Testimony for House Bill 2598
House Insurance Committee
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Thank you for allowing me the opportunity to speak on behalf of my profession in support of HB 2598. My name is Emily Scheck; I am a 2016 graduate of the University of Kansas School of Pharmacy. I currently practice as a staff pharmacist at Gibson's Pharmacy, a locally owned and operated pharmacy in my hometown of Dodge City, Kansas. I stand before you today to express my concerns about the impact Pharmacy Benefit Managers (PBMs) are having on patient care and access to medication.

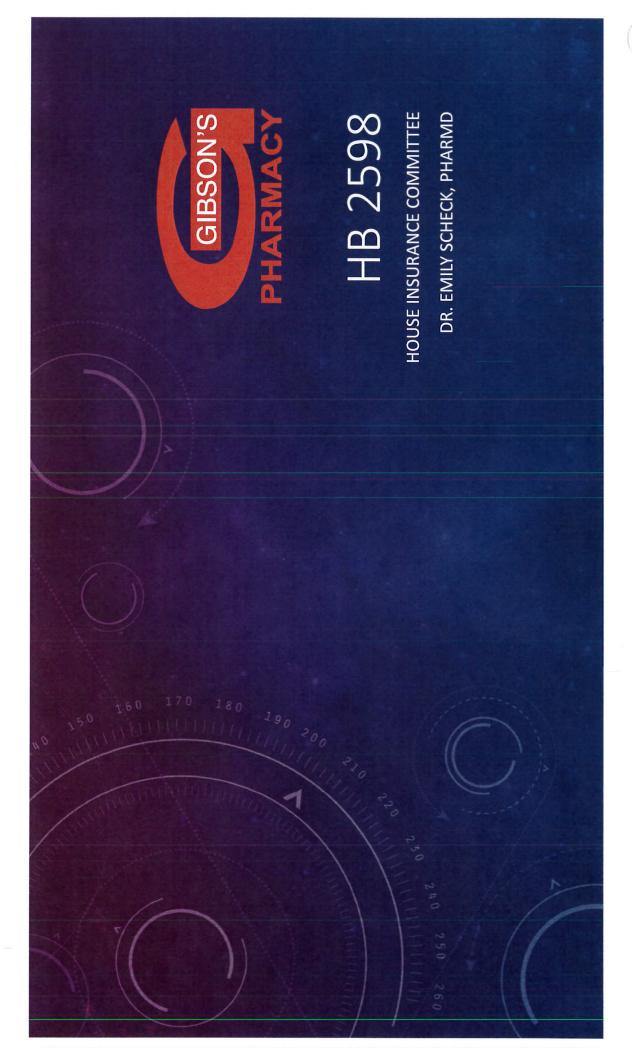
My main and arguably most important duty as a pharmacist is to regard patient safety and well-being above all else. Changes in the pharmacy marketplace are having a profoundly negative impact on my ability to provide quality care. A recent New York Times article cites pricing pressures from PBMs as a leading cause for increased burden on pharmacists and a troubling increase in mistakes pharmacists make. In the past year 2,284 pharmacies have closed nationwide. Most of these pharmacies cite the same pricing pressures from PBMs as the reason for their demise. The remaining pharmacies are left behind to pick up the slack of their departure at subpar reimbursement levels. This year, our pharmacy has been paid below our acquisition cost on 11.2% of submitted claims. Even more troubling, 91% of these loss claims are on prescriptions in which we are utilizing low-cost generics. This completely disincentives the use of drugs that help reduce patient out of pocket and in turn compromises patient care and clinical outcomes.

