NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

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For:

United States House Judiciary Subcommittee on the Administrative State, Regulatory Reform, and Antitrust

On:

"The Role of Pharmacy Benefit Managers"

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Introduction

The National Association of Chain Drug Stores (NACDS) thanks Subcommittee Chair Massie and Ranking Member Correa for the opportunity to submit a statement for the record for the House Judiciary Subcommittee on the Administrative State, Regulatory Reform, and Antitrust's hearing, "The Role of Pharmacy Benefit Managers."

NACDS is comprised of chains of diverse sizes that operate standalone pharmacies and pharmacies in grocery and mass retail settings. NACDS members include regional chains, with as few as four stores, and national chains.

NACDS applauds the Subcommittee's bipartisan efforts and willingness to investigate the role of market-dominant pharmacy benefit managers (PBMs) in escalating Americans' prescription drug costs; in diminishing Americans' access to the medications prescribed by their doctors; in blocking Americans' access to their convenient and trusted pharmacies; and in forcing pharmacies out of business. The Subcommittee's work is crucial for all Americans and for communities, employers, taxpayers, and pharmacies of all sizes.

The Ever-Rising Awareness of PBM Tactics and the Need for Reform

For more than a decade, NACDS has warned of the increasing threats posed by market-dominant PBMs to Americans, to pharmacies, and to others. Unfortunately, the effects of pharmaceutical benefit manipulation have become increasingly dire. The awareness of PBM tactics has intensified as well, and the Subommittee's hearing occurs at a pivotal time.

Every day that is allowed to pass without comprehensive PBM reform is another day that market-dominant PBMs are allowed to sustain and worsen their tactics. This year, the situation has deteriorated further. Pharmacies are experiencing rapidly decreasing Medicare Part D pharmacy reimbursements that are taking many pharmacies even further below cost for the prescriptions that they fill every day. This untenable situation of decreasing reimbursement, combined with lingering pharmacy direct and indirect remuneration (DIR) fees, is putting patient access and pharmacies in jeopardy.

The perils faced by Americans, by pharmacies, and by others continue to draw the attention and the justified ire of a broad array of observers. On June 21, 2024, *The New York Times* published the first article in an anticipated series of articles that exposes PBM tactics. In their work on the article, the reporters have said that they conducted more than 300 interviews with current and former PBM employees, patients, physicians, pharmacists and other industry experts.

The article, titled "The Opaque Industry Secretly Inflating Prices for Prescription Drugs," provides stunning examples directly relevant to the Subcommittee's work. One example describes that a PBM required a patient in rural Middleport, N.Y. to pay for a more expensive brand-name inhaler instead of the generic option that the patient usually obtained at their pharmacy. The patient could not afford the extra $60 and decided to leave the pharmacy without the needed asthma medication.

While *The New York Times* provided a compelling collection of examples that demand attention, sadly these examples are not new or limited in nature. On June 23, 2024, the House Committee on Oversight and Accountability published a report, titled "The Role of Pharmacy Benefit Managers in Prerscription Drug Markets." The report found the largest PBMs force drug manufacturers to pay rebates in exchange for the manufacturers' drugs to be placed in a favorable tier on a PBM's formulary, making it difficult for competing, lower-priced prescriptions (often generics or biosimilars) to get on formularies. Additionally, the report highlighted that as many states and the federal government weigh and implement PBM reforms, the three largest PBMs have begun creating foreign corporate entities and moving certain operations abroad to avoid transparency and proposed reforms – with these anti-competitive policies of the largest PBMs costing taxpayers and reducing patient choice.

Poignant examples have been documented by others as well, hence the increasing awareness and momentum for reform. The Florida Society of Clinical Oncology also has put forward alarming stories, including one in which a physician prescribed a widely and successfully used medication for a rare form of cancer – only for the PBM's gamesmanship to result in lengthy delays that allowed the disease to progress such that the medication no longer would be suitable.

At a Capitol Hill rally in March, which urged immediate action on PBM reform, pharmacists provided further examples. One NACDS member described this situation: "We had a patient who was diagnosed with a severe infection and could not find the antibiotic at any pharmacy in the large community in which she lived. After many calls she was finally able to locate a pharmacy 25 minutes away that had it in stock and while it was close to closing, the pharmacist agreed to remain open until she got there. The pharmacist went home 20 minutes after the store closed, and while he felt good that he was able to help a person in need, the PBM who processed the prescription for payment paid him approximately $50 below his actual cost to buy the medication. Being paid below the cost it takes to provide medication therapy literally happens hundreds of times a day."

This is just a few examples of the ways that PBMs jeopardize the health and well-being of Americans who depend on medications and on pharmacies – and jeopardize Americans' access to the very pharmacies themselves. In the worst cases, these actions result in tragic human costs, and at a minimum in higher healthcare options down the road (e.g., hospitalizations). These actions also result in an impossible operating environment for pharmacies of all sizes. Immediate enactment of real PBM reforms in Medicare and Medicaid are desperately needed.

