

United States House Judiciary Committee

Subcommittee on Regulatory Reform, Commercial and Antitrust Law

“The State of Competition in the Pharmacy Benefit Manager and Pharmacy Marketplace”

Testimony of Brad Arthur, Independent Pharmacist and President of the National Community Pharmacists Association

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Chairman Marino, Ranking Member Johnson and Members of the Subcommittee:

Thank you for conducting this hearing and providing me the opportunity to share my views and personal experiences regarding the state of competition in the pharmacy benefit manager and pharmacy marketplace. My name is Brad Arthur and I am a pharmacist owner of two independent pharmacies in the Black Rock community of Buffalo, New York-- an historic, ethnically diverse and predominantly blue-collar community. My pharmacies have been serving this community since 1957 when my dad opened his first pharmacy. I am also the President of the National Community Pharmacists Association (NCPA), which represents the pharmacist owners, managers and employees of nearly 23,000 independent community pharmacies across the United States. These pharmacies dispense approximately 40 percent of all community pharmacy prescriptions. I am here today as a healthcare provider and small business owner to present some of my experiences and those of my fellow independent pharmacists in dealing with the pharmacy benefit manager industry.

Community pharmacies represent the most accessible point in patient-centered health care where typically consumers do not need an appointment to talk with a pharmacist about prescription medication, over-the-counter products or really any other health-related concern. In this way, community pharmacies also serve as safety-net health care providers on the frontlines—not only when a natural disaster, such as a tornado, hurricane or flooding occurs, but every day when patients need help with their medications. Community pharmacists provide expert medication counseling and other cost-saving services that help mitigate the \$290 billion annual cost of treating patients that do not adhere to their medication regimen.

Concentrated PBM Marketplace

According to the Pharmaceutical Care Management Association (PCMA), the trade group that represents the PBM industry, PBMs manage pharmacy benefits for over 253 million Americans.¹ Three large companies lead the PBM market: ExpressScripts, CVSHealth (formerly CVS/Caremark), 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.² In addition, the annual revenues for these three entities are staggering. In 2014, annual revenues for ExpressScripts were approximately \$100.9 billion, annual revenues for CVSHealth were \$139.4 billion and annual revenues for OptumRx were \$31.97 billion. (In 2015, OptumRx acquired Catamaran, which reported annual revenues of 21.6 billion).³

Concentrated PBM Marketplace is Detrimental to Government Payers

You may ask, why should the federal government be concerned about this dynamic? For large plans, including the federal Medicare Part D program, TRICARE and FEHBP, there are only three PBMs to choose from. Because although there are other PBMs, none of them are large enough to administer the prescription drug benefit for these programs. The “Big Three” PBMs control almost 80% of the entire market, and these PBMs have the upper hand both in negotiating the contract with the payer as well as strongly influencing the actual plan design itself. In response to concerns about market concentration, the PBM industry typically states that they can use their economic power to harness enhanced “market efficiencies.” But, even assuming such claims are true, these companies are not obligated to “pass along” any savings to plans and consumers. The staggering annual revenues—that continue to grow each year—of the “Big Three” suggest that these “efficiencies” are going directly to their corporations’ bottom lines.

Community Pharmacies Lack Effective Negotiating Power

On a more personal level, small community pharmacies like mine are faced on a daily basis with the impact of the PBM’s disproportionate market power. Community pharmacies routinely must agree to “take it or leave it contracts” from the PBMs just to continue to serve their longstanding patients. Such contracts often include blind price terms, onerous obligations including gag clauses, and other provisions that disadvantage community pharmacies. As if that wasn’t enough, PBMs also directly set the ever-shrinking reimbursement rates for retail

¹ Testimony of Mark Merritt, President and CEO of the Pharmaceutical Care Management Association before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, October 21, 2015

² HealthStrategiesGroup, “Research Agenda 2015: Pharmacy Benefit Managers,” available online: http://www.healthstrategies.com/sites/default/files/PBM_Research_Agenda_PBM_RA101513.pdf

³ Ibid.

pharmacies—the very same pharmacies that stand in direct competition to the PBM-owned retail (in the case of CVSHealth) and PBM-owned mail order and specialty pharmacies. Therefore, it should come as no surprise when these PBMs present both employer and government payers with carefully tailored suggested plan designs that steer beneficiaries to PBM- owned mail order and specialty pharmacies.

