

**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 Delivery System Affects
What Patients Pay”**

June 13, 2017

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

Thank you for conducting this 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 present our thoughts on how Pharmacy Benefit Manager “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 \$81.5 billion health care 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.

Overly Concentrated and Largely Unregulated PBM Marketplace

Three large companies lead the PBM market – Express Scripts, OptumRx and CVS Caremark-- and these three companies that dominate the industry collect 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

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

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. to extract 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 health care programs, like Medicare and Medicaid.

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

PBMs serve as the “middlemen” in the majority of all prescription drug transactions in the United States. They are able to leverage the number of beneficiaries in a particular plan to negotiate lucrative rebates from pharmaceutical manufacturers. They also formulate pharmacy provider networks that will supply or dispense these drugs to the plans’ beneficiaries and in turn, charge the plan sponsor for these products. What most plan sponsors and consumers alike do not realize is that PBMs extract “spread” profits from both of these 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 that will be covered by a

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

specific health plan. Typically the actual drug products selected are chosen by the PBM to garner the greatest amount of rebate dollars. In addition, this “rebate game” has attracted a great deal of attention lately and 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 also extremely troubling when one considers the fact that in today’s health care marketplace-- in which many consumers receive prescription drug coverage under high-deductible plans-- their cost sharing amounts for medications are based off of 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 rebate dollars are not passed through directly to patients. The Center for Medicine in the Public Interest confirmed this report and specifically provided that rebates as percent of total price growth increased ten-fold since 2011.³

In addition, the amount that the PBM reimburses a pharmacy for dispensing a drug is not the same amount that the PBM “charges” the plan for the same drug. The PBM “marks up” the cost, charging the plan more than the pharmacy is reimbursed, keeping the difference as pure profit. It is precisely these hidden spread amounts that should be disclosed in some way to plan sponsors.

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

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

This type of information—about the vast sums of money that PBMs are making by virtue of the drug spend 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 about such information weakening their negotiating stance with manufacturers. If plan sponsors have a clearer picture about the amount of money that is being made by their vendor by virtue of handling the plan’s business—this may provide them with a greater ability to negotiate more competitive contracts with these vendors in the first place. In this way, plan sponsors could save money and realize actual savings in today’s increasingly difficult prescription drug marketplace.

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 somewhat 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 this list 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 the majority of the prescriptions they fill. In response to PBM secrecy surrounding the creation and maintenance of these lists, twenty-six states have enacted legislation to try to compel greater transparency into this system. The PBM industry in general

⁴ 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>

has vigorously opposed these efforts and in fact is currently engaged in litigation with a number of individual states that have sought to compel their compliance.

PBM Industry Largely Unregulated

Given the immense market influence that PBMs exert, one would expect these entities to be subject to the same type of comprehensive regulation that is currently required of commercial health insurers. However, 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 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. However, even in states that have been able to pass these limited reforms, PBMs typically resist complying and have recently filed lawsuits against two such states.

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 CMS identified several concerns resulting from the rapid growth in pharmacy DIR fees⁵. First, beneficiaries face higher cost-sharing for drugs and are

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

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 80 percent of the cost. (HHS Office of Inspector General has noted⁶ that these catastrophic costs have tripled in recent years - from \$10 billion in 2010 to \$33 billion in 2015 – driven by pharmacy DIR fees.) Third, liability for Part D costs is increasingly being shifted from Part D plan sponsors to CMS.

These findings were reinforced and bolstered by a report earlier this year by a leading actuarial firm commissioned by NCPA⁷. In addition, MedPAC 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 pharmacy benefits manager (PBM) often receives 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/“negotiated price” recorded on Prescription Drug Event (PDE) records is extremely significant. 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.

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

⁷ “The Impacts of Prescription Drug Direct and Indirect Remuneration under Medicare Part D”, Feb. 2017

⁸ “Payment and plan incentives in Part D”, April 7, 2017

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. 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 post point of sale pharmacy price concessions. This would lower beneficiary cost-sharing and reduce Medicare program costs and liability. This approach would not prohibit the use of pay for performance arrangements but rather would encourage true quality incentive programs rather than the misaligned programs that blur the line between reimbursement for ingredient cost and pharmacist performance.

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—and 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 the majority of Americans. Given the fact that the federal government is the largest single payer of health care in the United States,⁹ it makes financial sense for Congress to demand increased transparency into this aspect of the prescription drug marketplace in order to identify potential savings. In addition, Congress could enact common sense legislation to address the proliferation of PBM-generated pharmacy “DIR” fees in order to lower out-of-pocket costs to Part D beneficiaries and reduce federal government Medicare Part D spending.

⁹ Troy, Tevi D., 2015 “How the Government As a Payer Shapes the Health Care Marketplace” *American Health Policy Institute*.