OREGON STATE PHARMACY ASSOCIATION

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Written Testimony for HB 3013

House Healthcare Committee

Chair Nathanson & Members of the Healthcare Committee,

Community pharmacies in Oregon are in crisis. Reimbursements to pharmacies by third parties have fallen below levels necessary to sustain a pharmacy business or to provide adequate care to patients or timely access to drugs. In towns all over Oregon, people are experiencing wait times measured in days. Pharmacy phones are not answered. Pharmacy hours of access have been reduced or pharmacies have closed altogether. People with complex medical problems are having trouble finding a pharmacist who can help them. This is the crisis OSPA predicted if Pharmacy Benefit Manager (PBM) practices were not appropriately regulated.

PBMs have an effective monopoly in Oregon where single PBMs represent 70% or more of the market in some areas of the state. They have used this power to pay pharmacies lower and lower rates with outrageous contract conditions. Pharmacies must either accept the rates and conditions or close.

HB 3013 establishes a drug acquisition cost + fair dispensing fee minimum standard for all third-party payors which matches the Oregon Medicaid fee-for-service model. This will stabilize the pharmacy marketplace and help restore local community access to timely prescription drugs and care from a pharmacist. This model has the added benefit of transparency to the cost of drugs through community pharmacies- in effect, there will be one price. The model also removes the current incentives for pharmacies to charge high usual and customary prices or to refuse prescriptions with below cost payments.

HB 3013 also includes necessary enforcement and practice provisions:

1. Requires PBMs become licensed in Oregon. This allows for more of our existing insurance code to apply towards PBMs to help with enforcement.
2. Provides anti-retaliation language to protect pharmacies who file complaints against PBMs.
3. Provides reasonable notice and response language for PBM audits of pharmacies.
4. Gives all pharmacies the right to participate in PBM networks.
5. Dedicates resources at the Department of Consumer and Business Services (DCBS) for enforcement of PBM law and investigation of complaints.

These provisions have proven necessary as we have been told of retaliation in response to complaints, exclusion of pharmacies who question PBM practices, and predatory audit practices. Our pharmacists have found it difficult to file complaints with DCBS or contact a person when they need help. There are long response times to complaints and a stated shortage of resources for investigation or enforcement. A dedicated person at DCBS for PBM issues should help greatly and seems necessary due to the large scope of problems being experienced by pharmacies.

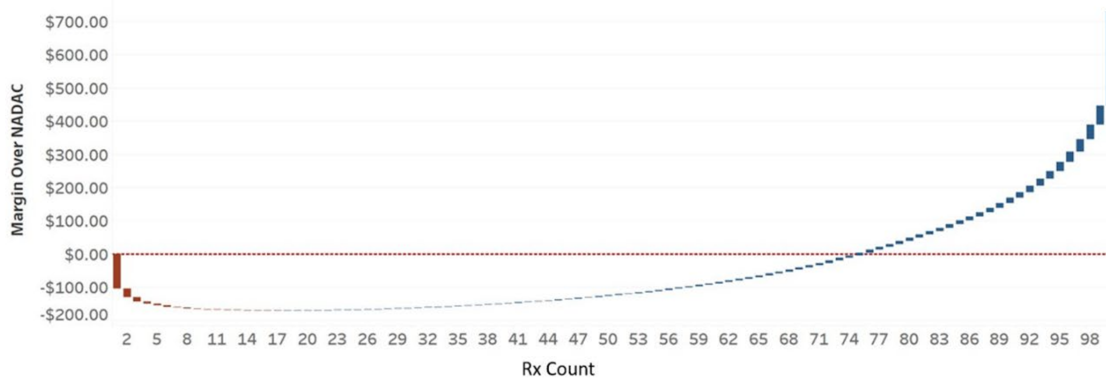
Background:
OSPA commissioned a study performed by 3-Axis Advisors: Understanding Pharmacy Reimbursement Trends in Oregon - Oregon State Pharmacy Association (oregonpharmacy.org) This study examined almost 12 million pharmacy claims for 86 participating Oregon pharmacies (16% of Oregon pharmacies) from years 2019-2021. The study had many eye-opening findings and it established that pharmacies were being paid an average of $7 margin above drug cost at the time claims were submitted. This study could not determine how much of this

$7 margin was actually realized by pharmacies, because PBMs charge pharmacies fees after the point of sale. Moreover, margin was not equitable with high variations between pharmacies in top payment gains or losses compared to drug cost. OSPA estimates that a pharmacy must make a $15 average margin above drug cost in order to be a sustainable business with good care, access, and service. Pharmacies are making less than half of that now. The below chart combines all study claims represented by 100 prescriptions comparing margin to drug acquisition cost using National Average Drug Acquisition Cost (NADAC). Margin is cumulative across the graph from lowest to highest margin prescriptions.

