Submitter: Randall Klemm

On Behalf Of: Achterhof Healthcare Pharmacy LLC

Committee: House Committee On Behavioral Health and Health Care

Measure: HB3013

It is my sincere hope that this bill will provide relief from the negative business practices of PBMs. Just today our pharmacy, Achterhof Healthcare Pharmacy, submitted an Rx to a PBM (CVS/Caremark) for a medication that has recently gone generic. This medication (DABIGATRAN ETEXILATE) is a generic for Pradaxa. It has only one generic manufacturer at the moment (CAMBER PHARMACEUTICAL). CVS/Caremark MAC'd our reimbursement at a level where we are losing $200.45 for a 30-day supply of this medication. MAC stands for Maximum Allowed Cost. This is a value assigned by the PBM. The PBM is also the arbiter if a pharmacy decides to appeal their MAC pricing. This is like having the fox guard the hen house. If our MAC appeal is denied, the PBM is not compelled to provide proof of where the product might be purchased at their MAC level. They are able to just deny and there is no further recourse for the pharmacy. PBMs need to compelled to provide RECENT proof of the ability to purchase a pharmaceutical at a price equivalent to their MAC at an accredited and national wholesaler. They should not be able to use a regional wholesaler in New York's price to MAC a pharmaceutical for a pharmacy in Oregon that cannot purchase that product from the wholesaler in New York.

PBMs have the ability to "adjust" claims already paid to a pharmacy without having to give the pharmacy notice or give an explanation as to why there was and "adjustment". The PBM can just reach into a pharmacy's claim "bucket" for the current claims cycle (usually every 2 weeks) and just make an adjustment without notice provided or gaining consent from the pharmacy. How would it go over if my pharmacy discovered that we had charged Mrs. Smith $200 less than what we should have and we just decided to take the credit card that we have on file and just charge her the $200 without so much as a call or letter of explanation. And trying to call one of these behemoth PBMs to get an explanation for something like this is the definition of impossible. In our case, these types of adjustments involve THOUSANDS of dollars of claims. If the PBM needs to make an adjustment because of their error, they should have to provide a letter of explanation to the pharmacy and then have an independent arbiter involved to make a determination as to the validity of their claim. In my opinion, if it was the PBMs fault that the claim was paid incorrectly, the PBM should not be able to recoup the cost of the mistake from the pharmacy.

PBMs (especially CVS/Caremark) have contracted with some of Oregon's Medicaid Managed Care Organizations. The PBMs and the MCOs are not required to set any minimum reimbursement levels for these patients due to the MCO organizational laws. As a result, we are being paid at a MAC rate plus a dispense fee of $0.10 PER

prescription. As a result, our pharmacy loses $10 to $12 PER PRESCRIPTION on the MCO patients. Many published cost-to-dispense studies have placed a value of what it costs a pharmacy to dispense a medication. For patients like ours that live in state-licensed care facilities and have to have their medications delivered to them, that cost to dispense is in the $12 to $14 per prescription. I would like the OHA to mandate that for MCOs, the minimum dispense fee is, at a minimum, aligned with the OHA calculated minimum dispense fee for the fee-for-service Oregon Medicaid patients.