I recently heard from someone in my community who said, "I want to thank you for being a sponsor of HB 4149 B. In my volunteer work, I have contact with terminally ill Oregonians who depend on a broad array of medications to ensure their comfort as they approach the end of their lives. It is vitally important that the power of PBMs be reined in so that Oregonians can get high quality medications at affordable prices."

This weekend I attended a seminar for pharmacists. I sat in for part of a session where they were learning about new drugs on the market, dosing, and warnings. At a break one of the pharmacists told me he had had to give up his pharmacy and was hoping he could find work in his profession, but uncertain whether he could. But people are standing in lines to get prescriptions filled at the pharmacy counters that remain. Something is not right.

This bill is about saving community pharmacies. and preserving choice for consumers. and enabling health care providers to prescribe what they know is best for the patient, without interference from the influence of contracts and deals and rebates.

In the world of prescription drugs, there's an important, powerful intermediary that's influencing prices, what drugs patients are taking, and where they can buy them. A mysterious middleman that most consumers – patients – won't ever know about. Pharmacy Benefit Managers. There's lots of talk about high prescription drug costs, for sure. But the go-betweens – the PBMs -- reimburse pharmacies less than the cost of the prescription drug and literally only cents (not dollars) for the work of acquiring, processing, and dispensing the prescription to the patient, and they steer patients to PBM-owned pharmacies and to different drug brands in order to boost their profits.

PBM history

Last year in this chamber I described the history of Pharmacy Benefit Managers, so I won't repeat the detail.- Over time it's clear that PBMs, originally designed to bring cost efficiency to the health care delivery system and savings to patients are responsible, instead, ***adding*** cost into the supply chain, for overhead and for profit.

A nationwide alarm and call to action

On March 30 last year, Senator Wyden's prepared testimony to the U.S. Senate Finance Committee, included these words: "In recent years, it's increasingly apparent that PBMs are using their data, market power, and know-how to keep prices high and pad their profits instead of sharing the benefits of the prices they negotiate with consumers and the Medicare program..."

In the same hearing at the US Senate Finance Committee, testimony from ,the Director of the Center for Innovation University of California Law, explained, "Quite simply, higher prices put more dollars into a PBM's pockets. When the starting price of a drug rises, and the PBM negotiates a rebate, the PBM appears successful. It's like a store that raises the price of a coat before putting it on sale. The markdown looks like a great bargain; but it's not. In addition, the PBM often keeps a percentage of the rebate, so it gets to pocket more."

The business relationships for PBMs, insurance companies, and their subsidiaries, is complex and still opaque. No one, federal or state – can tell what's going on with prices, fees, rebates, and charges. In other words, where does all that money go from all those deals, and why are pharmacies reimbursed at less than their cost to purchase and deliver the drug to the patient?

In 2022, at least 135 bills dealing with PBMs were introduced in state legislatures, and 19 were signed into law. Last year 43 states introduced a total of 137 bills. The **Federal Trade Commission** inquiry into the prescription drug middleman industry is still underway, looking into their business practice including fees and clawbacks; potentially unfair audits; complicated and opaque methods to determine pharmacy reimbursement; and the impact of rebates and fees.

The Problem

PBM business strategies are squeezing pharmacies to bolster profits for PBMs. As pharmacies close, in rural and underserved areas there is sometimes *no* pharmacy left.

Last year **35 more pharmacies closed** in Canby, Hines, Reedsport and Redmond, Albany and Aloha, Milton-Freewater, Mt. Angel, Medford, and more.

This year's bill

Since the 2023 legislative session we have had numerous conversations with stakeholders and legislators to be sure we understand the concerns. In the past few months we've talked with pharmacists and attorneys, people representing health care providers and public health officers, PBMs and insurers, and cities and labor unions. And agencies that would be administering the legislation. We have been communicating with Sen. Wyden's office, reviewing concerns and approaches to legislation. Senator Wyden's office has encouraged us to press ahead here with state legislation.