Overall Pharmacy Payment

Average margin is $7
19/100 reimbursements are below cost
75/100 prescriptions are needed to break even on drug cost
Top 3% of prescriptions account for 50% of margin and are not equitable between pharmacies

Overall Margin Over NADAC Per 100 Prescriptions, Oregon Retail Pharmacy Data Set
(2019 - 2021)



The current payment model is bad for business stability. Big losses or gains occur in the top and bottom 3%. Our data shows that there is high variation over time and between pharmacies. Pharmacies have little power in contract negotiation, and PBMs have incentive to drive down the amount they pay pharmacies. There is no guarantee pharmacies will make money on any drug. 32% of pharmacy claims were paid under the cost that pharmacies bought the drug for, and reports of underwater claims grow by the day. This instability prevents investment in pharmacies in critical access areas, incentivizes closure, and incentivizes investment in other industries or states. Further, the current model provides the wrong financial incentives to maximize use of high margin drugs or refuse access for drugs paying below cost. In fact, looking at the much worse CCO payment chart below, it is a wonder any pharmacy still accepts managed Medicaid in Oregon.

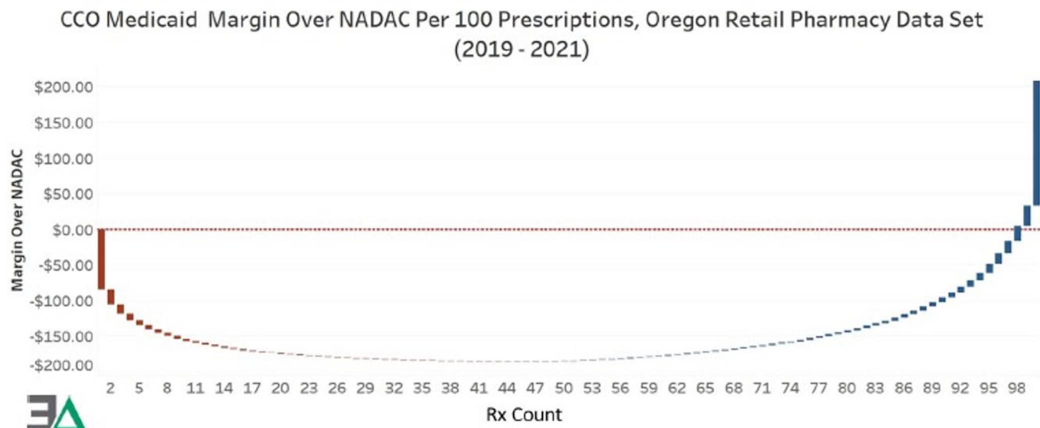
CCO Medicaid Payment

Average margin is $2

44/100 reimbursements are below cost

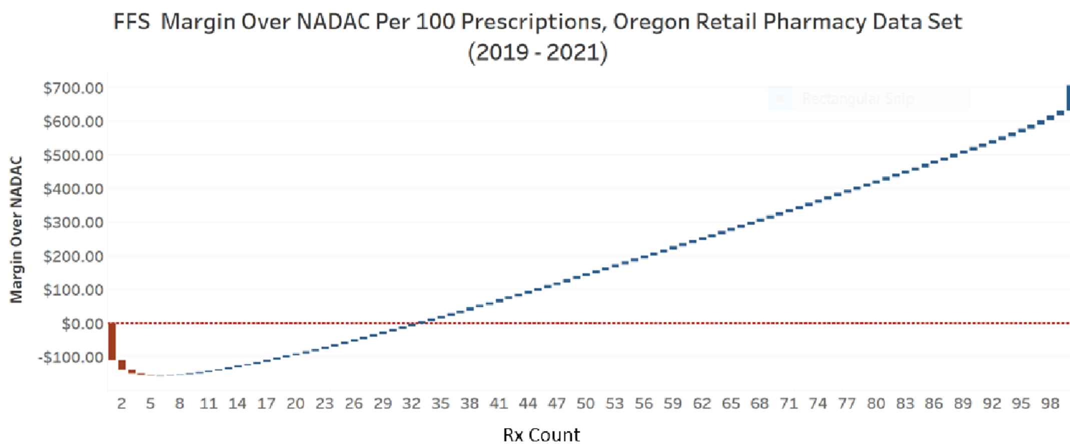
97/100 prescriptions are needed to break even on drug costs

