Chair Greenlick and members of the Committee,
Please pass HB 4151.

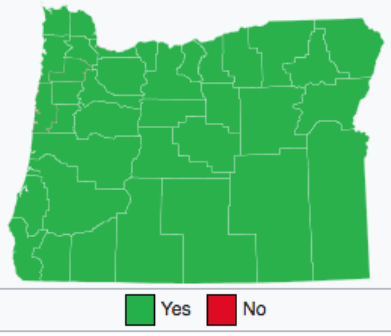
Measure 44

Allows any Oregon resident without prescription drug coverage to participate in Oregon prescription drug program.

Results

	Votes	%
✓ **Yes**	**1,049,594**	**77.96%**
✗ **No**	296,649	22.04%
Valid votes	1,346,243	96.18%
Invalid or blank votes	53,407	3.82%
Total votes	**1,399,650**	**100.00%**
Registered voters/turnout		68.11%

Results by county



Source: Oregon Secretary of State [1]

Every Oregon County overwhelmingly supported Measure 44, passed in the 2006[1] general election. Before that, the Oregon Prescription Drug Plan (OPDP) discounts had only been available to low income. This Measure gave *all* Oregon residents,[2] including Medicare Part D recipients,[3] free discounts at participating pharmacies.[4]

We know drug affordability is a bipartisan issue when Senator Linthicum and Representatives Noble and Kennemer testify to the failure of the market.

By requiring PEBB, OEBB and PERS enrollees to participate in OPDP, Oregon will create a larger purchasing pool that can negotiate better drug prices. This is the essence of a monopsony.[5] Provisions in this bill allow these programs to continue to obtain greater discounts and aggregate cost savings through other available purchasing mechanisms.

OPDP holds open a gateway to a *public* Pharmacy Benefit Manager (PBM), that could become available to commercial insurance providers and become multi-state. ” This contract, *and any future contract for these public employee plans*, should require the PBM collect an administrative fee as the only source of revenue for processing and managing

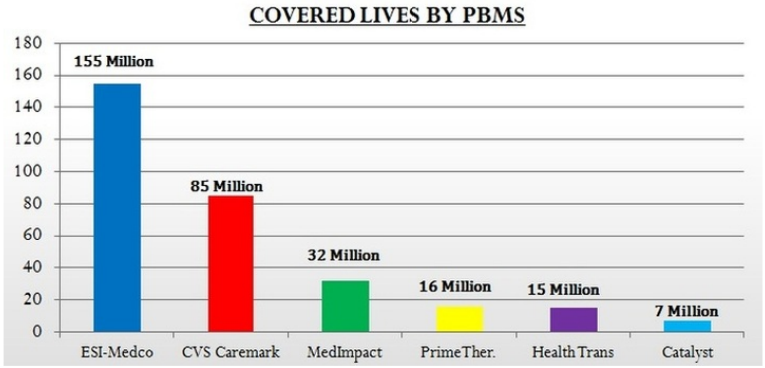
claims. Rebates must be disclosed and passed back 100 per cent to the payer. There should be no network spread.

Oregon already belongs to many multi-state Pharmaceutical Bulk Purchasing programs.[6] The Center for Evidence-based Policy at Oregon Health & Science University houses the nationally recognized Drug Effectiveness Review Project, a collaborative of 13 state Medicaid and public pharmacy programs.[7]

Oregon's OPDP and Washington's Prescription Drug Program combine as the Northwest Prescription Drug Consortium. The current administrator for both is Moda Health, using MedImpact as their PBM. PBMs generate revenues through rebates (payments negotiated directly with pharmaceutical manufacturers) and from the margin, or difference, between what a PBM charges a customer for a prescription and what the PBM pays a pharmacy to fill that prescription.[8] As such, this creates conflicts of interest when there is no transparency for how they make their money.

A few large medical carriers have acquired their own PBM and no longer need to subcontract those services: United Healthcare and OptumRx and 14 Blue Cross Blue Shield Plans and Prime Therapeutics.[9] MedImpact has a small share of the highly concentrated *carved-out* PBM market.[10]

The PBM market is highly concentrated. The recent merger of Express-Scripts and Medco resulted in an industry that is dominated by two major companies: ESI-Medco and CVS Caremark



The three largest companies in the PBM market are Express Scripts ®, CVSHealth ®, and OptumRx ®. In total, they cover more than 180 million lives in the United States, or roughly 78% of Americans whose pharmacy benefits are managed by a PBM.[11] With industry consolidation Express Scripts[12] (ranked 22 in Forbes Fortune 500) is the largest pharmacy benefit manager in the U.S. Despite a falling out with Anthem, the company processes more than 1.5 billion claims every year; covers 65 million people; and processes about 1 billion prescriptions a year.

