

Date: December 14, 2011
To: WV Legislature Joint Committee on Government Organization
From: Richard Stevens, Executive Director
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Current pharmacy law as it relates to a certain provision for generic substitution is antiquated. It has out-lived its usefulness and is counter-productive to saving consumers money on their prescription drugs.

Briefly, current law states when generic substitution is permitted, the savings passed on to the “purchaser” has to be at least the difference in the acquisition cost of the brand prescribed and the generic product dispensed.

The complexities and ambiguities of current law make enforcement by the Board of Pharmacy and compliance by pharmacists difficult if not impossible. For example, the Board regulates mail order pharmacies but does not investigate whether or not out-of-state mail order houses are passing legally required savings on to consumers.

There are more than 30,000 prescription drug products whose manufacturers change prices with some frequency – making it impossible for a pharmacist to identify specific costs of brand and generic products at the time they dispense a prescription and the savings is to be passed on to the purchaser.

To understand the need for revising the generic substitution law, it is beneficial to know that current law was passed in the mid-1970s. Pharmacy practices, consumer purchasing, insurance plans and market conditions were much different at the time than now. Here are some examples.

1. At that time there was significant differences in prices of brand and generic products. Today there is little differences in prices in many instances.
2. Branded products constituted over 80% of the prescriptions dispensed while generics made up the difference. It is completely reversed today with almost 80% of prescriptions dispensed are generics.
3. Today, there are multiple number of brand products in each therapeutic class, compared to very few – and sometimes only one – brand product in the 70s.
4. There were fewer low-cost generics that could be substituted for branded products in the 70s. Today there are multiple numbers of generics available at prices resulting in various levels of savings.
5. Over 90 percent of the public paid cash for their prescription drugs in the 70s, while approximately 10% had insurance benefits. It wasn't until 1990 that PEIA changed from a “cash” plan to a prescription card drug program. Today, as much as 90% of many

pharmacies' prescription drug business is paid by such third party payers as PEIA, Medicaid, Medicare Part D and private insurance, leaving 10% of patients paying cash for their medications.

6. When the law was passed, the purchaser was understood to mean the individual for whom the prescription was to be dispensed. It was not intended to mean a third party who was paying for the product. However, some legal interpretation today identify the third party payer as the purchaser. (WV Attorney General contends that Medicaid is a "purchaser" in his law suit against all chain pharmacies operating in WV alleging they have not passed the cost difference between brand and generic on to the purchaser.)
7. It should be noted that many states had a similar generic substitution law in the 70s, but West Virginia is the only state remaining with this antiquated law.

These dramatic changes over the years make current language not only antiquated but conflict with consumers third party prescription drug benefits and contractual provisions of third party contracts pharmacies have with insurance companies and pharmaceutical benefit managers (PBMs). It should be noted pharmacies have absolutely **NO LEVERAGE** with these contracts. Contracts are presented pharmacies by insurance companies and PBMs on a "take or leave it" basis. Pharmacists then dispense as directed by these third parties and PBMs **WITHOUT** regard to any differences in costs of brand and generic products. They either do it this way or the patient suffers with higher cost copays.

Most if not all third party plans today have "preferred drug lists" – which were not in place in earlier years – requiring pharmacists to dispense products whose manufacturers' are paying rebates to insurance companies or pharmaceutical benefit managers in exchange for their products of the list to be dispensed. Pharmacists must dispense these products – although they may not be the cheapest – in order for the consumer to receive their benefits or pay a lower copay. Consumer are isolated from the cost of the products under these plans because they pay a specific dollar copay, such as \$15, \$25 or \$50, regardless of the cost of the product. In other words the consumer has little if any choice in which product is dispensed to them. Medicaid and PEIA are among the benefit plans with preferred drug lists.

When passed by the Legislature in the mid-70s, the savings called for in the generic substitution law was well-intended and applicable to the market and consumer purchasing at that time. I respectfully suggest the intent of assuring consumers of maximum savings can be attained today with the amendment contained in the draft of House Bill 2513 you have before you today. You will find that language in Section 21(f). This applies to cash sales only, and not third party contracts. It states:

“A pharmacist may substitute a drug pursuant to the provisions of this section only if the drug is a lower cash retail price than the prescribed drug. When substitution is proper, pursuant to this section, or where the prescriber prescribes the drug by generic name, the pharmacist shall, consistent with his or her professional judgement, dispense an equivalent generic product with the lowest cash retail sales price which is available in the pharmacy at the time of dispensing”.