Similarly, in the commercial prescription insurance market, employers are increasingly choosing PBM alternatives to reduce costs. Recently, a major employer in the Fortune 100 announced it will drop its PBM for its 175,000 employees to reduce costs. Additionally, a recent 3 Axis Advisors study evaluated roughly 20,000 pharmacy claims in Washington State and found that the average plan sponsor (employer) costs were approximately $165,000 higher (roughly 80 percent more) than the reimbursement provided to pharmacies (approximately $8 more per prescription). This is yet another case study of spread pricing and how PBMs drive up costs throughout the system.

It is extremely important to note that all of this is happening to Americans, to communities, to employers, to taxpayers, and to pharmacies of all sizes while estimates project that PBMs more than doubled their revenue over the course of the last decade and that they will do so again in the current decade. For example, Fortune Business Insights projects PBM revenues of more than $800 billion by 2030, and Grand View Research projects more than $900 billion.

Subcommittee Encouraged to View PBM Rhetoric with Skepticism

PBM representatives when testifying before Congress, often cling to long-ago-debunked talking points about their alleged cost savings and about their purported value as negotiators with pharmaceutical manufacturers. Another often utilized defense is to position their PBM-driven solutions (e.g., "cost-plus" reimbursement models offered to pharmacies who participate in certain PBM networks) as examples of goodwill toward pharmacies.

To be clear, NACDS believes that these "solutions" are likely to have little-to-no effect on the market. They do not change or address any of the fundamental problems of market power that have arisen as a result of horizontal and vertical integration among the largest PBMs. They do not change the PBMs' incentive or ability to force unaffiliated pharmacies to accept "take-it-or-leave-it" contracts that lead to below-cost reimbursement, driving unaffiliated pharmacies out of business and reducing patient choice and quality of care. At the same time, these contracts have the perverse potential to raise prices for plan sponsors while also lowering reimbursements to unaffiliated pharmacies — this feature makes it unlikely that these networks will see widespread adoption, which alone will limit their marketwide impact.

Instead, NACDS believes these "solutions" announced by PBMs represent an effort to try to distract public and regulator attention away from PBMs and their well-documented history of self-enrichment at the expense of patients, and also to poison the well about the value of increasing transparency in the marketplace by (falsely) suggesting that the marketplace does not care about transparency. As Dr. Karen Van Nuys, economist and senior fellow at the USC Schaeffer Center for Health Policy and Economics, noted:

[The announcements are] window dressing. The press releases are pretty short, and details are pretty thin — and this comes at a time when PBMs are under increasing pressure from Congress. The timing of it, if nothing else, suggests that this is a response to try and forestall legislative actions that might clip their wings.

To explore this issue more deeply, it is important to note that these new "cost-plus" networks are simply an option that the PBMs will offer to some plan sponsors. They do not eliminate the existing reimbursement models that consistently reimburse pharmacies below their costs to buy and dispense prescription drugs. For those plan sponsors that continue to choose those existing reimbursement models without accountability and oversight, the harms to patients and pharmacies will continue. Furthermore, one of the PBM's cost-plus models will use its own internal and proprietary methodology to calculate acquisition costs. Unfortunately, the most likely outcome of a PBM being able to dictate acquisition cost is that unaffiliated chain and independent pharmacies will suffer the same issues they do under current maximum allowable

cost (MAC) reimbursement, where a PBM uses its market control to set the MAC price to dictate below-cost reimbursement rates. This opacity undercuts the claim that these "cost-plus" models represent efforts to improve transparency, and also makes it more difficult to quantify the likely effects. In theory, a "cost-plus" model could improve transparency and address some of the issues in the market today if it were a true "cost-plus" model – meaning one based on actual acquisition costs and that includes a reasonable dispensing fee that is sufficient to cover a pharmacy's fixed costs. Absent that, PBM arguments focusing on these models are worthy of Congress' and this Subcommittee's skepticism.

Barriers to Reform and Remedies: Fear of Retribution and PBMs' Stonewalling

The pharmacy community is appreciative of the Subcommittee's exploration into PBM practices and urges tenacity in waging it. With determination, hearings like this one have the potential to help overcome barriers to learning more about PBM tactics, and barriers to confronting them.

PBMs benefit from the darkness of confidential contracts. They also benefit from pharmacies' fear of retribution if specific examples are cited for purposes of encouraging reform. Still, if past is prologue, the Subcommittee must remain dogged in its approach. The simple truth is that PBMs have not been transparent, fair, or collaborative with the pharmacy community as evident by the PBMs' lack of substantive and positive action relative to the Centers for Medicare & Medicaid Services' (CMS) December 2023 notice. In that notice, CMS urged plans and PBMs "to engage in sustainable and fair practices with all pharmacies – not just pharmacies owned by PBMs" – and said the agency is "closely monitoring plan compliance with CMS network adequacy standards and other requirements."

The Federal Trade Commission (FTC) has encountered a similarly contemptuous response from the PBMs. The PBM industry continues to advocate against reform by citing documents that the FTC has withdrawn and warned against using for such purposes as they may no longer accurately reflect market conditions. This is consistent with the PBM industry's prior statements that they did not intend to adhere to the FTC's warning about continued use of these documents.

