These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks

report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

HOUSE COMMITTEE ON HUMAN RESOURCES

March 15, 1991Hearing Room D 1:00 p.m.Tapes 79 - 81

MEMBERS PRESENT:Rep. Mary Alice Ford, Chair Rep. Beverly Stein, Vice-Chair Rep. Jerry Barnes Rep. Cedric Hayden (2:10) Rep. John Meek Rep. Hedy Rijken Rep. Jackie Taylor

STAFF PRESENT: Melanie Zermer, Committee Administrator Angela MuÒiz, Committee Assistant

MEASURES CONSIDERED: SB 60 - Transfers responsibility for medical assistance programs

from AFS to DHR- PH, WS HB 2632 - Requires OMAP to revise its drug acquisition cost data at certain interval - PH HB 2695 - Prohibits AFS from purchasing drugs out-of-state or from reimbursing out-of-state pharmacy unless recipient requires out-of-state treatment - PH

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TAPE 79, SIDE A

010 CHAIR FORD: Calls the meeting to order at 1:32 p.m. Presents the 1991 program analysis and funding for Children Services Division to the committee.

SB 60 - TRANSFERRING MEDICAL ASSISTANCE PROGRAMS - PUBLIC HEARING: Witnesses:Jean Thorne, Office of Medical Assistance Program

028 JEAN THORNE, Director, Office of Medical Assistance Program: Presents written testimony and explains the need for changes in the statute (EXHIBIT A). The changes bring Oregon in line with federal law. It is basically a housekeeping measure.

CHAIR FORD: Would you go over the changes with the bill?

THORNE: The bill changes the references to Adult and Family Services to the Department of Human Resources. Page 5, Section 8 removes subsections e and f.

CHAIR FORD: So removing the subsections are the only changes in the bill except for the transfer of the program?

083 THORNE: Yes.

MELANIE ZERMER, Committee Administrator: Determining eligibility is still a function in AFS, it is not addressed in the bill?

THORNE: It is in AFS and in Senior Services. It is stated as the Department of Human Resources. That allows some things to go to AFS and some to go to children and senior services.

REP. BARNES: Will this increase paperwork or eliminate it?

THORNE: This authorizes what we already have. It won't change the systems we have already.

CHAIR FORD: How long have you been the office's director?

THORNE: Since February 1990.

CHAIR FORD: So were playing catch up.

THORNE: This is something that probably should have been done a number of years ago.

SB 60 - TRANSFERRING MEDICAL ASSISTANCE PROGRAMS - WORK SESSION:

105 MOTION:Rep. Stein moves SB 60 to the floor with a Do Pass recommendation.

VOTE:In a roll call vote the motion carried 7-0. Rep. Barnes will lead the floor discussion.

HB 2632 - REVISING DRUG ACQUISITION COSTS - PUBLIC HEARING:
Witnesses:Chuck Gress, State Pharmacists Association Mike Dewey, State Pharmacists Association Jean Thorne, OMAP Marv Schlabs, State Pharmacists Association John Brunscheon, NeigHB ors Pharmacies

130 CHUCK GRESS, Executive Director, Oregon State Pharmacists Association: Presents written testimony (EXHIBIT B). HB 2632 would allow pharmacies to continue to dispense drugs and information to Medicaid patients.

164 MIKE DEWEY, Portland Retail Druggist's Association: Explains the bill. Drug prices over time have increased higher than the Consumer Price Index. Budgets have increased but the CPI has increased more than projected for the budgets. The 1989 Legislature changed reimbursement for drugs to every 6 months. Because of an access problem for pharmacists, the Emergency Board changed the reimbursement schedule to a quarterly system. Wants it changed to a twice- monthly basis. The fiscal analysis for that is about $616,000 for the biennium or $230,000 in general funds.

214 REP. HAYDEN: Would that be all state funds or state and federal funds?

DEWEY: Thinks the $230,000 is general fund and the rest is federal funds. You will see examples of what the problems are. Pharmacists buy at the wholesale price and get reimbursed for less than the cost. Other aspects of the bill deal with the dispensing of drugs. Explains the Oregon dispensing fee. It is the cost of dispensing the prescription.