Top 2% of prescriptions are the entire margin



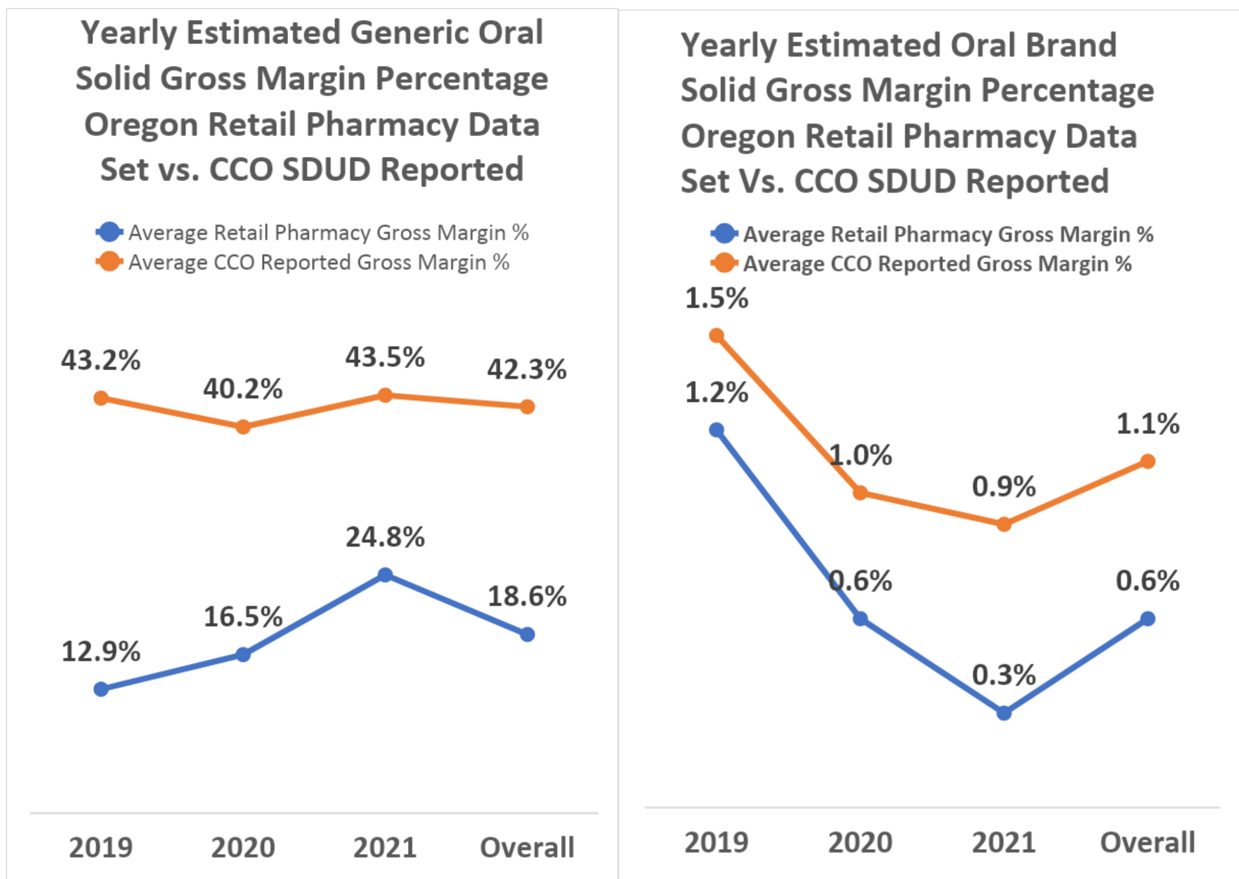
Sources: 86 Oregon retail pharmacies in study, CMS NADAC, 3 Axis Advisors, LLC

Oregon fee-for-service Medicaid already uses the payment model proposed in HB 3013. Here is how that data looks from our study:



Note that work is needed on the accuracy of actual acquisition cost data on a minority of claims but otherwise **the linear data shows equal payments which means predictability, transparency, business stability, and incentives to help all patients equally**. In this model pharmacies are still incentivized to buy drugs at the lowest price possible to improve margins and this in turn will lower the Oregon Average Acquisition Cost (AAC), further reducing the cost of drugs to patients and payors.

Will this change increase the cost of drugs?
PBMs will certainly have to pay community pharmacies more on average than they do today. This is necessary to sustain community access to drugs and the availability of local pharmacists to provide healthcare. This does not mean that insurers, employers, or patients will pay more for drugs. Insurers, employers, and the State of Oregon should demand that PBMs end their huge profit taking from the spread on drugs and the conflict of interest of routing prescriptions to their own affiliated pharmacies. If the proposed fee-for-service cost was used for all drugs (including ones filled at PBM affiliated pharmacies) and passed through to payers, we believe there would be a net savings rather than an increase in costs. Look at the chart below from our study.



The chart compares the margin % above acquisition cost paid to study pharmacies (blue) vs. the margin CCO PBMs charged the State of Oregon on average over all pharmacies for the same drugs (orange). This means that these PBMs are either billing for a higher amount than they pay pharmacies (keeping the spread), or some non-studied pharmacies are getting paid a much higher margin. We are told spread pricing is not allowed for PBMs working for Oregon Medicaid and there is scrutiny and audits, yet our data tells a different story. **The**

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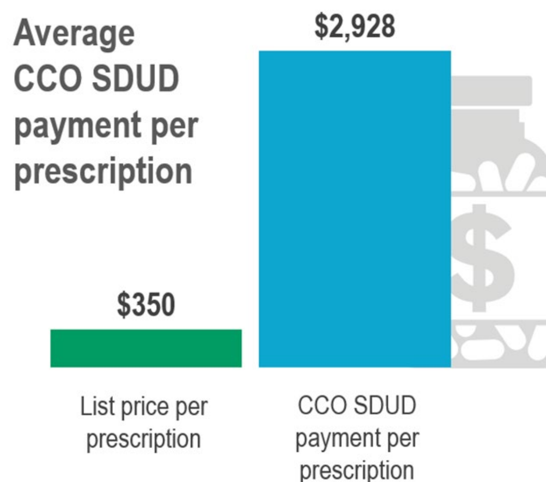
data suggests that PBMs are making a higher margin on drugs than the pharmacies who have to pay for facilities, staff, and provide care for patients! Whereas we can only make this comparison for CCO claims, we believe it is also occurring in the commercial and Medicare space. Eliminating this margin can provide the resources to pay pharmacies properly to take care of patients.

