Date: November 20, 2024

To: Members of the Insurance Committee

From: Sean Stephenson, Director of State Affairs for the Pharmaceutical Care Management Association (PCMA)

RE: Testimony in opposition to House Bill 505

Good morning, Chairman Lampton, Vice-Chairman Barhorst, and Members of the Insurance Committee. My name is Sean Stephenson and I am the Director of State Affairs with the Pharmaceutical Care Management Association (PCMA). Thank you for the opportunity to provide testimony to House Bill 505.

PCMA is the national trade association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided through employers, health insurance plans, labor unions, Medicaid Medicare, Federal Employees Health Benefit Programs, and other public programs.

Recognizing the Importance of Independent Pharmacists

A strong independent pharmacy marketplace is important for consumers to access health services and prescription drugs. PBMs need to ensure broad access to rural community pharmacies to remain competitive. PBMs would not be able to compete for the business of plan sponsors in rural areas if they did not include robust pharmacy access for their plan enrollees. In addition, both Medicare and TRICARE require explicit convenient access to pharmacies in urban, suburban, and rural areas.

It remains important that the independent pharmacy market remain stable and profitable, as it has over the last several years. Data from the National Council for Prescription Drug Programs (NCPDP) shows that over the last ten years, the number of independent retail pharmacies nationwide increased by 1,638 stores or 7.5 percent. Over the last five years, the number of independent pharmacies has increased 0.5 percent, indicating a stable marketplace. In fact, independent pharmacies' financials have also been stable. From 2016 to 2020, the average prescription gross profit margin for independent pharmacies ranged from 20.8 percent to 21.1 percent, showing little fluctuation.

"Actual Acquisition Cost" Definition will Not Capture True Cost of the Drug

House Bill 505 defines "actual acquisitional cost" as 'the amount that a drug wholesaler charges a pharmacy for a drug product as listed on the pharmacy's billing invoice.' It is important to note, pharmacies often receive discounts from wholesalers that are not detailed on their invoices, so evidence of a drug's 'cost' may not reflect the pharmacy's actual net cost to acquire the drug. Invoice-based reimbursement ignores these hidden discounts, further increasing profits for pharmacies.[1]

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[1] Drug Channels. "Key Insights on Drug Prices and Manufacturer Rebates from the New 2015 IMS Report," mentioning off-invoice discounts and rebates provided by wholesalers to pharmacies. 2016. https://www.drugchannels.net/2016/04/key-insights-on-drug-prices-and.html. See also, David A. Hyman. "The Adverse Consequences of Mandating Reimbursement of Pharmacies Based on Their Invoice Drug Acquisition Costs." 2016. https://www.pcmanet.org/wp-content/uploads/2016/08/hyman-pharmacy-reimbursement-january-2016.pdf[1]

Mandating Dispensing Fees does Not Lower the Cost of Prescription Drugs for Patients

The compensation a pharmacy receives from a PBM for dispensing a drug to an insured patient is the cost of the drug's ingredients plus a dispensing fee. The amount paid to the pharmacy is agreed upon between the pharmacies (or their pharmacy service administrative organizations (PSAOs))and the PBM. The amount of compensation varies by type of drug, individual contract, and type of health care program (e.g., Medicaid, commercial, etc.). Mandating a dispensing fee will do nothing to lower the cost of prescription drugs. The dispensing fee is paid to the pharmacy/pharmacists at the expense of the patient.

House Bill 505 creates a dispensing fee 'not less than the minimum fee for a drug as determined by the superintendent of insurance based on data collected by the department of Medicaid.' Medicaid rates in Ohio are tiered, with the high-frequency dispensing pharmacies being reimbursed $8.30 whereas low-frequency dispensers receive $13.64. For context, in the commercial market, the average dispensing fee is around $2.00 per prescription dispensed. This means that HB 505 would increase the cost of a commercially insured dispensed drug by $6 to $11, each and every time that drug is dispensed to an Ohioan. Ohio employers will need to decide if they want to cut benefits for their employees to compensate for the three-to-five-fold drug cost increase or pass that cost onto their employees through increased premiums, copays and deductibles.

Pharmacy Accreditation Standards ensure High Quality Standards for Patients

House Bill 505 forces PBMs to eliminate required accreditation standards for pharmacies. PBMs sometimes require pharmacies in their network to be accredited by an independent third party. The accreditation ensures the pharmacy's expertise dealing with specialty drugs or another special area of pharmacy care (such as home delivery), and its overall commitment to quality and safety. As scope of practice expands for pharmacists and the medications become more complex, pharmacy accreditation will become more essential for demonstrating high expertise in caring for patient and ensuring patient safety.

