Statement for the Record

Pharmaceutical Care Management Association
325 7th Street, NW
Suite 900
Washington, DC 20004

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"The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part I: Self-Interest or Health Care?"

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Introduction

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to submit this written statement for today's hearing on the role of pharmacy benefit managers (PBMs) in the prescription drug market and stands ready to engage with the House Oversight and Accountability Committee on this topic. PCMA is the national association representing America's pharmacy benefit companies, which administer prescription drug plans and operate home delivery and specialty pharmacies for more than 275 million Americans with health coverage.[i] Given that the hearing is wholly focused on the role of PBMs, PCMA is disappointed by the committee's decision not to include a witness broadly representative of the pharmacy benefit industry. Congress's oversight and policymaking process, normally deliberative, is poorly served without providing the public and legislators on the Committee a balanced view, inclusive of pharmacy benefit companies with a broad range of sizes, scale, business models, and geographic locations.[ii]

PCMA's members are hired by health plan sponsors – public and private employers, labor unions, retiree plans, Medicare, Medicaid, the Federal Employees Health Benefits (FEHB) program, and the exchanges established by the Affordable Care Act – for the primary role of securing savings and providing choice and specialized expertise on pharmacy benefit design, coverage, and delivery. PCMA's diverse membership works closely with health plans and health insurance issuers to secure lower costs for prescription drugs and achieve better health outcomes. These savings allow employers and labor unions to keep offering quality drug benefits to their employees and retirees across America – ensuring that premiums are affordable and patients have choices and access to pharmacies where they can get the drugs they need at a price they can afford.

Pharmacy benefit companies, also known as pharmacy benefit managers or PBMs, lower prescription drug costs for patients and a wide range of health plan sponsors – specifically by:

- Negotiating rebates from brand drug companies and discounts from pharmacies to reduce costs for patients, their families, and health plans – saving payers and patients an average of $1,040 per patient per year.[iii]
- Encouraging the use of more affordable alternatives to brand drugs, such as generics and biosimilars.
- Offering services that benefit patients, such as home delivery, which saves patients time and money while increasing access and care coordination.
- Managing and helping patients access high-cost specialty medications.
- Reducing waste, preventing potentially harmful drug interactions, and improving adherence.
- Providing clinical support in the form of services to plan enrollees, internal clinical expertise to support business operations, and assembling clinical experts to evaluate drug therapies and make coverage recommendations to plan sponsors.

Pharmacy benefit companies support a competitive market for prescription drugs. In this statement we review the policies PCMA members support to encourage a competitive market for prescription drugs, as competition is the most effective way to drive down high drug prices. We also discuss ways pharmacy benefit companies work to generate value for the U.S. health care system.

As an industry, we welcome any opportunity to discuss and advance ways to improve the prescription drug marketplace so Americans can better access and afford their prescription drugs. We believe any attempt at understanding the factors driving drug costs must include our voice and perspective, as well as an examination of the entire supply chain, including drug companies, large pharmacy collectives known as pharmacy services administrative organizations (PSAOs), wholesale distributors, employer benefit consultants, pharmacies, and all others with impact on the cost of prescription drugs. For instance, there is irrefutable evidence of certain drug companies repeatedly abusing the patent system to keep more affordable alternatives from entering the marketplace, which provides those companies excessive monopoly pricing opportunities for those products. We encourage the committee to review all these entities and any potential anticompetitive practices as it assesses how to improve the prescription drug market.

Pharmacy Benefit Companies Support Policies to Encourage Competition as the Best Way to Lower Prescription Drug Costs

Pharmacy benefit companies encourage use of the most affordable drugs for patients by providing prescribers with information about less expensive generic alternatives and biosimilars, setting performance standards for pharmacies to encourage generic fills and adherence, and ensuring patients are aware of lower-cost alternatives. Due in large part to these efforts by PBMs, 90 percent of prescriptions are filled with generics.[iv] Pharmacy benefit companies also support increased uptake of biosimilars by preferring both the brand and a biosimilar to ensure patients and providers have the incentive to choose lower-cost options and the choice to continue with a drug from which they may be reluctant to switch.