HB 4149B is based on a bill that we passed last year, 53-7, but with some important differences. It no longer includes specific reimbursement amounts that could have impacted costs, and it excludes third-party administrators and others that fall under federal ERISA law. Here's a quick run-through of the fundamental elements of the bill this year:

1. LICENSING. The same as what you saw and voted on last year, retaining the requirement for licensing. Licensing gives the Department of Consumer and Business Services the authority to step in – to review, oversee, audit, and enforce.

2. REGULATION. Nearly the same as what you voted on last year, retaining important regulatory policies, such as limiting burdensome audits, establishing a clear appeal process, and prohibiting retaliation and new fees.

3. TRANSPARENCY. Last summer the Secretary of State released the Audit of the role of pharmacy benefit managers in state expenses for Medicaid patients. The report

points out limited and fragmented regulation of PBMs, lack of price and other data transparency reporting, and unfair, variable reimbursements to community pharmacies. The transparency section is based on the Secretary of State audit report. It requires PBMs to disclose certain data as recommended in the report, such as dispensing fees, and fees from manufacturers and health plans. It also requires PBMs to provide a copy of a contract, on request, exempt from public disclosure.

Closing

Working together with the representative from the Timber District as a co chief sponsor, we listened to many stakeholders, and worked hard to understand and make adjustments.

Pharmacists would like to get paid enough to break even –the cost of what they pay for the drug, and to dispense it. This bill doesn't get them there. But the bill makes major strides that will benefit pharmacies and consumers. It gives meaningful oversight and audit functions for the state to protect pharmacies and consumers and will start to clear away the fog that keeps us from seeing the prices and profits in the money stream.

We need to finish what we started last year. This is for our pharmacies, and it's for our constituents, patients who need access to affordable prescription drugs at their local pharmacy.

I ask for your Aye vote.

2nd closing

I start by thanking the committee chair, the members of the committee that heard the bill, and the co-sponsors, in particular my co -chief sponsor, the representative from the Timber District.

The legislature has taken small stabs at regulating PBM practices in the past. In 2013, legislation required PBMs to register with DCBS. The requirements and fees were small and no follow-up or oversight was required.

Four years later, In 2017, legislation removed the whopping 50 dollar cap on registration fees[1] -- that's right, it was $50 on a business in an industry with annual profits in the double digit billion dollars. The 2017 legislation also and added more specifics to when the DCBS could revoke or deny a permit.

Then 2019 legislation said PBMs couldn't stop health plans from offering mail-order or other types of pharmaceutical delivery. But it also undercut a pharmacy's ability to effectively submit claims for reimbursement from the PBM.

[1] Current PBM registration fee is $1,100/yr

Last session, we passed Senate Bill 192, requiring PBMs report annually to the Drug Price Transparency Program. But since then, the Secretary of State's Audits Division cautioned that we need increased transparency with better and specific data.

Last session, we also passed legislation banning "clawbacks", an unfair practice where PBMs take back money from pharmacies after point of sale. We heard testimony last session from a pharmacist that had to give back 52 thousand dollars, with no effective means of appealing the PBM's actions.

Our mom-and-pop community pharmacies have no recourse to stop them. In no other industry would this be acceptable, and it's not in this case either.

This amended bill doesn't go as far as the original bill. The "no" votes in the committee reflect a wish to do *more*, not less.

With this bill we empower DCBS to oversee, audit, and enforce. And give DCBS the authority to request otherwise hidden data on fees and rebates from manufacturers and health plans, and take a look at contracts. We bring additional transparency to the PBM money stream.

With this bill, we can make our clawback law effective. We'll put teeth in legislation meant to protect pharmacies, consumers, and fair business practices. We put in place a law to stop unreasonable auditing practices and new fees, to prevent retaliation, and provide pharmacies with an effective means of appeal.

Pharmacy Benefit Managers hold a powerful position in the supply chain of prescription drugs: influencing patient and health provider choices, increasing costs, and squeezing out community pharmacies. With their "value added" in question, but the detrimental actions clear, we need to step in. We need fair business practices, and we need information that's been hidden too long.

Pharmacies simply cannot stay in business when they can't break even. Our constituents – patients – are facing higher co-pays, steered to drugs different from the one prescribed, and loss of their community pharmacy.

I ask for your aye vote.