Pharmacy Carve Outs & Single PBM Savings by State

*As of 12/21/24

Medicaid MCO Carve Out

State	Implementation Date	Savings
Missouri	FY 2023	$4.4M[i]
Tennessee	FY 2019	*Data not available
West Virginia	FY 2017	$54.4M[ii]
Wisconsin	FY 2019	$1.2B/year (projected)[iii]
Ohio	FY 2022	$38M[iv]

Full Carve Out

State	Implementation Date	Savings
California	FY 2022	$405M (projected)[v]
New York	FY 2023	$410M (projected)[vi]

Single PBM with Single Preferred Drug List (PDL)

State	Implementation Date	Savings
Kentucky	FY 2021	$283M[vii]
Louisiana	FY 2024	*Data not yet available
Mississippi	FY 2024	*Data not yet available

Hybrid Model

State	Implementation Date	Savings
North Dakota	FY 2020	$17.2M[viii]

*All data is of last known reporting date. Check source links for additional information
Unless otherwise indicated, states' savings are reported as "first year" and can be assumed to have continued at the same (if not more) in following years

[i] https://oa.mo.gov/sites/default/files/FY_2024_DSS_MO-HealthNet_Budget_Request_Book_1.pdf
[ii] https://dhhr.wv. gov/bms/News/Documents/WV%20BMS%20Rx%20Savings%20Report%202019-04-02%20-%20FINAL.pdf
[iii] https://www.ncpathinktank.org/pdfs/ib139.pdf
[iv] https://managedcare.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager/odm-spbm-ppac
[v] https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Medi-Cal-Rx-FAQ-11-06-2020.pdf
[vi] https://www.health.ny.gov/health_care/medicaid/redesign/2023/docs/2023-24_exec_budget_scorecard.pdf
[vii] https://www.newsfromthestates.com/article/reprieve-kentuckys-independent-pharmacies-saving-medicaid-millions
[viii] https://www.nd.gov/dhs/info/testimony/2021/house-approp-hr/hb1012-medical-services-overview-expansion-1-14.pdf

Additional Resources

- Congressional Budget Office Prescription Drug Pricing Act Projected Cost Savings
- NCPA Medicaid Managed Care Report 02.2023
- KFF Annual Medicaid Budget Survey for State Fiscal Years 2024 and 2025
- KFF Annual Medicaid Budget Survey for State Fiscal Years 2023 and 2024
- IPC The Case for States Regulating Medicaid Managed Care Pharmacy Benefit Managers Claims Charges
- GAO Report March 2024: Selected States Regulation of Pharmacy Benefit Managers

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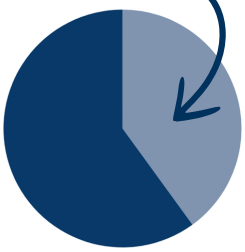
ACCESS TO A LOCAL PHARMACY IS CRITICAL
FOR PATIENT & COMMUNITY HEALTH

MNIndys
MINNESOTA INDEPENDENT PHARMACISTS

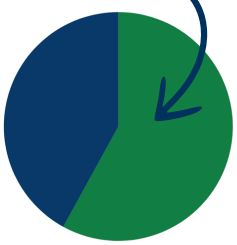
Pharmacies provide access to prescriptions, as well as additional essential healthcare services like blood pressure checks, vaccinations, and over-the-counter medications. **When pharmacies are local and accessible, patients are healthier:** health outcomes improve, emergency room visits are prevented. **When pharmacies are less accessible or unavailable,** studies show this contributes to medication non-adherence, especially among elderly adults.

