National Community Pharmacists Association
Statement for the Record
U.S. House Committee on Energy and Commerce, Subcommittee on Health
Hearing: "Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain"
May 9, 2019

Dear Chairman Eshoo, Ranking Member Burgess, and Members of the Subcommittee:

The National Community Pharmacists Association ("NCPA") appreciates the opportunity to submit this statement for the record on the Committee on Energy and Commerce, Subcommittee on Health's hearing titled, "Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain," held on May 9, 2019. NCPA represents America's community pharmacists, including 22,000 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care settings.[1] Together, our members represent a $76 billion healthcare marketplace, employ 250,000 individuals, and provide pharmacy services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers. NCPA submits this statement on behalf of both community and long-term care independent pharmacies.

Community and long-term care independent pharmacists are the healthcare providers on the front-lines that regularly talk to patients about their concerns with rising prescription drug costs and work diligently to address these concerns. Through these conversations, it has been clear that the issue of rising drug prices cannot be solved without addressing the role of pharmaceutical benefit managers ("PBMs") in increasing costs for healthcare's most vulnerable patients. NCPA submits this statement to address those concerns in the hopes that community and long-term care independent pharmacists can add meaningful solutions for patients' pocketbooks.

NCPA supports changes to manufacturer rebates and pharmacy DIR in Medicare Part D as a way to address rising costs

A conversation about rising prescription drug costs is incomplete without addressing the way in which PBM practices have contributed to patients' out-of-pocket spending in certain federal programs. Of late, there has been growing concern over the ways in which rebates and other price concessions are negotiated by PBMs and structured in the Medicare Part D program, which ultimately contribute to higher patients' out-of-pocket spending.

NCPA recognizes that the administration is focused on changes to the application and usage of manufacturer rebates as outlined in the pending proposed rule titled, *Fraud and Abuse; Removal of*

[1] *NCPA 2018 Digest by Cardinal Health* (2018).

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Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees.[2] NCPA has provided our position on this proposal in comments to the agency submitted on April 8, 2019.[3] For purposes of this statement, however, NCPA contends that rebates are not the only concession that leads to inflated drug prices and higher out-of-pocket costs for seniors. The out-of-pocket costs conversation is incomplete without specific discussion regarding direct and indirect remuneration ("DIR"), including all pharmacy price concessions in the Part D program, and how PBMs leverage these fees to pad their pockets at the expense of patients, the government, and small business community pharmacies.

Pharmacy price concessions (also known as "pharmacy DIR") are imposed on pharmacies participating in Medicare Part D networks by plan sponsors and their PBMs. As CMS noted in a recently proposed rule, these fees have exploded in recent years.[4] The treatment of these pharmacy price concessions as DIR rather than as reductions in the "negotiated price" of a drug at the point of sale has had a crippling impact on patients, the government, and community pharmacies. The retroactive nature of these fees means beneficiaries face higher cost-sharing for drugs and are accelerated into the coverage gap or "donut hole" phase of their benefit. What's more, beneficiaries reach the catastrophic phase of the benefit, for which CMS incurs almost 80 percent of the cost. Thus, costs to the government have surged as liability for Part D costs is increasingly being shifted from Part D plan sponsors to CMS. Finally, all retroactive pharmacy price concessions are taken back from community pharmacies months later rather than deducted from claims on a real-time basis. This reimbursement uncertainty makes it extremely difficult for community pharmacists to operate their small businesses.

Earlier this year, the administration underwent rulemaking on a proposal that sought to assess all pharmacy price concessions, excluding positive contingent amounts, at the point of sale.[5] The force of this proposal would effectively eliminate the retroactive nature of pharmacy price concessions in Medicare Part D. While the final rule has not been issued for this proposal, NCPA seeks needed relief from Congress as an avenue to ensure savings to patients and transparency for small business community pharmacies.[6] Therefore, NCPA urges Congress to pass H.R. 803, *Improving Transparency and Accuracy in Medicare Part D Drug Spending Act*, legislation that would eliminate the retroactive nature of pharmacy price concessions.

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[2] 84 Fed. Reg. 2340 (Feb. 6, 2019).

[3] NCPA Comments to *Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees*, OIG-0936-P (Apr. 8, 2019), *available at* https://www.regulations.gov/document?D=HHSIG-2019-0001-19758.

[4] Pharmacy price concessions are the second largest category of DIR received by sponsors and PBMs, behind only manufacturer rebates. CMS states, "[t]he data show that pharmacy price concessions, net of all pharmacy incentive payments, grew more than 45,000 percent between 2010 and 2017." 83 Fed. Reg. 62,152, 62,174 (proposed Nov. 30, 2018).

[5] *Id.* at 62,152.

[6] Patients win when pharmacy price concessions are included in the negotiated price and applied at the point of sale. In fact, CMS estimates that beneficiaries would save $7.1 to $9.2 billion over 10 years resulting from reduced cost-sharing, offset by slightly higher premiums. *Id.* at 62,154.