Pharmacy benefit companies offer programs to keep out-of-pocket costs low and work with those providing insurance to encourage patients through formulary design and cost-sharing incentives to use the most affordable drugs, which are usually generics. Generic dispensing has grown over the past decade as more generics have entered the market and patients have responded to health plan designs encouraging their use.[v] PBMs also employ other tools designed to deliver high-quality drug benefits while bringing down costs.[vi] For many brand drugs, PBMs negotiate directly with drug manufacturers who compete for formulary placement by offering a type of discount called rebates.[vii] For drugs on a preferred tier of a plan's formulary (list of covered drugs), patients typically have lower-cost sharing.[viii] As competing products enter the market, PBMs gain the flexibility to leverage competitor products to negotiate deeper drug discounts for patients and employers.[ix]

To enhance competition and enable pharmacy benefit companies to further drive down drug costs, PCMA encourages policymakers to do the following:

1. **Stop patent abuse.** Addressing drug companies' abuses of the patent system that allow them to block competition by extending monopoly pricing well beyond their products' original patent expirations would increase access to lower cost generics and go a long way toward reducing drug costs for patients and families.
2. **Reserve market exclusivities for true innovation.** Addressing overlong exclusivity periods for biologics and orphan indications will create more competition and lead to lower overall drug costs for patients.
3. **Ensure drugs can compete fairly.** Preventing practices like "shadow pricing" and abuses of the U.S. Food and Drug Administration's citizen petition process will improve the competitive market.

4. **Promote generic and biosimilar competition.** The most effective way to reduce prescription drug costs is to increase competition in the marketplace.
5. **Ensure a competitive Medicare Part D prescription drug market.** Care should be taken to incentivize production of competing products and improve the functionality of the prescription drug market as the drug pricing provisions of the Inflation Reduction Act are implemented.
6. **Support pharmacy networks.** Policies that restrict pharmacy benefit companies' ability to develop pharmacy networks drive costs up, while well managed pharmacy networks offer consumers choice, optimize quality, and save patients and plan sponsors money.

Despite the Rhetoric, the Market for Pharmacy Benefit Services is Diverse and Competitive

Savings from pharmacy benefit companies benefit health plans, employers, retirees, and patients directly. Pharmacy benefit companies save health plans, including Part D plan sponsors and employers (and their enrollees), an average of $1,040 per person per year.[x] The PBM market is dynamic, diverse, and growing. In 2019, there were 66 full-service pharmacy benefit companies active in the market.[xi] As of March 2023, there are 73 full-service pharmacy benefit companies in the U.S., with six new PBMs entering the market since 2021.[xii] In addition to these full-service companies, there are many companies that provide narrower PBM services to customers, with some catering to specific sectors, such as workers' compensation.

Prior to the shift in focus of the Federal Trade Commission (FTC), which has recently moved away from consumer protection, the commission evaluated the PBM industry numerous times and found it to be appropriately competitive. In 2005, the commission issued a report showing that PBM ownership of pharmacies does not result in higher costs for consumers. The chair at the time noted, "Health insurers manage their drug costs by choosing among a variety of PBM services and service providers," and "Data in the report demonstrate that PBMs' use of owned mail-order pharmacies generally is cost-effective for plan sponsors."[xiii]

Additionally, in 2012, the FTC completed an investigation evaluating the potential impact of a proposed merger between two PBMs, Express Scripts and Medco. As a result, the commission observed that the "market for the provision of full-service PBM services to health care benefit plan sponsors is moderately concentrated and consists of at least ten significant competitors," and further found that "competition for accounts is intense, has driven down prices, and has resulted in declining PBM profit margins—particularly in the large customer segment."[xiv] Over the 11 years since that investigation, the market for full-service PBMs has grown, with 73 full-service pharmacy benefit companies of varying sizes operating across the nation in a variety of markets in 2023.

Preserving the competitiveness of the PBM market is as important as ensuring competitiveness in all other aspects of the prescription drug supply and payment chain. Transparency that helps patients and payers is necessary across the entire supply chain. PBMs support and practice actionable transparency that empowers patients, their physicians and pharmacists, those sponsoring health coverage, and policymakers to make informed decisions that can lead to lower prescription drug costs. Thus, the PBM industry supported legislation enacted in 2018 to empower pharmacists to share information with patients about lower out-of-pocket cost alternatives.

