April 4, 2018

The Honorable Charles Grassley
Chairman
U.S. Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Dianne Feinstein
Ranking Member
U.S. Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Grassley and Ranking Member Feinstein:

The National Community Pharmacists Association represents 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. Independent community pharmacies are often located in traditionally underserved rural and urban communities, providing critical health care access to residents of those communities.

The numerous state pharmacy association signatories here represent broad constituencies of licensed pharmacists active in all pharmacy practice settings.

Pharmacists have long been concerned with pharmacy benefit managers operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe many PBM practices are anti-competitive and ultimately drive up health care costs for consumers and plan sponsors while reducing payments to pharmacies. For example, these reductions in payments to pharmacies by PBMs have resulted in the closure of 70+ community-based pharmacies in Iowa alone, and that in just a two-year period.

PBMs administer the prescription drug benefit for nearly every public and private health plan. Since their origination decades ago as flat-fee-based drug claim processors, PBMs have evolved into behemoth corporations that affect nearly all aspects of the prescription drug marketplace, including:

- Determining which drugs are covered on the formulary and setting copay amounts.
- Contracting to set pharmacy networks.
- Negotiating discounts and rebates with drug manufacturers.
- Processing and paying prescription drug claims.

In addition, PBMs incentivize or require patients to use a mail order or specialty pharmacy – often one owned/operated by the PBM – for certain medications, meaning they both compete with *and* determine reimbursement rates for community pharmacies.

A recent White House Council of Economic Advisers report found that just three PBMs – CVS Caremark, Express Scripts, and OptumRx – account for 85 percent of the market, "which allows them to exercise undue market power against manufacturers and against the health plans and beneficiaries they are supposed to be representing, thus generating outsized profits for themselves." Recently, two of the big

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three PBMs announced acquisition plans with large insurers (CVS Health to acquire Aetna Inc. for $69 billion; Cigna to acquire Express Scripts for $67 billion). If these acquisitions proceed, all three PBMs will be vertically integrated with an insurance company, as UnitedHealth Group Inc. currently owns OptumRx.

The potential harm from such continued market concentration cannot be overlooked. These mergers should be closely examined to determine whether they will lead to lower quality and fewer options for patients, as well as to higher costs and less competition in the health care market. Merging a pharmacy/PBM with a health plan will only solidify problems with respect to pharmacy access issues, especially in underserved and rural areas. An entity that controls the health care benefit as well as the prescription drug benefit raises both anti-competitive and conflict-of-interest concerns and will give consumers even less control over their choice of health care providers.

The merging entities purport that these transactions will be procompetitive, but previous consolidation in the industry has not resulted in efficiencies that have been passed on to consumers. In fact, a 2017 report by the American Consumer Institute noted "because of recent mergers, the PBM market has increased in concentration, and that provides negotiating leverage which enables them to extract additional revenues and earnings." The report further highlighted the market distortion between PBMs and pharmacies that has been exacerbated by consolidation: "Increased market concentration has allowed PBMs to become price-makers, and pharmacies as price-takers." That is also why the subject of PBM market concentration and dominance was a major theme of the February 14, 2018 hearing of the House Energy and Commerce Subcommittee on Oversight and Investigations entitled, "Examining the Impact of Health Care Consolidation." Soon after that hearing, the Cigna-Express Scripts merger was announced.

While PBMs play an oversized role in the marketplace – which will only get larger if these mergers are consummated – the lack of transparency or meaningful competition negatively affects patients, pharmacists, plan sponsors, and ultimately taxpayers who fund government-sponsored programs such as Medicare Part D, TRICARE and the Federal Employee Health Benefits Program.

