

**Statement Before
Insurance and Real Estate Committee
Tuesday, March 17, 2015**

**AN ACT CONCERNING MAXIMUM ALLOWABLE COST LISTS AND DISCLOSURES BY
PHARMACY BENEFIT MANAGERS.**

Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. My name is Marghie Giuliano and I am a pharmacist and Executive Vice President of the Connecticut Pharmacists Association, a professional organization representing close to 1,000 pharmacists.

I am submitting testimony today in *strong support* of *SB 1052 An Act Concerning Maximum Allowable Cost Lists and Disclosures by Pharmacy Benefit Managers*.

This legislation would establish some degree of transparency into how Pharmacy Benefit Managers (PBMs) determine reimbursement to pharmacies for multiple source generic drugs.

I would like to start by asking you a simple question. Would you sign a contract to perform a service if you did not know *exactly* what your contract terms were for payment? I'm sure you would not.

The essence of this bill addresses what Pharmacy Benefit Managers (PBMs) have been practicing for years - reimbursing for generic medications without a clear formula for reimbursement.

Pharmacies are reimbursed for *brand name* drugs based on bench mark numbers. These numbers are Average Wholesale Price (AWP) or Wholesale Acquisition Cost (WAC) plus or minus a percentage and dispensing fee. AWP and WAC are *published numbers* that pharmacies can reference to determine if reimbursement levels are equitable and reasonable.

Generic reimbursement is handled differently than Brand Name Drugs. Reimbursement for generic drugs is based on a Maximum Allowable Cost or MAC pricing. There is no clear definition of what MAC is or what drugs are on the MAC list.

It is important for legislators to understand that the Maximum Allowable Costs, or MAC, represents the *highest amount* at which the pharmacy will be reimbursed for a covered drug. And, MAC pricing may be established and amended by the PBM and/or payor in its *sole discretion*. But more importantly, MAC is not a published number and the PBM does not disclose or provide a definition.

Recently, the costs for many generic drugs have been skyrocketing by as much as 600%, 1,000% or more. The trend is well-documented by regional and national media outlets, including the *New York Times* and the *Wall Street Journal*.

PBMs may wait months before they adjust reimbursement rates to reflect these market changes, and rarely do they do so retroactively. This is forcing community pharmacies to 'buy high' and 'sell low' and routinely incur losses of \$60, \$100 or much more per prescription. Generic medications comprise about 80 percent of the drugs pharmacies dispense. This is a recipe for disaster.

This legislation would provide for criteria of what drugs should be placed on a MAC list.

It requires that the contract between the PBM and the pharmacy should disclose the methodology and sources that the PBMs use to determine the MAC for prescription drugs. In essence - what is the formula? For example, when the State of CT implemented their MAC list, it was clearly defined as AWP – 70% + the dispensing fee. The state posts their MAC lists and properly informs pharmacies when new drugs are added. The PBMs should be required to disclose their formula and post their MAC lists as well.

This legislation would also shine a light on those PBMs that have an inherent conflict of interest. For example, CVS Caremark is the PBM for the State of Connecticut - in this role, the Caremark division set their competitor's rates as Plan Administrator, but at the same time, the CVS division owns both a mail-order pharmacy and hundreds of brick and mortar pharmacies.

This legislation would require the PBM to disclose if it only uses a MAC list for community pharmacies but not for prescriptions dispensed through mail order.

PBMs would have to disclose whether it uses the identical MAC list to bill the plan sponsor as it does when it reimburses in-network pharmacies. If they use multiple lists the PBM would be required to disclose to the plan sponsor any difference between the amount the PBM bills the plan sponsor and the amount the PBM pays the pharmacy for that claim.

As you can imagine, the complexity combined with the lack of transparency create significant problems because pharmacies have no way of determining their actual reimbursement and employers don't really know if they are being charged an inflated price.

To that end, transparency is greatly needed and long overdue. MAC formulas should be available to pharmacies before contracting and the PBMs should use benchmark numbers as a basis for a reimbursement formula.