When measuring the ability of prescription drug plans to rein in drug prices, Medicare Part D is the canary in the coalmine. [13] Medicare Part D did not give CMS authority to negotiate prices of drugs —a windfall for PhRMA. Medicare Part D was implemented in 2006, the same year the OPDP became available to all under-insured Oregonians.

Medicare Part D created the infamous "donut hole,"[14] shifting high out-of-pocket costs for seniors with standard benefit plans. In reality, very few Part D plans offer this "standard" benefit, which includes: a deductible and flat co-insurance after the deductible is met, the donut hole reduced coverage, and then a catastrophic benefit. Part D plan sponsors offer "actuarially equivalent" plan designs that include a formulary with tiered cost-sharing, similar to those seen in commercial health plans, though most Part D plans use more tiers.

Since its inception, Medicare Part D plan sponsors have been required to disclose rebates and other price concessions to CMS. A few takeaways:

- **Disclosure requirements, when properly protected with confidentiality clauses, do not necessarily hinder a PBM's ability to negotiate competitive rebates with manufacturers**
- **Annual Medicare Part D manufacturer rebates, as a percentage of total program drug costs <u>doubled</u>** in its first decade.
- **While the PBM industry asserts they pass through rebates and other concessions to the customer, this is not demonstrated with even large federal contracts.**

Despite the integral role PBMs play in how patients access their prescription drug benefit in both commercial health insurance and Medicare Part D, they are not subject to industry-wide regulation similarly required of large commercial health insurers.

And that is NOT likely to happen at the federal level.

A recent report, "Making Medicines Affordable: A National Imperative,"[15] identifies eight steps to cut drug prices. Kaiser Health News talked to experts[16] who speculated on how likely Congress, the Federal Trade Commission and the U.S. Departments of Justice and Health and Human Services would implement those 8 actions. A few notable ones:

- The federal government is **unlikely to negotiate drug prices**.
- The FDA is **very likely to speed approvals of safe and effective generics and biosimilars.**
- Because **increasing price transparency is very unlikely at the federal level,**[17]

Consequently, States are taking the lead on transparency.[18] **With increased bulk purchasing, Oregon can better negotiate prices—including blockbuster drugs that launch into the marketplace at high prices.**

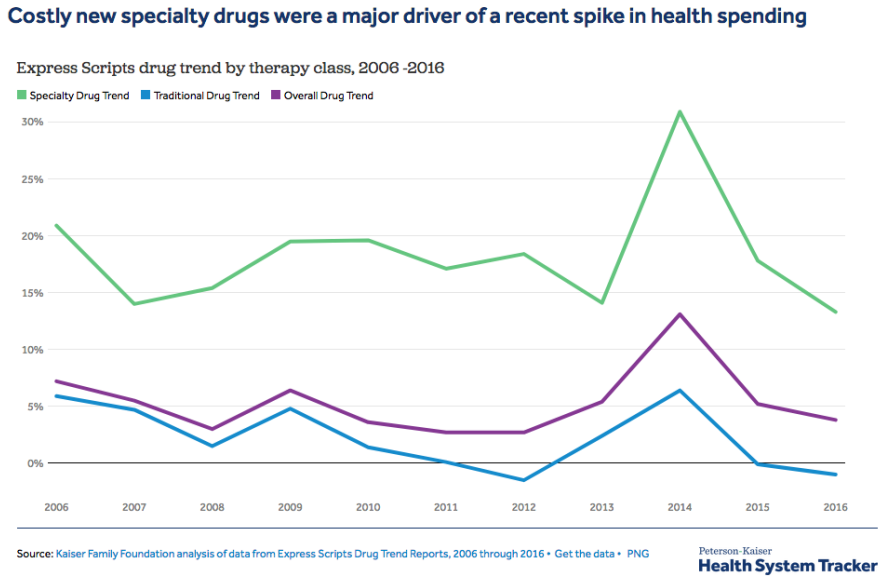
PBMs began hand-processing medical claims in the 1970s. Touting their ability to use corporate customers' combined purchasing power to negotiate huge discounts from pharmaceutical companies, **PBMs have largely become pharmaceutical middlemen who further compound America's highly wasteful administrative excesses toward their own gains.** According to a study commissioned by the drug companies, ***PBMs and other wholesalers and retailers now capture 30 percent of the $469 billion the country spends for prescription drugs every year***,[19] up four percentage points in just two years.

