

Statement for the Record: The National Community Pharmacists Association (NCPA)

United States Senate Health, Education, Labor and Pensions Committee

Hearing: “The Cost of Prescription Drugs: How the Drug Delivery System Affects What Patients Pay, Part II”

October 17, 2017

Chairman Alexander and Ranking Member Murray, and Members of the Committee:

Thank you for conducting this second hearing on how the current pharmaceutical supply chain and delivery system may contribute to the rising costs of prescription medications. In this statement, NCPA would like to reemphasize our thoughts on how Pharmacy Benefit Managers (“PBMs”) that are the “middlemen” in the supply chain are a leading contributor to the pressing issue of escalating drug costs. NCPA represents America’s community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an \$80 billion healthcare marketplace and employ more than 250,000 individuals on a full or part-time basis. These pharmacies dispense approximately 40 percent of all community pharmacy prescriptions and are typically located in underserved rural or urban areas.

The Overly Concentrated and Largely Unregulated PBM Marketplace

Three large companies lead the PBM market – Express Scripts, OptumRx, and CVS Caremark. These three companies dominate the industry through collecting more than \$200 billion a year to manage prescription services for insurance carriers covering 180 million Americans and government programs servicing about 110 million more.¹ In addition, the largest PBM has increased its profit per-adjusted prescription 500 percent since 2003.² Since their inception, PBMs have morphed from claims adjudicators into little-known and largely unregulated corporate giants that exploit their strategic position at the “middle” of nearly all drug transactions in the U.S., extracting profits from the upstream and downstream participants in the drug supply chain while providing questionable value to the ultimate consumer. PBMs are also heavily involved in and reap enormous profits from their involvement in federally supported or subsidized healthcare programs, like Medicare and Medicaid.

Current Lack of Transparency Regarding PBM Retained Rebates and “Spread” Profits

PBMs serve as the “middlemen” in most prescription drug transactions in the United States. First, they leverage the number of beneficiaries in a plan to negotiate lucrative rebates from

¹ *How ‘price cutting’ middlemen are making crucial drugs vastly more expensive*, June 9, 2017, available at <http://www.latimes.com/business/hilzik/la-fi-hilzik-pbm-drugs-20170611-story.html>.

² *Investor’s Business Daily*, Nov. 21, 2016, available at <http://www.investors.com/politics/commentary/a-sick-calculation-about-prescription-drugs/>.

pharmaceutical manufacturers. Second, they formulate limited pharmacy provider networks that will supply or dispense these drugs to plans' beneficiaries and in turn, charge plan sponsors for these products. What most plan sponsors and consumers do not realize is that PBMs extract "spread" profits from both activities. Unless a plan has negotiated a true "pass through" contract with its PBM – and typically only the largest and most sophisticated plans are able to do so – the PBM will keep a significant percentage of the rebate dollars that they have obtained only by virtue of the number of the plans' beneficiaries for themselves.

It is also through these activities that PBMs wield immense power in influencing precisely what prescription drug products will be considered "on formulary" or what will be covered by a specific health plan. Typically, the PBM chooses specific drug products to garner the greatest amount of rebate dollars for its profits. Lately, the PBMs' "rebate game" has attracted a great deal of attention as it has come to light that the proliferation of these rebates is causing drug manufacturers to offset their payments to PBMs by raising the list prices of medications. This dynamic is extremely troubling because in today's healthcare marketplace – in which many consumers receive prescription drug coverage under high-deductible plans – patient cost sharing amounts for medications are based off these artificially inflated "list prices." Patient cost sharing is a percent of the "invoice" or retail price, not the net or rebated price. This suggests that ultimately rebate dollars are not passed through directly to patients. The Center for Medicine in the Public Interest confirmed this report and has specifically stated that rebates as percent of total price growth increased ten-fold since 2011.³ In addition, the amount that PBMs reimburse a pharmacy for dispensing a drug is not the same amount that PBMs "charge" plans for the same drug. PBMs "mark up" the cost of drugs, charging plans more than pharmacies are reimbursed and keeping the difference as pure profit. We believe that these hidden spread amounts should be disclosed to plan sponsors.

