By electronic submission via transparency@cassidy.senate.gov

March 23, 2018

The Honorable Bill Cassidy, M.D.
United States Senate
520 Hart Senate Office Building
Washington, DC 20510

Re: The National Community Pharmacists Association's Recommendations on Efforts to Increase Health Care Price and Information Transparency

Dear Senator Cassidy:

Thank you for the opportunity to submit our comments regarding ongoing efforts to improve health care price and information transparency. The National Community Pharmacists Association ("NCPA") represents the interests of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together, they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis. By volume, 52 percent of the total prescriptions our members fill is covered by Medicaid or Medicare Part D.

Independent community pharmacies play a critical role in ensuring patients have immediate access to medications and offer face-to-face counseling, as well as other services to help boost patient adherence to medications. This accessibility provides our members with extensive knowledge and experience regarding ways to reduce costs for patients and payers.

NCPA is committed to working collaboratively with Congress, the administration, and other stakeholders in adopting viable solutions to increase drug pricing transparency. We agree that there is an inherent need to ensure prescription drug access and affordability. NCPA will address viable and recommended solutions below through answering presented questions.

NCPA will focus our comments on the prices related to prescription drugs only.

- **What information is currently available to consumers on prices, out-of-pocket costs, and quality?**

Insured consumers can gain information on drug prices from a variety of sources, but information primarily comes from the entity that manages their pharmacy benefit (pharmacy benefit manager or PBM that administers the pharmacy benefit for the plan sponsor) and their community pharmacy. To determine the price of a prescription drug under their pharmacy benefit, a consumer will need to give their prescription and insurance information to the pharmacy to process the prescription (and the

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pharmacy must pay adjudication fees) to establish what the consumer will owe under their pharmacy benefit. PBMs are responsible for setting the price the consumer will pay when using their prescription benefit. PBMs set the price of the drug and determine the amount the insured consumer will pay out of pocket whether a flat co-payment, percentage coinsurance, or full amount of the drug if it is excluded from the PBMs formulary or not covered during a deductible phase. Alternatively, an insured consumer can ask a community pharmacy about the cash price (i.e., not using their prescription benefit) of a given drug, strength and quantity at any time.

Regarding pharmacy quality, the Pharmacy Quality Alliance ("PQA") is an organization that develops strategies for measuring and reporting performance information related to medications. Independent community pharmacies are measured primarily by health plans/PBMs in the Medicare Part D program and are held to a variety of quality metrics that have been developed for health plans. CMS measures help plans' quality in the Part D space by utilizing PQA measures. There are currently efforts underway at PQA to create measures that can be used at the pharmacy level itself.

- **What information is not currently available, but should be made available to empower consumers, reduce costs, increase quality, and improve the system?**

To empower consumers, reduce costs, increase quality, and improve the system, information that is not currently available today but should be available includes information from PBMs related to generic drug pricing. The PBMs should be required to disclose maximum allowable cost ("MAC") pricing lists, which are used to reimburse community pharmacies for generic drugs. As a result, consumers and plan sponsors may not be aware that they may be paying more for a drug than the PBM is reimbursing the pharmacy, allowing the PBMs to "pocket the spread." The opaque nature of MAC pricing keeps any meaningful information about drug costs from plan sponsors and consumers. Moreover, because pharmacies are not privy to the reimbursement methodology for any generic drug, it hinders the ability to foresee expenses and allocate funds accordingly, which in turn can hinder consumer access.

As a solution, H.R. 1316, the *Prescription Drug Price Transparency Act* would codify Medicare transparency provisions concerning MAC pricing for generics and apply them to TRICARE and the Federal Employees Health Benefits ("FEHBP") Program. It would also establish a MAC appeals process and prohibit PBM requirements to use a PBM-owned pharmacy, a clear conflict of interest.

- **What role should the cash price play in greater price transparency? How should this be defined?**

Each pharmacy sets their own cash prices for the various drugs they provide. Consumers can ask their pharmacist or pharmacy staff at any time for the cash price. They will need to provide the exact name of the drug, strength, and quantity. They will also need to specify if they want the brand or generic. The cash price of prescription drugs should continue to be defined by each individual pharmacy provider.