Wants the dispensing fee moved up to compensate for the discrepancies. May be able to find a solution or compromise on the dispensing portion of the bill because it is potentially $2.8 million from the general fund.

300 REP. BARNES: On subsection 3, 2, it is just talking about the break even point. It is not dealing with the attached personal profit by the owners of the pharmacies?

GRESS: That's right, it is the break even point. Medicaid may say there is some because all pharmacies purchase drugs differently. There are a number of discounts that Medicaid takes advantage of. It is the break even point, and the pharmacy is not making any money. If there is any profit to be made for the pharmacy it should be with the dispensing fee. With the current dispensing fee system there are few pharmacies that can meet the overhead costs and still make a profit.

BARNES: Do you know what percentage of the total prescriptions are being filled for Medicaid in an average pharmacy?

GRESS: It varies. About 5 or 6 percent of the pharmacies have stopped filling Medicaid prescriptions. Pharmacies are picking which drugs to dispense based on the reimbursement amounts. That puts Medicaid patients at a disadvantage.

358 DEWEY: Part of the problems is the demographics. The Portland area has a large low-income clientele. Also, the federal government has passed legislation requiring drug manufacturers provide rebates based on the Medicaid portion of state programs. There is a potential for savings.

405 REP. MEEK: Rationally, whether you adjust the fees every two weeks or every six months, the cost of the item would average out. Could you speak to Section 2 of the bill and the impact to the state. In theory there wouldn't be any change in the costs the pharmacies collect. Section 3 seems to be the cost inhibitor. Could you describe how dispensing fees are calculated today and how it would be revised with the bill.

GRESS: In terms of drug acquisition costs, Medicaid reimburses at the old price even if the price increases during the quarter. The pharmacy must absorb that cost until the next price update. That can be an extreme financial hardship because there are many expensive drugs.

480 REP. MEEK: So any period of time from the quarter up would be more responsive to the actual cost of the wholesale price.

TAPE 80, SIDE A

030 GRESS: Yes, even the change from six months to quarterly helped. The dispensing fees relate to paying for the overhead costs. The fiscal impact would be divided into annual surveys and the increases in costs. Knows the dispensing fees can be too much. Anything above $3.67 to $4.02 is a significant improvement. It would allow more pharmacies to participate and more people to be served.

REP. MEEK: Asks for a copy of the fiscal report Mr. Dewey is quoting (EXHIBIT C).

070 DEWEY: Other states have a much higher dispensing fees and there is little difference of costs between states.

REP. STEIN: There is an insurance study that shows the average dispensing fee in Oregon is $3.50 and the national average is $3.84. If pharmacies are willing to take $3.50 from private insurers why aren't you satisfied with $3.50 to $4.02 in Medicaid?

GRESS: The $3.50 figure is the average dispensing fee for pharmacies in a managed care setting. Is referring to retail, independent and chain pharmacies in HB 263 2. Explains how Medicaid figures its reimbursements.

DEWEY: Reads from another study in 1983 that says that $3.75 is sufficient. That would increase by now. There needs to be a survey to reflect the costs.

131 REP. STEIN: The Office of Inspector General did an audit and found that the average pharmacy purchases drugs at 84% and we reimburse at 89%.

GRESS: That may be true in the case of chain pharmacies and pharmacies that operate purchase on a volume basis. They are limited instances. Many independent pharmacies purchase at wholesale price.

REP. HAYDEN: Is the situation where the high volume stores with a large clientele purchase in bulk and save, but the smaller retail that are accessible to more people can't purchase in bulk and their costs are higher.

GRESS: Yes. There are two aspects to pharmaceutical purchasing: volume discounts and different classes of trade. Volume discounts allow larger pharmacies to buy bulk and warehouse it. HMO's also are able to purchase pharmaceuticals at much lower prices.

