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On Behalf Of:

Committee: House Committee On Behavioral Health and Health Care

Measure: HB3013

Oregon State Legislature

House Committee on Behavioral Health and Health Care

900 Court Street NE

Salem, OR 97301

Chair Nosse, Vice-Chairs Goodwin and Nelson, Members of the Committee:

Oregonians need access to prescription drugs. Nearly every one of your constituents lives in a part of Oregon that has limited options and continues to see the problem worsen because of Pharmacy Benefit Manager (PBM) practices. I am an Oregon licensed pharmacist and I am submitting written testimony in support of PBM bills HB 3012, HB 3013 and HB 3015.

These bills will save lives in Oregon. They will:

Require that PBMs be licensed by the Department of Consumer and Business services.

Establish a dedicated FTE to regulate their business practices in Oregon.

Additionally, to combat unfair reimbursement practices that are driving pharmacies out of business, this bill will require that pharmacies are reimbursed at the same rate as fee-for-service Medicaid, which sets its rates to reimburse pharmacies only for the costs they incur for filling a prescription.

This reimbursement provision will also add some level of transparency to prevent spread pricing.

Other provisions, such as requiring that PBMs do not retaliate against pharmacies for trying to enforce fair business practices, regulating remote or desk audits, and preventing excess fees for submitting claims, will help prevent PBMs from shifting their current practices to other practices that are unforeseen at this time.

PBMs are companies that manage prescription drug benefit programs for health plans. PBMs promote themselves as saving health plans and their covered members money, which helps them avoid regulation and so they keep their negotiations and the discounts or rebates they get from drug companies are very secretive.

PBMs commonly pocket funds that ought to be used to lower drug prices or lower copays. The common practice known as “spread-pricing” enables the PBMs to charge health plans higher prices than the PBM is paying to pharmacies, yielding additional unknown profits.

Reimbursement issues remain the biggest threat to community pharmacy viability, thus one of the biggest threats to patient access. Underwater reimbursement and non-transparent and outdated maximum allowable cost (MAC) lists, which reimbursements in most health plans and programs are based on, remain two of the biggest problems. Pharmacies are constantly reimbursed below drug acquisition cost and the cost to dispense regardless of the health plan or program because of PBM business practices.

Not only are pharmacies too often reimbursed below their cost at the time they fill a prescription, but they are also subject to retroactive claims reductions, or DIR fees. DIR fees are assessed weeks or even months after a prescription is filled. This practice further reduces reimbursements while providing little, if any, transparency, while straining pharmacy operations.

Because pharmacies have essentially no competitive bargaining power when "negotiating" a contract with PBMs they are usually forced to accept all contract terms-even those terms that are unfair and arbitrary. Considering three PBMs monopolize the marketplace and cover over 76% of insured lives, as a practical matter, a pharmacy cannot refuse a contract when potentially up to 50% of their patients would be covered by the contract.

These "take it or leave it" contracts are full of provisions that seem more anti-competitive in nature than for patient safety or program integrity. To compound matters, some PBMs require pharmacies to opt-out. That is, they will consider a pharmacy has agreed to the contract terms unless the pharmacy specifically opts out of the contract.

I work for a rural independent pharmacy that has been devastated by the horrible PBM reimbursement rates and policies. We were overwhelmed by the Bi-Mart pharmacy closures due to this issue. We want to protect patients from pharmacy errors and increase safety measures for our staff.