September 28, 2023

Chairman James Comer
U.S. House Committee on Oversight and Accountability
2157 Rayburn House Office Building
Washington, DC 20515

Ranking Member Jamie Raskin
U.S. House Committee on Oversight and Accountability
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Comer, Ranking Member Raskin, and Members of the Committee:

Thank you for the opportunity to submit a statement for the record in connection with this Committee's September 19, 2023, hearing on the role of pharmacy benefit managers in prescription drug markets (the "hearing"). In light of the mission of this Committee, to ensure the efficiency, effectiveness, and accountability of the federal government and all its agencies, scrutinizing the role of large pharmacy benefit managers (PBMs) could not be more important given their practices in Medicare Part D which raise drug prices at the counter for patients, increase costs for taxpayers, reduce patient access to medications and pharmacies, and allow them to profit off of conflicts of interest and misaligned incentives.

The undersigned offer these comments in the hopes that they are helpful to the Committee in its work to rein in problematic practices of large PBMs, something that is a priority for both of the undersigned organizations.

Transparency-Rx is a non-profit coalition of pharmacy industry experts led by transparent PBMs representing over fourteen million five hundred thousand (14,500,000) covered lives with operations, employers, patients, and plans in all fifty (50) states. Transparency-Rx's members are committed to increasing transparency in the prescription drug market and lowering costs. American Pharmacy Cooperative, Inc. ("APCI") is a member owned cooperative consisting of approximately sixteen hundred (1,600) independent pharmacies in thirty (30) states and is likewise committed to prescription drug pricing transparency and lowering costs.

What is noteworthy, and perhaps surprising to some, is that Transparency-Rx and the transparent PBM business leaders it represents, and APCI, reflective of independent

community pharmacies, are aligned on the need and demand for meaningful and robust PBM reform. Our shared values are a by-product of our desire to address misalignments and advance like the Committee greater transparency in the PBM industry. Both organizations are committed to fighting the practices of large PBMs that drive up drug costs and create barriers to care, competition, and policy solutions that drive down drug prices. The undersigned agree with the Committee's public finding that big "Pharmacy Benefit Managers (PBMs) have an oversized role in the pharmaceutical marketplace and push anticompetitive practices that undermine patient health and drive up the cost of prescription drugs….[and that] Congress must address PBMs' harmful tactics."[1]

In that regard, our organizations are supportive of, amongst other policies, current efforts in Congress to prohibit spread pricing in Medicaid managed care, require a 100% pass through model, delink PBM profits from high drug prices, rein in PBM steering to affiliated pharmacies, and increasing transparency.

With regard to the hearing itself, the undersigned were encouraged to see references to several recent studies that go a long way towards shining a light on large PBM practices and their impacts on, amongst other things, drug pricing. The studies referenced in the hearing include the most recent 3 Axis Advisors report released this month and a Medicare Payment Advisory Commission ("MedPAC") report released in June of 2023.

As more fully elaborated below, the undersigned believe that these reports taken together stand in stark contrast to sweeping claims made by large PBMs that they are not responsible for setting drug prices and that their practices, including self-interested transactions as a result of vertical integration, lower drug costs for beneficiaries. For your convenience we have provided some of the highlights of the respective reports below.

3 Axis Advisors – Unraveling the Drug Pricing Blame Game

The 3 Axis Advisors report entitled: Unraveling the Drug Pricing Blame Game, made several key findings, including but not limited to, large PBMs setting drug prices for patients at the counter, large PBMs creating massive variability in drug prices even when the national average drug acquisition cost is stable, and large PBMs setting drug prices higher when beneficiaries have out of pocket costs.[2]

Large PBMs are setting drug prices

Contrary to the claims of large PBMs and their advocates that they do not set drug prices, the report found that "[t]he overwhelming majority of the prices paid at the pharmacy counter are based on price points established by the drug supply chain intermediaries known as pharmacy benefit managers (PBMs)."[3]

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[1] Committee on Oversight and Accountability, "Hearing Wrap Up: Pharmacy Benefit Managers Prioritize Their Pocketbooks Over Patient Care, May 23, 2023, available online at https://oversight.house.gov/release/hearing-wrap-up-pharmacy-benefit-managers-prioritize-their-pocketbooks-over-patient-care%EF%BF%BC/.

