



Bringing **TRANSPARENCY & ACCOUNTABILITY** to Drug Pricing

**A special report on the role of pharmacy benefit managers
by Pennsylvania Auditor General Eugene A. DePasquale**



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Dear fellow Pennsylvanians,

We all know health care costs are enormous in the United States. In fact, health care spending reached \$3.3 trillion in 2016 — that's \$10,348 per person annually.¹

Among the biggest factors in these costs are prescription drug prices.

Companies you've never heard of — and some you have — decide what your co-pay will be, which prescription drugs will be covered by your plan, the overall premiums you pay and more.

A largely unknown but massive player in this field is a group of companies known as pharmacy benefit managers, or PBMs. They are the middlemen, so to speak, between your pharmacist, drug manufacturers and your insurance plan sponsor — which, for nearly 3 million adults and children in Pennsylvania in 2018, was Medicaid.

It is these PBMs — particularly CVS Caremark, Express Scripts and OptumRx, the largest three operating in the U.S. — that have garnered intense public scrutiny across the country.

When Pennsylvania community pharmacists began sounding the alarm in 2017 about certain PBM practices, I stepped in to learn about the process and to listen to all sides in this issue. During 10 hours of testimony at five public hearings held across the state in 2018, I heard from more than 30 people, many of them community or independent pharmacists and PBM representatives. I also held meetings with other stakeholders to gain a full perspective on how this segment of the health care industry functions.



This special report details how the pharmacy reimbursement process works and what I heard consistently at my hearings: Because of the lack of transparency regarding how PBMs operate, pharmacy patients and Pennsylvania taxpayers — you — might be paying too much for medications, and PBMs might be pocketing that money.

This report also offers recommendations to increase Pennsylvania's oversight of PBMs, including suggested legislative action that could, ultimately, affect how much you pay for your medications at the pharmacy counter.

To everyone who contacted me, met with me, provided information to me and cooperated with my team's research, I thank you. We gathered all of the information and data we asked for.

Thank you for the opportunity to serve you.

Sincerely,

A handwritten signature in black ink, reading "Eugene A. DePasquale". The signature is fluid and cursive, with the first name "Eugene" being more prominent.

Eugene A. DePasquale

¹ U.S. Centers for Medicare & Medicaid Services. "National Health Expenditures 2016 Highlights." <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf> Accessed Nov. 29, 2018

Glossary

DHS: Pennsylvania Department of Human Services

MCOs: Managed care organizations, or health care managers

PBMs: Pharmacy benefit managers

Medicaid: Pennsylvania's medical assistance program

Medicare Part D: Federal prescription drug assistance program

PSAOs: Pharmacy services administration organizations, or pharmacy contracting experts

Independent or community pharmacies:
Pharmacies not owned by retail chains such as Rite Aid or CVS

Spread pricing, or "the spread": PBM practice of reimbursing the pharmacy one price for a drug while billing the plan sponsor (such as Medicaid) for a higher amount for the same drug.

Formulary: A list of prescription drugs that a health care manager or plan sponsor will cover for its plan members. Also known as a prescription drug list (PDL).

Cash price: The cost of a medication if it is not billed through a patient's prescription benefit manager. Also known as the out-of-pocket cost.

"Gag rule": A clause in a contract that prevents pharmacists from telling patients how they might pay less for their prescriptions.

Background

Although the process is complex, all pharmacy patients — whether they have government-sponsored insurance, such as Medicaid, or private insurance to cover their prescription drugs — should understand the role pharmacy benefit managers play in getting their medications.

What is an independent pharmacy?

Independent community pharmacies are those not owned or managed by a retail chain such as CVS or Rite Aid. They are usually run by small-business owners who are members of the community they serve.

Nationwide, independent community pharmacies represent an \$80 billion health care marketplace and employ more than 250,000 people, according to the National Community Pharmacists Association (NCPA). More than 80 percent of these pharmacies are in communities of 50,000 or fewer people — that's about the size of Harrisburg, Altoona or York.

In Pennsylvania, about 990 community pharmacies employ more than 9,000 people and did nearly \$3.5 billion in total sales in 2017, according to NCPA. Independent pharmacists filled nearly 10 million Medicaid prescriptions that year.

Independent pharmacies often provide a higher standard of care than chain pharmacies and offer services such as same-day home delivery and one-on-one medication counseling.