HB 3013 does not address PBM steering patients to their own affiliated pharmacies. However, reform in this area can provide another financial means to pay for the fee-for-service model. Our study found a glaring example of this when a specialty drug, Tefidera™, became available in the generic, dimethyl fumarate. By January of 2021 the acquisition price of this drug fell to under $350 per prescription. There were no study pharmacy claims for this drug in 2021 indicating it was restricted and likely filled at a PBM affiliated pharmacy. Per the State Drug Utilization Database, CCO PBMs charged the state an average of $2,928 per prescription for dimethyl fumarate in 2021. **This represents an overcharge of about $2 million dollars for just one drug!**



PBMs can steer or force patient to use their own affiliated pharmacies and also can determine what they pay themselves and bill for. They can also determine which drugs they will allow community pharmacies to fill and which they keep for themselves. They convince payors that this will save them money and yet have no true transparency. The below chart shows dimethyl fumarate margin compared to the total margin paid to our 86 study pharmacies for all of 2021. **PBMs billed a higher margin for just one drug than they paid to all study pharmacies for filling 585,600 prescriptions! Reform to end this type of overcharge will pay for fair fee-for-service payments to community pharmacies.**

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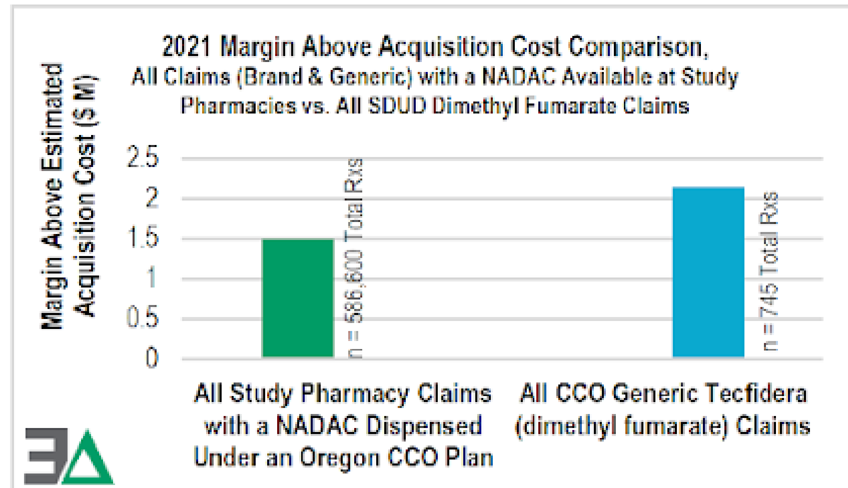


In conclusion, HB 3031 will stabilize the failing community pharmacy marketplace and help restore timely access to drugs and pharmacist healthcare services for people in every community in Oregon. In addition, it creates needed transparency to drug costs and prices. It incentivizes pharmacies to lower the cost of drugs. Finally, it creates equity where all pharmacies and patients are treated equally across the State of Oregon.

Please vote "Yes" to support passage of HB 3031!

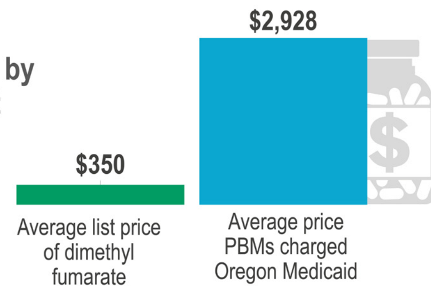
Thank you for your consideration.

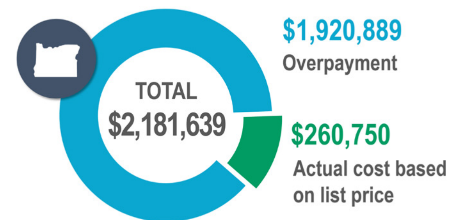
Oregon State Pharmacy Association &
Oregon Society of Health-System Pharmacists

Inequity in PBMs' Drug Pricing Practices in Oregon Raises Serious Questions

The Oregon State Pharmacy Association (OSPA) and 3 Axis Advisors recently released a **report** that illustrates the worrying tactics pharmacy benefit managers (PBMs) employ to increase their profits at the expense of local pharmacies, taxpayers and patients. The study, *Understanding Pharmacy Reimbursement Trends in Oregon*, found that PBMs are reimbursing pharmacies at wildly different rates while at times charging Medicare and Medicaid astronomical prices.

A particularly troubling example seen in the enclosed figures shows that **the state Medicaid program was made to pay more than eight times the manufacturer's asking price** for a generic multiple sclerosis drug.





Here are other key findings from the study:

- Among the three broadly different payer types – Medicaid, Medicare and Commercial – PBMs operating in each of the segments are setting different incentives for pharmacies. For example, PBM reimbursements for the Oregon Medicaid Coordinated Care Organization program were associated with the lowest margins for pharmacies, creating incentives that may drive providers away from underserved communities.
- On a per-100 prescription basis, PBM reimbursement for the majority of claims (75 out of 100) dispensed at a typical retail Oregon pharmacy* were insufficient to cover the pharmacy labor and drug costs.
- The PBM incentives embedded in the current system appear to reward and encourage higher drug prices at pharmacies, resulting in higher out-of-pocket costs for patients who obtain their medications through cost sharing or without insurance coverage at all.