[2] 3 Axis Advisors, "Unraveling the Drug Pricing Blame Game," September 2023, available online at https://static1.squarespace.com/static/5c326d5596e76f58ee234632/t/650924780b6b9c590edfa2b4/1695097983750/Unravelling_the_Drug_Pricing_Blame_Game_3AA_APCI_0923.pdf.

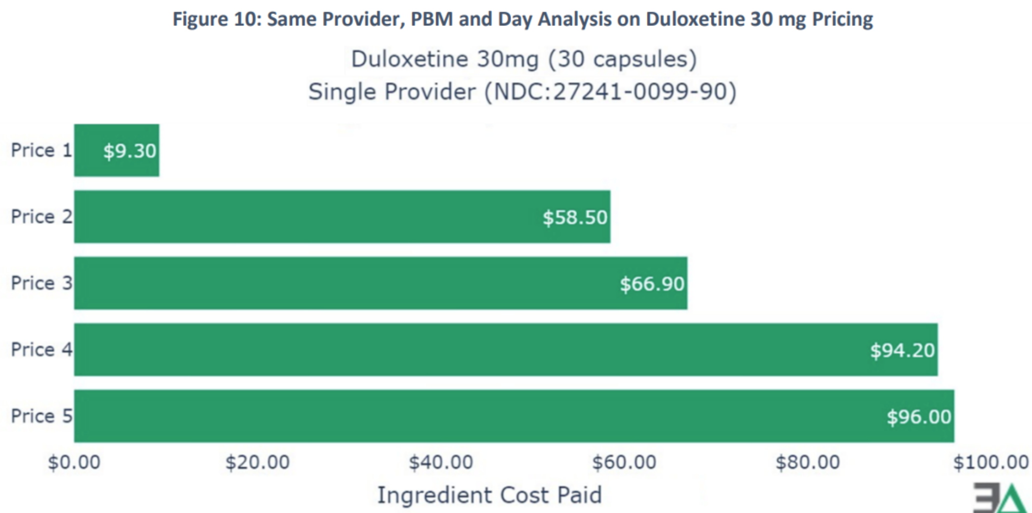
[3] Id. at p. 1.

Put another way, while large PBMs like to claim that drug manufacturers alone are responsible for setting drug prices because they are the ones who set "list prices," it is large PBMs who are the ones setting drug prices for patients at the counter in the overwhelming number of cases.[4]

<u>Drug pricing variability</u>

The report also found that there is massive variability in the prices set by large PBMs, and that patients disproportionately suffer the greatest harm as a result of large PBM variable drug prices.[5]

In one example, the same PBM, on the same day, setting prices at the same community pharmacy, for the same anti-depressant medication, had five different price points ranging from $9.30 to $96.00.[6]



This was no aberration. The report conducted a brand drug pricing case study on Eliquis, which was the single highest gross spending medication in Medicare in 2020.[7] The report found more than $100 difference between the worst PBM price for Eliquis and the best PBM price for Eliquis.[8] This range is significant considering the NADAC range for Eliquis varied less than twenty cents during the same 12 month period.[9] Interestingly, despite Medicare being the largest purchaser of Eliquis, Large PBMs often hit seniors in Medicare with the worst price relative to the prices that the same PBMs set in other lines of businesses including commercial and Medicaid markets.[10] In other words, Eliquis prices were often highest in the Medicare Part D program.

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[4] Id.
[5] Id. at pp. 26-27.
[6] Id.
[7] Id. at pp. 37-38.
[8] Id.
[9] Id. at p. 37.
[10] Id. at pp. 38-39.