205 REP. STEIN: So it is the small pharmacy you are talking about. How far in advance do they buy their drugs?

GRESS: As close to the time of dispensing as possible. Most pharmacies do not buy more than a two or three week supply. Pharmacies in urban areas buy more often. They do not stockpile because they out date very quickly.

REP. TAYLOR: Has a rural pharmacy and orders not more than half a week in advance. Does that to keep the inventory down.

249 REP. HAYDEN: In order for the pharmacy to function by ordering in small quantities, it shifts the cost to the client who may have to come back when the druggist has the order stocked. The cost is passed on to the Medicaid recipient.

GRESS: Most pharmacies deliver or borrow drugs from other pharmacies. That is not a problem.

CHAIR FORD: About how many drugs manufacturers are there and how many drugs are there?

GRESS: There are about 460 companies that manufacture drugs. There are about 155,000 pharmacy items that Medicaid lists.

CHAIR FORD: What would you say the average number of items and prescriptions a small pharmacy could fill?

GRESS: It depends on the prescription.

CHAIR FORD: Rep. Taylor, how many items does your store carry?

REP. TAYLOR: Hundreds perhaps thousands.

320 JEAN THORNE, Director, Office of Medical Assistance Programs: Presents written testimony (EXHIBIT D). Primary concern about the bill is the extra cost for the dispensing fee. Presents a copy of a report from the Office of the Inspector General (EXHIBIT E).

CHAIR FORD: Does that mean that the costs of dispensing is going down?

377 THORNE: The costs are going up. We pay at 89% and the Inspector General report says the average is 84%, so there is enough of a cushion to absorb any cost increases.

REP. MEEK: If you were updating your files more readily, there would be an equitable balance. We could bring that difference down to 3 or 4 percent and both parties would benefit.

THORNE: Are you suggesting bringing the rate down and updating more frequently?

REP. MEEK: By updating more frequently, lowering the rate would occur naturally because there wouldn't be the high cost factor.

THORNE: The 89% is not based on the frequency of the updates. It is what the purchasing actually costs based on earlier surveys. The Inspector General report shows that it is actually 84%.

REP. MEEK: Your cost factors are based on three months of data and you have to factor in the cost increases. If you adjust more often, you will be at a truer cost.

417 THORNE: If we wanted to update more frequently, we would be at a truer cost, but we would be paying lower than 89%.

REP. MEEK: That would be fine. That is what the pharmacists are asking.

THORNE: They are not asking that we lower the rate, just that we update more often.

CHAIR FORD: Do you have any figures about when the OMAP was updating twice a month. Were there any reimbursement to the pharmacists compared to updating every six months?

THORNE: It is two different issues. The surveys on updating more frequently looked at the average costs compared to average wholesale costs.

467 REP. BARNES: What do you mean by average wholesale costs? Is that a state average?

THORNE: It is a term manufacturers use. It is the cost of the drugs

themselves as opposed to the dispensing fee. It is a nationally set figure but they rarely sell at that price.

REP. BARNES: Is that average cost for each type of drug?

THORNE: Yes, there is an average price for each of the 150,000 drugs on file.

TAPE 79, SIDE B

030 REP. HAYDEN: Why not just pay the pharmacist the cost plus the dispensing fee and the cost not to exceed the average wholesale cost?

THORNE: The problem is in defining costs. Pharmacies may pay different costs for the same drug. Is required to have an estimated acquisition costs.

REP. HAYDEN: If you know approximately what it is going to cost, why can't they bill you for what it is?

THORNE: They are required to charge OMAP their usual and customary cost. That includes the acquisition cost and dispensing fee. Has to have some standard by which to set prices. In this case need to have the estimated cost of the drug and the dispensing fee.

REP. TAYLOR: Does the average wholesale price include HMO's

THORNE: It is not our average; it is a sticker price. It is nobody's average even though HMO's get drugs at a discount.

REP. TAYLOR: What about the usual and customary? Is it just a term?

THORNE: That is what the pharmacy would normally charge a private pay patient.

