NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

November 28, 2022

The Honorable Eileen Cody
Washington House of Representatives
303 John L. O'Brien Building
PO Box 40600
Olympia, WA 98544

Submitted via eileen.cody@leg.wa.gov

Re: Regulation Pharmacy Benefit Manager Practices

Dear Representative Cody,

On behalf of our members operating chain pharmacies in the state of Washington, the National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit comments to you ahead of your participation in upcoming the House Health Care and Wellness Committee meeting on "Pharmacy Benefit Manager Impacts on Prescription Drug Cost and Regulatory Developments." "Pharmacy Benefit Manager Impacts on Prescription Drug Cost and Regulatory Developments." We also applaud your leadership on health care cost transparency in Washington and believe the time is ripe and warranted for legislative action on these pharmacy benefit manager (PBM) matters.

A growing number of reports explain how PBMs engage in practices that serve the best interest of the PBM while jeopardizing patient access to care. Most recently, a Forbes article entitled *How To Get Away With Corporate Murder: Unbundling And Disrupting Pharmacy Benefit Managers (Part 1)* highlighted many of the common PBM practices that serve PBM's financial interests at the expense of patient care.[1] These include practices such as requiring or otherwise incentivizing patients to use certain pharmacies over others, limiting pharmacies' participation in provider networks, and reimbursement practices that result in below-cost reimbursement to pharmacy providers. Moreover, the federal Centers for Medicare & Medicaid Services (CMS) reported the use of PBM fees such as Direct or Indirect Remuneration or DIR fees has exploded by 107,400 percent between 2010 and 2020 – a dramatic increase from the 45,000 percent CMS reported between 2010 and 2017. For continuity of services, pharmacies must pay these DIR fees imposed at will by the PBM. Laws, oversight, and policies are needed for payment reform in this industry to curb these types of harmful PBM practices and to help protect patient access to care.

As lawmakers come together to deliberate on PBM matters, NACDS offers the following insights and recommendations for needed regulation of these entities.

PBM Market Power

PBMs exert tremendous market power that negatively impacts patients and the pharmacies that serve them. This is because prescriptions filled by patients who are paying cash without any form of insurance or discount card account for only about 3% of the total volume of prescriptions.[2] While approximately 91% of prescriptions filled have a payment component coming from Medicare Part D, Medicaid, or a commercial insurance plan, these plans are ordinarily administered by PBMs. The top three PBMs manage about 80% of the volume.[3] The top six PBMs and

[1] 2022, November 13. How To Get Away With Corporate Murder: Unbundling And Disrupting Pharmacy Benefit Managers (Part 1), Forbes. Available at: https://www.forbes.com/sites/sethjoseph/2022/11/13/how-to-get-away-with-corporate-murder-unbundling-and-disrupting-pharmacy-benefit-managers-part-1/?sh=4c34c13a7bc0

[2] Source: IQVIA, National Prescription Audit & RxInsight, June 2022; Approximately 5.4% of patients use a discount card to assist with payment.

[3] https://www.drugchannels.net/2022/04/the-top-pharmacy-benefit-managers-of.html

plans manage about 96% of the volume.[4] Five of those six PBMs are owned by large national health insurers. This business environment makes it very difficult for pharmacies to negotiate equitable business practices and transparency because the PBMs and health insurers have more commercial market power and leverage in the relationship due to their size and scale.

Retail pharmacies are in crisis, facing unsustainable financial pressures as they are increasingly reimbursed by payers below the cost of buying and dispensing prescription drugs. Dire financial pressures have forced an alarming number of pharmacies to shut their doors. Payers have increasingly reduced reimbursements; in many cases, pharmacies receive reimbursement that is well below the cost to acquire and dispense prescription drugs . In addition to constant reductions in reimbursement, retroactive fees and claw backs, often occur weeks or months after a transaction closes, when a PBM decides to recoup a portion of the pharmacy's reimbursement further decreasing the amount pharmacies are paid for dispensing prescription drugs. These fees have made the economic viability of community pharmacies increasingly difficult, due to the unpredictability of reimbursement and the increased damage to bottom lines.

A study commissioned by the PBMs' own trade association, the Pharmaceutical Care Management Association (PCMA), recognizes that community pharmacies, and particularly chain pharmacies, are in trouble.[5] PCMA concludes over the last ten years (2012-2022) the total number of chain pharmacies decreased by 5.2% and decreased by 6.7% over the last five years (2017-2022).[6] PCMA's chart from the study shows an accelerating decline in chain pharmacies since 2017.[7] While PCMA does not suggest why chains are closing pharmacies, in a recent Supreme Court filing, PCMA agreed it is "undisputed" that "reimbursements below cost are approximately 10% of prescriptions filled."[8]

The epidemic of pharmacy closures is reducing access to vital healthcare services, especially in rural areas where options are already limited. Recent polling by Morning Consult confirmed that patients heavily rely on retail pharmacies among all healthcare destinations.[9] However, patients' access to retail pharmacies is increasingly threatened as more pharmacies go out of business.

