

Testimony concerning raised Senate Bill 1059; An Act Implementing the Recommendations of the Commission on Enhancing Agency Outcomes

Distinguished Members of the Government Administration and Elections Committee;

My name is Edward Schreiner. I am a resident of 36 Pineridge Drive, Oakville, Ct. Since 1988 I have owned and operated Stoll's Pharmacy in Waterbury, Ct. I am also the Chairman of the Board of Directors for Northeast Pharmacy Service Corporation, a company that provides business development services to approximately 250 community pharmacies throughout New England.

I am writing this letter to voice my ardent opposition to Raised Senate Bill 1059; An Act Implementing the Recommendations of the Commission on Enhancing Agency Outcomes. The provisions of this bill concerning the pharmacy benefit for State Employees, Medicaid, ConnPace, CADAP and Husky plan beneficiaries will have dire financial implications for *all* pharmacies operating in Connecticut. The perception exists that pharmacists are vastly overpaid for their services. The reality is that year after year pharmacy has worked with the Department of Social Services to come up with creative ways to save money and control spending associated with the Medicaid, SAGA, ConnPace and CADAP programs. When the 3.5% rollback in AWP occurred in 2009, the Department of Social Services did not alter the reimbursement rate to pharmacy providers and retained the 3.5% savings; however this will never be attributed in any DSS report as savings achieved at the expense of the pharmacy provider community. I have determined that this reduction in reimbursement in brand name drugs, when combined with the reductions in state generic drug list pricing, reduces reimbursement to my business by \$110,000 ANUALLY. I was planning to hire an additional full time pharmacist and technician in 2010 however the reduction in reimbursement has made this economically unfeasible. By not adjusting reimbursement for the AWP rollback, as all commercial plans did, Medicaid and the other state funded programs became the payer with the lowest reimbursement rate for brand name drugs in my pharmacy.

Most community pharmacies are "for profit" business. As with many other small businesses in Connecticut, most of my pharmacy's profit is derived from the sale of a product. Our primary product is prescription drugs. My pharmacy receives no government subsidies. We must be profitable selling prescription drugs if we are to survive. Located in downtown Waterbury, the majority of my customers are participants in the Medicaid, SAGA, CADAP and ConnPace programs. Further drastic cutbacks, as proposed in SB 1059 threaten my ability to remain in business. If enacted as proposed, SB 1059 may force my withdrawal from the programs or possibly the closure of my business entirely, thereby reducing pharmacy access for Connecticut residents and adding my employees to the already excessive roster of unemployed in our state.

As a taxpayer, I am strongly opposed to giving more of our non-existent tax dollars to any Pharmacy Benefit Manager. From 2004-2008, the three major PBM's (Medco, CVS Caremark, and Express Scripts) faced six major federal or multidistrict cases over allegations of Fraud, misrepresentation to plans, patients and providers, improper therapeutic substitution and unjust enrichment through secret kickback schemes. These cases have resulted in over \$371.9 million in punitive damages so far. The PBM currently contracted by the state is under FTC investigation for alleged anti-competitive and deceptive conduct and is also being investigated by a multi-state consortium of Attorneys General that includes Connecticut.

PBMs are not fiduciary agents that are financially obligated to act in the best interest of their clients: (In this case the State of Connecticut and its taxpayers). The top 3 PBMs are publically traded corporations whose

primary mission is to maximize shareholder value. A recent MarketWatch analysis demonstrated that major PBMs experienced a five-fold increase in profits over the last decade. PBMs are corporate middlemen who add little value and provide no direct healthcare services of their own while adding massive overhead and administrative costs to the healthcare system in order to support their excess profits. When estimating the \$66 Million in supposed state budget savings, did anyone compare PBM administrative fees to existing Medicaid programs, which are currently run more efficiently through fiscal intermediaries? By giving complete administrative control of Medicaid to PBMs, our legislature will fail to protect the Medicaid program's ultimate shareholders, the taxpayers, from the diversion of funds that should be used to provide healthcare to Connecticut's most vulnerable residents to increase an out-of-state corporation's profits.

PBMs can't get Medicaid better prices on drugs: By federal law, Medicaid programs get the manufacturer's "Best Price" for a particular drug. PBM's simply cannot negotiate better prices for drugs than Medicaid is able to. Moreover, PBMs are notorious for retaining a large percentage of the rebates they obtain from manufacturers. Why would Medicaid want to turn their program over to a PBM when by federal law, they are already getting the full benefit of the best price that manufacturers offer to any purchasers in the marketplace?