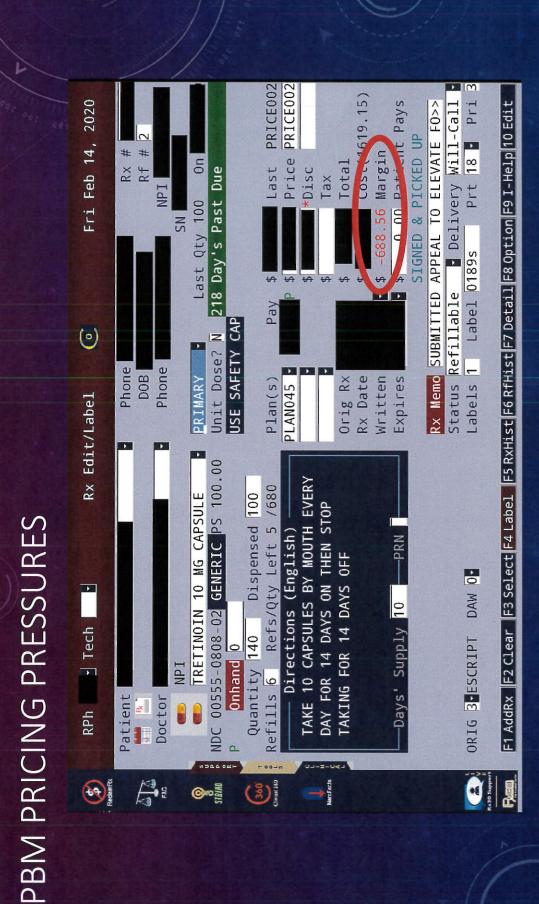
PBMs regularly use financial incentives or mandates to coerce our patients into using mail order pharmacies that the PBMs own. Oftentimes this occurs when a patient has been prescribed a "specialty" medication, which are typically high-cost, high-margin drugs. Steering patients to a "preferred" or "specialty" pharmacy for financial gain is extremely detrimental to patient safety. When a patient is forced to use a pharmacy other than the one they use locally for such medications, it becomes impossible for both of the pharmacies and pharmacists to accurately assess a patient's medication profile for drug-drug interactions, drug-allergy interactions, vaccine recommendations and administration, and assessment of appropriateness for over-the-counter products. This practice puts financial gain over patient well-being. Local pharmacies and pharmacists are the most equipped to handle these medications for several reasons. First, patients are not forced to receive care from strangers in different cities and in most cases other states. They can get their questions answered in person, from someone they know and trust — many "specialty" medications have unique routes of administration that are most easily understood when they are shown how to be used in person, not over the phone from a stranger. Our patients report that when they receive medications from mail-order pharmacies they very

rarely or NEVER speak to a pharmacist. ALL patients in my store get a face to face interaction with a pharmacist before they leave with a new medication. Local pharmacies also reduce the amount of time it takes for a patient to get access to care. Patients could walk into their local pharmacy and receive their treatment the same day, instead of through the oftentimes unreliable and slow mail services. Drug integrity from these pharmacies is also a source of concern; all medications have specific storage and stability specifications such as temperature fluctuations and fragility. PBM mail order programs are a detriment to my patients, reduce their free choice for where to receive care, and hinder positive clinical outcomes.

It has become exceedingly difficult to provide patients the medications that are originally prescribed to them at an affordable cost and in a timely manner. Formularies (or covered drug lists) are no longer based on clinically relevant data. Instead they are nothing more than a list of medications with the most financial gain and incentive for the PBM. I'm also concerned about the practice of PBMs artificially inflating drug prices or forcing utilization of high cost brand name product when low cost generic equivalents are available. PBMs utilize these tactics in order to collect higher rebates or kickbacks. These money hungry tactics place a financial strain on the overall health care system, as well as the pockets of patients both with and without insurance. All too often, patients are left with three options: One, pay an inflated out of pocket price for the non-formulary medication that their physician deemed most appropriate for them based on their medical history. Two, request that the physician prescribe a different, potentially non-appropriate medication that MIGHT have a lower price tag. Or three, go without the medication. It is my job as a pharmacist to help each patient navigate these three options to the best of my ability, with their well-being as my number one priority. PBMs are making this more difficult by the day.

In conclusion, the PBMs that were originally established as intermediaries for data exchange have grown into large corporations that have and continue to manipulate the pharmacy market for their own financial benefit. These manipulations are having profound impact on patients, prescribers, pharmacies, and pharmacists in our state. House Bill 2598 will help to shed light and require PBM transparency in this marketplace. I appreciate your time today and appreciate your support.





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## MAIL ORDER "SAVINGS"

Patient complains "I paid \$1,400 for 60 Enoxaparin 40mg syringes at "specialty" pharmacy last month."

- Test claim at independent pharmacy shows identical claim would only cost patient \$280.95.
- Patient was misled into thinking he could only use PBM owned pharmacy.
- PBM owned pharmacy sets higher net price at pharmacy they own.



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