PBM Reimbursement Practices Are Widespread

The harmful effects of PBM reimbursement practices have been well-documented by other states that have conducted audits of PBMs. In August 2021, the Delaware State Auditor concluded that "[b]y restricting more and more patients to mail order only pharmacies, PBMs are limiting access to medications for [patients]."[10] In 2018, a similar audit report in Ohio found the impacts of "reductions in pharmacy reimbursement on access to care, particularly in rural communities."[11] Similarly, audit reports in other states have recognized the dangerous nature of PBM reimbursement practices and have recommended increased oversight of PBMs. A Maryland audit report concluded that "[t]he [PBM] spread pricing model tends to obscure the amount of remuneration retained by PBMs and makes it difficult for state agencies administering the Medicaid benefit to determine if the amount of PBM remuneration is a reasonable expense to be borne by a Medicaid program."[12] A need for greater PBM oversight was also found by an audit report of a PBM's compliance with a Louisiana state contract to administer prescription drug benefits for state employees, retirees, and their dependents.[13]

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[4] *Id.*
[5] See https://www.pcmanet.org/the-independent-pharmacy-marketplace-is-stable/
[6] *Id.*
[7] *Id.*
[8] *Rutledge v. Pharmaceutical Care Management Association*, 18-540, 1 App. 341 (*petition granted* Jan. 10, 2020) (referring to the joint appendix in the case now pending before the Supreme Court of the United States).
[9] A poll of adults conducted March 4-6, 2022, by Morning Consult and commissioned by NACDS found that retail pharmacies received the highest ratings for ease of access among the destinations tested. Of note, 79 percent of those surveyed support pharmacists helping patients prevent chronic diseases.
[10] *See:* https://auditor.delaware.gov/wp-content/uploads/sites/40/2021/08/PBM-Survey-Report-Final.pdf
[11] *See:* https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf
[12] *See:* https://health.maryland.gov/mmcp/SiteAssets/Pages/Reports-and-Publications/hb589PBMauditappealsJCRfinal12-19%20(1).pdf
[13] *See:* https://app.lla.la.gov/PublicReports.nsf/3631E09F3B442E468625839900683DB6/$FILE/0001BB0A.pdf

PBM Reimbursement Practices Harm Patients

Harmful practices utilized by PBMs not only harm pharmacies, but these practices also can increase patient costs and shift costs to the government. The impact of higher cost-sharing for beneficiaries not only increases out-of-pocket costs for prescription drugs but also negatively impacts medication adherence, leading to the increased total cost of care and poorer health outcomes.

Medication non-adherence—that is, patients not taking their medications as prescribed by their healthcare provider—contributes to $100-290 billion in unnecessary healthcare expenditures every year as a result of increased hospitalizations and other avoidable, expensive medical services.[14-16] A systematic literature review of 79 studies conducted in 2018 revealed the adjusted total cost of non-adherence across multiple disease groups ranged from $949 to $52,341.[17] A 2017 white paper found that the direct medical costs and consequences related to not taking medication as prescribed is estimated to be 7 to 13 percent of national health spending annually – approximately $250 billion to $460 billion in 2017, translated to a potential cost to taxpayers of $6 trillion over 10 years.[18] And a 2016 cost-benefit analysis concluded that between one and two-thirds of medicine-related hospitalizations are caused by poor adherence. Improving adherence could result in annual per-person savings ranging from $1,000 to $7,000, depending on the disease state.[19] Multiple, credible sources have drawn the same conclusion: medication non-adherence is a costly, preventable problem that dramatically affects the total cost of care.

Legislative Action Needed to Prohibit PBMs Practices that Harm Patient Access and Jeopardize Pharmacy Care

The people of Washington rely on their trusted neighborhood pharmacy for access to important healthcare services. Many patients now regularly visit their local pharmacy for care such as health screenings, disease management, vaccinations, and testing – all in addition to essential medication access. With nearly 90 percent of Americans living within 5 miles of a pharmacy, public reliance on pharmacy care has only amplified over the years. Maintaining patient access to these pharmacy services is of paramount importance. Common PBM practices such as requiring or otherwise incentivizing patients to use certain pharmacies over others, limiting provider networks, and reimbursement practices that result in below-cost reimbursement for pharmacies can impede patient access to pharmacy care. To prevent this, we urge lawmakers in Washington to take action to prohibit these harmful PBM practices by enacting laws that do the following:

1. **Enact laws that support patient choice and access by prohibiting PBMs from requiring or steering patients to use certain pharmacies over others.**