** As represented by those in the study*

We need to make a change – not just here but across the US – to protect our pharmacies and help lower prescription drug costs at the pharmacy counter. The urgency of taking action couldn't be more clear.

OSPA Executive Director Brian Mayo

These trends are detrimental to patients in rural and minority communities who are most impacted by increasing disparities in accessing care. If you can no longer afford your medication or your only local pharmacy closes down, you quickly run out of options.

Michele Belcher, OSPA member and immediate past president of the National Community Pharmacists Association

We have real concerns about what this means for patient health and safety. When we see these unfair markups, it means more and more patients are struggling to afford and adhere to the medications they depend on.

Lincoln Alexander, local Portland pharmacist and immediate past president of OSPA

To learn more, visit oregonpharmacy.org

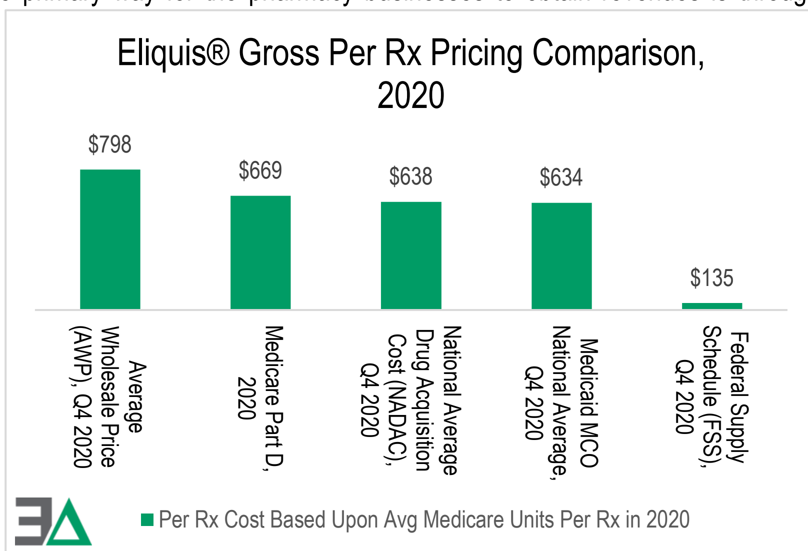
You can also read the full report here

Executive Summary

On September 30, 2021, Bi-Mart, a regional retail chain in Oregon and surrounding states, announced plans to exit the pharmacy business by January 2022. Citing increased costs and ongoing reimbursement pressures, the company transitioned their pharmacy inventory and prescription files to competitor Walgreens. (1) The move was perhaps unsurprising as just two years prior, Bi-Mart had shuttered its pharmacy services in 13 locations in the Portland area. (2) Predictable or not, the impact of the pharmacy closures was one that almost certainly was going to increase healthcare inequities in Oregon. That's because there were rural areas in Oregon where Bi-Mart was virtually the only pharmacy accessible to their patients.[i] By shutting their pharmacy businesses, available pharmacy options became more limited, potentially creating access issues in critical areas of the state (Oregon statute [OAR 431-121-2000] identifies a critical access pharmacy as one where there is no other pharmacy within 10 miles). As a result, the ability to get prescriptions timely, obtain needed vaccinations, receive needed healthcare screenings and monitoring, or any number of pharmacy services in the area decreased with the ceasing of pharmacy operations.

Pharmacists provide essential care to the residents of Oregon. Pharmacy staff actions were critical to getting people vaccinated against COVID-19, implementing the state's key public safety response to the pandemic and saving lives. However, the profession of pharmacy faces challenges that have led to shorter operating hours, longer wait times for prescriptions, and less time for pharmacists to collaborate with physicians, counsel their patients, better manage chronic diseases, and address other broader health concerns. The Oregon Board of Pharmacy states that it continues to receive a high number of complaints from licensees and the public about conditions at retail pharmacy. (3)

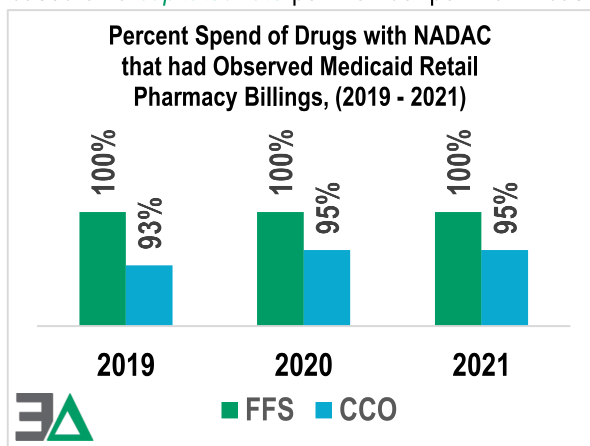
In addition to being essential healthcare providers, pharmacies are businesses. From a business perspective, we should expect that their financial incentives will have a meaningful impact on the focus of their services, as their viability will be determined by their ability to minimize losses and maximize profits. However, the desire of drug pricing policy to pay less for prescriptions is often at odds with the goals of ensuring the availability and accessibility of quality pharmacy services. This is because the primary way for the pharmacy businesses to obtain revenues is through dispensing medications. Despite prior work in the subject of prescription drug reimbursement practices, it is often forgotten that the revenues obtained from dispensing medications are highly differentiated within the market, such that some payers or purchasers of drugs incur significantly higher costs than others. For instance, Eliquis®, the drug with the highest gross Medicare expenditures in 2020, shows how a price for single-source brand product can be significantly different from program-to-program (i.e., 80% different in the reviewed gross spending in federal programs in 2020).