Pharmacy benefit companies provide health plans, employer plan sponsors, and consumers with a broad array of accurate, actionable information on price and quality to make efficient purchasing decisions. As part of their requests for proposals when putting their pharmacy benefits out to bid, PBMs' customers lay out the terms of the transparency and information they want to receive, as

well as their audit rights to ensure those terms are met, and all of this is formalized in their contracts. In a May 2022 letter to the FTC, the School Employees Retirement System of Ohio described this dynamic stating "SERS' PBM contracts are on a transparent pricing basis, with 100% pass-through of rebates and pharmacy pricing. All rebates and pricing discounts are applied directly to SERS members as reduced pharmacy premiums every year. The pass-through contract provision is independently audited bi-annually, confirming that all monies related to the retiree prescription drug benefit are passed back to SERS."[xv]

In recent years, Congress has added more requirements for PBMs to report to federal agencies, as well as public reporting in more aggregated form. In both cases, these laws included appropriate protections for confidential data to avoid encouraging tacit collusion, and PCMA supported that approach. We have also supported legislation that is now law, which provides congressional support agencies, including the Congressional Budget Office (CBO), Government Accountability Office (GAO), Medicare Payment Advisory Commission (MedPAC), and Medicaid and CHIP Payment and Access Commission, with access to Medicare and Medicaid claims-level data to ensure that Congress can perform appropriate oversight.

As Congress considers how best to preserve the competitiveness of the PBM market, we encourage consideration of the administrative burdens that extensive, unharmonized, duplicative reporting requirements create for smaller PBMs. While larger PBMs may be able to adapt, smaller PBMs may find these new regulations overly burdensome or wholly unworkable, forcing them to either close their doors or consolidate; effectively reducing the competitive market for PBMs. It is also important to note that these added reporting burdens on top of existing requirements could lead to higher costs for consumers.

In addition, while supporting PBM clients' right to request pricing information, we caution against public reporting of competitively sensitive pricing information such as manufacturer and pharmacy price concessions, which would lead to lower price concessions and higher costs through tacit collusion for both plan sponsors and patients. As the CBO cautioned in the early years of the Medicare prescription drug benefit:

> *The disclosure of drug rebates could affect Medicare spending through two principal mechanisms. First, disclosure would probably make rebates less varied among purchasers, with large rebates and small rebates tending to converge toward some average rebate. Such compression, for reasons discussed below, would tend to reduce the rebates that PDPs received and thus would raise Medicare costs. Second, for a range of medical conditions, drugs appropriate for treatment are available from only a few manufacturers; disclosure of drug-by drug rebate data in those cases would facilitate tacit collusion among those manufacturers, which would tend to raise drug prices.*[xvi]

More recently, in February of this year, the U.S. Department of Justice Antitrust Division withdrew three outdated antitrust policy statements related to enforcement in health care markets. As Principal Deputy Assistant Attorney General Doha Mekki remarked:

> *Courts have long recognized that the exchange of competitively-sensitive information can subvert the competitive process and harm competition. …The Second Circuit explained in Todd that "[p]rice exchanges that identify particular parties, transactions, and prices are seen as potentially anticompetitive because they may be used to police a secret or tacit conspiracy to stabilize prices." …Where competitors adopt the same pricing algorithms, our concern is only heightened. Several studies have shown that these algorithms can*

lead to tacit or express collusion in the marketplace, potentially resulting in higher prices, or at a minimum, a softening of competition."[xvii]

Indeed, there are numerous examples of tacit price collusion across multiple markets, from airline tickets and gasoline to credit card interchange fees, to cell phone text messaging and roaming rates, or real estate and travel agent commissions. [xviii]