NCPA also urges Congress to limit and control the way in which PBMs and plan sponsors impose arbitrary and inconsistent performance-based standards and incentive-payment schemes on community pharmacies. While not all pharmacy DIR is performance based, the proliferation of pharmacy DIR is now intricately tied to performance-based standards. PBMs and plan sponsors have argued they should have the ability to create programs that are accounted for as DIR to reward pharmacies for achieving contractual, performance-based metrics. However, these retroactive fees are based on a payment methodology that withholds a certain amount with the opportunity for the pharmacy to either "earn back" or have the retroactive fees decreased based on achieving certain arbitrary quality measures. Therefore, NCPA requests Congress define pharmacy quality within the Medicare Part D program and hold plans accountable for determining performance-based payments by passing H.R. 1034, *Phair Pricing Act*. This piece of legislation will ensure that performance-based payments should be based on standardized, achievable, and proven criteria that measure pharmacy performance, as opposed to criteria that focus on measuring plan performance or criteria which pharmacies have little to no opportunity to influence.

NCPA urges Congress to consider the two pieces of legislation on pharmacy price concessions as a way to meaningfully address PBM practices in the Medicare Part D program that contribute to higher patients' out-of-pocket spending and today's rising drug prices.

NCPA urges Congress to continue to examine PBMs' spread pricing practices that may contribute to rising prescription drug prices

Legislators and Medicaid officials in several states are actively considering substantive regulation and reform to rein-in practices by PBMs 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, a practice that is typically called "spread pricing."

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 between reimbursements to pharmacies and medication charges to the health plan.[7]

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

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

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.[8] Therefore, NCPA urges Congress to examine how PBMs' spread pricing models may be impacting other federal and commercial payers, thus contributing to the rise in prescription drug costs.

NCPA encourages Congress to be ensure certain pricing information is made available to empower consumers and reduce costs

To empower consumers, reduce costs, increase quality, and improve the system PBMs should be required to disclose maximum allowable cost ("MAC") pricing lists, which are used to reimburse community pharmacies for generic drugs. 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" (another aspect of PBMs' spread pricing practices is outlined above). 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. 1035, the *Prescription Drug Price Transparency Act* would codify Medicare transparency provisions concerning MAC pricing for generics and apply them to the Federal Employees Health Benefits ("FEHBPs") Program. It would also establish a MAC appeals process and prohibit PBM requirements or incentives to use a PBM-owned pharmacy, a clear conflict of interest. NCPA supports this legislation as a way to provide transparency in drug pricing, which could ultimately contribute to lowering sky-rocketing drug prices.

NCPA encourages Congress to advance greater awareness and usage of information for patients

A way to ensure greater awareness and usage of 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."[9] Absent action from CMS, however, NCPA supports legislation that would allow community pharmacies 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. Allowing patients to have access to their pharmacy of choice will allow patients to select pharmacies based on a number of factors including location and access to discounted copays for prescription drugs.

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[8] 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.

[9] 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* (Apr. 1, 2013).

Congress should collaborate with federal antitrust agencies to evaluate PBM consolidation and its impact on drug pricing

Consolidation in the health care industry may also be contributing to higher drug costs and negatively impacting patient choice. Such consolidation includes the recently consummated merger of Express Scripts ("ESI") and Cigna, as well as the CVS Health Corporation/Aetna merger, for which a consent decree is currently under review at the United States District Court for the District of Columbia. To address PBM market dominance, NCPA has long argued for additional scrutiny of PBMs, including their inherent conflicts of interest, lack of transparency, and one-sided take-it-or-leave-it contract negotiations with independent pharmacies. We urge Congress to work with the antitrust agencies to take a closer look at PBM consolidation and vertical mergers in the health care market for their effects on patient access, costs, and competition, and whether the purported savings from these mergers will, in fact, be passed on to customers.

PBMs already have extraordinary market power; the top three PBMs control as much as 89 percent of the market: 238 million lives[10] out of 266 million lives.[11] This dominance has allowed PBMs to leverage their market power to the detriment of plan sponsors (government and commercial payors), providers, and consumers. Additionally, PBMs claim that they help plan sponsors generate savings by negotiating rebates, however, recent reports have shown the opposite. A report from 2017 found that PBMs have been utilizing their market power to try to increase their profits and encourage higher list prices for prescription drugs, which increases co-pays for patients.[12]

Health care costs have clearly continued to rise despite previous vertical mergers. Continued vertical healthcare consolidation could further impede competition and foreclose any meaningful entry into the market, leading to fewer choices and higher healthcare costs. These huge entities increasingly rely on limited preferred networks that have impacted consumer choice. For example, as stated above, not all Part D sponsors and their PBMs prioritize access to local community pharmacies in their preferred networks. Instead, these networks are often limited to a smaller number of select pharmacies and regularly exclude independent community pharmacies even when such pharmacies are willing to accept the terms and conditions of a Part D sponsor's network. For this reason, NCPA is concerned that, with consolidation, major PBMs will continue to limit their networks and further worsen patient choice and access.