- **Different states have used different methods to work towards price transparency. What are the pros and cons of these different state approaches? What is the best quality and price information to collect for consumers and businesses?**

Legislators and Medicaid officials in several states are actively considering substantive regulation and reform to rein-in practices by pharmacy benefit managers that may drive up drug costs, increase state

spending on prescription drug benefits, and disadvantage pharmacy patients and pharmacies. Much of the focus is on Medicaid spending on prescription drug benefits and the profit-taking by PBMs that results from the difference between what the PBM reimburses pharmacies and what it bills the plan sponsor.

From initial data-reporting, legislators are seeing that savings associated with moving from a spread model for compensating PBMs towards a transparent model of PBM pricing are large enough to simultaneously lower administrative costs to the state Medicaid agency or state health plan, reimburse pharmacies in a fair manner, lower any copayments or premiums a patient might be charged, and free up funding for pharmacy performance-based incentives.

For example, in Virginia, a requirement effective July 1, 2017 requires health plan sponsors to report pharmacy reimbursements and the amount charged to the plan sponsor for each claim by its PBM. Initial data for Q3 2017 show a considerable spread – millions of dollars of profit taken by the PBM – between reimbursements to pharmacies and medication charges to the health plan.[1]

In that same vein, West Virginia's state Medicaid agency carved the prescription drug benefit out of Medicaid managed care in that state effective July 1, 2017, citing an actuarial study showing that Medicaid could save $30 million annually by administering the benefit directly, and that doing so would also put $34 million back into local economies in the form of pharmacy reimbursements. NCPA has been told by a state official that preliminary results showed a $12 million savings in Q3 2017 alone.[2]

Another approach is to require direct state regulation of PBMs. In Arkansas, Governor Asa Hutchison recently signed into law a bill that establishes the standards and criteria for the regulation and licensure of PBMs in Arkansas. Under the act, a PBM must obtain a license from the Insurance Commissioner to operate in the state and a PBM must provide a reasonably adequate and accessible provider network that provides for convenient patient access to pharmacies within a reasonable distance from a patient's residence. The act also prohibits a PBM from proscribing a pharmacist from discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured. The act provides the Insurance Commissioner and the State Insurance Department with the authority to enforce its provisions.

- **Who should be responsible for providing pricing information and who should share the information with consumers?**

Currently, as discussed above, the PBM is solely responsible for setting the cost of drugs for insured consumers. The pharmacy must adjudicate the prescription claim (at a cost to the pharmacy) to be able to tell the patient what their price with insurance will be. Upon a consumer's request, a

[1] Department of Medical Assistance Services, Common Wealth of Virginia, Report on Managed Care Pharmacy Benefit Manager (PBM) Transparency, Dec. 1, 2017, *available at* https://rga.lis.virginia.gov/Published/2017/RD595/PDF.

[2] West Virginia Bureau of Medical Services, Pharmacy Benefit Changes for Medicaid Managed Care Members, May 31, 2017, *available at* http://dhhr.wv.gov/bms/News/Pages/Pharmacy-Benefits-Changes-for-Medicaid-Managed-Care-Members.aspx.

community pharmacy also can provide information about the price without using insurance for that prescription.

In Part D, an important aspect of pricing transparency is the way in which direct and indirect remuneration ("DIR") fees impact drug pricing during the deductible phase where consumers pay the

full cost of the drug and not the negotiated price. By way of background, DIR Fees imposed on pharmacies participating in Part D networks by sponsors and their PBMs have exploded in recent years. These fees take many forms—preferred network fees, "true ups" to various effective rates and adjustments due to performance compared to other pharmacies in Sponsors' Part D networks based on various quality measures. The treatment of these pharmacy price concessions as DIR rather than as reductions in the "negotiated price" of a drug has concerned not only NCPA but CMS and the Medicare Payment Advisory Commission ("MedPac") alike for many reasons.[3] Specifically, in certain instances, the treatment of pharmacy price concessions as DIR results in the price for certain brand and generic drugs appearing lower at preferred pharmacies when at the end of the year considering all the price concessions in DIR, the cost to beneficiaries and the Medicare Part D program as a whole is actually higher for certain drugs at preferred pharmacies than at non-preferred pharmacies. In addition, by including such price concessions in DIR versus in the "negotiated price" at the point of sale, beneficiary cost-sharing is higher than it should be for certain drugs dispensed at certain pharmacies. Accounting for retrospective pharmacy price concessions and pharmaceutical manufacturer rebates as DIR rather than concessions in the "negotiated price" at the point of sale permits sponsors to artificially moderate premiums at the expense of higher cost-sharing for beneficiaries.