Pharmacy Benefit Companies Improve Care for Patients

Pharmacy Benefit Companies Simplify the Patient Experience

People with health insurance filled more than 6.4 billion prescriptions in retail pharmacies in 2021,[xix] amounting to almost 17.5 million prescriptions each day. Patients' ability to obtain their prescriptions as quickly as possible at the pharmacy counter (or at home via mail delivery) helps establish and maintain medication adherence. PBMs perform essential functions that combine disparate information and expertise, and utilize advanced technology to facilitate and streamline getting a prescription filled as seamlessly as possible.[xx] In doing so, PBMs optimize the patient's experience of filling a prescription. Once a pharmacy enters a prescription into its system, the PBM electronically verifies the patient and prescription information against the patient's insurance benefit. Technology allows real-time, almost instantaneous access to a patient's prescription drug records, and because the PBM can see all a patient's prescriptions processed through insurance across pharmacies – whether home delivery, local or out-of-town, it is positioned to support patient safety. The PBM uses this information to determine if there is any reason that a patient should not take a prescribed drug and can alert the pharmacist to any potentially dangerous interactions before the patient receives any medication or pays any associated cost sharing. All of this happens rapidly, seamlessly, and behind the scenes to improve patient safety and care.

To support beneficiaries in Medicare Part D, plans and the PBMs that administer Part D plans must offer real-time benefit tools to give patients and prescribers transparency with respect to cost sharing and benefits information at the point of prescribing.

Pharmacy Benefit Companies Lower Drug Costs for Patients

As mentioned, pharmacy benefit companies work with plan sponsors to encourage patients through formulary design to use the most affordable drugs, which are usually generics. For brand drugs, PBMs negotiate directly with drug manufacturers, who compete for formulary placement by offering rebates.[xxi] For drugs on the preferred tier of a plan's formulary, or list of covered drugs, patients typically have lower cost sharing – flat dollar copays instead of percentage-based coinsurance.[xxii] As competing products enter the market, PBMs can leverage competitor products to negotiate deeper drug discounts for patients and employers.[xxiii] This is why competition is so effective in driving down drug costs. PBMs also negotiate price concessions with pharmacies as they create pharmacy networks for plans.

The Medicare Part D program, where older Americans and those living with disabilities can choose among private plans to get their drug benefits, is a notable example of the value PBMs provide. Pharmacy benefit companies support Part D plans by negotiating rebates and discounts and promoting better pharmacy quality, passing 99.6 percent of manufacturer rebates through to the Part D plans, which in turn use rebate dollars to enhance drug benefits and keep premium costs reliably low for beneficiaries.[xxiv]

Pharmacy Benefit Companies Reduce Costs for Employers

Employers need choice and flexibility when designing prescription drug benefits that meet the health and affordability needs of unique employee populations. Employers and other health plan sponsors vary dramatically in size, resources, and function and serve diverse populations.

PBMs have an established record of negotiating price concessions from drug manufacturers and pharmacies to reduce drug costs. No Medicare Part D plan sponsor, public or private employer, union, retiree health plan, pension fund, or other health plan is required to hire or use a pharmacy benefit company, but virtually all do. The vast majority of them are pleased with the services their pharmacy benefit companies provide, with about 80 percent reporting satisfaction with the cost-saving, health-improving services provided by their PBM.[xxv]

Health plan sponsors choose PBMs through a highly competitive bidding process. Optimizing this process depends on maintaining a competitive market that provides choice among PBMs and the ability to decide how to set up drug benefits to best serve health plan sponsors' unique populations. For small employers that may struggle to provide health insurance to employees, PBMs both lower drug costs and provide cost predictability, enabling them to stretch their benefit dollars even further.

In addition to making decisions about plan design, plan sponsors should continue to have the ability to determine how they would like to pay the pharmacy benefit company they select for their services. "Spread pricing" is a risk-mitigation contracting model in which employers choose to let the pharmacy benefit company hold the risk that plan participants may use more expensive pharmacies to acquire drugs in exchange for the option to keep the savings when a patient uses a less expensive pharmacy, as well as to take a loss when they use costlier pharmacies. Today, employers can choose spread pricing or, alternatively, "pass-through" contracting, in which the plan sponsor pays whatever the pharmacy charges. While larger employers typically select pass-through contracts, as they have the scale to deal with the variability of pharmacy charges, smaller employers may choose spread contracts because of the pricing predictability and savings they derive.