Auditor General Eugene DePasquale, center; Sen.-elect Judy Ward, left; and Rep. Seth Grove, right, listen Sept. 24, 2018, as testifiers present information regarding the practices of pharmacy benefit managers in Pennsylvania and how these practices ultimately affect the price patients pay at the pharmacy counter for their medications.

What is a PBM?

According to CVS Health, pharmacy benefit managers (PBMs) “administer prescription drug benefits to more than 266 million Americans on behalf of a variety of plan sponsors — including health plans, employers, unions, and government programs like Medicare Part D and Medicaid.”²

Health care managers — also known as managed care organizations, or MCOs — provide comprehensive care for members enrolled in their health care plans. So, for example, a health care manager might offer coverage for physical health needs, mental health needs and prescription drug needs for its members.

But a health care manager cannot specialize in all of these areas. Therefore, it might rely on a subcontractor who is a subject matter expert for each of those areas. When it comes to the experts on prescription drugs, health care managers turn to PBMs.

According to CVS Health, “Plan sponsors rely on PBMs to assemble network options that provide convenient access to pharmacists and pharmacy

services, negotiate the lowest possible net price from drug manufacturers, and provide a portfolio of clinical programs and services that help ensure positive health outcomes and secure overall value for the (plan) sponsors and their members.”³

For example: If your doctor has ever prescribed you a new medication and, when you got to the pharmacy, you were told a “pre-authorization” was required, you’ve bumped up against a PBM.

Or if your doctor ever prescribed a newer, brand-name medication that you can’t get filled because it’s not on your insurer’s list of approved drugs, you’ve run into a PBM.

But, because PBMs are middlemen, operating multiple steps removed from patients and health insurance companies, their roles — and their effects on patient care and costs — have long been overlooked. Many PBMs take advantage of being able to operate more or less in the shadows, where a complex administrative process allows them to control patient medication outcomes without direct government oversight or review of their practices.

² CVS Health handout, “Pharmacy Benefit Managers: What We Do.”

³ Ibid.

In Pennsylvania, the Department of Human Services oversees the Medicaid program, which provides health coverage for an average of about 2.9 million Pennsylvanians each year.⁴

In 2017, Pennsylvania taxpayers paid \$2.86 billion to PBMs for Medicaid enrollees, according to DHS. That's an increase of 100 percent in four years, from \$1.41 billion in 2013. That \$2.86 billion includes both the cost of doing business as well as profits, but because PBMs' business practices are shielded from public or government scrutiny, there's no way to verify how much was profit.

How is that lack of transparency possible? It is made possible by the fact that PBMs are subcontractors of the state, not direct contractors; therefore, their contracts are not required to be open for any entity — including the Department of the Auditor General and the Department of Human Services — to review.

Here is how the process works:

- **Pennsylvania, through the Department of Human Services (DHS)**, contracts with **health care managers** (such as Gateway Health) to administer health care plans for its Medicaid enrollees. Because these are contracts signed directly with the state, these contracts are subject to transparency requirements, such as an audit by the Department of the Auditor General.
- Each **health care manager** (such as Gateway Health) then contracts with a **PBM** (such as CVS Caremark) to administer its prescription drug plans. Because these contracts are not signed directly with the state — meaning they are subcontracts — there is no provision requiring that they be made available for anyone to review, including the Department of the Auditor General or DHS. Without the ability to directly oversee these contracts, Pennsylvania has no idea, for example, how much profit PBMs are making from Medicaid prescriptions and how much money PBMs are charging overall.
- Each **pharmacy benefit manager** then presents contracts to **pharmacy contracting experts**, known as pharmacy services administration organizations or **PSAOs**, which represent groups of individual member pharmacies. Nearly 90 percent of independent pharmacists rely on PSAOs to handle their contract deals.

The **PBMs** and the **PSAOs** sign contracts detailing terms of prescription drug pricing and reimbursements for **the pharmacies**, which then dispense medications to Medicaid patients for the prescription co-pays guaranteed by their Medicaid plans.

⁴ Pennsylvania Department of Human Services Medical Assistance, Food Stamps and Cash Statistics Archives on Listserv16.0. Data pulled from MA-FOOD-STAMPS-AND-CASH-STATS Archives, August 2018 data. <http://listserv.dpw.state.pa.us/Scripts/wa.exe?A2=ind18&L=ma-food-stamps-and-cash-stats&F=&S=&P=6866>. Accessed Oct. 3, 2018.



