OREGON STATE PHARMACY ASSOCIATION
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Written Testimony for HB 4149

House Healthcare Committee

Chair Nosse & Members of the Healthcare Committee,

The fact below comes directly from the Oregon Secretary of State's Audit Report on Pharmacy Benefit Managers (PBMs) titled, "Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies."

> **Oregon's PBM legislation**
>
> In the last 10 years, 28 PBM reform bills have been introduced, but only seven have passed.

For a state that prides itself on leading the nation with legislative initiatives, this is surprising. In 2023, legislators were pressured by dismaying opposition because of the concerns about the part of the PBM bill that fought for fair pay for skilled work. Our life-saving PBM reform bill failed in 2023 because some legislators had no time to call their local pharmacists and were unable to balance the decision on the whole.

In this Secretary of State audit, they found the following:

1) **The current structure of Medicaid PBMs is too complex for the State of Oregon to efficiently measure value.** The prescription drug process in Medicaid involves multiple entities including sixteen CCOs (Coordinated Care Organizations), six PBMs, hundreds of pharmacies, multiple drug manufacturers, wholesalers, pharmacy administrative organizations, OHA, and the Department of Consumer and Business Services, among others. (pg. 6)
2) **Oregon's regulation of PBMs is limited and fragmented.** Other states have meaningful legislation targeted at patient protections, pharmacy protections, and transparency. PBM reforms are bipartisan policy efforts to limit unfair practices, which can hurt community pharmacies and limit access for people. Other states are also adopting different PBM models for Medicaid, making it easier for governments to provide effective oversight. (pg. 14)
3) Pharmacy reimbursements vary significantly depending on the drugs, pharmacy type, and PBM. **Pharmacies often lose money when filling certain prescriptions.** We found that national chains, some of which are owned by PBMs or PBM parent companies, were reimbursed twice the amount independent pharmacies were for selected drugs. (pg. 20)
4) **OHA does not ensure sufficient transparency and compliance from PBMs**. While OHA has improved CCO contract language, more needs to be done to ensure high-risk areas are monitored appropriately and contract provisions are comprehensive. (pg. 28)

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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.

In 2023 alone, Oregon had 36 pharmacies close. Two more already announced in January that they would close. Following the release of the Oregon Secretary of State's audit on PBMs in August, **the Oregon Health Authority recommended that the state "should enact legislation that focuses on patient and pharmacy protections and increasing transparency in the prescription drug supply chain."**

If this PBM bill does not pass, more pharmacies will close. This will add to the already congested workload pharmacies have, since they have had to pick up the covered lives for those pharmacies that are closing. Oregon already has a significant problem for patient access; their prescriptions have to be filled somewhere.

Real-time patient access matters to parents when their child has strep throat, to seniors who rely on personalized attention and medication counsel and to every Oregonian under the threat of a pandemic or other communicable disease outbreak.

HB 4149 is also important to save Oregon taxpayers money. In 2022, 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 from 2019-2021. Our study found a glaring example of this when a specialty drug, Tecfidera™, 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!**

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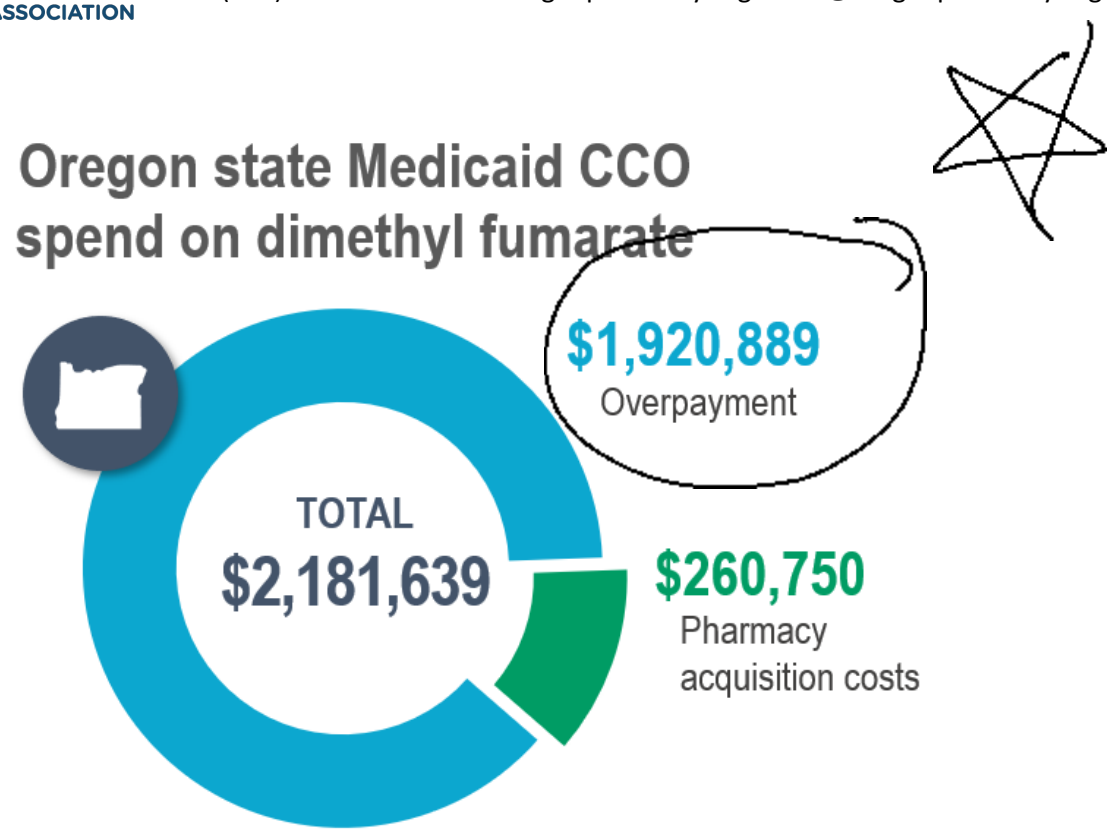

Per SDUD, Oregon Medicaid was charged an average of $2,578 in margin over WAC for each claim, totaling $1,920,889!

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. **PBMs billed a higher margin for just one drug than they paid to all study pharmacies for filling 585,600 prescriptions!**

Please vote yes on (an extremely narrowed) HB 4149 this session. This year's PBM bill will provide pharmacies with the regulatory foundation they need to **continue to serve their neighbors at the pharmacy window.**

Sincerely,
Brian Mayo
Executive Director