Earlier this year, one health care value chain expert pointed out that "PBMs get drug makers to compete on price and get pharmacies to reduce their fees. PBMs also compete with one another in terms of claim processing fees and a host of client services to get contracts with insurers and employers. They are, thus, pro-competitive."[xxvi] PBMs have a pro-competitive influence on the prescription drug marketplace, and PBM services provide a significant and measurable benefit for businesses and others providing health insurance. Without PBMs, plan sponsors would be left to negotiate drug discounts on their own, forgoing the benefits of scale when negotiating with a monopoly supplier, or required to pay the full costs of these drugs.

PBMs Save Taxpayers Money and Improve the Efficiency of Government Programs

Pharmacy benefit companies play a significant role in federal health coverage programs, providing prescription drug benefits to approximately 67 million people across Medicare Part D, TRICARE, and the FEHB program. Pharmacy benefit companies save the Part D program an average of $2,026 per Part D beneficiary per year and will save the program over $430 billion over the next 10 years.[xxvii] In addition to drug savings, pharmacy benefit companies provide important clinical services that help patients lead healthier lives. For example, over the next 10 years, PBMs will prevent one billion medication errors.[xxviii] Across the three federal programs,

pharmacy benefit companies facilitate affordable prescription drug access to enable better health outcomes.

The Medicare Part D program covers 49 million beneficiaries through private prescription drug plans and offers different coverage options. For 2023, beneficiaries enrolled in original Medicare could choose from 801 stand-alone prescription drug plans (PDPs),[xxix] while those with Medicare Advantage (MA) have their medical benefits and prescription drug benefits (MA-PDs) integrated into one of nearly 4,000 available plans.[xxx]

PBMs help control drug costs in Part D. The Part D program has grown both in terms of the number of prescriptions filled and overall program expenditures since its inception in 2003. However, despite its growth, during its first ten years in operation, total Part D spending was 50 percent lower than expected.[xxxi] Again in 2023, CBO found that spending in Part D has been much lower than anticipated.[xxxii]

One major driver of lower spending has been the steady increase in the generic utilization rate among patients participating in the Part D program. Across MA-PD plans, the generic dispensing rate was just 63 percent in 2006, yet climbed to 90 percent by 2016.[xxxiii] As academic research confirms, "Part D plan formularies are designed to encourage the use of generics rather than their brand name counterparts."[xxxiv]

In addition to the increased use of generics, lower-than-predicted Part D net spending – that is, after discounts and rebates – was also in part due to rebates negotiated by pharmacy benefit companies. The average net price of a prescription drug, after all pharmacy benefit company-negotiated discounts and rebates, fell from $57 in 2009 to $50 in 2018.[xxxv]

Additionally, the GAO found that rebates negotiated by pharmacy benefit companies kept Part D spending 7 percent lower than it would have been without rebates, and further found that pharmacy benefit companies do not keep rebates in Part D. Rather, they pass 99.6 percent of rebates through to plan sponsors, which use these rebates to improve benefits and hold down premiums for beneficiaries.[xxxvi]

Beneficiary premiums in Part D have been relatively stable since 2010,[xxxvii] and the average monthly premium declined by 1.8 percent to $31.05 in 2023.[xxxviii] GAO found that "downward pressure [by rebates] on premiums is one reason that premiums remained relatively unchanged between 2010 and 2015, according to [the Centers of Medicare and Medicaid Services (CMS)], even though total gross Part D drug costs grew about 12 percent per year in that period." [xxxix] MedPAC agrees, finding that growth in rebates has helped keep the average premium affordable for beneficiaries.[xl]

Pharmacy Benefit Companies Support Plan Sponsors' Ability to Make a Range of Informed Choices Related to Drug Benefit Design, Coverage, and Delivery

Employers, union and retiree plans, states, and others who provide health care coverage know more about their financial resources and plan participants than any other entity, and they need the ability to design plans tailored to the unique needs of their participants. As health plan sponsors strive to create accessible, affordable benefits that meet the needs of the populations they cover, policymakers should avoid mandates that could increase costs and decrease quality.