Cost Savings to Health Plan Sponsors Could be Realized with Increased PBM Transparency

Information on the vast sums of money that PBMs are making by virtue of the drug spread of a particular plan should not be "proprietary" on the part of the PBM but rather should belong to the plan. These disclosures could easily be protected by confidentiality agreements to address possible PBM concerns that this information weakens their negotiating stance with manufacturers. If plan sponsors have a clearer picture about the amount of money that PBMs make by handling a plan's business, disclosure of the drug spread may provide plans with a greater ability to negotiate more competitive contracts with PBMs in the first place. In this way, plan sponsors could save money and realize actual savings in today's increasingly difficult prescription drug marketplace.

³ Robert Goldberg, *Drug Costs Driven by Rebates*, Center for Medicine in the Public Interest, available at <http://bionj.org/wp-content/uploads/2015/11/drug-costs-driven-by-rebates.pdf>.

Lack of Transparency in Generic Drug Reimbursement

In today's marketplace, generic drugs currently comprise approximately eight-six percent of all prescriptions dispensed in the United States.⁴ Given this fact, it is surprising that there is no standardized method for determining how pharmacies are reimbursed for generic drugs. PBMs create and maintain "Maximum Allowable Cost" or "MAC Lists" that set the upper limit or maximum amount that a PBM/plan will pay for most generic drugs. Pharmacies are not provided any insight into how drug products are selected to be put onto these MAC Lists or how exactly these prices are determined or updated. In short, contracted pharmacies have zero insight or transparency into the MAC process and sign contracts without having any idea of the rate at which they will be reimbursed for many of the prescriptions they fill. In response to PBMs' secrecy surrounding the creation and maintenance of these MAC Lists, twenty-six states have enacted legislation to try to compel greater transparency into this system. Unsurprisingly, the PBM industry has vigorously opposed these efforts and is currently engaged in litigation with a number of individual states that have sought to compel their compliance with price transparency laws.

The PBM Industry is Largely Unregulated

Given the immense market influence that PBMs exert, one might expect that these entities would be subject to the same types of comprehensive regulation that is currently required of commercial health insurers. However, PBMs are *not* subject to industry-wide regulation. In fact, there are no federal laws or regulations that are 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. Unfortunately, even in states that have been able to pass limited reforms, PBMs typically resist complying with no recourse. To this end, there are currently two lawsuits filed against two states which attempted to legislatively address onerous PBM business practices.

Explosion of Pharmacy "DIR Fees" in the Medicare Part D Program are Increasing Costs to Consumers and the Medicare Program

Pharmacy direct and indirect remuneration ("DIR") fees are effectively "clawback" fees assessed on pharmacies retroactively months later, rather than deducted from claims on a real-time basis at the point-of-sale. Earlier this year Centers for Medicaid and Medicare ("CMS") identified several concerns resulting from the rapid growth in pharmacy DIR fees.⁵ First, beneficiaries face higher cost-sharing for drugs and are accelerated into the coverage gap or "donut hole" phase of their benefit. Second, more beneficiaries reach the catastrophic phase of the benefit, for which CMS incurs approximately eighty percent of the cost (The HHS Office of Inspector General has

⁴ PhRMA, *The Reality of Prescription Medicine Costs in Three Charts*, May 27, 2014, available at <http://www.phrma.org/catalyst.the-reality-of-prescription-medicine-costs-in-three-charts>.

⁵ CMS, *Medicare Part D – Direct and Indirect Remuneration*, available at <https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-19-2.html>.

noted⁶ that these catastrophic costs that are driven by pharmacy DIR fees have tripled in recent years – from \$10 billion in 2010 to \$33 billion in 2015). Third, liability for Part D costs is increasingly being shifted from Part D plan sponsors to CMS.

A leading actuarial firm reinforced and bolstered these findings in a report earlier this year commissioned by NCPA⁷. In addition, MedPAC has recently warned⁸ that because of DIR, the gap between gross and net drug prices has grown 20 percent annually from 2010-2015 and that “plan incentives [are] not aligned with beneficiary and Medicare.” By utilizing tactics such as pharmacy DIR fees, the Part D plan sponsor or its PBM often receive additional compensation after the point-of-sale that serves to change the final cost of the drug for the payer or the price paid to the pharmacy for the drug.