Why should you care about this provision? If you care about improved outcomes for patients and lower health care costs, then you should care about accreditation. Restricting or prohibiting PBMs and health plans from requiring accreditation as a condition for participating in a pharmacy networks is actually counter to what pharmacy leadership groups, including the NABP, have worked for as they have partnered to establish an accrediting body (the CPPA). Why should pharmacies be accredited? To quote the CPPA, an "accredited pharmacy practice improves patient outcomes and contributes to overall lower healthcare costs."[2]

"Decline to Dispense" Provisions Make it More Difficult for Patients to Access Medications

Under House Bill 505, an Ohio pharmacy may decline to provide a drug product to an individual or a PBM if, as a result of a maximum allowable cost list, the Ohio pharmacy would be paid less than the actual acquisition cost of providing the drug product. Denying a patient their medication does not help the patient improve their health. During proponent testimony, pharmacists testified that they are losing money because of reimbursements. In Ohio, 88% of independent pharmacists[3] use a PSAO, which work on behalf of independent pharmacists to negotiate drug reimbursements. These negotiations are usually done in aggregate, meaning multiple drugs at

[2] The Center for Pharmacy Practice Accreditation, https://www.pharmacypracticeaccredit.org/

[3] https://www.milliman.com/en/insight/pharmacy-services-administrative-organization-landscape

once, with the outcome of creating a net profit for the pharmacy. Without knowing the contract details that the pharmacists agreed to and signed, it is possible that they could be losing money on dispensing some of the drugs but making up those losses with higher reimbursements on others, again to provide a net profit. Another detail that is often left out, pharmacists agree to these reimbursement rates in a contract with a PBM. As a result, this legislation is interfering in a private contract between two private entities.

Prohibition on Retaliation Provision is Broad and Interference with a Private Contract

House Bill 505 defines "retaliation" to mean any of the following actions:

(1) Terminating or refusing to renew a contract with a pharmacy;
(2) Subjecting a pharmacy to increased audits;
(3) Failing to promptly pay a pharmacy any money the PBM owes to the pharmacy

All the items listed above are part of the contract negotiating process between PBMs and pharmacies and are ultimately agreed to by both parties. Again, this legislation should be seen as interfering in a private contract between two private entities.

Compliance with Mandated Reporting Requirements is Not Possible

House Bill 505 creates four reporting mandates:

1. APBM has to, in a machine-readable format, provide "all drug claims processed the previous month" to the following five separate entities: the superintendent of insurance, contracted insurers, plan sponsors, public employee benefit plans, and contracted employers offering a self-insurance program

2. The following three entities receive 'an itemized list of the Maximum Allowable Cost of each drug product from all drug product claims processed by the PBM: the insurer, plan sponsors, and the Medicaid Program.

3. PBMSs must submit to the superintendent of insurance, 'an itemized list of the actual acquisition costs (definition created in the bill) of each drug product from all drug product claims processed by the PBM for all insurers and plan sponsors

    1. The following metrics to be included in the "itemized list for each drug product" to the superintendent of insurance:
        i. If the drug was procured pursuant to the PBM, insurer, plans sponsor, or the department of Medicaid's drug formulary or list of covered drugs,
        ii. If the drug was procured outside of the drug formulary or list of covered drugs
        iii. If the drug is a 'brand name drug'
        iv. If the drug is a generic drug
        v. If the drug is a specialty drug, including biological products

A monthly cadence creates a lot of operational burden. As previously stated, the definition of "actual acquisition cost" is a black box to PBMs. Off-invoice discounts and rebates pharmacists receive from wholesalers are not required to be reported in the bill. It would be nearly impossible to comply with this section

Suggested Provisions to Support Ohio's Independent Pharmacies

PCMA supports the expansion of pharmacists' scope of practice to allow pharmacists to operate at the top of their license. As you may know, Representative Scott Lipps introduced House Bill 80

authorizing a pharmacist to conduct screenings, order lab diagnostic tests, evaluate the results of screenings and tests, and treat for flu, COVID-19, and strep throat. Also, the House Bill 80 authorizes pharmacists to administer by injection HIV treatment drugs in long-acting or extended-release forms and other drugs specified by the State Board of Pharmacy in rules. We are very supportive of Representative Lipps's House Bill 80 and hope you will consider including these provisions in your legislation to support independent pharmacies.

PCMA supports transparency requirements for Pharmacy Service Administrative Organizations (PSAO) who advise many independent pharmacies throughout Ohio. As you know, 89% of independent pharmacies use a PSAO to negotiate with a PBM for drug reimbursements. Often times, when a pharmacist mentions a 'take it or leave it' contract, it is coming from a PSAO, and not the PBM. Providing actionable transparency requirements from the PSAO to the pharmacists would help empower pharmacists. Inclusion of these provisions will help pharmacies better understand the contract provisions and have a better negotiating position.

Chairman Lampton, members of the committee, thank you for the opportunity to testify today. I am happy to answer any questions you may have at this time.