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

House Committee on Oversight and Government Reform

"Developments in the Prescription Drug Market: Oversight"

Thursday, February 4, 2016

Chairman Chaffetz, Ranking Member Cummings, and Members of the Committee:

Thank you for conducting this hearing on the current state of the prescription drug market and the potential need for oversight. In this statement, NCPA would like to present our thoughts on how increasing transparency into the business practices and potential conflicts of interest of Pharmacy Benefits Managers (PBMs) could provide tangible benefits to health plans/payers, pharmacists, and patients. NCPA 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 and are typically located in rural or very urban areas.

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 their prescription medication, over-the-counter products or really any health-related concern. In this way, community pharmacies serve as safety-net health care providers in their communities—not only 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 who do not adhere to their medication regimen.

Concentrated and Powerful 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]

[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.

Three large companies lead the PBM market: ExpressScripts, CVS Health (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 CVS Health 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).

Current Lack of Transparency Regarding PBM "Spread" Profits

PBMs serve as the "middleman" 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 "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 by virtue of the number of plan beneficiaries for themselves. In addition, the amount that the PBM reimburses the pharmacy for dispensing the drug is rarely the same amount that the PBM "charges" the plan for the same drug. Typically, the PBM "marks up" the cost of the drug, charging the plan more than the pharmacy is reimbursed, keeping the difference as profit for the PBM. It is precisely these hidden spread amounts that should be disclosed in some way to plan sponsors.

It is also through these activities that PBMs wield immense power in influencing precisely which prescription drug products will be considered to be "on formulary" or that will be actually covered by a specific health plan. Typically, the actual drug products selected and plan design

[2] Health Strategies Group, "Research Agenda 2015: Pharmacy Benefit Managers," available online: http://www.healthstrategies.com/sites.default.files:PBM_Research_Agenda_PBM_RA101513.pdf

are largely calculated by the PBM to garner the greatest amount of rebate dollars—that may or may not be passed along to the actual plan sponsor.

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

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.

Community Pharmacies Lack Effective Negotiating Power

Small business pharmacy owners are faced on a daily basis with the difficulties of dealing with the PBM's disproportionate market power. Community pharmacies routinely must agree to "take it or leave it" contracts from the PBMs just to be able to continue to serve their longstanding patients. Such contracts often include blind price terms, onerous obligations including gag clauses that restrict their ability to communicate with patients and other provisions that disadvantage both community pharmacies and patients. PBMs also directly set the ever-shrinking reimbursement rates for retail pharmacies—the very same pharmacies that stand in direct competition to the PBM-owned retail (in the case of CVS Health) and PBM-owned mail order and specialty pharmacies. Therefore, it should come as no surprise when PBMs present both employer and government payers with carefully tailored suggested plan designs that steer beneficiaries to PBM owned mail order and specialty pharmacies.

Although many independent community pharmacies rely on a Pharmacy Services Administrative Organization or PSAO to contract on their behalf, these PSAOs are no match for the PBMs. In 2013, the Government Accountability 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 the PBMs' use of standard contract terms and the dominant market share of the largest PBMs. Many PBM contracts contain standard contract terms and conditions that are largely non-negotiable."[3]

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 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

[3] GAO-13-176 Pharmacy Services Administrative Organizations
[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

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.

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,[5] it makes financial sense for Congress to demand increased transparency into this aspect of the prescription drug marketplace in order to identify potential savings.

[5] Troy, Tevi D., 2015 "How the Government As a Payer Shapes the Health Care Marketplace" *American Health Policy Institute.*