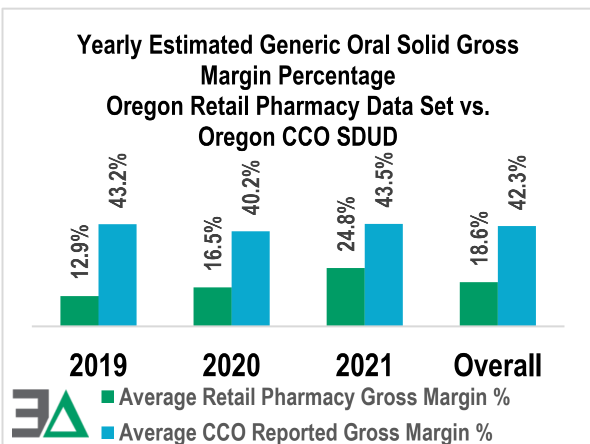
[i] The Oregon Health & Science University (OHSU) identified the 2022 Critical Access Pharmacies per Oregon Statute. Among the identified regions were Sutherlin and Veneta where Bi-Marts are located. (103)

The disparities in pharmacy pricing and the inequity of payment resulted in 3 Axis Advisors, LLC, being commissioned by the Oregon State Pharmacy Association (OSPA) to review reimbursement trends between payers and retail pharmacies between 2019 and 2021. The primary request was to identify if there may be *differential pricing* in payment or *spread pricing* among Oregon Medicaid retail pharmacy networks, which could compromise the sustainability of some providers and create barriers to care for many Oregonians.

Oregon Medicaid, like many other states, administers health benefits to beneficiaries either through a *fee-for-service (FFS)* arrangement, where the state pays providers directly for delivered healthcare service, or by way of *managed care organizations (MCOs),* in which the MCO provides care based on a *capitated rate* per member per month basis (also referred to as *Coordinated Care Organizations (CCOs)* within the Oregon Medicaid system). (4) In the CCO arrangement, the CCO will form its own network of providers in which payment rates may vary from FFS published rates and amongst providers.



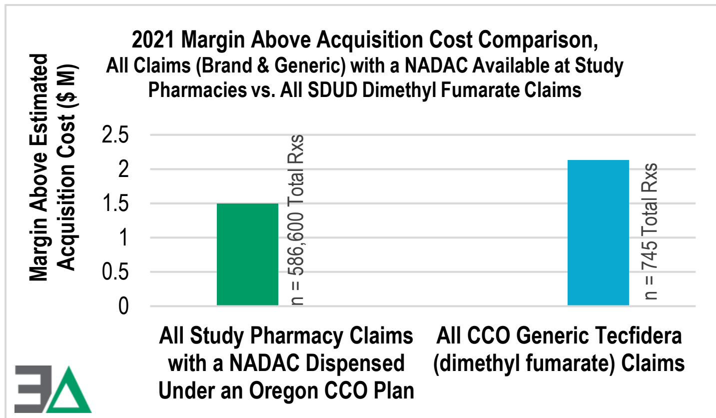
We obtained reimbursement data between 2019 and 2021 from 86 of Oregon's estimated 534 retail community pharmacies as of 2020 (16.1%).[ii] (5) Our findings identified significant disparities in reimbursement between the pharmacies in our study and all pharmacy providers based on reimbursements reported to the Oregon Medicaid program as reflected in the *State Drug Utilization Database (SDUD)*.



For example, in comparing reimbursements between the aggregate Oregon Medicaid program and our studied retail pharmacy group, there were substantial differences in both access to claims and gross margins with the CCO figures. Our study pharmacies on average had access to 7% less of the basket of CCO claims (on a product basis) than the aggregate program. However, there were no apparent access to claims issues with the state-run FFS program (as there were dispensations of every identifiable retail drug). At the same time, the CCO claims were associated with up to 24% less gross margin opportunity for our study pharmacies than the aggregate CCO program.

