establish a network of retail pharmacies so that consumers with prescription drug insurance can fill their prescriptions. Plan sponsors want members to have convenient access to pharmacies providing high quality service. A consumer with a prescription drug benefit plan must utilize a pharmacy that accepts payment for that plan. Therefore, retail pharmacies must compete to be part of the retail pharmacy network for a particular PBM or risk losing access to the consumer. Store-based retail pharmacies enter into contracts with a PBM to participate in the PBM's retail network and provide prescriptions to a plan's beneficiaries.

A consumer's out-of-pocket costs and co-payments are typically identical regardless of which pharmacy in the network dispenses the prescription. Therefore, network pharmacies compete on service, convenience, and quality to attract consumers within a

particular plan. PBMs offer their clients a choice of more selective networks as a way to reduce costs further. A more selective network provides the plan sponsor with the greatest degree of economic control over prescription fulfillment. A pharmacy will offer bigger discounts or a lower dispensing fee to be in a more exclusive network because each pharmacy in the network will fill a larger percentage of prescriptions for the plan. Plan sponsors must balance the access and availability of pharmacies against a higher level of discounts achieved by a smaller network. The network must be sufficient to maintain access but selective enough to garner the necessary discounts.

PBMs are often the only entity with complete information on a patient's medications—particularly when enrollees are prescribed medication by more than one physician or fill prescriptions at different pharmacies. Pharmacy networks can also reduce costs because PBMs can screen pharmacy claims for fraud, waste, and abuse. Typical fraud, waste, and abuse detected prior to a claim being paid include prescription claims submitted with the improper quantity, improper day supply, improper coding, duplicative claims, and other irregularities. PBMs detect pharmacy fraud, waste, and abuse by screening and auditing prescription claims for common errors, irregular information, and suspicious patterns over time within their pharmacy networks.

5) Provide examples of additional regulation of pharmacy benefits management companies about which policymakers should be made aware. Provide any relevant detail supporting or opposing implementation of such regulation, and comment sufficient to explain your particular perspective on the regulatory action in question.

Mail service consistently shows that it increases patient adherence, especially with chronic medical conditions such as Diabetes, Hypertension and Hypercholesterolemia. A recent study found that consumers who receive their prescription medications for chronic conditions through a mail-service pharmacy "were more likely to take them as prescribed by their doctors than did patients who obtained them from a local pharmacy." In fact the same study showed that 84.7% of patients who received their medications by mail at least two-thirds of the time stuck to their physician-prescribed regimen, compared to 76.9% of patients who picked up their medications at "brick and mortar" Kaiser Permanente pharmacies.[1] Other studies have shown that the use of a mail order pharmacy may even improve clinical outcomes because of better adherence rates. A published study by OptumRx, showed that Rheumatoid Arthritis (RA) patients who were taking specialty medications via mail had significantly higher medication adherence with their (RA) injection therapies compared to patients who relied on community pharmacies to receive their medications. Outcomes were improved because our specialty pharmacy disease therapy management programs are designed to empower patients and increase their knowledge of often complex clinical conditions compared to other pharmacies.[2]

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[1] The American Journal of Managed Care, Volume 16, No. 1, 2010, Mail Order Pharmacy Use and Adherence to Diabetes-Related Medications.

[2] Journal of Managed Care Pharmacy, Volume 16, No. 8, October 2010, Outcomes of Rheumatoid Arthritis Disease Therapy

Mail service utilization also has the additional benefit of cost savings in the form of leveraged buying power. This is particularly critical in today's specialty marketplace where products are not getting any cheaper, and patients who rely on these products require vigilant monitoring. Many local pharmacies simply do not have the ability to keep specialty products on their shelves. Further, accredited specialty mail service pharmacies like our own, have the benefit of utilizing large data pools, and through the use of skilled case managers and clinical pharmacy experts we provide clinical consultations by a pharmacist 24 hours a day 7 days a week. In order for any pharmacy to promote adherence they must be maintain a clinical presence." We are ready willing and able to answer clinical questions related our patient's medications at all times. Our clinical doors do not close like those of a community pharmacy. This is particularly important in patients taking specialty products who often have multiple comorbid conditions. The ability to speak to a clinical pharmacist at any time would undoubtedly enhance medication adherence.

The importance of medication adherence cannot be emphasized enough. With the ever increasing costs of medication therapy and with the clinical dangers of not having timely use of prescription medications, OptumRx has invested heavily in an efficient, cost effective mail-order pharmacy system designed to provide patients with consistent access to low-cost medicine while ensuring that our patients take their medications.

Normally, when an employer or health plan elects to require the use of mail service for maintenance medications, the patient first goes to a brick-and-mortar pharmacy to make sure the prescribed regimen is effective. Then the patient transitions to a mail-service system where co-payments are generally lower. Regulations and state policy decisions that do not allow for these types of co-payment differentials take choices away from North Carolina consumers. Mail-service pharmacies are able to keep prescription drug costs down because they have greater efficiency and lower overhead costs than retail pharmacies. Utilizing this option provides significant cost savings, particularly for medications prescribed for chronic conditions. Anti-mail legislation that restricts the appropriate use of mail-service for long-term prescriptions amounts to nothing more than special-interest legislation that will raise costs for consumers.

6) Provide additional comment on issues related to pharmacy benefits management that may not otherwise be represented in responses to previous questions.

OptumRx has no additional comments at this time.

Waddell, Karen E

From: Popkin, Ben
Sent: Friday, January 16, 2015 10:01 AM
To: Waddell, Karen E
Subject: FW: Your Request for input on Survey

From: Gene Minton [mailto:gene@drugcopharmacy.com]
Sent: Monday, December 08, 2014 11:30 AM
To: Popkin, Ben
Subject: Your Request for input on Survey

Mr. Popkin, thanks for the opportunity to share info with you.

Question 1.
It has been totally devastating how slowly the PBM's update prices, specifically price increases that we receive on drugs that we dispense everyday. While the payers seem to update their files daily as drug prices decrease (rarely) they seem to take from 2 weeks to 2 months to correctly update prices as they increase to our pharmacies. This results in us being paid below cost routinely for drugs as they increase in price, and this has been a bad situation during the year 2014. Also, they seem to search high and low for maximum allowable costs to find prices that are not available in the market place, and actually use NDC's that are no longer available and subsequently not even updated. And question 2. And when we do question the PBM's on maximum allowable costs, we rarely are able to find anyone who can truly respond, but typically the answer is you need to buy it someplace else at a cheaper price, which generally is not possible.
Question 3. We believe that protected patient information is used routinely by PBM's to steer patients to their mail order programs and often to competitor pharmacies. I routinely have patients come in with a letter that details what medications they are taking, and asks them to use a certain mail order house or preferred pharmacy to supposedly get a better price or lower copay. This is inappropriate use of patient information, and undermines our ability to care for the patients that we serve in our pharmacy area of the patient medical home. It also breaks the chain of patient care as we are unable to monitor and maintain patient compliance, relate to the prescribers, and make decisions about optimum therapies.

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Gene Minton, RPh, CEO Drugco Pharmacies
Office Phone 252-519-1140
Cell Phone 252-532-9999
Office Fax 252-533-0620

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