One way that PBMs have made money is through **"spread pricing"**[20] (charging a health plan potentially much more than the PBM pays the pharmacy for filling a prescription), which can increase premiums and copays for patients. In 2013, Oregon lawmakers passed HB 2123[21] giving **DCBS oversight of PBMs and "Maxable Allowable Cost" pricing**.[22] **It would be worthwhile for this body to know how well this law has mitigated spread pricing.**

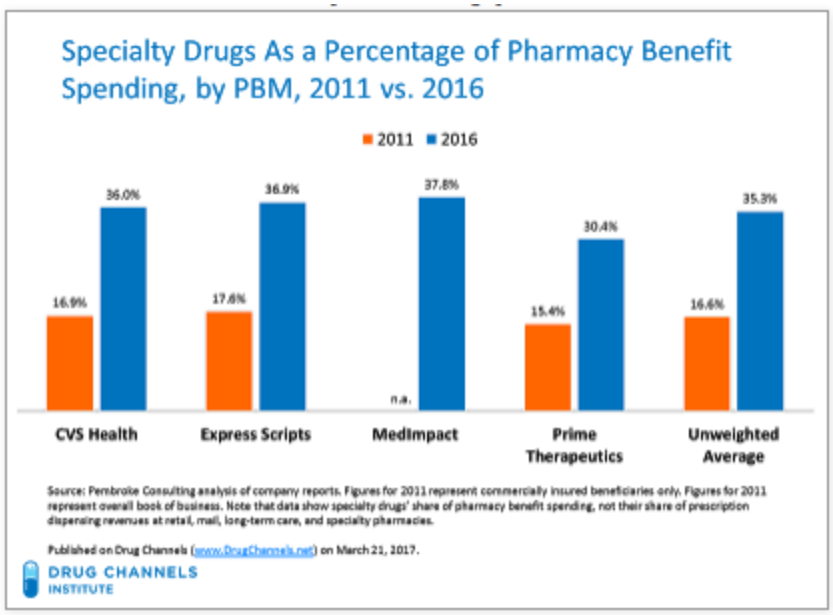
Pharmaceutical companies enjoy preferred drug status on PBM formularies. They offset increased prices by paying the PBMs a **rebate** for the excess. This conflict of interest means that lower cost generics are often excluded and the insurer has no knowledge of how much of the rebate the PBM pockets for itself. [23]

Indeed, two health plan participants filed a class action lawsuit against both Express Scripts Inc. and Anthem Inc.,[24] accusing them of breaching their ERISA fiduciary duties by entering into a 10-year, $5 Billion prescription-drug agreement that caused plan participants to overpay as much as $15 Billion for benefits.

Specialty drugs are used for the treatment of complex, chronic, or rare conditions such as cancers and hepatitis C. [25] Specialty drugs' share of costs has doubled over the past five years.[26]



The chart below shows specialty drugs' share of pharmacy benefit costs *after rebates*. **Drug Channels Institute estimates that for 2016, specialty drugs accounted for 28% of the pharmacy industry's prescription dispensing revenues.**



Specialty drugs include biologics and their "generic" biosimilars. Biolosimilars are "generics" of biologics. Inflectra is a biosimilar of arthritis drug Remicade, which has a wholesale price of $4,000-a-dose. Claiming exclusionary contracts and rebates are being used to thwart Inflectra's entry into the marketplace, Pfizer recently filed an anti-trust suit against Johnson & Johnson and Janssen Biotech.[27]

It's highly doubtful increased profits and market power from the proposed $69 billion merger between CVS Health (the country's largest pharmacy and owner of PBM CVS Caremark) and Aetna (one of the largest national health insurers) will be passed on to consumers in any significant way.[28] Amazon has received licenses to become a wholesale drug distributor in at least 12 states, [29]including Oregon.[30] Asked about this, Merck's CEO says more of drug rebates should end up with consumers.[31]

Never mind that it's ok for Merck to launch blockbuster drugs at what-the-market-will-bear obscene prices.

What passes for competition in the pharmaceutical sector today is really just giant drug companies, giant insurers and giant pharmacies fighting over how to divide a pot of outsize profits that, in a genuinely competitive market, would never have been so large in the first place.

Pass this bill and look toward creation of a public PBM that can negotiate drug prices on behalf of the people!