REP. TAYLOR: But they can only bill what is allowable, so it doesn't really mean anything?

THORNE: They should bill what they would normally bill, not what they think we will pay.

090 REP. BARNES: In estimating the costs, do you use computer trending?

THORNE: For the drug prices, uses a national firm that tracks the average wholesale prices as charged by the manufacturers. Doesn't do trending.

REP. BARNES: Have you considered establishing tiers of sales for the differences between HMO's and the small business.

THORNE: The dispensing fee makes those differentiations. The average costs is similar for the big and large pharmacy.

REP. BARNES: That contradicts what was said before about volume discounts.

CHAIR FORD: How does reimbursement for the levels of pharmacies relate to the reimbursement level of other providers.

THORNE: Doesn't have tiers for other types of providers such as a

one-physician office. The usual and customary is about 72-78% for pharmacies, 50% for physicians and 45% for dental.

135 CHAIR FORD: It compares them to other types of providers or materials. There is a higher reimbursement for pharmacists than other providers.

THORNE: Pharmacists are reimbursed more closely to what their actual costs are then other providers.

REP. TAYLOR: Is it true that the dispensing fee is the same despite the cost of the prescription? Mr. Dewey spoke of a rebate by the drug manufacturer. How would OMAP use that?

THORNE: Yes, the dispensing fee remains the same. Federal law now requires that drug manufacturers give rebates to Medicaid programs. States cannot decrease the dispensing fees. In Congress the rebate dollars were used to fund Medicaid expansion. Coverage of children to 100 % of the poverty level was mandated to the states. The state rebate money is being used to fund those mandates. Is a potential problem that many of the manufacturers haven't signed an agreement to the rebate and the rebate may be lower than anticipated.

REP. TAYLOR: The anticipated rebates are going to cover other federal mandates that deal with pharmacy products?

THORNE: The mandates do not deal directly with pharmacies.

220 REP. TAYLOR: But the pharmacies are the ones who have generated the money.

THORNE: There are costs in HB 2632 that are high. Given the cuts that are occurring, there are other priorities for funding.

REP. BARNES: Averages don't tell you the real picture. Have you considered developing a median of wholesale prices to look at the range of prices?

THORNE: Hasn't done that. Could do it but it would cost to conduct the survey.

REP. BARNES: It would be more realistic than the average price. Do you have the physical capability to update in the frequency the bill requires?

THORNE: Yes, it would take some systems time but we could do it.

275 MARV SCHLABS, President, Oregon State Pharmacist Association: Displays a chart showing the increase in dispensing fees over 16 years. There has been a 21% increase in 16 years. The state has a four tier system but doesn't know if any pharmacy gets the low fee. Lists other expenses in dispensing drugs that has not been mentioned. Twice monthly updates are important. Explains the costs pharmacists incur when the price goes up before the update is made.

405 REP. STEIN: Does the AWP cost include any discount you may get?

SCHLABS: No, it doesn't.

REP. STEIN: What would be the discount on the example you gave of

$42.84 for Seldane?

SCHLABS: It is not clear cut. The average cost to the wholesale is an unprinted, undocumented price. There are other fees for labels, delivery, etc. The wholesale cost is the base because it is somewhere in the 84% range.

REP. STEIN: Is the $42.84 the actual price you pay for the Seldane? You don't get any discount because you buy a lot?

SCHLABS: Yes, until the update. Doesn't know exactly how much he pays for the drug because of the variety of costs.

REP. STEIN: You can't allocate between each drug about how much each one costs. So the $42.84 includes what.

SCHLABS: That is the printed price. The only printed price is the AWP.

484 REP. STEIN: When you pay the manufacturer, you pay the $42.84 and another bill on the side for the extra charges?

SCHLABS: No. They have a level based on volume and stores.

REP. STEIN: You don't know how much each drug costs because the manufacturer gives you a total that includes all those other costs. You do not know which goes to the drug and which to the other factors?

SCHLABS: No. Could look at the bill and find the price charged for the drug, but other fees are added to that and need to go into the price of the drug. That is where it is hard to figure out what was paid. We need some printed costs to start from.