Notably, some PBMs that administer patients' prescription drug benefits require beneficiaries to fill prescriptions through a mail-order pharmacy or otherwise use financial incentives and differential copays to this achieve same end. This can be especially problematic for patients who are sicker and require more prescription drugs, as these individuals greatly benefit from coordinated prescription management and other in-person services provided by their trusted, local pharmacist. Enacting a law prohibiting PBMs from requiring beneficiaries to use certain pharmacies (including mail-order pharmacies) or otherwise imposing financial penalties on patients to steer them to use certain pharmacies, will help to ensure that PBMs do not implement unwarranted plan restrictions to penalize or impede patients' ability to choose the pharmacy provider that best suits their individual needs.

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[14] Rosenbaum L, Shrank WH; "Taking Our Medicine - Improving Adherence in the Accountability Era;" *New England Journal of Medicine*; Aug. 22, 2013

[15] Network for Excellence in Health Innovation; "Bend the Curve: A Health Care Leader's Guide to High Value Health Care;" 2011. https://www.nehi.net/writable/publication_files/file/health_care_leaders_guide_final.pdf

[16] The NCPIE Coalition; "Enhancing Prescription Medicine Adherence: A National Action Plan;" 2007. http://www.bemedwise.org/docs/enhancingprescriptionmedicineadherence.pdf

[17] Cutler RL, et al; "Economic Impact of Medication Non-Adherence by Disease Groups: A Systematic Review;" *BMJ Open* 2018;8:e016982. doi:10.1136/bmjopen-2017-016982 https://bmjopen.bmj.com/content/bmjopen/8/1/e016982.full.pdf

[18] "A Treatable Problem: Addressing Medication Nonadherence by Reforming Government Barriers to Care Coordination;" *Prescriptions for a Healthy America*; October 2017. https://static1.squarespace.com/static/589912df1b10e39bd04eb3ab/t/59f0e439edaed84e6822d9bd/1508959306380/P4HA+WhitePaper+E-DigitalFinal+1017.pdf

[19] Patterson JA, et al; "Cost-Benefit of Appointment-based Medication Synchronization in Community Pharmacies;" *American Journal of Managed Care;* 2016. https://www.ajmc.com/journals/issue/2016/2016-vol22-n9/cost-benefit-of-appointment-based-medication-synchronization-in-community-pharmacies

2. **Enact laws that require PBMs' pharmacy reimbursements to cover at least a pharmacy's costs (i.e., rate floor), considering both the drug's ingredient cost and dispensing fee.**

Below-cost reimbursement from PBMs continues to be a major challenge for many pharmacies. When reimbursement does not cover a pharmacy's costs, this puts pharmacies under immense financial pressure—potentially forcing cutbacks on staff and operations, and even permanent closures. Solutions such as a "rate floor" have been implemented by the Centers for Medicare and Medicaid (CMS) to support reimbursement that covers the costs that pharmacies incur when acquiring and dispensing prescription drugs. To that end, PBMs should be required to comply with a reimbursement rate floor that encompasses both the ingredient cost and dispensing fee, and that considers pharmacy expenses such as pharmacy work related to clinical services (e.g., medication management, patient counseling), payroll, personnel expenses, inventory and auditing services, warehouse expenses, insurance, pharmacy building, and equipment. Such requirements would help maintain robust public access to pharmacies for essential medications and health services.

3. **Enact laws that require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM.**

Another way that some PBMS limit patient access to pharmacy care is through the construction of restricted pharmacy networks and contract barriers that limit pharmacy participation in a network. Consequently, many community pharmacies willing and ready to serve patients may be ineligible to provide important pharmacy services to beneficiaries. As a result, patients may in turn experience reduced access to certain pharmacies which deteriorates patient choice, impacts health outcomes, and can cause unnecessary delays and interruptions in patient care. Patients should have the choice and flexibility to utilize the pharmacy that best meets their healthcare needs and should not be forced or steered to inadequate pharmacy networks or face more costly options at non-preferred (or out-of-network) pharmacies. Laws that require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM will serve this important purpose.

Conclusion

Thank you for the opportunity to share our insights and recommendations on the important impact of PBMs on prescription drug costs and patient access to care, and the need to regulate these entities further to address harmful PBM practices. Should you have any questions, please reach out to NACDS' Senior Vice President of Reimbursement, Innovation and Advocacy, Christie Boutte at CBoutte@nacds.org

Sincerely,

Steven C. Anderson, FASAE, CAE, IOM
President and Chief Executive Officer

cc: Jenny Arnold, Chief Executive Office, Washington State Pharmacy Association
Christopher Blake, Counsel, Washington House Health Care & Wellness Committee
Samantha Morrow, Legislative Assistant, Office of Representative Eileen Cody