PBMs make money in three main ways:⁵

Administrative fees

PBMs often charge drug manufacturers and plan sponsors, such as Medicaid, fees and payments that they then keep for themselves. Because the PBM process is so opaque and their contracts are not required to be made available for public scrutiny, determining exactly what these fees and costs are is impossible.

Spread pricing

PBMs can reimburse the pharmacy one amount for a medication, charge the plan sponsor (such as Medicaid) a higher price for the same drug, and pocket the difference. For a discussion on spread pricing and how much it cost Pennsylvania taxpayers in 2017, see page 15.

Rebates

A rebate is “a discount on a medication a drug manufacturer gives a PBM in return for the PBM agreeing to cover the drug manufacturer’s product,” according to the NCPA’s website. “Sometimes that means eliminating a less-expensive, comparable medication from the formulary. Usually, only a portion of those rebates are shared with the plan sponsor,” such as Medicaid. This topic will be addressed in a future report.



Auditor General Eugene DePasquale listens as a testifier speaks during the Bethlehem hearing.

⁵ National Community Pharmacists’ Association. “The PBM Story.” <http://www.ncpa.co/pdf/PBM-Storybook-6pg.pdf>. Accessed Oct. 4, 2018.

A national view

Nearly all other states have already considered and passed legislation aimed at making PBMs' practices more transparent so that state leaders can ensure taxpayers are not overpaying for unnecessary services.

Here are a few highlights:

Ohio

Pharmacies are now required by law to share information about lower-cost alternative medications with patients.

Maryland

The state regulates how PBMs may negotiate contracts with pharmacies, bans "gag clauses" and provides a role for the state Insurance Commissioner to oversee whether PBMs comply with state law.

North Dakota

Bipartisan legislation passed here has been upheld twice in court. The legislation forces more transparency by prohibiting all "gag rules," requiring upon request details of medication costs, and requiring some disclosure by PBMs on potential conflicts of interest (such as the fact that pharmacy chain CVS Health owns PBM and mail-order prescription company CVS Caremark).

South Dakota

PBMs must now obtain licenses to conduct business in the state, and they are required to disclose revenue received through rebates or other incentives.

West Virginia

Pharmacists may now legally inform customers of lower-cost alternative medications, and all "gag rules" are banned.

Unlike Pennsylvania, dozens of states have directly addressed how PBMs may determine the price per individual medication and how often that list price is to be updated.

What We Heard

During 2018, Auditor General DePasquale listened to hours of testimony by independent pharmacists, pharmacy association representatives, and officials from the Washington, D.C.-based Pharmaceutical Care Management Association (PCMA), which represents PBMs nationally.

Three major observations emerged from those hours of testimony:



Auditor General Eugene DePasquale, left, and Sen. Tom McGarrigle listen during the Delaware County PBM hearing.

1. **Lack of transparency:** PBMs operate with little to no transparency and have expanded beyond their original role as third-party claims administrators.
2. **Lack of oversight:** No federal or state oversight of the contracts that PBMs require community pharmacists to sign means that some PBMs have been presenting take-it-or-leave-it contracts with unduly restrictive clauses.
3. **Reimbursement disparity:** Independent pharmacists believe that PBMs are not paying fair prices to reimburse pharmacies for all the medications they dispense.

Nearly every pharmacist who testified spoke of their concern that PBMs would retaliate against them by canceling their contracts because they spoke out about what they see as PBM injustices. For that reason, this report does not identify participants by name.

“Many of us are fearful to provide testimony in person, due to (the) possibility of retaliation by the PBMs, up to and including terminating our stores from all their contracts,” one western Pennsylvania pharmacy owner wrote anonymously in September 2018. “That is why I am only willing to provide this statement without identifying myself or my stores’ locations.”

Many pharmacists also spoke about the relationships they develop with their regular customers, including one pharmacist who related a story about delivering a customer’s needed prescription medication by snowmobile during a snowstorm.

“For many of our patients, we are the safety net for their overall health care needs, especially our senior citizens and other most vulnerable patients,” the same western PA pharmacy owner wrote. “We are oftentimes the main health care access point for our patients.”

