February 14, 2019

SB No. 332: AAC Compensation Paid By Pharmacy Benefit Managers To Pharmacies
Supporting Testimony Submitted to the Insurance and Real Estate Committee

Senator Lesser, Representative Scanlon and the Distinguished Members of the Insurance and Real Estate Committee;

Thank you for the opportunity to offer testimony in support of SB 332.

My name is David Benoit. I am a pharmacist working as Vice-president of Patient Care Services at Northeast Pharmacy Service Corporation, a company that acts like chain headquarters for independent community pharmacies. Approximately, 260 Participating Pharmacies are operating in four states, including about 120 in Connecticut. Last year at this time there were approximately 15% more stores.

The reasons for the decline in independent community pharmacies are manifold. There are certain controllable expenses that we voluntarily assume in order to better serve our patients. They may include, simple things like serving a disproportionately large share of Medicaid patients, store charge accounts and home delivery. At greater complexity we try to organize patients" medications so that they all can be filled at the same time, making it easier to take them correctly. If that is not quite enough, we offer special compliance packaging to organize all the medicines. Some of us specialize in medication customization, compounding, specialty patient care services, group home and facility services, medical equipment and supplies, and even straightening out patients medications after they are discharged from one facility to another or to home. We never wanted to be your average drug store.

We can reduce our expenses by reducing or eliminating a number of these patient care services; a choice that none of us wants to face, but which challenges us now.

This matter is complicated by the known and unknown reductions to our revenues which we do not control. We know that the Prescription Benefit Managers' (PBM"s) contracts are unfair, lopsided, and offered on a take-it-or-leave-it basis. We don't know once we have received a paid response in real time for a claim, how much they are going to take back from the claim under a cloud of complexity we do not quite understand. They take money back because we did not fill enough prescriptions with generics; we filled the brand prescriptions that authorized prescribers wrote. They take money back because they say our performance was not adequate, using measures designed for health systems. Sometimes, they take it back and call

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it DIR (direct and indirect remuneration) without any attempt to explain it. In 2017, these fees doubled over the prior year. In 2018 they doubled again, a fourfold increase over 2016.

We also notice that in a world where even chain pharmacies cannot negotiate with the PBMs, more and more multisource generic products are paid further and further below cost.

PBMs handle over 80% of the money in the nation's spend on drugs. They have invented multiple ways to profit handsomely from a business that essentially processes prescription claims. It is time for government oversight. SB 332 is a good place to start. It would establish a fair pricing requirement for all drugs in all pharmacies. NPSC has successfully supported MAC (Maximum Allowable Cost) legislation in Maine, Massachusetts and Rhode Island. In Connecticut we have yet to succeed; we would like you to consider adding some of the MAC language to this bill. In 2017, the MAC bill was HB 7124.

Generic shortages are expected to continue, restricting access to needed medications. Ridiculous, unfair reimbursements artificially support further reductions in patient access to needed medications. Preserving patient care services that so many Connecticut residents currently enjoy, will require government to act to ameliorate the behavior of PBMs regarding their extraordinary market power.

America's research and discovery drug manufacturers complain that their high prices and rapid price inflation are driven by PBM rebate demands not profitability. Patients in non-government programs make their copays and deductible payments based on these artificially inflated prices. State Medicaid programs, like New York and Ohio, have found hundreds of millions of dollars in PBM claim markups. Pharmacies are forced into multiple price concessions that may occur over a year later. Whichever strategy concerns one the most, they all add profit to the PBMs" bottom line.

There is much work to be done. Let us begin with SB 332 and work quickly. How can we help?

Thank you very much for your time and attention.

Respectfully submitted,

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