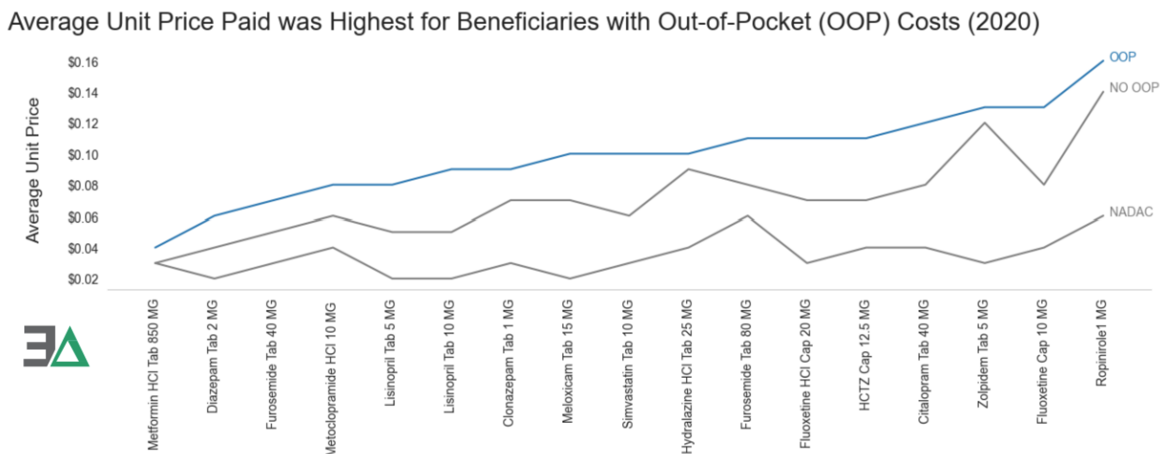
The study also found multiple examples of drugs for which there were no changes to their national average drug acquisition cost price ("NADAC"), but which saw numerous and indiscriminate price points set by the PBMs.[11] For example, generic arthritis medication meloxicam, in a fifteen (15) milligram tablet form, saw more than one hundred and seventeen (117) different price points over the course of a year.[12] Prices for patients ranged from a low of less than one dollar ($1.00) to more than Two hundred dollars ($200.00) per prescription despite meloxicam's NADAC price remaining low and unchanged throughout the year.[13]

Had drug prices for the generic arthritis medication been based upon NADAC, the arthritis medicine would have been unchanged throughout the year as opposed to over 117 different price points.[14] Similarly, utilizing transparent PBMs that implement pass through models would garner similar stability in pricing for a drug like Eliquis. This is because transparent PBMs do not manipulate the price of a drug via engaging in spread pricing on the front or back end of transactions but rather implement pass through pricing that better reflects true market pricing. In addition to saving money by eliminating spread pricing practices, transparent PBMs are also able to achieve savings via passing rebates back to patients and unaffiliated plans as well as collaborating with physicians and pharmacists to increase medication adherence.

<u>Evidence that drug prices higher when beneficiaries have out of pocket costs</u>

As reflected in the chart below, the report found examples of drug prices being higher when beneficiaries had out of pocket costs.[15]

Figure 37: Comparison of Drug Costs Based Upon Presence or Absence of Patient Cost Share, Selected Drugs (2020)



The potential implications to this study are extremely concerning, that "[p]atients whose insurance plans are covering the full price of medications (i.e., requiring no patient cost sharing) can secure for themselves lower drug prices, for the same medications, than patients who are being asked to help share in drug costs (i.e., they are being required to pay more)."[16]

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[11] Id. at pp. 50-52.
[12] Id.
[13] Id.
[14] Id.
[15] Id. at p. 69.
[16] Id.

Drug prices being higher when beneficiaries have out of pocket costs, combined with findings that large PBMs are setting prices and doing so variably stand in stark contrast to large PBM claims that they are not price setters and that they work to lower drug prices.