Lack of transparency

PBMs operate with little to no transparency and have expanded beyond their initial role as third-party claims administrators.

Third-party administrators for prescription drug benefits began appearing in the 1960s and 1970s, according to long-time pharmacists who testified at the Delaware and Erie hearings. These administrators initially processed prescription medication claims — for a small fee per claim — for insurance companies and plan sponsors.

Over the decades, these administrators began to take on more duties, such as helping health care managers create formularies, or preferred drug lists (PDLs), that detail which medications members will have covered through their prescription plans — and how much each pharmacy will be reimbursed for filling those prescriptions.

In the last roughly 10 years, PBMs have grown into big business, with each of the top three PBMs in the country — CVS Caremark, Express Scripts (ESI) and OptumRX — raking in more than \$15 billion annually while claiming to hold down costs for prescriptions.⁶

PBMs might indeed be able to hold down some costs — but, community pharmacists argue, at the expense of patients' quality of life.

For example, one pharmacist shared an example of an elderly patient who needed medication for gout, a form of arthritis. While on a generic medication to control gout, the patient had routine flare-ups. Her doctor prescribed a different, more expensive brand-name medication to prevent flare-ups altogether. However, the PBM would not allow the patient to get the brand-name medication because it was not on her insurer's formulary — which means the patient ends up back in the hospital regularly with gout flare-ups, raising her health care costs exponentially.

"This type of 'cost control' by PBMs gets in the way of the care doctors are trying to provide for their patients," another pharmacist wrote in 2018. "It should not be a PBM's decision which medication is best for any patient."

The lacking transparency also means that PBMs can shield important information, such as:

- Whether they are reimbursing community pharmacists the same amount as their affiliated pharmacies for the same drugs;
- The total amount of business they do in a year;
- How they choose which prescription medications to cover; and
- How much profit they are making off of consumers.

⁶ Hoffman-Eubanks, Brittany. "The Role of Pharmacy Benefit Managers in American Health Care: Pharmacy Concerns and Perspectives: Part 1," Pharmacy Times. Nov. 14, 2017. <https://www.pharmacytimes.com/news/the-role-of-pharmacy-benefit-mangers-in-american-health-care-pharmacy-concerns-and-perspectives-part-1>. Accessed Oct. 4, 2018.

Lack of oversight

No federal or state oversight of the contracts that PBMs require community pharmacists to sign means that some PBMs have been presenting take-it-or-leave-it contracts with unduly restrictive clauses.

Repeatedly during the hearings, pharmacists said they don't believe they have a choice whether to sign the contracts that PBMs present through their PSAOs, the pharmacy contracting experts.

"PBM contracts are take-it-or-leave-it," one community pharmacist testified during the Beaver County hearing. "And if we leave it, then we have no patients, which means we have no business to run."

"If you don't sign them (the PBM contracts), you might as well go outside and close your doors," one pharmacist testified in Delaware County. "During the day, all pharmacy operations are decided by PBMs. We, the pharmacists, decide what time the pharmacy opens and what time it closes. That's it."

"The system is flawed in that the motivations of the PBMs don't align with the interest of providing quality patient care at the best possible cost," another pharmacy owner testified in Beaver County.

"All I want to be able to do is provide the medications my patients need at the best price possible," another pharmacist said after the Delaware hearing, "and at the end of the day, have earned a little bit of money to keep my business open so I can do it again tomorrow."

"Gag" rules

One type of restrictive clause that community pharmacists repeatedly testified about seeing in their contracts was a so-called "gag rule." Gag rules prevent pharmacists from being allowed to voluntarily tell patients they might be able to pay less for a medication if they paid the out-of-pocket price, or cash price, instead of using their prescription drug insurance.

This is the essence of the auditor general's concern that some patients are overpaying for their prescription drugs, and their pharmacists may be prevented from telling them how to get their medications for less money.

Not all PBMs use gag rules — in fact, some say they never used them — but pharmacists said they feel overly constrained by the ones that do. Even though some PBM officials insist their contracts have never contained gag rules, there is no legal requirement for them to produce any contracts to prove their assertion.

In October 2018, a federal legislation was signed banning PBMs from using gag rules in their contracts. However, according to the Pennsylvania Pharmacists Association, the order does not apply to all PBMs for all insurance plans, so loopholes remain in the law that allow PBMs to maintain gag clauses in certain contracts.