In addition, merging parties typically state that proposed transactions will create efficiencies and save hundreds of millions of dollars for consumers. They often do not explain, however, whether or how those purported savings will be passed on to consumers. The largest PBMs already claim their size enables them to achieve significant efficiencies and cost savings. As patients' out of pocket costs and premiums continue to rise, there is evidence to suggest that these savings are not, in fact, being passed on to consumers. NCPA suggests that whether the purported cost savings will be passed on to consumers remains unclear.

The CVS/Aetna merger is an example of a specific transaction that is likely to significantly decrease competition for pharmacy products and services. Although CVS and Aetna agreed to sell Aetna's Part D

[10] Mathematical calculation based on number of covered lives CMS/Caremark, UnitedHealth and ESI self-reported.

[11] Council of Economic Advisers, *Reforming Biopharmaceutical Pricing at Home and Abroad* (Feb. 2018), *available at* https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf; *see also* testimony of PCMA CEO Mark Merritt before the U.S. House of Representatives Energy & Commerce Committee Subcommittee on Health (Dec. 13, 2017).

[12] Steve Pociask, *Pharmacy Benefit Managers: Market Power and Lack of Transparenc*y (2017), *available at* http://www.theamericanconsumer.org/wp-content/uploads/2017/03/ACI-PBM-CG-Final.pdf.

prescription drug plan business to address their horizontal competitive overlap as a condition of approval of the deal, substantial anticompetitive concerns were not addressed. In fact, Aetna's Part D assets were sold to WellCare Health Plans, Inc. who is using CVS Caremark as their PBM. Therefore, this divestiture of Aetna's Part D business essentially just maintains CVS' market share instead of resolving any anticompetitive concerns.

CVS Caremark, the PBM for CVS, is the second largest PBM in the U.S., accounting for nearly 34 percent of covered lives.[13] This significant market share allows CVS Caremark (as well as the other largest PBMs) to exercise undue market leverage and generate outsized profits for themselves. Community pharmacies have very little negotiating power when contracting with PBMs like CVS Caremark, and routinely must agree to take-it-or-leave-it contracts to be part of a PBM's pharmacy network. Having the opportunity to be part of a plan's preferred network can be critical, as nearly all Part D plans include preferred networks that offer lower co-pays to beneficiaries.

Further, some states have found that CVS and other large PBMs engage in questionable pricing and reimbursement practices towards pharmacies. Last year, the Kentucky Department of Insurance fined CVS Caremark a $1.5 million civil penalty for violations related to reimbursements to pharmacists, including claim denial violations and providing inaccurate information.[14] In addition, the Auditor of the State of Ohio found that Ohio, where CVS Caremark is the PBM for four of Medicaid's five managed care plans, was charged around $225 million in spread amounts for Medicaid prescription drugs in a one-year period while other pharmacies were reimbursed at, or below, cost.[15] Of the total $225 million, Optum Rx was paid $28.9 million in spread. The report also confirmed that these drastic reimbursement cuts from the Ohio Medicaid PBMs caused a significant amount of independent pharmacy closures in the state. Lastly, the Auditor in Pennsylvania conducted a similar investigation, indicating that three PBMs made between $2 million and nearly $40 million on spread pricing.[16] Thus, NCPA recommends that Congress work with the antitrust agencies to more thoroughly evaluate the effects of consolidation on the health care market to ensure that plan sponsors and consumers continue to have competitive choices.

Conclusion

In conclusion, NCPA supports Congress in implementing policies that ensure prescription drug access and affordability for the American patient. As established above, however, this issue cannot be solved without addressing the role of PBMs in increasing costs. Thank you.

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[13] According to CVS, it has 90 million PBM plan members. *See* CVS, *available at* https://cvshealth.com/about/facts-and-company-information. The Pharmaceutical Care Management Association ("PCMA") testified that PBMs administer drug plans for more than 266 million Americans. *See also* Testimony of Mark Merritt, PCMA.

[14]Commonwealth of Kentucky Public Protection Cabinet Department of Insurance, *Kentucky Department of Insurance Issues Penalty Against PBM, CaremarkPCS Health LLC, a subsidiary of CVS Caremark*, *available at* http://ppc.ky.gov/Lists/News%20Releases/Kentucky%20Department%20of%20Insurance%20Issues%20Penalty%20Against%20PBM,%20CaremarkPCS%20Health%20LLC,%20a%20subsidiary%20of%20CVS%20Caremark.pdf.

[15] Ohio's Medicaid Managed Care Pharmacy Services, *Auditor of State Report* (Aug. 16, 2018), *available at* https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.

[16] Auditor General DePasquale, *Bringing Transparency & Accountability to Drug Pricing* (Dec. 2018), *available at* https://www.paauditor.gov/Media/Default/Reports/RPT_PBMs_FINAL.pdf.