Medicare Advisory Commission's June 2023 Report to the Congress: Medicare and the Healthcare Delivery System

Chapter 2 of the MedPAC report delivers sweeping findings that provide a glimpse behind the curtain of large PBMs and their vertically integrated Medicare Part D prescription drug plans ("PDPs") and helps to expose how their practices raise costs at the counter for America's seniors.[17] As more fully elaborated below, the report addresses, amongst other things, the extent of vertical integration in Part D; disparities in payment that favor pharmacies vertically integrated with PBMs/PDPs; current rebate and DIR practices and their impact on patient costs; and disproportionate costs shares seniors are forced to pay.[18]

Extent and implications of vertical integration in Part D

One thing that was evident from this Committee's September 19th hearing is that large PBM advocates do not want to squarely discuss the extent of vertical integration in Medicare Part D.[19] This because when a PBM states treatment of rebates, for example, is a "client," or "plan sponsor," decision, in many cases they are omitting that the client or the plan sponsor is in fact affiliated with the PBM.

The MedPAC report found that the top five (5) plan sponsors in Medicare Part D own or are owned by a PBM.[20] In addition, in 2021, the top five (5) companies sponsored plans with seventy four percent (74%) of Part D enrollees and obtained eighty one percent (81%) of direct and indirect remuneration ("DIR").[21] Not surprisingly, as vertical integration has grown, so too has the share of prescriptions filled in Part D at vertically integrated pharmacies with nearly one-third (1/3) of all Part D prescriptions being filled at a vertically integrated pharmacy in 2021.[22]

While vertically integrated PBMs, insurers, and PDPs so often claim that vertical integration increases efficiencies and allow them to reduce costs via use of their affiliated pharmacies, the MedPAC report's findings indicate otherwise.[23] More specifically, the MedPAC report's findings "are consistent with the idea that vertical integration in this space created conflicts of interest and that a vertically integrated "entity can financially benefit from higher payments to their [vertically integrated] pharmacies."[24] Indeed, the average gross payments to pharmacies were more likely to be highest for transactions between vertically integrated plans and their pharmacies."[25] In addition, with regard to net costs, in seventy one percent (71%) of cases, net

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[17] See Medicare Advisory Commission's June 2023 Report to the Congress: Medicare and the Healthcare Delivery System available online at https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.
[18] See id.
[19] Committee on Oversight and Accountability, May 23, 2023 hearing, available online at https://www.youtube.com/watch?v=Qj--BG_kwrE.
[20] MedPAC report at p. 86.
[21] Id. a p. 85.
[22] Id. a p. 92.
[23] See Id. at p. 96.
[24] Id.
[25] Id. at pp. 96-97.

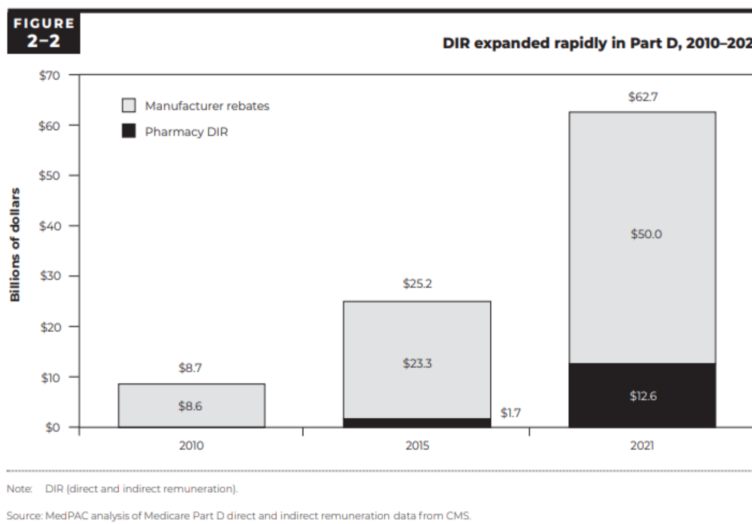
costs were highest at vertically integrated PDPs to their vertically integrated pharmacies ("meaning that, for these cases, ***vertical integration may have resulted in higher costs to Part D and their enrollees"***).[26]

These findings are critically important when viewing the impact of vertical integration, but also when assessing claims by PBMs/PDPs that vertically integrated pharmacies are a tool used to save money.