Health plans, including those serving federal programs, rely on pharmacy benefit company expertise to secure savings through price concessions from pharmaceutical companies, administer medication adherence and health coaching programs, and provide overall guidance and expertise on pharmacy benefit design and coverage. Plan sponsors may base selection criteria on pharmacy benefit companies' scale, ability to negotiate deep discounts, or effectiveness managing the risk of price changes. Others may base selection criteria on pharmacy benefit companies' innovative care management programs or different levels of service. With 73 full-service pharmacy benefit companies in the market – including new entrants – health plan sponsors have an opportunity to evaluate the differentiated value propositions of multiple companies and select the one that best meets their needs.[xli]

According to a GAO report from 2019, PBMs provided services for over 600 Part D plan contracts.[xlii] In addition to the multitude of PBM choices available to plan sponsors, Medicare beneficiaries are presented with options for coverage. For 2023, beneficiaries enrolled in original Medicare could choose from 801 stand-alone prescription drug plans (PDPs),[xliii] while those with Medicare Advantage (MA) typically have their medical benefits and prescription drug benefits (MA-PDs) integrated into one of nearly 4,000 available plans.[xliv]

Partnership between Pharmacy Benefit Companies and Pharmacies is Critical for Cost Savings and Health Outcomes

The structure of a health plan's provider network is one of the most important elements of health benefit design. In working with their pharmacy benefit companies, plans exercise careful judgment to construct pharmacy networks that meet patients' needs, balancing breadth of coverage, provider access, provider quality, and cost-efficiency, often on a multi-jurisdictional basis.

Pharmacies large and small are important partners in delivering care to patients, and where a patient acquires a drug can impact its cost significantly. Pharmacy benefit companies negotiate with pharmacies to establish pharmacy networks that support consumer choice while offering high quality pharmacy care at competitive prices. Most pharmacy networks are designed to provide patients with a variety of options allowing them to get the drugs they need where they need them at a price they can afford. Beyond lower patient out-of-pocket costs, strong partnership between pharmacy benefit companies and independent pharmacies can lead to better patient outcomes through improved medication adherence (i.e., staying on a doctor-prescribed course of prescription therapy), fewer medication errors, avoidance of potentially harmful drug interactions, and better overall care coordination.

Policies that restrict pharmacy benefit companies' ability to develop pharmacy networks drive costs up, while well-managed pharmacy networks offer savings to both plan sponsors and enrollees. For instance, some states have passed laws constraining provider networks, to the detriment of employers, Medicare Part D, and union plan sponsors. Such regulation sometimes even seeks to intrude into Medicare Part D despite federal preemption, which should prohibit states from acting on exclusive areas of federal authority. These provider network restrictions could lead to a patchwork of inconsistent state laws, creating administrative burdens for plan sponsors offering benefits across state lines and boosting costs for employer and Part D sponsors, which can result in higher beneficiary cost sharing and premiums.

Health plan sponsors may select – or in the case of Medicare Part D, prefer – specific networks of pharmacies to provide drugs to their enrollees at competitive prices. Plans with pharmacy

networks that include “preferred cost sharing pharmacies” have proven very popular in Medicare Part D, as 98 percent of Part D stand-alone plans (PDPs) and 52 percent of Medicare Advantage plans (MA-PDs) use these networks.[xlv] In the private market, nationally, 76 percent of employers report using a tailored pharmacy network, and employees typically save about 38 percent out-of-pocket using in-network vs. out-of-network pharmacies.[xlvi]

Understanding the Role of Wholesalers and PSAOs is Critical

To preserve the benefits of pharmacy networks, it is important to understand the role of PSAOs. PSAOs negotiate pharmacy network contracts with PBMs and perform fundamental back-office operations for the pharmacies they contract with, and the relationships between large wholesaler-owned PSAOs and independent pharmacies are complex and worthy of scrutiny.

The largest PSAOs are subsidiaries of the three largest wholesalers, which also typically operate the equivalent of networks of pharmacy franchises, providing branding, organization support, and back-office support. The significant role large wholesalers play in the prescription drug supply chain and the often symbiotic relationship wholesalers have with independent pharmacies is just beginning to be explored and shining a light on this relationship is exposing potential areas of concern, underscoring the need for Congress to examine all players in the supply chain that have a direct impact on the price of prescription drugs. For example, the PSAO marketplace is dominated by the “Big Three” wholesalers, AmerisourceBergen, Cardinal Health, and McKesson. Unlike pharmacy benefit companies, PSAOs operate with no state or federal regulation or oversight, and according to PBM reporting data, demand higher rates for drug reimbursement for independent pharmacies than PBMs offer for non-independent retail and chain pharmacies.