TAPE 80, SIDE B

036 REP. STEIN: And who provides the printed costs?

SCHLABS: There are books with the prices of the thousands of items involved. The printed book comes out yearly so it is always behind. Gets updated information weekly on a computer service.

047 JOHN BRUNSCHEON, NeigHB ors Pharmacies: Medispan, for example, updates prices and there are more than 22,000 price changes per year. There are about 100 price changes a day.

SCHLABS: To have prices updated only every three months means that you are behind on prices on many products. Displays another chart showing significant price increases for several drugs. Pharmacies lose money until the update occurs.

REP. STEIN: You could show me another set of charts where the AWP was lower and pharmacies were getting paid more than the cost of the drug.

SCHLABS: Yes, could show items that had no increase and lower prices. Explains usual and customary price. Need to have the price updates done in a timely manner so pharmacists don't lose money and the dispensing fee should reflect the CPI.

115 BRUNSCHEON: Presents written testimony (EXHIBIT E). Displays a graphic also copied in the testimony showing the price changes during the quarter. Chose the drug because it fit into the example, but it is

representatives. The price differential is hurting small pharmacies.

REP. BARNES: Have you given any thought to the correlation between the increasing price of drugs and the national inflation rate?

SCHLABS: The inflation in the costs of drugs has far exceeded the CPI. The CPI has gone up about 4 or 5% a year while the cost of drugs has increased about 15 to 20% a year.

202 REP. TAYLOR: There is a misconception about the margin of profit for pharmacies. Is it still the case that the margin is about 5%?

BRUNSCHEON: Yes, the latest estimate is in the area of 5%.

REP. TAYLOR: Pharmacies get a rebate for prompt payment and that may be what Rep. Stein was referring to earlier.

SCHLABS: You get 2% cash discount for prompt payment. That is about half of the profit. The average prescription costs around $20 and the dispensing fee is about $4. That is a 20% gross profit. It takes about 30% profit to stay in business.

BARNES: When you say it takes 30% to stay in business that doesn't mean making a profit on your part?

SCHLABS: No that is just paying the bills.

REP. STEIN: The updates where changed recently to every three month, and before they had been twice a year. How long had they been twice a year?

254 SCHLABS: It was for about 6 or 7 months. Prior to that it was twice monthly. Guesses that the twice yearly updates cost pharmacies about 5%.

REP. TAYLOR: Why do you fill Welfare prescription?

SCHLABS: Doesn't in three of his stores. In one store feels obligated because it is the only store in that area with a high elderly population. Loses money on that store.

BRUNSCHEON: Does fill Welfare subscriptions. They are about 35% of his patient base. Two pharmacies have gone out of business in the community because of increased AFS patients and decreased payments. Feels the same economic pressures, but has other stores to subsidize the cost. Doesn't want to leave the community.

HB 2695 - PROHIBITS AFS PURCHASE OF OUT-OF-STATE DRUGS - PUBLIC HEARING: Witnesses:George Gerding, Pharmacist Nancy Kaib, State Pharmacists Association Jean Thorne, OMAP

315 CHAIR FORD: Will have another hearing on both HB 2632 and HB 2695.

MELANIE ZERMER: Provides background of the bill. OMAP contracts with a New Mexico firm for its mail order drugs. OMAP is currently allowed to reimburse for out-of-state drugs.

344 GEORGE GERDING, Pharmacist: Presents written testimony (EXHIBIT F). When allow out-of-state drugs, they are not bound by Oregon laws. It can pose a health risk.

416 NANCY KAIB, Pharmacist: Presents written testimony (EXHIBIT G). Shows the committee a mail-order prescription that was filled incorrectly.

CHAIR FORD: So the person would be taking something that Medicaid was paying for, but was not effective.

466 KAIB: It is worse than that. The medication is to regulate the heart beat. The label would have the person take the wrong dosage which is very dangerous.

CHAIR FORD: Where did you get this example?