These findings help dispel the myths that in Part D, the large PBMs are merely administering benefits on behalf of their clients and that vertical integrated pharmacies save plans/taxpayers/and patients money. The five largest plans own or are owned by large PBMs administering their benefits and both the gross price (paid at the counter) and the net price (post DIR) analysis in this report indicate PBMs/PDPs often pay their vertically integrated pharmacies more. Notably, these findings, which the undersigned believe are reflective of anti-competitive behavior, also correspond with the reality that transparent or 100% pass-thru PBMs have not traditionally been a part of the Part D market in any form. For a variety of reasons, PDPs have overwhelmingly contracted with only the largest vertically integrated PBMs, a mistake in our view.[27]

Rebates: Patient cost shares

As reflected in the below chart, PBMs and PDPs negotiated and received approximately $62.7 billion in DIR in 2022 consisting of $50 billion in drug maker rebates and $12.6 billion in pharmacy DIR.[28]



Note: DIR (direct and indirect remuneration).
Source: MedPAC analysis of Medicare Part D direct and indirect remuneration data from CMS.

As stated by Ranking Member Raskin, the $50 billion in manufacturer DIR represent discounts from drug manufacturers that were not shared with beneficiaries at the point of sale.[29] As noted above, the top five (5) companies administering Part D plans were responsible for eighty-one

[26] Id. at p. 98. (emphasis added).
[27] See Id. at pp. 88-89.
[28] Id. at p. 74.
[29] Committee on Oversight and Accountability, May 23, 2023 hearing, available online at https://www.youtube.com/watch?v=Qj--BG_kwrE; see also MedPAC report at p. 74.

percent (81%) of the DIR and, when a large PBM is administering benefits for one of the five (5) largest plans in Part D, because they are vertically integrated, the large PBM is de facto passing those rebates back to back to themselves.[30] The result is higher cost sharing for beneficiaries who are on rebated drugs and higher Medicare cost sharing subsidies as well as reinsurance.[31] The implications to higher costs at the counter can result in less adherence and, as a result, poorer health outcomes.[32]

Large PBMs/PDP current DIR practices also lead to absurd results. For example, the report provides that approximately eight percent (8%) of the time the beneficiary pays more in cost share than the total cost of the drug in Part D.[33] In addition, formulary decisions are influenced by rebates and can lead to coverage of higher priced drugs thereby leading to increased beneficiary cost sharing.[34] To be clear, in these scenarios, not only are beneficiaries being denied drug manufacturer rebates/discounts, but they are also paying for more expensive drugs thereby compounding the problem.[35]

The chart below illustrates just how brazen and absurd the current system in Medicare Part D has become by drilling down to the drug product level for two asthma/COPD medications.[36] The chart reflects the range of cost sharing amounts for these two asthma/COPD medications as well as the median cost sharing amounts.[37] For product D across six (6) plans, five (5) sponsors had a median cost sharing amount greater than fifty percent (50%) of the drug price net of rebates.[38] For product E, the median cost sharing amount exceeded fifty percent (50%) of the drug's net price across all 6 plans.[39]