We respectfully request the Senate Judiciary Committee hold a hearing to investigate the following problems associated with PBM practices:

1. **Lack of Oversight**

While the majority of the prescription drug supply chain is highly regulated, PBMs operate with little to no state or federal oversight. Many states have enacted regulation of one type or another, but those laws are not always effectively enforced. In 2017, Iowa's PBM law to require disclosure of pricing methodology was struck down by the U.S. Court of Appeals for the Eight Circuit (*PCMA v. Gerhart*, 2017 BL 7351). As was a central issue in *PCMA v. Gerhart*, the overly expansive scope of ERISA preemption severely limits state efforts to regulate PBMs.

2. **PBMs and Pharmacies: a One-Sided Business Arrangement**

PBM contracts that determine pharmacy network participation are typically presented to community pharmacies as take-it-or-leave-it arrangements with no ability to negotiate the terms and conditions. While independent pharmacies may work with pharmacy services administrative organizations,

who contract on their behalf, these organizations report little success in being able to modify contracts. Typical features of these contracts include:

- **Restrictions on Delivery** – PBMs encourage plan sponsors to use mail order and specialty pharmacies which are often owned by the PBM. PBMs write contracts that sometimes restrict the community pharmacy from mailing prescriptions to patients – "snowbirds," for instance – and send warning letters to pharmacies that provide this service.
- **MACs** – There is no transparency into this PBM reimbursement benchmark, known as maximum allowable cost, which is used to determine pharmacy reimbursement for most generic drugs. MAC rates change constantly without notice to pharmacies. MAC-based reimbursement is at times below cost or fails to keep up with price spikes or inflation. Community pharmacies need insight into the basis for MAC reimbursement rates, certainty that they are updated to reflect real-world prices, and an effective appeal process to contest below-cost payments.
- **Retaliation –** Due to the strict nature of PBM contracts, pharmacists and pharmacy owners often fear retaliation for exposing questionable PBM practices or advocating for PBM legislation and regulation. For example, PBMs may exclude a pharmacy from a limited (or "preferred") network or terminate or decline to renew a contract with a pharmacy.

3. Spread Pricing

Many PBM contracts with health plans operate on a "spread" pricing model, as the following example illustrates. In one Iowa county, the publicly-funded county prison contacted a local pharmacy to determine why the prison's prescription costs for inmates were drastically increasing. Upon comparing charges to the prison and payment to the pharmacy, it was determined that the PBM charged the prison $3,000 for the same prescription claims for which the PBM reimbursed the pharmacy $400 – even though the pharmacy's actual cost was over $700. The PBM kept the resulting spread.

Furthermore, PBMs often contractually prohibit plan sponsors from knowing what the PBM is reimbursing pharmacies, making it difficult for plan sponsors to evaluate PBM performance. The current system not only hurts pharmacies, but costs millions of dollars to the public. A recent report from Kentucky showed that state's Medicaid program spent $1.68 billion on pharmacy benefits last year, of which about $1 billion went to pharmacies. The remaining nearly $700 million went to PBMs, which would not disclose what they did with the money. (*Bill Would Let Kentucky Take Over Medicaid Pharmacy Benefits,* Associated Press, Feb. 14, 2018).

4. Self–Dealing

In a recent analysis of the CVS/Caremark cost-estimator online tool, the Iowa Pharmacy Association found that CVS paid itself (CVS pharmacies) on average 35.8 percent higher than it paid independent and regional chain pharmacies. This average was calculated for a 30-day supply of the 150 most common prescriptions. In addition to paying some of its competitors less than it pays itself, CVS also capitalizes by trying to acquire these smaller pharmacy operations. Solicitation letters from CVS Health

to independent and regional chain pharmacies state that CVS understands the difficulties pharmacies are facing with declining reimbursement rates, followed by an offer to buy the pharmacy. Again, many

independent pharmacies are finding it hard to sustain their business due to these PBM practices and are closing nationwide, leaving many communities with no pharmacy option. The number of U.S. independent community pharmacies has declined in the past five years, and a recent study estimated three million rural residents are at risk of losing the only pharmacy in their community, with the next nearest pharmacy more than 10 miles away.