**“PBM contracts
are take-it-or-
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Separation?

The lack of any government oversight has also led to suspicions that some of the major companies — particularly CVS Health — are not keeping the PBM segment of their business completely separate from the pharmacy acquisition segment.

Dozens of pharmacists noted that, a few weeks after CVS Caremark dramatically decreased drug reimbursement prices in late 2017, they began receiving letters from CVS offering to buy their pharmacies, citing those dropping reimbursement prices. CVS officials said the acquisition offer letters are very similar to ones the company has been sending to community pharmacists for years and had no relation to the drop in reimbursement prices.

Community pharmacy closings are indeed a concern. Between 2003 and 2013, about 12 percent of all independently owned rural pharmacies in the U.S. closed⁷, which has limited patients’ ability to use the pharmacy of their choice.

According to the Federal Trade Commission (FTC), major companies must keep the PBM segment and the pharmacy acquisition segments of their companies completely separate. A two-year FTC investigation of CVS Caremark found in 2012 that those two segments were indeed being kept separate. However, according to the letter sent to CVS Caremark’s attorneys, “the Commission reserves the right to take such further action as the public interest may require,”⁸ meaning that it could open a new investigation at any time.

⁷ Ullrich, Fred; Mueller, Keith J. “Update: Independently Owned Pharmacy Closures in Rural America, 2003-2013,” RUPRI Center for Rural Health Policy Analysis Rural Policy Brief. University of Iowa. <https://www.public-health.uiowa.edu/rupri/publications/policybriefs/2014/Pharm%20Closure%20Brief%20June%202014.pdf>. Accessed Oct. 4, 2018.

⁸ https://www.ftc.gov/sites/default/files/documents/closing_letters/cvs-caremark-corporation/120112cvsclosingletter.pdf

Reimbursement disparity

Independent pharmacists believe that PBMs are not paying fair prices to reimburse them for all the medications they dispense.

At least a dozen community pharmacists submitted paperwork — sometimes hundreds of pages — showing individual prescriptions they lost money on because PBMs did not reimburse them adequately to cover not only the acquisition cost of the medication, but also the time and supplies required to dispense the medication to a customer.

When asked to explain how the reimbursement rates are set, PBMs and pharmacists begin talking in acronyms: The average wholesale price (AWP), the wholesale acquisition cost (WAC), the maximum allowable cost (MAC), the National Average Drug Acquisition Cost (NADAC) and more.

As with many facets of the health care industry, determining how much the drug manufacturer wants to be paid for supplying a drug is a complex mathematical equation, as is the equation for how pharmacies are reimbursed for dispensing those drugs. Each PBM has its own formula and system for reimbursements, including for generic drugs, which make up roughly 85 percent of all prescriptions filled annually nationwide.

PBMs consider the exact formulas for reimbursements of individual drugs to be proprietary information that amounts to trade secrets. Here again, the lack of transparency allows these companies to set their own prices without government oversight.

Community pharmacists believe PBMs are reimbursing chain pharmacies more per prescription but, because the contracts are not subject to any government oversight, there is no way to independently verify that claim.

“Short-changing local pharmacies on the front end through low reimbursements only hurts patients on the back end.”

What all the pharmacists' documentation boils down to is this: Community pharmacists say they are losing money on 20 to 25 percent of all prescriptions they fill because PBMs are not reimbursing them enough to cover the acquisition cost of medications, much less the cost of employee time and supplies required to dispense those medications.

"Small pharmacies often see the most vulnerable patients, such as the elderly, the disabled and the mentally ill," one pharmacist said during the Beaver County hearing. "These people often have nowhere else to go or no one else to assist them with their medications. And if small pharmacies are forced out of business, these patients will have to travel greater distances to get the medications they need – if they aren't forced into getting their prescriptions through mail-order, as many are now.

"Short-changing local pharmacies on the front end through low reimbursements only hurts patients on the back end."

Among the many examples pharmacists provided during the hearings:

- One pharmacist filled 15 prescriptions for a husband and wife. The pharmacist's total cost was \$55.27, but the pharmacy was reimbursed only \$50.43, so that pharmacy lost time and money.
- Another pharmacist provided documentation showing that their pharmacy filled a prescription for an antipsychotic medication on Oct. 31, 2017, and was reimbursed \$605.62 less than the cost to acquire and dispense the medication.