For these reasons, NCPA supports a requirement to include all pharmacy price concessions in the drug's "negotiated price" at the point of sale rather than accounting for retrospective pharmacy price concessions as DIR long after completion of the plan year. NCPA has been a longtime advocate of an approach that would require sponsors to recognize retrospective pharmacy concessions as price concessions in the "negotiated price" used to adjudicate Part D claims at the point of sale rather than as DIR after termination of the plan year.

Another solution to consider is that PBMs and plan sponsors could share robust pricing information with patients during enrollment periods for insurance, including the usage of copays versus coinsurance for certain plans. In Part D plans, NCPA has recently supported reasonable copays and CMS' view that consumers often prefer copayments to coinsurance because the former are more transparent and make it easier for consumers to predict their out-of-pocket costs." The use of coinsurance defeats the purpose of providing patients with greater clarity in a plan's design because the PBM has the unilateral ability to determine the price to consumers of the drug from which the coinsurance percentage is calculated. The inability to access drug information prior to choosing a plan puts individuals who rely on prescription drugs at a significant disadvantage.

[3] *See* Centers for Medicare & Medicaid Services, *Medicare Part D – Direct and Indirect Remuneration (DIR),* Jan. 17, 2017, *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19-2.html; *see also* MedPac, Meeting Agenda and Presentations including the discussion of Payment and Plan Incentives in Part D, April 6-7, 2017, *available at* http://www.medpac.gov/-public-meetings-/meeting-details/april-2017-public-meeting.

NCPA remains concerned about increasing beneficiary costs for generic drugs. We are concerned that, should many generic drugs shift to coverage on a non-preferred drug tier, beneficiaries could face significant cost sharing increases. As plans increasingly employ coinsurance amounts more than 40 percent of the negotiated price of the drug on non-preferred tiers, it is essential that the government assess their composition to ensure appropriate access and prevent discrimination.

- **How do we advance greater awareness and usage of quality information paired with appropriate pricing information?**

As discussed above, there are currently efforts underway at PQA to create measures that can be used at the pharmacy level itself. Once these measures are developed, tested and then endorsed it may be possible for consumers to have better insights into pharmacy quality information.

Another way to ensure greater awareness of quality information is to support meaningful prescription drug coverage and pharmacy choice in all plans. For example, in Part D plans NCPA supports giving seniors more access to discounted copays for prescription drugs at their pharmacy of choice. CMS can implement its proposed "pharmacy choice" policy to allow patients to use any pharmacy that accepts the drug plan's terms and conditions, including pricing, for "preferred pharmacies." CMS has called this "the best way to encourage price competition and lower costs in the Part D program."[4] Further, NCPA supports S. 1044/H.R. 1939, *The Ensuring Seniors Access to Local Pharmacies Act,* which would allow community pharmacies that are located in medically underserved areas ("MUAs"), medically underserved populations "(MUPs"), or health professional shortage areas ("HPSAs") to participate in Part D preferred pharmacy networks so long as they are willing to accept the contract terms and conditions which would empower more seniors to choose the pharmacy that best fits their needs.

- **What other common-sense policies should be considered to empower patients and lower health care costs?**

Drug manufacturers ultimately establish list prices for drugs at the top of the supply chain and are obviously a factor in this debate. At the same time, PBMs set the prices for insured consumers and often fly under the radar while prices continue to escalate.

There are several PBM practices that contribute to higher costs which we believe should be addressed as you look for ways to lower the costs of prescription medications.

First, as mentioned above, the use of DIR fees charged to pharmacies lead to higher out-of-pocket drug costs for Medicare Part D beneficiaries. DIR fees are assessed weeks or months after a prescription drug claim has been processed and adjudicated and result in recoupments by PBMs from pharmacies. However, since these fees are not reflected at point of sale, a report by CMS found this can push beneficiaries into the coverage gap prematurely, where patients and Medicare pay a bulk of the costs. Moreover, the report indicates that as use of DIR increases, so do the costs to Medicare, while plan liability decreases.[5]

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[4] Centers for Medicare & Medicaid Services, *Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 1, 2013.