Further, in January 2024, U.S. Senators Chuck Grassley (R-IA) and Maria Cantwell (D-WA) led a bipartisan letter to the FTC saying that the PBMs were stonewalling the Commission's study of PBM tactics and ultimately harming Americans. The PBMs seem not to see the irony in their protestations about the interim staff report issued by the FTC on July 9, 2024, when considered alongside their own lack of full cooperation with the FTC.

Nonetheless, the FTC found – consistent with the findings of many other entities on a bipartisan basis – that "PBMs wield enormous power over patients' ability to access and afford their prescription drugs, allowing PBMs to significantly influence what drugs are available and at what price." The FTC also described PBM tactics as "imposing unfair, arbitrary, and harmful contractual terms' on pharmacies."

It must be emphasized that the PBMs rely on an opaque operating environment. The FTC's interim report discusses at length the effects of "self-preferencing" and "unfair contract terms" –

whereby "vertically integrated PBMs appear to have the ability and incentive to prefer their own affiliated pharmacies, creating conflicts of interest that can disadvantage unaffiliated pharmacies and increase prescription drug costs." Moreover, the analyses suggest that certain PBMs may be steering or pushing patients to their affiliated pharmacies and away from unaffiliated pharmacies – resulting in affiliated pharmacies receiving higher reimbursement rates (20 to 40 times higher than the national average drug acquisition cost [NADAC] in some cases) than those paid to unaffiliated chain and independent pharmacies. This usually translates to higher out-of-pocket costs for patients. These practices have allowed pharmacies affiliated with the three largest PBMs to keep dispensing revenue well above drug costs, resulting in approximately $1.6 billion of additional revenue on only two cancer drugs in under three years (2020-2022). These actions are unacceptable and are hurting smaller and larger pharmacies, including chains, unaffiliated with health plans and PBMs.

We encourage the House Judiciary Subcommittee on the Administrative State, Regulatory Reform, and Antitrust to keep pressing on bipartisan PBM reform and stay engaged on its vigorous inquiry into PBMs and their anti-competative practices.

Leading Pharmacy Organizations Call for Immediate Enactment of Key Components of Bipartisan PBM Reform

Pharmacies and pharmacists are firmly united across all practice settings on next steps for bipartisan and bicameral PBM reform to help curb the middlemen's pharmaceutical benefit manipulation. It is past time for action. NACDS and collaborating pharmacy organizations have worked together to call attention to needed reforms. While we understand that the breadth of these reforms may extend outside this Subcommittee's jurisdiction, it is vitally important for Congress to hear consistently on what is needed and expected to protect Americans and their pharmacies.

Throughout the 118th Congress, pharmacy organizations have spoken with one voice and clearly articulated pharmacies' legislative priorities that are necessary to confront the harms that are ravaging Americans and their pharmacies. **The following aspects of reform are absolutely necessary to ensure that a reform package is effective and that it can be supported by pharmacies:**

- Medicaid managed care pharmacy payment reform and a ban on spread pricing by requiring 100% pass-through to the pharmacy of the ingredient cost and of the professional dispensing fee, which could allow the federal government and states to save billions of dollars.
    - Ensuring fair and adequate Medicaid managed care pharmacy reimbursement from PBMs to cover the cost to acquire and dispense prescription drugs.
    - Requiring National Average Drug Acquisition Cost (NADAC) survey participation to help establish benchmarks for Medicaid reimbursement to retail

pharmacies which can be used to ensure fair reimbursement to pharmacies in Medicaid managed care and in the commercial markets.

- Requiring the Centers for Medicare and Medicaid Services (CMS) to define and enforce "reasonable and relevant" Medicare Part D contract terms, including information about reimbursement and dispensing fees, and establishing in Medicare Part D an approach by which "any willing pharmacy" can truly participate and serve patients.

- Establishing relevant, standardized and transparent pharmacy quality measurements in Medicare Part D.

These, along with additional policies have been the subject of bipartisan and bicameral work across key committees of jurisdiction, creating a robust package of Medicare, Medicaid, and commercial market reforms that also include:

- Promoting transparency of insurer claims and reimbursement information to the pharmacy, including independent audits and enforcement measures in Medicare Part D.

- Prohibiting PBM compensation in Medicare Part D from being tied to the manufacturer's list price of a drug.

- Prohibiting spread pricing in the commercial market by requiring 100% rebate pass-through of rebates and payments from drug manufacturers to commercial health plans to lower beneficiary cost and ensure adequate reimbursement for pharmacy acquisition and dispensing costs.

To reiterate, given the intolerable nature of market-dominant PBMs' practices and their far-reaching negative effects, the reforms that now enjoy bipartisan and bicameral consensus must be considered "must-pass" legislation in the 118th Congress.

Conclusion

NACDS thanks the Subcommittee for the opportunity to comment and to communicate pharmacy priorities that will save Americans from inflated prescription drug costs, save Americans from pharmacy and medication access burdens, and save pharmacies from anti-competative and predatory PBM tactics.

For continued dialogue on these important issues, please contact NACDS' Dr. Christie Boutte, Senior Vice President, Reimbursement, Innovation and Advocacy at CBoutte@nacds.org or 703-837-4211.