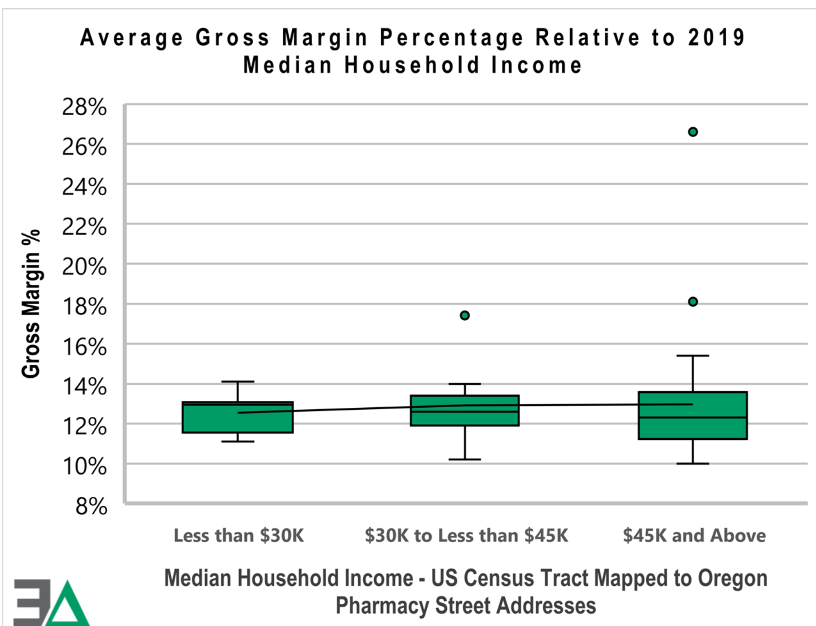
These findings show that the other Oregon retail pharmacies were potentially positioned for greater financial success for the delivery of pharmacy services in the state Medicaid program. And while the aggregate numbers are demonstrative of the variability in claim access and reimbursement, perhaps nothing shows the difference in margin

[ii] Data limitations outlined in the **Methods** section detail the need to limit the usage to 72 of the 86 pharmacies (13.5% Oregon Retail Community Pharmacies) for the granular Oregon Medicaid portion of analysis. Throughout the report, any time 16.1% of Oregon retail pharmacies are referenced, the data was from all 86 pharmacies. Whereas, when 13.5% is referenced, the data was obtained from the 72 pharmacies who provided all needed information to complete the Oregon Medicaid portion of the analysis.



opportunity created through Oregon Medicaid CCO pharmacy services than our findings related to generic Tecfidera® (dimethyl fumarate). As can be seen, just 745 claims for generic Tecfidera® produced $2.4 million in estimated margin above the drug's acquisition cost for all of Oregon's CCO pharmacy claims in 2021. In contrast, our study pharmacies during the same year made $1.5 million in estimated margin above drug acquisition cost **for all the claims they dispensed under the Oregon Medicaid CCO program (n = 586,600 claims).** This data demonstrates a significant gap between workload and financial success ($2.4 million in gross margin for 745 claims is more than 1,000-times greater value per transaction than $1.5 million in gross margin for 586,600 claims). Furthermore, it should be noted that despite having data for over 13.5% of all retail pharmacies in Oregon, our study pharmacies did not dispense a single claim of this financially lucrative dimethyl fumarate drug in the Medicaid CCO program in 2021. This may speak to *patient steerage* or other efforts by CCOs/PBMs to capture disproportionate shares of select prescription claims. Across all analyzed claims, our study estimates savings of up to $40 million to the state if the aggregate observable payment for our study pharmacies was applied throughout the entire Medicaid CCO program.

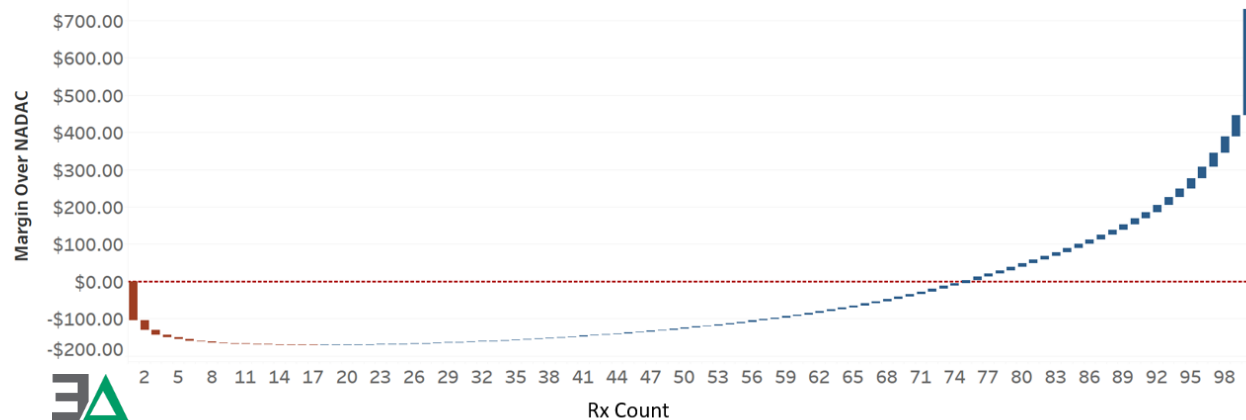
While Medicaid is a unique program that enables us to make comparisons between our study pharmacies and the aggregate payer experience, the data from our study pharmacies can highlight payment disparities within how people obtain medications. The pharmacy market is broadly divided into three payer types: Medicaid, Medicare, and Commercial. Each of these segments is setting potentially different incentives for pharmacies. As our study pharmacies demonstrated, Oregon Medicaid reimbursements were associated with the lowest margin experience in our pharmacies, whereas Medicare was the most profitable. This is despite many of the medications used overlapping between the payers.



