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Tavia Galonski
State Representative

Chairman Lipps, Vice Chairman Manning, Ranking Member Boyd, and my colleagues of the House Health Committee, I appreciate the opportunity to be able to offer sponsor testimony on House Bill 396.

Right now our health system is in a crisis. Drug prices are rising along with care costs as Ohioans find themselves making the difficult decision between medical treatments and keeping their lights on. Cutting pills to make them last longer or even forgoing medication in general has become a common practice amongst many of our neighbors. Quite literally looming in the background of the chaos has been Pharmacy Benefit Managers, commonly known as PBMs.

PBMs have taken a backseat role in America's healthcare system despite their massive influence on drug prices. By taking on the role of negotiating with drug manufacturers and pharmacies, PBMs ultimately influence drug costs for insurers, patient access to certain medications, and how much pharmacies are paid[1]. The impact ultimately ends up being twofold: higher costs for patients and higher costs for pharmacies.

During negotiations with drug manufactures, PBMs have reason to be inclined to choose higher priced drugs over equally as effective cheaper drugs. Mostly because PBMs receive a larger rebate from the manufactures due to the rate often being calculated as a percentage of the manufacture's list price. This may mean more money for PBMs, but depending on the patient's health insurance plan it can mean more out of pocket costs for them. If a patient has a high deductible plan or their copay is based on a drug's list price, they will get stuck with a higher out of pocket cost[1]. Keep in mind that in this case the patient is not paying more for a better quality or more effective drug. Unbeknownst to them, the extra money out of their wallet is being used to pad the wallet of the PBM.

Furthermore as a result of gaps in regulation, PBMs have been able to operate in a manner that undercuts pharmacy monies to the point of closure. Community pharmacies are often reimbursed by PBMs at a rate so low that pharmacies lose money from the drugs they are dispensing. Notably, over the course of a year, 3.3% of all the community pharmacies and chain drugstores in the United State closed[2]. With PBMs deliberately undercutting pharmacies for their own profit, patients ultimately end up losing easy access to their medications. The impacts

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[1] https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending

[2] https://www.ncpanet.org/newsroom/ncpa-executive-update/2020/01/10/sending-an-sos-to-scotus-save-us-from-pbms-ncpa-executive-update-january-10-2020

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can be quite literally life threatening as one works to find a new, accessible location. In the event that they can, there is still the ever present risk of price gouging as previously mentioned.

Cases of PBM regulation have been popping up across the United States. One case in particular began in Arkansas in 2015. The Arkansas General Assembly passed a law that would regulate the conduct of PBMs. One of the requirements imposed by the act was "[mandating] that pharmacies be reimbursed for generic drugs at a price equal to or higher than the pharmacies' cost for the drug based on the invoice by the wholesaler[3]". This specific part of the act was intended to eliminate the price gouging that was disproportionally impacting rural, independent pharmacies in Arkansas. PCMA is currently fighting the act in a lawsuit on the grounds that it is preempted by both ERISA, Medicare Part D, and that it is unconstitutional on other grounds. The case has been working its way through the appeals process and may be heard by the Supreme Court.

House Bill 396 aims to serve as Ohio's means to regulate PBMs while also supporting independent pharmacies. First and foremost, this bill will eliminate spread pricing defined "the model of prescription drug pricing by which a pharmacy benefit manager charges a plan sponsor a contracted price for a prescription drug, and that contracted price different from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist of pharmacy for that drug or for the pharmacist services related to that drug". Furthermore, with a few exceptions, PBMs would not be allowed to retroactively deny a claim after it has been adjudicated. PBMs would also no longer be able to reduce payment to a pharmacy for pharmacist services to an effective rate of reimbursement or to reimburse a pharmacy at an amount less than the national average drug cost. Lastly, PBMs would be required to report the following to the superintendent of insurance:

1.) The aggregate amount of rebates received
2.) The aggregate amount of rebates distributed
3.) The aggregate amount of rebated passed on to the enrollees of each plan sponsor at the point of sale
4.) The individual and aggregate amount paid by the plan sponsor to the PBM for pharmacist services
5.) The individual and aggregate amount a PBM paid for pharmacist services

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[3] https://caselaw.findlaw.com/us-8th-circuit/1898787.html

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House Bill 396 provides necessary oversight to PBMs to ensure that pharmacies are able to operate in a way that benefits the patients. Not only will the individual benefit with more affordable drug prices, but also small business pharmacies will be able to operate in the areas where they are most needed. Regulating PBMs influence and ensuring best practices is not only cost effective for all those involved, but also gives greater healthcare access to Ohioans.

Chairman Lipps, Vice Chairman Manning, Ranking Member Boyd, and my colleagues of the House Health Committee, I appreciate the opportunity to be able to offer sponsor testimony on House Bill 396. I stand open for any questions from the committee.