The practice of billing a plan sponsor one price and reimbursing a pharmacy a lesser amount is known as "spread pricing." To better understand spread pricing and how it affects the state's Medicaid plan, in early October 2018, Auditor General DePasquale requested three data points from five PBMs that operate in Pennsylvania:

- The total number of Medicaid-covered prescriptions each PBM handled in Pennsylvania in 2017,
- The total amount each PBM billed the state for those Medicaid-covered prescriptions in 2017, and
- The total dollar amount each PBM reimbursed all pharmacies for those Medicaid-covered prescriptions in 2017.

The answers received varied widely.

One PBM made no money on spread pricing for Medicaid prescriptions because it does not engage in spread pricing; instead, it relies solely on administrative fees for profit from Medicaid. Another PBM did not participate in Medicaid in 2017, so it did not fill any prescription under the medical assistance plan.

The other three PBMs made between \$2 million and nearly \$40 million on spread pricing, earning average profits between 28 cents and almost \$13 per Medicaid prescription filled.

This wide disparity in profit per prescription demonstrates the free rein PBMs have been given. The lack of transparency and government oversight have led to haphazard pricing schedules.

Conclusion

Being able to afford prescription medications can be the difference between life and death for a patient. Despite the wave of less-expensive, generic drugs that have hit the market, studies show that prescription drug costs continue to rise.

As the health care system has grown increasingly complex, PBMs have ballooned in the shadows of the prescription drug market, drawing in skyrocketing profits while exerting increasing control over who may access which prescription medications.

Legislative attempts to rein in some of these PBMs' practices fell short of passage in Pennsylvania's 2017-18 legislative session, but that does not mean that the General Assembly has no appetite to pass such legislation. Instead, a new crop of incoming legislators will need to be educated on PBMs and their powerful tactics, and new legislation must be introduced to do the following:

1. Allow Pennsylvania to directly manage its prescription drug benefits instead of contracting with health care managers to do so,
2. Increase transparency into PBM pricing practices,
3. Allow state oversight of PBM contracts with PSOs and pharmacies, and
4. Require a flat-fee pricing model for compensating PBMs so that the state pays only for those services PBMs render.

The time is now for the state and federal governments to act to bring transparency and oversight to the practices of these PBMs. Your money, taxpayer money and patients' lives depend on it.

Recommendations

1. **The General Assembly** should immediately pass legislation banning all “gag rules” and allow pharmacists to tell all patients if they could be paying less for a medication.
2. To ensure taxpayer dollars are being handled effectively and efficiently, **the General Assembly** should immediately pass legislation allowing the state to perform a full-scale annual review or audit of subcontracts with pharmacy benefit managers.
3. To better control costs, **Pennsylvania** should consider directly managing its Medicaid prescription drug benefits instead of contracting with managed care organizations to do so.
4. **The General Assembly** should pass legislation that increases transparency into PBM pricing practices.
5. **The General Assembly** should pass legislation to use the federal Centers for Medicare & Medicaid Services’ National Average Drug Acquisition Cost (NADAC) for pricing prescription drugs filled through Medicaid.
6. **The General Assembly** should grant state oversight of contracts signed between PBMs and pharmacies or pharmacy services administration organizations, which are currently shielded from oversight because they are subcontracts.
7. So the state pays only for services PBMs render, **the General Assembly** should pass legislation requiring a flat-fee pricing model for compensating PBMs.
8. **Pennsylvania’s Department of Human Services** should use Texas’ Vendor Drug Program as a model to create Pennsylvania’s own universal preferred drug list for Medicaid clients.
9. **Pennsylvania’s Department of Human Services** should add “good steward” language to all Medicaid-related contracts.
10. **The Federal Trade Commission** should investigate whether separation truly exists between the PBM and pharmacy acquisition segments of major companies that operate both.
 - If the FTC does not investigate, then **the General Assembly** should consider legislation that prevents managed care organizations from using a PBM for Medicaid if the PBM is part of a larger company that also owns retail pharmacies.

3 QUESTIONS YOU SHOULD ASK

To help consumers take an active role in getting the best price possible for their prescriptions, Auditor General DePasquale released a short informational video with **three questions everyone should ask their pharmacist.**

[Watch online here.](#)



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