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House Committee on the Judiciary Concerning HR 971, the Community Pharmacy Fairness Act

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Chairman Conyers, Ranking Members Smith and Keller, and Members of the Antitrust Taskforce, good morning and thank you for allowing me to testify this morning on behalf of the Association of Community Pharmacies Congressional Network and the independent pharmacies they represent across the country. I would also like to thank you for holding this hearing to address a crucial problem in the health care system.

My name is Mike James; I am Vice President and Director of Government Affairs for the Association of Community Pharmacies Congressional Network, a practicing pharmacist and the owner of an independent, community pharmacy in Raleigh, North Carolina.

Years ago, as managed care began to invade health care in this country, insurance companies began to hire Pharmacy Benefit Administrators (known as PBAs) to become electronic claims clearing houses between the insurance company and the pharmacies. This was done in an effort to centralize all claims from the thousands of pharmacies to a central switch, to then be routed to the correct insurance company. This is a transaction much like a credit card transaction – a central switch, an electronic transfer.

But as managed care became the norm, these PBAs began to realize they could become a bigger player in the *business* of health care and convinced insurance companies, large corporations, and government entities that *they* were the experts in the prescription delivery process. These PBAs sold this idea as a cost-savings mechanism. The Pharmacy Benefit Administrators then became known as Pharmacy Benefit Managers (PBMs) and their business model was to manage the entire prescription program and promised as much as 30 to 40% off prescription prices to the insurance companies. But these so-called "savings" came at a high price for consumers and pharmacies.

Back when the Pharmacy Benefit Administrators were used, they handled about 10% of the prescriptions filled in the US. By 2005, the number of prescriptions

being handled by PBMs was over 60%. Today, after the implementation of Medicare Part D, about 95% of all prescriptions filled in the United States are handled by PBMs.

As a result of this near-monopolistic power, the PBM industry now dictates, without negotiation, reimbursement rates and terms of contracts to independent pharmacies. In order to continue serving their patients, pharmacies are required to fill prescriptions under PBM agreements at prices that do not cover costs. This has resulted in the closing of 1,152 independent pharmacies in 2006. Every one of the pharmacy owners I have spoken with who has closed their pharmacy since January 2006 indicated that their reason for closing is low third-party PBM reimbursement. The PBM strategy of putting independent pharmacy out of business is working well and I believe we will see a larger number of closings in 2007 and 2008 if nothing is done.

The take-over by PBMs is also resulting in movement on a large-scale of senior patients—particularly those in rural areas—to mail-order prescription programs. This has provided a perverse outcome for patients, who have no say in how their pharmacy benefits will be delivered, and are afraid to complain in fear of losing

their benefit. These patients are denied their traditional right to seek personal and confidential professional assistance from local, hometown pharmacy professionals.

Today, the goal of PBM contracts is not to support critical pharmacy-patient relationships. Rather, the goal of PBM contracts is to systematically undermine the solvency of independent pharmacies and force patients covered under the agreements into highly profitable proprietary mail-order programs. PBMs promote mail-order as a cheaper alternative to visiting your local pharmacy. However, this is a conflict of interest – the PBMs run their own mail-order programs in direct competition with retail pharmacies. The argument of cost-savings is completely false – mail order programs won't necessarily offer a less expensive generic alternative to a medication because the PBM has rebate agreements with the brand drug makers. And the mail-order programs can't possibly fill a script the day it is written – there must still be a local pharmacy to fill that script written for antibiotics to cure an infection or a painkiller after a broken bone is set. Can those patients mail off the prescription and wait another two weeks before it arrives in the mail?

The mail-order programs run by PBMs are truly a conflict of interest. For example, there is a distinct inequity of forcing patients to pay a higher co-pay in

the pharmacy for the same prescription than they pay through mail-order. And it is putting patients at a disadvantage by not allowing a local retail pharmacy to fill a 90-day supply when that same benefit is offered through mail-order. But the PBMs do this because they run the mail-order programs and these are effective methods of putting retail pharmacy out of business.

You will be told that allowing negotiation will increase cost by $29 billion dollars. This is strictly a decision of the PBM. PBMs have great flexibility in determining how much they shift over to patients and taxpayers. CMS handed over all power and authority to PBMs to run Medicare Part D, but rather than be good stewards of the taxpayers' interest, the $29 billion indicates that Charles River Associates and the Congressional Budget Office understand well that PBMs will continue to put their profits above the interest of the taxpayer. If the cost goes up, it will be because the PBMs raised cost, not because the pharmacies were allowed to negotiate.

You will also be told that surveys show a huge majority of Medicare Part D patients are happy with the program. I would contend this survey didn't include those patients who had entered the "no coverage zone" or "doughnut hole" as it is called. I own a pharmacy and I do surveys everyday and everyday I council

patients who have hit the doughnut hole and have no idea how they are going to buy their medication. They are still paying a monthly premium, the Federal government is still paying their monthly allowance to the PMB for that patient and the patient is paying the total cost of the medication and will not escape the doughnut hole before the program begins again in January. All this time, the PBM is collecting money and paying nothing to help the patient receive their medication. I can assure you these patients are not happy with the program.

Independent pharmacies provide invaluable health care services on a daily basis to millions of patients nationwide. They know their patients and their health care history. This is especially important for patients who have multiple doctors and prescriptions. The pharmacist is the only health care professional who knows all of the patient's medications, their interactions, and whether there are lower cost generics available to address the patient's needs.

Hometown pharmacies are the only health care providers who do not require appointments and in many communities, pharmacists are the primary or only health care resource for American families. The role of the hometown pharmacist as part of the health care team cannot be duplicated through the PBM mail-order process. The human interaction with the patient is a vital part of the entire process

of the delivery of care to the public – this is the fulcrum of the integration of standard of care for the patient. Patients can't ask their postman about their medication – not everyone can call a 1-800 number and navigate through a directory of options only to be put on hold or speak with an operator nor will everyone remember to order each of their prescriptions two weeks before they run out – many patients take multiple drugs, especially seniors and those who have serious illnesses. Shouldn't we be taking extra care with them rather than forcing them into faceless mail-order programs?

There is only one way to combat the takeover of your constituents' health care by these huge companies whose only interest is the bottom line, not the health of patients. Independent pharmacies must have the right to negotiate to keep these PBMs from taking over the prescription delivery system. But antitrust law prohibits these small pharmacies from banding together to discuss terms of a contract. If Main Street Pharmacy talks to Elm Street Pharmacy about reimbursement rates or dispensing fees and agree to turn down the contract from a PBM unless they offer a reasonable contract, they are in violation of the law. Currently, these pharmacies tend to accept contracts that will put them at a loss because they lead with their hearts, not with their business sense. But with pharmacies shutting down every day, and the alternative being patients forced into

mail order or going to the next town to get their prescription filled, I believe Congress must act. When Medicare Part D was signed into law, PBMs were given more power, more lives to control – now almost every American with prescription drug coverage is at the mercy of a PBM. I believe Congress must give independent pharmacies the right to negotiate, a way to help the patient, a way for pharmacies to negotiate a fair contract, a way for these local, hometown pharmacies to continue to serve their communities and keep America healthy.

Mr. Chairman, this legislation is the cornerstone for the future of healthcare reform because without the independent pharmacy network, reform will not work. I ask you and this committee to move this legislation forward to mark-up to enable passage of this important bill.

Thank you for this time.