BUT PHARMACIES ARE RAPIDLY CLOSING IN MN,
LEADING TO PHARMACY DESERTS & A CRISIS FOR ACCESS

44% (474) of pharmacies have closed in the past 10 years

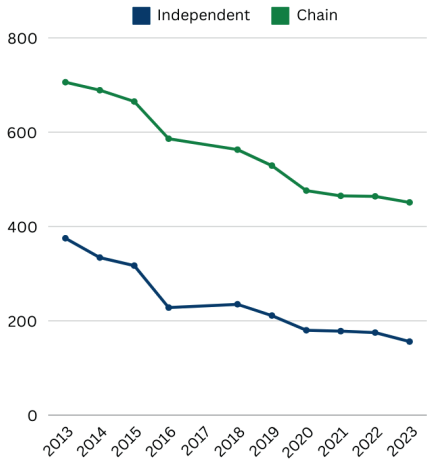


Of these, 58% (219) were independent (non-chain) pharmacies



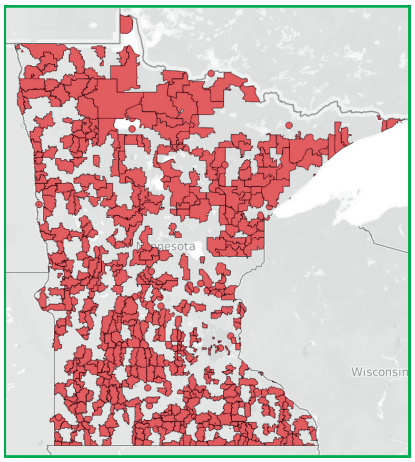
Data from MN Board of Pharmacy

Both independent & chain pharmacies are rapidly closing



Data from MN Board of Pharmacy

Zip codes without pharmacies (in red) are growing



Data from MN Board of Pharmacy. Map by Luke Slindee, PharmD.

AFFECTING BOTH URBAN & RURAL AREAS

Minnesota Department of Health (MDH) estimates that **more than one-third of residents in Minneapolis, St. Paul, and the first-ring suburbs are living in pharmacy deserts.** The risk for pharmacy closures is higher in predominantly Black and Latino neighborhoods, as well as in rural areas. In a 2024 study, **Minnesota ranked 10th in the nation for the largest proportion of residents living in a pharmacy desert.**

THE PRIMARY THREAT TO LOCAL PHARMACIES

is the chronic under-reimbursement from pharmacy benefit managers, as well as their exclusions of certain pharmacies from their preferred networks, affecting pharmacies' profitability which leads to disparate closure rates.

Pharmacy benefit managers (PBMs) serve as middlemen between pharmacies who fill prescriptions and payers (such as insurance companies or government programs like Medicaid or Medicare) **who cover the cost of patients' pharmacy care.**

Originally created to streamline the insurance claims process, they are now **vertically integrated** with insurance companies and influence **what drugs are available to and covered for patients, how much they cost, where patients can fill them, and how much the pharmacies who fill them are reimbursed.**

Minnesota Farmers Union

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April 2, 2025

Co-Chair Jeff Backer
Co-Chair Robert Bierman
House Health Finance and Policy Committee
St. Paul, MN 55155

Dear Co-Chairs Backer and Bierman and committee members:

On behalf of Minnesota Farmers Union (MFU), I am writing to share our support for Representative Nadeau's HF2242 which would implement a "single PBM" model for drug benefit management under Medical Assistance. This model will help address some of the structural forces that are harming local pharmacies while also helping save patients and taxpayers money.

MFU is a grassroots organization that has represented Minnesota's family farmers, ranchers and rural communities since 1918. At our annual convention in November, members voted to make ensuring affordable and accessible care a key priority and identified supporting independent pharmacies as an important part of meeting that goal.

Unfortunately, it is becoming more and more difficult for community pharmacies in Minnesota to survive. While surveys suggest independent pharmacies outperform their larger competitors on price, quality of care, and wait times, they are disappearing fast.[i] Over the past two decades the number of independently-owned pharmacies has dropped from 478 to 156.[ii] Beyond independent pharmacies, 39% of chain and regional chain pharmacies have also closed in that same period.

This dramatic decline has left nearly half a million Minnesotans in pharmacy deserts and over 15% of rural residents with limited access to pharmacies according to the Minnesota Department of Health.[iii] The loss of community pharmacies robs main streets of important small businesses and leaves patients without access to necessary healthcare services.