5. Conflict of Interest

PBMs own mail order pharmacies and mail order specialty pharmacies that directly compete with retail pharmacies. They determine payment rates for competing retail pharmacies and their own mail order pharmacies – an inherent conflict of interest.

6. Manufacturer Rebates

PBMs negotiate rebates directly with drug manufacturers. These rebates are often based upon preferred placement on a formulary tier or on utilization of the drug. In theory, these rebates are passed through to plan sponsors, or employers and consumers, lowering the cost of drugs. However, there is growing skepticism regarding whether these rebates are being passed along to customers. Recent inquiries by the U.S. Securities and Exchange Commission have demonstrated the unwillingness of PBMs to shed light on whether these rebates are benefiting pharmaceutical manufacturers over customers (*The Feds Just Asked a Huge Healthcare Company Who Their Real Clients Are and the Answer is Totally Unsatisfying,* Business Insider, Dec. 7, 2017). Moreover, these contracts may allow for the retention by PBMs of various fees that fall outside the definition of "rebates," which have the effect of lowering the net discount from a rebate that is realized by customers. In addition, Medicare officials have questioned whether the surge in manufacturer rebates collected in the Part D program by plan sponsors and/or their PBMs has resulted in misaligned incentives that actually may encourage plan sponsors and PBMs to favor highly rebated brand-name drugs over less expensive generics.

7. Pharmacy Direct and Indirect Remuneration Fees

Pharmacy DIR fees are charged to pharmacies by PBMs weeks or months after a prescription has been dispensed, negatively impacting cash flow and pharmacy operations. This also adversely affects Medicare Part D beneficiaries, particularly those with plans that require the patient to cover a set percentage of the cost of the medication (i.e., the price is higher at the register than the ultimate patient cost should have been once DIR fees are retroactively assessed). In the end, pharmacy DIR fees cloud the government's ability to oversee the Part D benefit and push patients into the catastrophic phase sooner. CMS is aware of this issue, and is working to propose a solution, but not in a timely enough manner for small business pharmacies, many of which see $100,000 or more recouped in DIR fees by PBMs each year.

8. Preferred Pharmacy Networks

PBMs dictate which pharmacy beneficiaries can use based on exclusionary "preferred pharmacy" arrangements between PBMs and, often, big box pharmacies in which the PBM may have an ownership

interest. Independent pharmacies are not allowed to participate in some of these arrangements, even if they offer to accept the same contract terms and conditions. These arrangements can separate patients from longstanding relationships with their community pharmacist and force them to travel additional miles for their medications.

Conclusion

Our hope is that pharmacists ultimately gain provider status and are paid fairly for the value they bring to the healthcare system. However, the current system today is focused solely on drug costs, without sufficient consideration of the entire health care picture, and any pharmacy quality incentives for the pharmacy are in reality a diminished financial penalty from the PBM. The continuing increase in market concentration and influence wielded by PBMs disadvantage community pharmacies, their patients, and health plan sponsors.

For these reasons, we ask that you schedule a hearing to examine these issues and potential solutions Congress can pursue.

Sincerely,

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Illinois Pharmacists Association
Indiana Pharmacists Alliance
Kansas Pharmacists Association
Kentucky Independent Pharmacist Alliance
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Maine Pharmacy Association
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New Mexico Pharmacists Association
North Carolina Association of Pharmacists
North Dakota Pharmacists Association
Ohio Pharmacists Association
Oklahoma Pharmacists Association
Oregon State Pharmacy Association
Pennsylvania Pharmacists Association
Pharmacists Society of the State of New York
Pharmacy Society of Wisconsin
South Carolina Pharmacists Association
South Dakota Pharmacists Association
Tennessee Pharmacists Association
Texas Pharmacy Association
Texas Pharmacy Business Council
Utah Pharmacy Association
Virginia Pharmacists Association
Washington State Pharmacists Association
West Virginia Independent Pharmacy Association
West Virginia Pharmacists Association

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Senator Cory Booker

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Senator Mike Crapo
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