

Comments received 12/6/2023:

I would like to share my story from a pharmacy perspective. Smaller pharmacies are closing at an unprecedented rate. Fewer pharmacists are enrolled at schools and we already have a shortage of both pharmacists and technicians. There's a push to unionize across the industry and we're not only seeing strikes and walkouts, we're seeing pharmacies closing for a day, a weekend, or shortening their hours with no notice due to lack of staffing. This is going to get much worse in the near future without some drastic changes in healthcare.

Pharmacy benefits managers (PBMs) are making millions of dollars annually to the detriment of doctors, patients, and pharmacies. They are putting demands on us that siphon off our time and our profits, along with medical staff that prescribe. My physician closes on Fridays now, just to deal with the excessive and unnecessary requirements of insurance companies and PBMs. We spend a large portion of our time fighting for our patients right to get the medications that they need and paid for in a timely manner. And we see, on a daily basis people going without, or waiting for weeks to get their meds.

For example, we are now required to get clarification from the prescriber, on every cream, lotion, ointment, etc, as to how much is used, and how long it should last. The doctor cannot just write it in as a 30-day supply. They have to include how many grams per dose or per day, and the site of application. If we don't get this information on the Rx, we can get audited, and they can charge us back for every time the patient has filled it. My pharmacy has at least 25 prescriptions right now, where we are waiting to hear back from the office, and the patients are not getting their topical meds for sometimes weeks, because the offices are overwhelmed with these details that should be between the doctor and the patient.

When an eye drop is needed, different insurers have different ways to measure the amount, and how long it should last. They require this specified in 'drops per milliliter'. Yes, your insurance company may allow 16 drops per mL, and your neighbor gets 19 drops per mL. There's no allowance for an elderly person with a shaky hand that misses their eyes on a regular basis. So, seniors are going days without the eye drops that allow them to see clearly or treats their disease, because the insurance response is that it's a "refill too soon" and that they'll pay for it again next week.

Insulins are very expensive. Although proper insulin treatment requires differing doses in response to the blood glucose test, weight, exercise, diet and illness, your insurance company limits the amount. We have to count the calibration units on every dose. If the doctor writes that you're using 50 units daily, but doesn't specify that it's divided into 4 shots a day, you're going to run out before they will pay for it again, because you're using an extra 10 units a day to calibrate four shots. If you're sick and not exercising, you'll need more insulin, but the doctor will have to write a new Rx for a dose increase or you'll run out before insurance will pay.

Medicare will pay for supplies for 3 daily tests if you're using insulin and 1 daily test, if not. I have to explain to both patients and prescribers all the time, that yes, as a newly diagnosed diabetic you should be testing 6 times a day to establish a pattern and learn how to get it under control. But if you have to pay \$100 out of pocket for a box of test strips and \$20 for lancets, you're not going to be testing at all. And if insurance requires a prior authorization (PA) for 6 times daily testing, it may be another week before the paperwork goes through. By then, you're going to be back in the hospital. If the Rx doesn't have a diagnosis code, the doctor's NPI (national prescriber ID) or specify whether or not you're using insulin, they won't pay. Can't the doctor just call and give us that information? Can't we just look to see if you get insulin? No! It

has to be written on every single Rx, every single time. If we don't have a copy of your Medicare card, and a signature on several Medicare specific forms, they won't pay.”

But that's just Medicare. If you're on Medicaid you can test more often... you and your doctor actually get to decide. So, long as it's on a freestyle lite device that only works with freestyle lite strips and lancets. Why? Because they've contracted with freestyle and won't pay for anything else. You lost your job and are temporarily on Medicaid? Now your doctor has to send in 3 new prescriptions for the freestyle meter, strips and lancets, with all the correct information and you have to learn how to use the new meter. You changed jobs and have a new insurance? Well, your new insurance is contracted with one touch, so we'll need 3 new prescriptions for that. The numbers on your new meter are too small for you to read? Your doctor can get a prior authorization for a low vision 'non-preferred' meter and write 3 more correct Rx ...that will take a few more weeks. Why won't they pay for any meter? They signed a 'preferred' contract with one touch and get a lower price by doing that. So, you get it cheaper? Well, no, they keep the extra money and also their top executives get a bonus (kickback) for every Rx while you go days or weeks without testing and your disease does unseen damage to your body.