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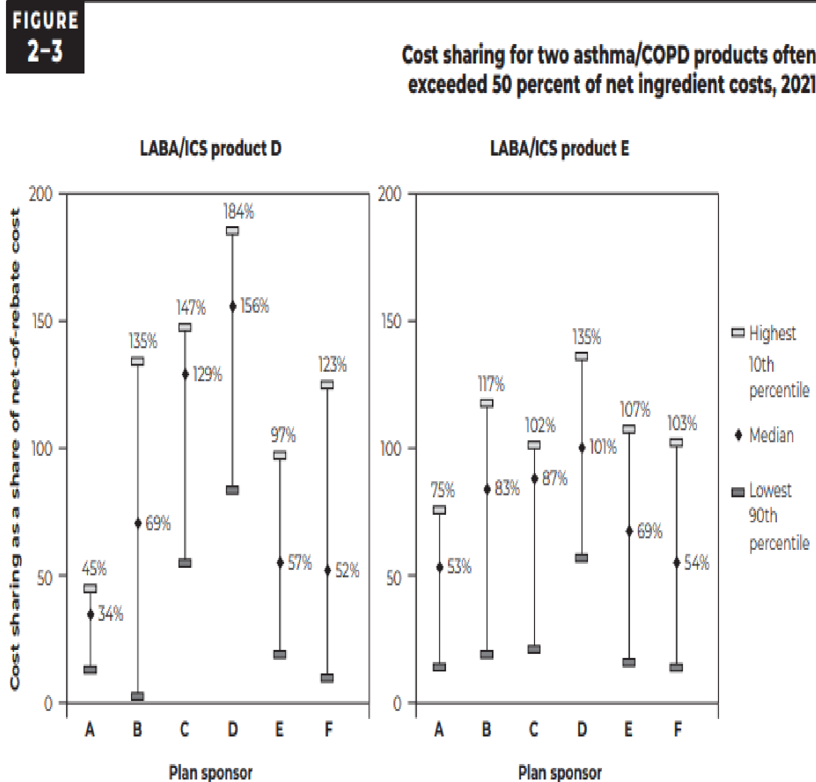
[30] See Id. at p. 86.
[31] Id. at p. 75.
[32] Eaddy et al. How Patient Cost-Sharing trends Affect Adherence and Outcomes: A literature review PT. 2012 Jan; 37(1):45-55. Available online at https://pubmed.ncbi.nlm.nih.gov/22346336/.
[33] MedPAC report at p. 69.
[34] Id. at p. 81.
[35] See id.
[36] See id. at pp. 81-82.
[37] Id.
[38] Id.
[39] Id.

For product D, the median cost share amount for two of the plans are one hundred and twenty-nine percent (129%) and one hundred and fifty six percent (156%) of the drug's net costs after rebates.[40]



The rebate practices of large PBMs and large PDPs, in light of the report's other findings with regard to vertical integration mean, in essence, that large PBMs are depriving beneficiaries of the benefit of discounts from drug makers at the pharmacy counter so that large PBMs can pass those savings on to their affiliates. This stands in contrast to large PBM claims that they utilize rebate negotiations to lower drug costs for beneficiaries.

Conclusion

Transparency Rx and APCI commend the Committee for its attention to large PBM practices. As indicated above, the undersigned believe that together, the reports provide data and findings that refute claims of large PBMs that they are not responsible for setting prices and that they are acting in the best interest of patients to lower drug prices.

The 3 Axis report's findings with regard to large PBMs setting drug prices at the counter for patients, creating volatility in prices at the counter, and setting higher prices when patients

[40] Id.

have out of pocket costs are well worth the scrutiny of this Committee and action on the part of Congress.

Similarly, the MedPAC report's findings with regard to vertical integration in Medicare Part D, higher payments to vertically integrated pharmacies, and rebate practices are also well worth the time and attention of this Committee and action by Congress.

In order to better protect patients, community pharmacies, and foster competition, the undersigned believe action is needed to remove the conflicts of interest of large PBMs so that they and their affiliated prescription drug plans can no manipulate drug prices, steer patients to PBM affiliated pharmacies, or profit off of misaligned incentives.

Thank you for the opportunity to comment and for your attention to this important matter.

Sincerely,

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