As you can imagine, I, as an owner of two pharmacies, have a very limited ability to negotiate network participation or reimbursement terms with these entities. However, from a business standpoint, community pharmacies cannot just walk away from these contracts—because if we did, we would lose a significant amount of our prescription revenue given the large share of covered lives these PBMs represent. From a patient care and consumer services standpoint, if we drop a contract—we drop our patients. Independent community pharmacies across the country have been built on a philosophy of community service. However these one-sided contracts force us to provide pharmacy services at unsustainable rates. We are in a no-win situation.

Although many independent community pharmacies rely on a Pharmacy Services Administrative Organization or a PSAO to contract on their behalf, these PSAOs are no match for the PBMs. In 2013, the Government Accounting Office (GAO) conducted a study on the role and ownership of PSAOs and stated that “over half of the PSAOs we spoke with reported having little success in modifying certain contract terms as a result of negotiations. This may be due to PBMs’ use of standard contract terms and the dominant market share of the largest PBMs. Many PBM contracts contain standard terms and conditions that are largely non-negotiable.”⁴

Lack of Clarity in Generic Drug Reimbursement

One specific topic that I would like to highlight for the Committee, is the non-transparent process by which community pharmacies are reimbursed for generic drugs. A “Maximum Allowable Cost” or “MAC” list refers to a PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs. There is no standardization in the industry as to the criteria for the inclusion of drugs on the MAC lists or the methodology as to how the PBM will determine the MAC price or how it is changed or updated. In short, contracted retail pharmacies have zero insight or transparency into the MAC process and sign contracts without having any idea the rate at which they will be reimbursed for generic drugs—which comprise approximately 86 percent of all prescriptions dispensed in

⁴ GAO-13-176 Pharmacy Services Administrative Organizations

the United States.⁵ There are typically two different sets of MAC lists—one that is used to reimburse the pharmacy and another one to charge the plan sponsor. Many plan sponsors are not aware of the fact that PBMs generate a significant amount of revenue by pocketing the difference between what they reimburse the pharmacy and the higher amount that they charge the plans sponsor for the same drug—otherwise known as “spread pricing.”

Generic Price Spikes and Payment Lags

The issue of generic drug price spikes is one that has received a lot of press attention lately and the volatility in these prices has caused significant issues for pharmacists, physicians, patients and payers alike. These dramatic spikes in the costs of these medications combined with the fact that the PBMs are not updating the MAC lists or reimbursement amounts in a timely fashion to keep up with these skyrocketing prices, is creating a situation in which many pharmacists are consistently underwater or under-reimbursed on an increasing number of medications. A survey of members of the National Community Pharmacists Association in January 2014 showed that over 75% of respondents reported instances of a large price increase in at least 26 generic drugs over the last six months of 2013. This same survey also showed that over 85% of survey respondents reported it could take a PBM between two to six months to update their reimbursement rates for generic drugs.

On a typical day in either of my pharmacies, I can expect to see no less than 12-18 prescriptions filled at a loss with the total losses from these prescriptions in the thousands of dollars each and every month.

Inherent Conflicts of Interest in PBM Ownership of Mail Order and Specialty Pharmacies

Another area where I see the anti-competitive effects of PBMs on the market is the PBM ownership of mail order pharmacies and specialty pharmacies. This creates a situation in which the PBM creates a plan design and establishes reimbursement rates for networks of retail pharmacies that are in direct competition with the mail order and specialty pharmacies owned by the PBM—and keep in mind that the PBM knows exactly what the reimbursement amounts are for all of the players in this equation. With regard to PBM-owned mail order pharmacies, not only do the PBMs incentivize beneficiaries to use PBM-owned mail order pharmacies, but they also may be motivated to switch patients to more costly medications on which the PBM receives additional rebate amounts from the manufacturer. In addition, PBMs typically charge customers or payers for the cost of a drug that is based on a package size that is commonly

⁵ PhRMA; *The Reality of Prescription Medicine Costs in Three Charts*; 5/27/14; available online: <http://www.phrma.org/catalyst/the-reality-of-prescription-medicine-costs-in-three-charts>

purchased by a retail pharmacy in spite of the fact that mail order pharmacies typically buy drugs in much larger package sizes or quantities at much lower prices. Also, medication waste is rampant in mail order pharmacy and it's not as anecdotal as the PBMs claim.

