OHIO PHARMACISTS ASSOCIATION
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Chairman Lampton, Ranking Member Sweeney and members of the House Insurance Committee, thank you for the opportunity to provide proponent testimony on House Bill 505, the Community Pharmacy Protection Act.

With just 3 massive Pharmacy Benefit Mangers (PBMs) controlling 80% of the prescription drug claims and likely nearly all the pharmacy networks, Representatives Barhorst and Stewart have brought before you the real issues impacting Ohio pharmacies. While independent pharmacies are generally the most impacted by PBM tactics, pharmacy chains that do not own a PBM are also placed in a disadvantaged position. To that, one of the largest PBMs is also one of the largest pharmacy chains as well as one of the largest health insures in this country. Generating $357.8B in revenue for 2023, up 10.9% from 2022, to say this single vertically integrated PBM alone is not a shaping market force would be naïve at least and conflictive at worst.

To maintain a competitive marketplace, regulators must oversee this market dominance. PBMs are no longer function as simple claims administrators or even formulary managers. They are, for all reasonable purposes, insurers acting at the behest of health insurers.

House Bill 505 addresses three primary areas requiring oversight to maintain patient access and maintain a competitive market. First, the requirement of accreditation beyond those in law and under the Board of Pharmacy is an overreach by the PBMs. Be clear, we are not talking about quality, specialty, performance networks or even payment methodology. We are talking about legal, licensed, and generally rural pharmacies that provide access to many of Ohio's most in need. These pharmacies are being blocked from providing care to their very neighbors with a network pharmacy often miles away.

Second would be dispensing fees. Like any business, staff, electricity, taxes, insurance, and even the bottle, label and bag are operating costs that must be covered for the business to survive. In pharmacy this occurs through a dispensing fee, drug reimbursement, which I will speak to in a moment, or a combination of both. Other than Ohio Medicaid, no other insurer surveys or actuarily sets a dispensing fee. Payment for dispensing a prescription is rarely more than 50 cents and often it is simply zero.

Drug cost reimbursement would be the final issue raised by the bill. This is critically important as pharmacy, possibly outside of durable medical equipment, is a tangible good business model. This means the pharmacy has a fixed cost on the products it sells. Unlike professional service models, the tangible cost of drugs creates a known breakeven point for pharmacies. What used to be called *lost leaders* or *one-offs*, today PBMs have methodically degraded drug pricing through their intermediary activities. To the point, they have become both the price maker, as the PBM, and price taker, as the insurer. Amazingly, the drug manufacturer and particularly the pharmacy are decoupled from this price setting activity. Today, most prescriptions filled in some pharmacies are filled below the cost of purchase by the pharmacy. With limited margin on those sold above cost, a pharmacy quickly has a negative cashflow and thus closure. Surprisingly, spending on retail prescription drugs has risen rapidly over the past three decades[i].

Accreditation, dispensing fees, and drug cost reimbursement are three PBM tactics that are slowly eliminating independent pharmacies and straining non-PBM chain pharmacies. There is a paradox in that the more prescriptions you fill, the worse your business often does. These business tactics are a race to the bottom and patients will be the ultimate casualty. The price will be paid by employers and plan sponsors.

PBMs were supposed to lower drug costs. Due to rebates to PBMs this has not been the case. There is a growing belief that PBMs increase drug costs. This has drawn the attention of Congress. In 2023, the US House of Representatives released an authoritative and insightful report on upward spiraling drug prices[ii]. In Ohio we have seen an October 27, 2021 Columbus Dispatch article titled "Medicaid chief quietly drops bombshell: Millions obtained by PBMs unaccounted for by state" or an Ohio Attorney General News Release on March 23, 2023 which reads "In a landmark lawsuit filed today, Ohio Attorney General Dave Yost accuses pharmacy benefit managers Express Scripts and Prime Therapeutics of using a little-known, Switzerland-based company to illegally drive up drug prices and ultimately push those higher costs onto patients who rely on lifesaving drugs such as insulin.[iii]". It would seem the evidence of price gouging by PBMs is all around us. Meanwhile, rebates and fees received by PBMs account for 42% of every dollar spent on brand medicines in the commercial market, according to Nephron Research[iv].

As this legislation matures, the Ohio Pharmacists Association wishes to engage towards meaningful dialog to improve the solutions within the bill but not a debate over the problems which are glaringly obvious. While I am sure the PBM association will tell employers this bill will cost them untold dollars and be the end of times, study after study has shown PBMs to be a major cost driver in the pharmacy benefit while consuming resources meant towards patient care. It is time we move past debating the problems and turn towards meaningful solutions. Thank you for your time and attention and I am open to any questions you might have.

Respectfully,

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Ohio Pharmacists Association

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[i] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

[ii] *Comer Releases Report on PBMs' Tactics leading To Soaring Prescription Drug Prices, Press Release.* 2021 December 10;

[iii] https://www.ohioattorneygeneral.gov/Media/News-Releases/March-2023/Yost-Sues-Express-Scripts-Prime-Therapeutics-and-5

[iv] https://www.healthcarefinancenews.com/news/pbms-are-driving-drug-prices-through-fees-phrma-report-claims