There's a record number of drug shortages right now. We do everything we can to keep every drug our patients need in stock. One month, we can't get anything but brand name Adderall, the next month we can't get any of the generics. I actually had a patient drive from Bend to Salem just to get her generic Adderall because she isn't able to function at work without it. We are now having trouble getting pain meds. (No matter how you feel about the opioid epidemic, most patients that are prescribed pain meds desperately need them to get through the day. They rarely abuse them, and don't get “high” from them, they just get pain relief). There's a 2 day window for refilling these drugs. You can only fill them 2 days before you run out. If your insurance is contracted with the company that makes brand Adderall, they won't pay for the generic without a prior authorization. This means we email the doctor, along with every other pharmacy and request that they complete the PA process, which can take anywhere from 3 to 10 days if started immediately.

By the time we have an approval, we may not be able to get brand or have run out of generic. We get about 50 calls a day from people looking for a specific drug that's in short supply. Sometimes we only have a small amount and run out before they're able to get ahold of the doctor and get a prescription to us, and they have to start again. These types of meds are non-transferable. The doctor has to cancel the Rx at one pharmacy and send a new one to the pharmacy that has it in stock. We also have insurance companies that call us to find out if we have any of these drugs in stock, and base their decision of whether to pay for brand name on the local results. I recently had an elderly patient that is wheelchair bound and had been without pain meds for a week. We had 20 mg tabs that she could cut in half for her 10 mg dose. Insurance wouldn't pay for that. They had called and found some 10 mg tabs at another chain 5 miles and 2 bus transfers away and based their decision on that. If she could stand the pain until she got there, and if the doctor could get a new Rx to that pharmacy before the other 50 people in town that were out of that drug got there first and they ran out. Or if, she got all that done in time, spent half a day in agony to get there and found out through a sign on the door that the pharmacy was closed for the weekend for lack of staffing.

If a patient is on Medicaid, and has a teledoc appointment, or is in college with their primary in another state, Medicaid will not pay for the Rx, because the provider isn't registered with them. This happens with new prescribers in this state who didn't realize that our state Medicaid requires prescribers to register.

If a prescriber writes for a drug that's not on the patient's formulary, it requires a PA. Hospitals and urgent cares don't do PA's. If a prescriber writes for a "form" that's not covered such as chewable tablets versus regular tablets, it's not covered. Some insurers will only cover capsules of one drug, or tablets of another. Inhalers can run into hundreds of dollars, and almost every insurer has a preferred brand. If the doctor writes it for a non-formulary inhaler, many patients can't afford it, and in order to breathe, they can't afford to wait.

If a patient responds to treatment better by taking a lower dose more often, the insurance may refuse to pay and require a PA or a higher dose taken once daily. If the patient has a hard time remembering to take their evening pills, the doctor may prescribe a long acting once a day dose, also requiring a PA depending on what drug it is. If a patient just had surgery and needs a pain med for the first time, the insurance will label them "opioid naïve" and limit them to a seven day supply, even though the surgeon gave them enough for the 2 weeks they'll need it. These meds can't be refilled. The surgeon can't prescribe more, because they only treat the patient once for the surgery. If they have a PCP, and if they can get in to see them after a week, they may prescribe more. But are also paying for another appointment and may not be ambulatory, so they pay out of pocket, or go without. If an insurance company thinks the doctor is prescribing too many pain meds (without knowing what surgery they had, or how severe the injury was), they demand a PA. Hospitals don't do PAs and it takes from 3 to 10 business days. So again, they pay out of pocket, or do without.

All of these examples are not isolated or rare. They're happening dozens of times daily in just my pharmacy. They're resulting in serious lapses in treatment and patients paying out of pocket or going without. They're impacting those with limited resources or an inability to navigate the health care system due to physical or mental impairment. They're bogging down our healthcare system and stretching our resources. What gives an insurance company the right to decide which medication or regimen is best for the patients? Most pharmacies aren't even answering their phones, because they lack the staff, or are calling doctor's back for clarification, or permission to switch to tabs or caps, or are on endless holds with insurance companies. Most patients are going without other needs to pay for their meds out of pocket, if they can. Please help us help our patients! I would love to testify in person, but we don't have enough staff for me to take the day off.

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