I can tell you story upon story of patients in my pharmacy who come in and bring boxes and bags of expensive drugs they received from a mail order pharmacy. One such example of the inappropriate use of mail-order in specialty was a 78 year old male in late 2014 with Hepatitis C, who presented at the pharmacy with a second round of the very expensive treatment of Solvadi+Ribavarin. Upon closer inspection, we learned that the patient had been mailed the 3 month course of therapy (approximately \$60,000 in total), and without any initial or follow up consultations, proceeded to take only one of the two medications prescribed as per the regimen. At the conclusion of the course of therapy, he returned to his physician to learn that as a result of the absence of any follow-up, the treatment was unsuccessful and would need to be repeated. In this case his coverage was thru a Medicare Part. D plan.

An area of increasing competitive concern is PBM's ownership of specialty pharmacies. There is no industry-wide definition of "specialty drug, but generally these are high cost medications that treat chronic, complex illnesses and are the wave of the future. It is estimated that eight of the top ten drugs in 2016 will be specialty drugs—compared with only five in 2008 and just one in 2000.⁶ Currently the largest PBMs already dominate this market due the fact that they have the ability to call any high cost drug in the commercial marketplace a "specialty" drug and effectively prevent retail pharmacies from filling these prescriptions. Instead, they redirect these highly lucrative prescriptions to their own specialty pharmacies.

Regulation of PBM Industry?

One question that I am asked when I describe some of the difficulties that I currently face in dealing with the PBM industry is whether this industry is regulated in any comprehensive fashion. This would seem to make sense given the fact that three PBMs control almost 80 percent of all prescriptions that are administered by a PBM. In addition, the influence of PBMs continues to grow with coverage expansions in Part D and the commercial markets, combined with an increase in prescription drug spending that has motivated commercial plans and self-insured employers to outsource the management of their drug spend.

⁶ CVSHealth; What's Special about Specialty; available online: <https://www.cvshealth.com/research-and-insights/expert-voices/whats-special-about-specialty>

One would expect these entities to be subject to the same type of comprehensive regulation that is currently required of commercial health insurers. Commercial health insurers that offer employer-sponsored health plans are regulated under the Employee Retirement Income Security Act (ERISA) as well as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). In addition, Medicare Advantage plans are regulated by CMS and health plans offered to federal employees must meet requirements established by the Office of Personnel Management (OPM). However, the bulk of insurance regulation resides at the state level, where insurer solvency, underwriting, coverage mandates and access requirements are regulated.

In spite of the fact that PBMs play an integral role in how patients access their medications in both commercial health insurance and government programs, PBMs are not subject to industry-wide regulation similar to what is generally required of commercial health insurers. There are no federal laws or regulations specific to the PBM industry. Instead, PBMs face a patchwork of regulations at the state level that are designed to curtail some of the more onerous PBM business practices such as abusive PBM audits of pharmacies and requirements related to timely MAC updates. In addition, even in the states that have been able to pass these limited reforms, the PBMs typically resist complying with these laws and have recently filed lawsuits against two such states.

Conclusion

In conclusion, the healthcare industry in general seems to be at a crossroads. Large mergers seem to be announced every day in rapid succession while at the same time healthcare costs—and particularly prescription drug costs—are at an all-time high. I can tell you that as a small business owner and healthcare provider, the current situation and overall business climate that exists in which market power is increasingly concentrated in an ever-shrinking number of corporations—makes me apprehensive about what is around the bend. From my personal experience, the overly concentrated and largely unregulated PBM industry is wreaking havoc on small business pharmacy owners like myself.

If you haven't already done so, I urge you to support H.R. 244, a bipartisan bill that would require the same timely updates to MAC pricing lists in the Federal Employee Health Benefit Program and the military's TRICARE program that will be required in Medicare Part D in 2016. In addition, I urge you to support H.R. 793, a bipartisan bill that would allow any pharmacy located in a health professional shortage or medically underserved area to participate in any preferred pharmacy network if they are willing to meet comparable terms and conditions.

I want to thank you for affording me the opportunity to talk with you today and tell my story and I would be happy to answer any questions that you may have.