PBMs don't increase generic dispensing rates – Pharmacies do: Using lower cost generics is an important strategy for managing Medicaid drug costs. In 2009, the average independent community pharmacy had a generic dispensing rate of 69% while the dispensing services of the 3 largest PBMs had generic dispensing rates under 58% for the exact same time period – leaving potential savings on the table resulting from increased brand usage! The difference can be attributed to PBMs financial incentive to generate brand name manufacturer rebates while discouraging them from dispensing lower-cost, lower-rebate generics. While this bill encourages the state to increase generic utilization, it also encourages the state to lower the amount the state pays for generics. This is very short-sighted proposal. By lowering generic reimbursement the plan discourages pharmacists from helping increase the generic dispensing rate. Other states, such as North Carolina, have seen their generic utilization rates increase significantly by enhancing the dispensing fees paid to pharmacists to promote movement from brand to generic utilization. North Carolina pharmacists were able to help improve the state generic dispensing rate by approximately 8% in the first year of their program. The state determined that moving generic utilization by 1% created \$20 million in savings! As you can see, **by partnering with pharmacists and supporting their activities, the state of North Carolina is able to create \$160 MILLION in savings ANNUALLY.**

PBMs cost in-state Jobs and revenues: This proposed bill ignores the potential loss of jobs and tax revenues by driving Medicaid prescription revenue to out-of-state PBMs. It also ignores the multiplier effect that the loss of jobs and taxes would have in local communities. CVS Caremark and the two other major PBMs own and operate their own mail-order pharmacies. It is inevitable that the PBM administering the state Medicaid program would attempt to divert vulnerable Medicaid recipients to their corporately owned pharmacies. We have already seen these types of tactics with the incentives CVS uses to drive Connecticut state employee prescriptions to CVS Caremark's own retail and mail-order pharmacies at the expense of local competitors.

The Actual Cost of Procurement: Under this proposed bill, the Comptroller does not procure drugs, pharmacies do. The Comptroller funds the prescription benefit and procures the services of a PBM to administer the program, thus they pay the expense of the drug benefit PLUS the fees for the PBMs services.

Unlike the current arrangement with a fiscal intermediary (HP), the service being provided by a PBM is not transparent. Is there any assurance that, as in the current Medicaid structure, the bill paid by the comptroller will be the same amount that the pharmacy is paid? If not, why would the PBM be allowed to profit on prescriptions that are not provided by their own dispensing services? If this is assured by the PBM, then one must ask how the PBM intends to make a profit to maximize their shareholder value?

\$2.90 Dispensing Fee; If pharmacies are reimbursed at (or below) our actual acquisition cost for the drug, the proposed \$2.90 dispensing fee, as the only source of profit, is insufficient. An independent 2007 study of the actual cost of dispensing by Grant Thornton stated that the actual cost to dispense a prescription in Connecticut is over \$12. I am sure that the cost of doing business in Connecticut has not gone down since 2007. Dispensing a prescription to the Medicaid population is more labor intensive than other population groups. Pharmacies experience more rejected claims and prior authorization requirements for Medicaid recipients than for any other payer group. Language and educational barriers to proper medication use also require more resources from the pharmacy staff. The Medicaid population is more transient in nature and often have limited access to transportation, thus requiring expensive delivery services be provided to ensure that they receive their medications in a timely manner. When workman's compensation contributions, insurance, fuel, vehicle and employee salary costs are considered, my company spends approximately \$ 36,300 on delivery expenses annually. This extrapolates out to \$1.45 in cost per delivered prescription (or ½ of the proposed fee). It will be impossible to cover all of my other costs, such as rent, light, heat, payroll, employee benefits and corporate business taxes with the remaining \$1.45 in dispensing fee. Delivery service at my pharmacy will have to end if the proposed bill becomes reality. This one cutback represents two lost driver positions at my pharmacy at a time when elected officials are promising that job creation is an important priority.

In conclusion, I strongly urge you to oppose passage of SB 1059 for the numerous, serious reasons I have presented today. As a taxpayer I ask you to instruct the Department of Social Services to work with Connecticut's pharmacists to find better ways to control prescription drug spending for the Medicaid population (as the state of North Carolina has done) without jeopardizing Connecticut jobs and tax revenue for the benefit of out-of-state PBM profits.

Thank you for the opportunity to express my opinion.

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