Approximately 83 percent of independent pharmacies use PSAOs to negotiate favorable contracts with pharmacy benefit companies.[xlvii] While some claim otherwise, the independent pharmacy market is stable and profitable. Data shows that over the last ten years, the number of independent retail pharmacies nationwide increased by 1,638 stores or 7.5 percent.[xlviii] Over the last five years, the number of independent pharmacies has increased 0.5 percent, indicating a stable marketplace. In fact, independent pharmacies’ financials have also been stable. From 2016 to 2020, the average per prescription gross profit margin for independent pharmacies ranged from 20.8 percent to 21.1 percent, showing little fluctuation.[xlix]

Data from the lobby group for independent pharmacy, the National Community Pharmacists Association (NCPA), agrees that the independent pharmacy market is stable, growing 0.4 percent over the last year,[l] and it is the only sector of retail pharmacy that has experienced growth over the last 10 years. The same report finds that between 2020 and 2021, the average independent pharmacy location dispensed ten percent more prescriptions, gross profit margins increased to 23.3 percent, and average sales per location were up more than $570,000 – in excess of $4 million. As noted, by leveraging the power of large pharmacy collectives to negotiate with pharmacy benefit companies on their behalf, independent pharmacies can secure favorable contract terms, and on average, higher reimbursements than chain drugstores.[li] PSAOs and PBMs also provide pharmacies with software, such as Pharmacy Quality Solutions’ Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP), which allows pharmacies to access their contracted pharmacy measures, track their own performance against those measures, and compare benchmark measures of their contracts across plans and against other pharmacies.

There are many types of pharmacies – retail, specialty, hospital, clinic, home care, mail-order, compounding, and assisted living or long-term care – to name a few. These pharmacies offer different levels of expertise and services to ensure patients are getting what they need to secure the best health outcomes. In fact, there are more than 60,000 retail pharmacies in the United States, including 23,000 independent community pharmacies, large chains, mass merchants, and grocery stores. Health plans with a variety of sites of care in their pharmacy networks are able to promote access, affordability, and value. For example, the right mix of brick-and-mortar, mail, and specialty pharmacies improves adherence to therapy and patient safety.

Pharmacists are skilled health care providers who are often more convenient to access than doctors in a hospital, private practice, or other clinical setting. To better contain drug costs and improve access to quality patient care, pharmacy benefit companies support laws and regulations that allow pharmacists to "practice at the top of their license," based on their specific expertise. Pharmacy benefit companies continue to call on policymakers to enact legislation enabling pharmacists, where appropriate, to perform diagnostic testing, prescribe indicated medication, and administer vaccines to expand access to care.

Conclusion

Pharmacy benefit companies exist to reduce drug costs for plan sponsors, and most importantly, for the patients our companies serve. In doing this work, pharmacy benefit companies generate tremendous value for society, estimated at $145 billion annually,[lii] and when taking Medicare savings into account as well as other programs and the commercial market, save payers and patients an average of $1,040 per person per year.[liii] Much of this value is generated by the savings pharmacy benefit companies negotiate with pharmaceutical manufacturers and pharmacies. Pharmacy benefit companies also lower prescription drug costs by promoting the use of generic medications, encouraging better pharmacy quality, and offering things like home delivery of medications. Through their work, pharmacy benefit companies lower the cost of health coverage, reduce drug costs, and support better and more affordable prescription drug access for patients, which means more people can get on and stay on the medications they need. For many years, evidence has shown a return of 10:1 on investments in pharmacy benefit company services for their private sector and government partners.[liv] As a result, pharmacy benefit companies will lower the cost of health care by $1 trillion over the next ten years.[lv]

As we have indicated, PCMA welcomes the opportunity to engage with the Committee. We are prepared to offer insights into the interplay among members of the prescription drug supply chain, real solutions to reign in drug costs, and a deep understanding of the impact and potential unintended consequences of proposed new regulations and government mandates. We look forward to working collaboratively with Congress and other stakeholders to build on the existing private market framework to address prescription drug affordability challenges and improve functionality for patients.

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