Kris Alman MD

[1] https://en.wikipedia.org/wiki/Oregon_Ballot_Measure_44_(2006) - cite_note-voters_pamphlet-M44-2
[2] http://www.oregon.gov/oha/hpa/csi-opdp/pages/index.aspx

[3] https://en.wikipedia.org/wiki/Medicare_Part_D
[4] http://www.oregon.gov/oha/HPA/CSI-OPDP/Pages/Participating-Pharmacies.aspx
[5] In the same manner that a monopolist can influence the price for its buyers, a single entity has market power over terms of offer to its sellers as a dominant purchaser of a good. https://en.wikipedia.org/wiki/Monopsony
[6] CMS approved in 2006, the Sovereign States Drug Consortium was the first state-administered multi-state Medicaid supplemental drug rebate pool. The Minnesota Multistate Contracting Alliance for Pharmacy offers cooperative multistate contracting agreements for additional health-care related supplies, equipment and services to participating states and facilities. http://www.ncsl.org/research/health/bulk-purchasing-of-prescription-drugs.aspx
[7] https://comm.ncsl.org/productfiles/103128143/Drug_Effectiveness_Review_Project.pdf
[8] http://www.ncpa.co/pdf/applied-policy-issue-brief.pdf
[9] They have also formed a long-term "strategic alliance" with Walgreens. https://www.forbes.com/sites/brucejapsen/2016/08/29/walgreens-partners-with-blue-cross-owned-pbm-prime-therapeutics/#346d65636d97
[10] http://www.pbmwatch.com/problems-in-the-market.html
[11] http://www.ncpa.co/pdf/applied-policy-issue-brief.pdf
[12] http://fortune.com/fortune500/express-scripts-holding/
[13] http://www.ncpa.co/pdf/applied-policy-issue-brief.pdf; https://www.kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/
[14] Co-insurance during donut hole phasing out until 2020, after which standard benefit recipients will pay no more than 25% co-insurance for generic and trade name drugs. https://www.medicare.gov/part-d/costs/coverage-gap/more-drug-savings-in-2020.html
[15] http://www.nationalacademies.org/hmd/Reports/2017/making-medicines-affordable-a-national-imperative.aspx
[16] https://khn.org/news/experts-tell-congress-how-to-cut-drug-prices/
[17] Sen. Wyden's S. 1348 has only 7 co-sponsors—all Democrats. Transparency kicks in at even higher thresholds than HB 4005. https://www.congress.gov/bill/115th-congress/senate-bill/1348/cosponsors?q=%7B%22search%22%3A%5B%22S+1348%22%5D%7D&r=1
[18]https://public.tableau.com/views/HowStatesAreTacklingSkyrocketingDrugPrices_0/SkyrocketingDrugPrices?:embed=y&:toolbar=no&:display_count=no&:showVizHome=no#1
[19] https://www.washingtonpost.com/news/wonk/wp/2017/12/15/why-cvs-aetna-may-be-bad-for-your-health/?utm_term=.89092e6e338d
[20] http://www.ncpanet.org/advocacy/pbm-resources/lack-of-transparency-and-higher-costs/spread-pricing---marking-up-drug-claims
[21] https://olis.leg.state.or.us/liz/2013R1/Downloads/MeasureDocument/HB2123
[22] https://olis.leg.state.or.us/liz/2013R1/Downloads/CommitteeMeetingDocument/24737
[23] http://www.businessinsider.com/scrutiny-express-scripts-pbms-drug-price-fury-2016-9
[24] https://s3.amazonaws.com/assets.fiercemarkets.net/public/004-Healthcare/external/BurnettVExpressScripts_Anthem+(1).pdf The complaint alleges that Anthem used Express Script's payment to fund stock buybacks in 2009 and 2010, enriching Anthem's stockholders and management. A third party market analysis revealed Express Scripts' pricing exceeded competitive benchmark pricing by more than $3 billion annually.
[25] https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#item-diabetes-medicines-topped-traditional-drug-spending-2016-doubling-spending-second-leading-category_2017
[26] http://www.drugchannels.net/2017/08/which-pbm-best-managed-drug-spending-in.html
[27] https://khn.org/news/biosimilars-biologics-and-new-legal-challenges-for-ra-treatments/; http://www.foxbusiness.com/features/2017/09/21/pfizer-files-antitrust-lawsuit-against-j-j-wsj.html
[28] https://www.washingtonpost.com/news/wonk/wp/2017/12/15/why-cvs-aetna-may-be-bad-for-your-health/?utm_term=.89092e6e338d
[29] http://www.stltoday.com/business/local/amazon-gains-wholesale-pharmacy-licenses-in-multiple-states/article_4e77a39f-e644-5c22-b5e6-e613a9ed2512.html
[30] AMAZON.COM.INDC LLC: License #: W3-0000150, W3-0000151, W3-0000152
[31] https://www.cnbc.com/2018/01/08/merck-ceo-says-more-of-drug-rebates-should-end-up-with-consumers.html