[5] Centers for Medicare & Medicaid Services, *Medicare Part D – Direct and Indirect Remuneration*, *available at* https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-192.html.

Also, of concern are potential PBM conflicts of interest. PBMs contract with pharmacies while also owning their own mail order and/or specialty pharmacies. PBMs often design plans that require patients to use the PBM-owned pharmacy option or a preferred retail pharmacy. However, this is not necessarily the most cost-effective option. A 2013 study by Norman V. Carroll, PhD, a professor at Virginia Commonwealth University, found that the total cost for 90-day prescriptions filled at retail

pharmacies were lower than those filled by mail order pharmacies.[6] CMS has also raised concerns over limited networks, stating that pharmacy competition is the best way to reduce costs in the Medicare program. As such, policies should be pursued that promote pharmacy competition and patient pharmacy choice.

Furthermore, the rebate relationships between PBMs and manufacturers should be examined. Manufacturers often offer steep discounts to the PBMs for preferential placement on formularies, or a prescription drug plan's list of covered medications. While in theory this should bring prices down, the savings aren't necessarily passed along to patients and plan sponsors. IMS Health data demonstrates that the list price of medications is growing at a far faster rate than the net price, which has led some to conclude that most of the increase in drug spending has been from rebates pocketed by PBMs and insurers.[7] Additionally, a recent article noted that PBMs prefer the non-transparent nature of higher list prices and higher rebates that provide little insight to the plan sponsor as to what is being passed on and what is kept by the PBM.

Citing one pharmaceutical representative from Gilead, "if it [Gilead] slashed Sovaldi's list price by tens of thousands of dollars, the middlemen would 'rip up our contract' and refuse to include the drug in its formulary."[8] This indicates PBMs have an incentive to favor drugs on its formulary that have the highest rebates and not necessarily the lowest net cost. This masking of rebates from manufacturers also seems to be corroborated by a lawsuit filed by Express Scripts, Inc. ("ESI") against the drug manufacturer Kaleo. In its legal complaint, ESI indicated that they billed Kaleo thirteen times more in administrative fees than in formulary rebates that would be passed on to plan sponsors.[9] If the administrative fees are included in the percentage of price concessions PBMs tout they obtain from manufacturers, shouldn't these too be passed on to the patients and plan sponsors?

Conclusion

We all agree on the need to ensure prescription drug access and affordability. However, this issue cannot be solved without addressing the role of PBMs in increasing costs. As the PBMs have expanded well beyond their original role as claims processors to include negotiating with manufacturers, contracting with and paying pharmacies, and administering plans and billing plan sponsors, they have grown into Fortune 100 companies that touch nearly every part of the drug supply chain. NCPA believes that it is time to rein in these behemoths with meaningful and reasonable oversight.

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[6] Carroll, Norman V., Ph.D., *A Comparison of the Costs of Dispensing Prescriptions through Retail and Mail Order Pharmacies*, Feb. 2013.

[7] Goldberg, Robert, *Most of the Increase in Drug Spending Pocketed by PBMs and Insurers*, Drug Wonks, April 15, 2016, *available at* http://drugwonks.com/blog/most-of-the-increase-in-drug-spending-pocketed-by-pbms-and-insurers.

[8] Shah, Sandip, *Middlemen not passing on all drug discounts intended for patients*, Sonoran News, June 20, 2017, *available at* http://sonorannews.com/2017/06/20/middlemen-not-passing-drug-discounts-intended-patients/.

[9] Cahn, Linda, *Express Scripts Lawsuit Should Raise Everyone's Eyebrows*, *available at http://nationalprescriptioncoveragecoalition.com/author/linda/.*

We would appreciate the opportunity to meet with you and discuss these issues and solutions that we believe can help reduce costs.

Sincerely,

Karry K. La Violette
Vice President, Government Affairs and Advocacy
National Community Pharmacists Association

Cc: Senator Michael Bennet
Senator Charles Grassley
Senator Tom Carper
Senator Todd Young
Senator Claire McCaskill