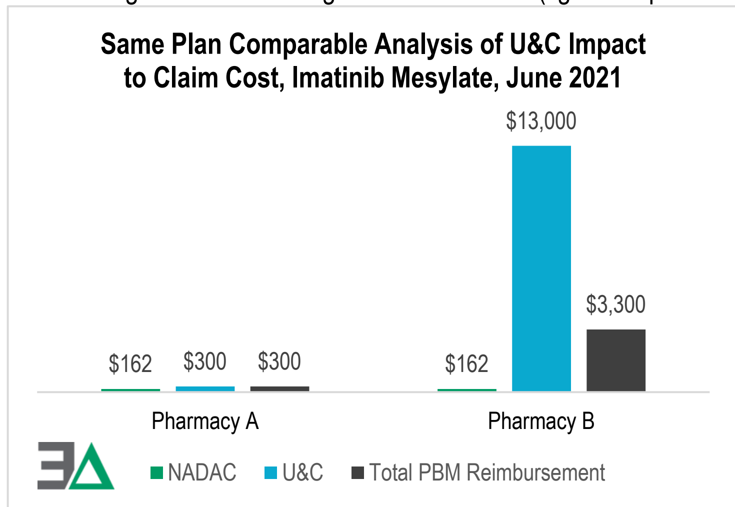
Overall profitability (as measured by gross margin above drug acquisition cost) at the pharmacy level was highly differentiated based upon whether the pharmacies were in high-income or low-income areas. As can be seen to the right, the higher the median income of the individuals in the geographic area of the pharmacy, the greater the average gross margin was likely to be – potentially demonstrating how pharmacies would be better served financially by investing in wealthier communities, and conversely, avoiding more impoverished areas of Oregon. Many pharmacies were seemingly rewarded for having

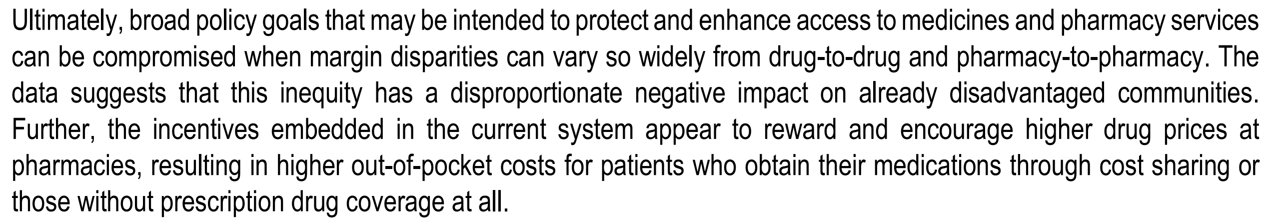
lower average acquisition costs (via higher gross margins); however, the most profitable pharmacy had the highest average drug costs (the opposite of the assumed drug pricing policy goal of incentivizing utilization of low-cost drugs).

Our study also demonstrated the broad reimbursement challenges and opportunities facing Oregon pharmacies. The reimbursement trends are such that for every 100 prescriptions filled (based upon percentiles), the majority of claims (75 out of 100) dispensed at a typical retail Oregon pharmacy (as represented by those in our study) were insufficient to cover approximate pharmacy labor and drug costs. At the same time, a small number of claims (2 out of 100) were reimbursed extremely well – at times thousands of dollars above pharmacy labor and drug costs. The market incentives seemingly incentivize pharmacy businesses to seek out claims with high reimbursements (i.e., specialty), while trying to avoid the claims that are less financially lucrative or at worst, dispensed at a loss to the pharmacy. Said differently, the financial incentives appear to promote healthcare inequality, where financial rewards are distributed unevenly among pharmacy market participants and those pharmacies are encouraged to service some members above others.



The pressure to avoid losses can result in pharmacies setting very high cash prices (i.e., usual & customary [U&C] prices) to ensure maximum revenues are obtained from their primary customers, pharmacy benefit managers (PBMs) and insurers. If a pharmacy sets a low U&C, it risks missing the tail end of high reimbursements (figure on previous page). As the previous chart demonstrated, failure to capture the tail end of reimbursements can be financially devastating to pharmacy business operations. Arguably, the disparity results in higher than reasonable pharmacy "sticker prices" that can have a disproportionate impact on patients in high deductible plans or those without insurance. Our report found vast differences in payment amounts for the cancer medication imatinib mesylate (generic Gleevec®), resulting in provider reimbursement (and by default, beneficiary cost sharing) that were over a 1,000% difference despite the prescription being reimbursed within the same plan by the same payer.





Ultimately, broad policy goals that may be intended to protect and enhance access to medicines and pharmacy services can be compromised when margin disparities can vary so widely from drug-to-drug and pharmacy-to-pharmacy. The data suggests that this inequity has a disproportionate negative impact on already disadvantaged communities. Further, the incentives embedded in the current system appear to reward and encourage higher drug prices at pharmacies, resulting in higher out-of-pocket costs for patients who obtain their medications through cost sharing or those without prescription drug coverage at all.

With this in mind, policymakers face real challenges in addressing reimbursement inequities given that the current paradigm results in many prescriptions being reimbursed below levels of provider sustainability (based upon Medicaid's definition of actual acquisition cost plus a professional dispensing fee). While this report showcases a number of instances where incentives may be working against efficient spending on pharmaceuticals and equitable access to care, it is important to note that the findings suggest a more thorough examination of the drug marketplace as a whole is needed.