The point-of-sale price also known as the “negotiated price” that is recorded on Prescription Drug Event (“PDE”) records is extremely significant because it is used to calculate beneficiary cost-sharing and to adjudicate the Part D benefit. Any fees or payment that are made after the point-of-sale are not reflected in the negotiated price but rather are reported to CMS separately.

Many beneficiaries and caregivers rely on the online Medicare Plan Finder to evaluate and choose a Part D plan. However, the data displayed on Medicare Plan Finder are based on point-of-sale prices. Thus, the vast proliferation of DIR and post point-of-sale price concessions have rendered this drug price information grossly inaccurate.

To address these concerns, and to help preserve access to independent community pharmacies,
Congress could:

Enact S. 413 to ban retroactive “DIR fees” on community pharmacies which increase both beneficiary out-of-pocket medication costs and CMS’ Part D catastrophic costs, as well as jeopardize the viability of many independent community pharmacies.

This approach would require Medicare Part D Plan Sponsors/PBMs to utilize point-of-sale discounts, rather than retroactive pharmacy payment reductions. This approach would also lower beneficiary cost-sharing and reduce Medicare program costs and liability. Finally, this approach would allow the use of pay-for-performance arrangements and encourage true quality incentive

⁶ HHS Office of Inspector General, *High-Price Drugs Are Increasing Federal Payments for Medicare Part D Catastrophic Coverage*, available at <https://oig.hhs.gov/oei/reports/oei-02-16-00270.asp>.

⁷ NCPA, *The Impacts of Prescription Drug Direct and Indirect Remuneration Under Medicare Part D*, Feb. 2017.

⁸ MedPac, *Payment and Plan Incentives in Part D*, Apr. 7, 2017, available at <http://www.medpac.gov/docs/default-source/default-document-library/payment-and-plan-incentives-in-part-d-april-2017-for-public.pdf?sfvrsn=0>.

programs instead of misaligned programs that blur the line between reimbursement for ingredient cost and pharmacist performance.

The overall positive impact of enacting S. 413 is outlined NCPA's recently commissioned study with an outside consulting group. The study found that eliminating retroactive pharmacy payment reductions in Medicare Part D would *save the federal government \$3.4 billion over 10 years* in Part D payments made to plan sponsors.⁹ This kind of savings is possible because CMS would spend less on federal reinsurance and low-income cost-sharing subsidies. The presence of additional discounts would contribute to lower total drug costs at the point-of-sale which would decrease the federal government subsidy of low-income cost-sharing amounts while keeping low-income patient pay amounts relatively steady. The decrease in total drug cost at point-of-sale would also lower the amount of claim dollars in the catastrophic phase of the Part D benefit, because claims and amounts accumulating toward the true out-of-pocket catastrophic threshold would be lower.

Conclusion

In conclusion, the prescription drug marketplace continues to grow at an alarming pace. Large mergers continue to be announced every day while at the same time healthcare costs—particularly prescription drug costs – are at an all-time high. The current business climate seems to be one in which market power is increasingly concentrated in an ever-shrinking number of corporate entities. In particular, the overly concentrated and largely unregulated PBM industry exerts immense influence over how prescription drugs are accessed by many Americans. Given the fact that the federal government is the largest single payer of healthcare in the United States,¹⁰ it makes financial sense for Congress to demand increased transparency into this aspect of the prescription drug marketplace to identify potential savings. In addition, Congress could enact common sense legislation to address the proliferation of PBM-generated pharmacy “DIR” fees to lower out-of-pocket costs to Part D beneficiaries and reduce federal government Medicare Part D spending. Thank you for hearing our concerns.

⁹ Wakely Consulting Group, LLC, *Impact of H.R. 1038/S. 413 on CMS Payments Under Part D*, available at <http://www.ncpa.co/pdf/wakely-report.pdf>.

¹⁰ Troy, Tevi D., American Health Policy Institute, *How the Government as a Payer Shapes the Health Care Marketplace*, available at http://www.americanhealthpolicy.org/Content/documents/resources/Government_as_Payer_12012015.pdf.