TAPE 81, SIDE A

025 KAIB: A patient brought it in. Points out other things on the prescription bottle that do not meet Oregon law.

REP. TAYLOR: Could you talk about the fact that people who get mail order prescriptions also go to the local pharmacy to fill short-term needs?

KAIB: Yes. The bottle used as an example was probably brought to a local pharmacy to ask advice. It is common. The Welfare recipient is the most at-risk mail order customer. They cannot take care of themselves, that is why the state is taking care of them, and they do not have access to a pharmacist. Summarizes testimony.

REP. BARNES: What is the price differential for the mail order and residential delivery. What is the savings?

KAIB: They pay about 10% less for the product than an independent pharmacy. The patient receives more than the prescription at a pharmacy though.

BARNES: What about the liability? Would Oregon's liability cover that?

074 KAIB: No, our laws couldn't touch an out-of-state pharmacy if the person was injured by a mistake.

ZERMER: This bill does not outlaw mail order entirely?

KAIB: No, it just addresses out-of-state mail order. It keeps the money and standards in the state.

ZERMER: How would you address border town citizens who may find it easier to go out of state to fill the order? Is that generally a problem and would the bill prohibit them from doing that?

KAIB: That is not the intent.

GERDING: That will have to be worked out in the wording. It is not the intent.

CHAIR FORD: Is concerned about the language that says the division shall not cause prescription drugs to be purchased outside the state. What does that mean?

GERDING: The state is the payor, so that is the purchase.

KAIB: They are the contractors and we don't want them to purchase out of state.

REP. RIJKEN: Are there any drugs available out of state that we cannot get in this state?

KAIB: No.

CHAIR FORD: There is one that you can't get very often. It is a pain killer in a liquid form.

REP. RIJKEN: There was testimony in another hearing about a drug for the mentally ill that is not available.

KAIB: It is available through a closed distribution system set up by the manufacturer.

REP. RIJKEN: How do you get it then?

KAIB: It is dispensed though the manufacturer directly. After the doctor prescribes the medicine, the patient goes to the manufacturer. They are getting sued for that practice.

154 REP. RIJKEN: Where are they located?

KAIB: There is a local Portland distribution center.

REP. BARNES: How do you feel when your government is helping another business in another state when it pays for an out-of-state drug?

GERDING: It is frustrating, especially when you own a small business. Has learned to be objective and look at it from the marketplace viewpoint. Has a problem when the state requires Oregon pharmacists to comply with high standards but not the out-of-state pharmacists they contract with.

KAIB: As a tax payer, is angry to see that happen.

215 JEAN THORNE, Director, OMAP: Presents written testimony (EXHIBIT H). The bill needs to be worded more carefully to make allowances for reciprocal work with Washington Medicaid.

CHAIR FORD: If a person on Medicaid has surgery in Portland and stays in Vancouver, they would not be able to get their prescriptions filled in Vancouver.

THORNE: Has addressed that problem in the testimony.

CHAIR FORD: But you have no problem with the out-of-state mail order other than financial?

THORNE: That is a decision for the committee. The financial impact is not that large.

CHAIR FORD: Is that in your rules that the physician can voluntarily prohibit mail order prescriptions.

THORNE: Will check on that.

267 CHAIR FORD: Adjourns the meeting at 4:15 p.m.

Submitted by, Reviewed by,

Angela MuÒiz Melanie Zermer

EXHIBIT LOG: A - Testimony on SB 60 - Jean Thorne - 2 pages B - Testiomny on HB 2632 - Chuck Gress - 2 pages C - Fiscal impacts of HB 2632 - Mike Dewey - 3 pages D - Testimony on HB 2632 - Jean Thorne - 2 pages E - Audit by the Office of the Inspector General - Jean Thorne - 9 pages F - Testimony on HB 2632 - John Brunscheon - 8 pages G - Testimony on HB 2695 - George Gerding - 1 page H - Testimony on HB 2695 - Nancy Kaib - 3 pages I - Testimony on HB 2695 - Jean Thorne - 2 pages