Testimony and Remarks for Dr. Donald Sullivan, Ph.D., R.Ph.

Good morning and thank you for allowing me to testify as a proponent of H.B. 505. My name is Donald (Donnie) Sullivan and I am a Professor of Clinical Pharmacy at The Ohio State University College of Pharmacy. I have been teaching pharmacy operations, finance, health care systems, and pharmacy law for 27 years. Basically, I teach pharmacy students and pharmacists how to operate and run community pharmacies. I am also the vice-chair for the State of Ohio Drug Utilization Review Board for Ohio Medicaid. The payment model for prescriptions has been deteriorating for several years and recently has become significantly worse. Approximately 90% of consumers have some type of prescription drug insurance that covers their prescriptions. Three large pharmacy benefit managers (PBMs) control between 70%-80% of this market. This means that pharmacies have no choice but to accept whatever contract terms these PBMs offer to them. The monopoly-like power of these PBMs has most pharmacies being paid below their actual cost to provide prescription drugs to their patients/customers. It really is as simple as economics 101 and basic business. You cannot stay in business when your costs exceed your revenue (in this case your reimbursement from the PBMs). This is not only a problem for independently owned pharmacies. Chain pharmacies such as Krogers, Wal-Mart, Walgreens, and others are facing the same harsh economic realities. Here is a discussion in very basic terms.

NCPA, the largest organization of independent community pharmacists, publishes an annual document stating the financial health of independent pharmacies called *2022 NCPA Digest Financials*. This organization surveys thousands of independent pharmacies across the country to obtain this data. Based on this data, 33.5% of independent community pharmacies operated at a loss. There are two easy changes to the way all community pharmacies are reimbursed by pharmacy benefit managers (PBMs) and insurance companies that would significantly increase the overall financial health of community pharmacies, both independent and chain.

1) Require PBMs to pay pharmacies at least their actual acquisition cost of the drug. A significant number of prescriptions filled by community pharmacies are reimbursed below the actual cost of the drug to the pharmacy. This means the pharmacy is not paid enough to cover what they pay for the drug from their wholesaler. This does not take into account the overhead (salaries, utilities, rent, etc.). For example: A pharmacy is paid by XYZ pharmacy benefit manager $25 for a drug that costs the pharmacy $100 from their wholesaler. The business model where a pharmacy is paid below the actual cost of the product without including overhead is unsustainable. Pharmacies need to be paid at least what they pay for the drug.

2) Require PBMs to pay pharmacies the actual cost to dispense of the drug. To help cover overhead costs, pharmacies are paid a dispensing fee by PBMs and insurance companies for each prescription they dispense. This fee is supposed to cover most overhead costs and include a small profit. The *2022 NCPA Digest Financials* found that the cost to dispense (overhead) a prescription by a pharmacy is between $10.10 and $12.61 per prescription depending on region of the country. This cost to dispense has been well validated by several other sources as well. Most PBMs/insurance companies pay pharmacies significantly less than this amount. Many of these dispensing fees are $1.00 or less, with some dispensing fees being $0. Pharmacies need a fair dispensing fee to cover their overhead costs.

If these issues are not addressed, patients and consumers face the crisis of pharmacy deserts, lack of access to care, and/or extremely long wait times to have prescriptions filled. I urge you to give this bill every consideration as patient lives are at stake here. Thank you.