A key culprit driving the decline of independent pharmacies are pharmacy benefit managers (PBM), opaque middleman that have built immense power in the healthcare system. The three largest PBMs manage nearly 80% of prescription claims and are all vertically integrated into large insurance plans and operate their own mail-order and specialty pharmacies. PBMs have used rebates and fees to raise the cost of prescription drugs for patients while reimbursing independent pharmacies a fraction of the actual costs they incur.[iv]

Under Medical Assistance, each PBM separately controls their payment rates to pharmacies. The PBMs use their market power to pay as little as possible. According to Minnesota's most recent Cost of Dispensing Survey, it costs a pharmacy an average of $11.55 per prescription.[v] Despite these costs, it is not uncommon for PBMs to pay pharmacies much less for a prescription. In Oregon, a study of PBM reimbursements to independent pharmacies in that state's Medicaid program found that 75% of reimbursements failed to cover labor and drug costs.[vi]

HF2242 would replace the current Medical Assistance model with a single PBM and a preferred drug list selected by the state. HF2242 would also prohibit the PBM from using anticompetitive tactics like spread pricing, claw-backs, below cost reimbursement and formulary fees. This approach was first tested by Kentucky and has since been adopted by Ohio, Louisiana and Mississippi. In Kentucky the state has saved nearly $283 million and Ohio's savings have exceeded $100 million each year.[vii] This means a fairer playing field for independent pharmacies and less costs to taxpayers.

We are grateful that Representative Nadeau has introduced this bipartisan legislation and urge the committee to support HF2242. If you have any questions, please contact our Antimonopoly Director, Justin Stofferahn, at justin@mfu.org or (612) 594-1252 (C). Thank you for considering the needs and perspectives of Minnesota's farm families.

Sincerely,

Gary Wertish
President, Minnesota Farmers Union

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[i] https://www.consumerreports.org/pharmacies/consumers-still-prefer-independent-pharmacies-consumer-reports-ratings-show/
[ii] https://www.startribune.com/pharmacies-closing-pharmacy-deserts-growing-health-care-access-walgreens-cvs/601173628
[iii] https://www.health.state.mn.us/diseases/cardiovascular/documents/pharmacy.pdf
[iv] https://www.ftc.gov/reports/pharmacy-benefit-managers-report
[v] https://www.lrl.mn.gov/docs/2023/mandated/231385.pdf
[vi] https://www.3axisadvisors.com/projects/2022/10/27/understanding-pharmacy-reimbursement-trends-in-oregon
[vii] https://kentuckylantern.com/2023/10/05/reprieve-for-kentuckys-independent-pharmacies-is-saving-medicaid-millions/

MINNESOTA COUNCIL of HEALTH PLANS

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April 2, 2025

House Health Finance and Policy Committee
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Chair Backer, Chair Bierman, and Members of the Committee,

We are writing to express our concern over HF 2242 which establishes a single state pharmacy benefit manager (PBM).

Minnesota implemented Managed Care almost 40 years ago to provide better access to care for Minnesotans served by public programs and financial certainty for the state. Through care coordination, enrollees receive optimal care, providers are better informed and compensated, and there is less wasteful spending on unnecessary testing or duplicative procedures. Care coordination means serving the whole person and managed care is most effective when care management extends across all health care services.

Prescription drugs are a central component of these services and separating this benefit from the Managed Care Organizations (MCO) and moving them to a separate PBM will have a number of downstream impacts for enrollees. We should look to the other states who have implemented similar policies and learn from the challenges they have experienced.

Data: After moving to a single PBM, it has been difficult for MCOs to get clean data from the state's selected PBM. This makes it challenging for MCOs to understand which enrollees may have a new diagnosis as evidenced by new prescriptions, to do medication therapy management, to stratify for clinical program enrollment, to identify enrollees that may have medication adherence issues, and to manage the pharmacy lock-in program to assist

enrollees with high potential for medication misuse. The lack of clean data has also caused concern for Medicaid risk adjustment purposes.

Administrative Burden: Under a single state PBM, MCOs have no flexibility nor ability to negotiate a contract with the state-selected PBM. This has resulted in contracts requiring convoluted processes for MCOs to pay the PBM for services and validate invoices. In other states, it took over six months to implement the new vendor to include file exchanges and to operationalize.

Member Experience: In other states, moving to a single PBM has created unnecessary challenges for enrollees. Enrollees have been faced with excessive call center wait times with the single PBM. When they eventually hang up and call their MCO, the MCOs have limited ability to answer questions related to their prescriptions or to help facilitate solutions. Despite the other states having established portals to assist with data access for MCOs, the data was not always current, and plans were not always receiving the data.
We urge the committee to consider the data challenges, administrative burden, and poor member experience that implementing HF 2242 would create and to oppose this bill.

Sincerely,

Lucas Nesse
President and CEO