Statement for Hearing on

"Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain"

Submitted to the
House Energy and Commerce Committee
Subcommittee on Health

May 9, 2019

America's Health Insurance Plans (AHIP) and our members are strongly committed to ensuring that Americans are able to get the medications they need at a price they can afford.

We thank the committee for focusing on issues surrounding the drug supply chain and solutions that are needed to help millions of people who are burdened by out-of-control prescription drug prices. As the bargaining power of the American people, health insurance providers collaborate with their pharmacy benefit manager (PBM) partners to negotiate lower prices from drug makers. These savings are delivered to patients and consumers through lower premiums and out-of-pocket costs.

We are deeply concerned about the lack of transparency in how drug makers set list prices—and those prices are controlled solely by manufacturers, no one else in the supply chain—and why drug prices go up on the same exact product year after year. These factors create a barrier to

---

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

developing new solutions to lower drug prices. Drug prices are out of control, and hardworking American families shouldn't have to choose between paying their bills and getting the medications they need.

Our statement for today's hearing focuses on: (1) the role of health insurance providers in the drug supply chain; and (2) our support for market-based solutions that hold drug makers accountable for high list prices and put downward pressure on prescription drug prices through competition, consumer choice, and open and honest drug pricing.

The Role of Health Insurance Providers in the Supply Chain: Negotiating Lower Costs for All Consumers

It is an understatement to say that prescription drug pricing in the United States is extraordinarily complex. Despite this complexity, in many cases, but especially where competition exists among prescription drugs (either from similar therapeutic alternatives or from generic or emerging biosimilar products), health insurance providers have leverage to negotiate with drug makers to provide savings for all consumers.

Health insurance providers negotiate with drug makers for lower net prices—and then pass those savings on in the form of lower premiums and lower out-of-pocket costs for all consumers. The focus on how some of these savings, which sometimes take the form of "rebates," are distributed to consumers—whether to a small group of patients or across the broader covered population—is a deliberate tactic to obscure the more serious issues surrounding the lack of competition, transparency, and accountability in the pricing of prescription drugs.

In discussing rebates, it is important to understand the role they play within the broader system for setting the cost of drugs that consumers pay at the pharmacy. It is also important to understand that for some branded drugs and biologics without therapeutic alternatives, the willingness of drug makers to negotiate on price is small or nonexistent. Further, rebates are not commonly found for physician-administered drugs, which account for 30 percent of prescription drug spending.[1]

The bottom line is that the original list price of a drug is solely determined and controlled by the drug company—not the market—and it drives the entire pricing process. And if the original list

[1] "Trends in Specialty Drug Benefits," Pharmacy Benefit Management Institute, 2017.

price is high, the final cost that a consumer pays will be high. If manufacturers took steps that are fully within their control to lower drug prices, consumers would pay less. **It is that simple: the problem is the price.**

Unfortunately, manufacturers of branded drugs and biologics are working to divert attention from high prescription drug prices and instead point to problems in the drug supply chain and the role of wholesalers and PBMs. However, we should focus on how the supply chain actually works.

Drug makers sometimes sell their products directly to the pharmacy (e.g., large chain retail pharmacies), but more often sell their products through a wholesaler. The price that pharmacies and wholesalers pay is highly correlated to the original list price set by the drug maker. Wholesalers and some pharmacies may acquire the drug at a modest reduction off the list price as a result of volume and/or prompt pay discounts. These discounts are not significant because wholesalers do not influence the "market share" of specific prescription drugs. Wholesalers then take possession of the drug and distribute and resell the drug to pharmacies (e.g., smaller community pharmacies) after a small markup above the discounted price. This total cost represents the pharmacy's acquisition cost.

At this point, the consumer enters the process. For individuals who lack health insurance but are prescribed a medication, they often pay the highest prices, especially for branded drugs. Typically, they pay the full list price set by the drug company (i.e., the wholesale acquisition cost, or WAC) plus a markup.

By contrast, for individuals with prescription coverage who are dispensed a covered prescription drug from a pharmacy in the health plan's network, the pharmacy typically communicates electronically with a PBM, which administers drug benefits under a contract with the health insurance provider. From the PBM, the pharmacy receives confirmation of coverage; whether the drug is subject to any formulary tools (e.g., step therapy or quantity limits); whether there are any potential safety issues (e.g., drug-drug interactions or other contraindications for the patient); the reimbursement amount to be paid by the plan; and the co-payment (usually a flat dollar amount) or co-insurance (usually a percentage tied to the reimbursement amount) owed by the consumer. The total payment to the pharmacy is typically based on a negotiated contract rate between the pharmacy and the health insurance provider (or the PBM acting on behalf of the health insurance provider). This contract reimburses the pharmacy for its acquisition cost and provides a dispensing fee.

The amount that the consumer or patient pays depends on several factors: (1) the negotiated rate between the plan and pharmacy; (2) the type of drug (i.e., branded or generic); (3) the plan's benefit design (e.g., co-pay or co-insurance); and (4) where the enrollee is within that benefit design at the time of purchase (e.g., in the deductible period, copayment period, maximum out-of-pocket (MOOP) limit or catastrophic phase for those in Medicare Part D). The pharmacy collects the appropriate cost sharing amount from the consumer and receives the remainder from the health insurance provider or PBM at later settlement time based on the payment terms under the contract. (The process described above assumes that there are no manufacturer-sponsored drug coupons and/or co-payment cards, where the drug maker directly pays a large portion of the consumer's cost sharing. These payment schemes are often not operationally transparent to payers, distort an already dysfunctional pricing market, and further complicate a confusing process for consumers.)

Given that the amounts charged by pharmacies for branded drugs reflects the pharmacies' acquisition costs, these charges are closely correlated to the list price set exclusively by the drug maker. That is why out-of-control drug prices show up at pharmacy counters. It is also why health insurance providers aggressively negotiate with drug makers for ways to reduce the impact of these prices, so they can pass savings onto consumers.

For example, if a health insurance provider's pharmacy and therapeutics (P&T) committee[2] determines that two or more drugs are therapeutically equivalent from a purely clinical perspective and eligible for formulary inclusion, health insurance providers (or PBMs) negotiate with drug makers for rebates in exchange for plans placing the drugs on a preferred formulary tier and/or waiving utilization management tools, such as step therapy protocols. Since drug costs comprise a significant portion of a health insurance provider's total costs, these discounts, which typically take the form of rebates, reduce the net price of the drug.

Rebate amounts typically are calculated and paid by a drug maker to a health insurance provider on an aggregate basis, long after an individual prescription is filled by a consumer. Because

[2] P&T Committees are external advisory bodies of experts with broad clinical backgrounds regarding prescription drugs and typically are comprised of physicians from different medical specialties and pharmacists. P&T Committees review medications from a purely clinical perspective and make decisions based on several factors, including clinical and scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines and other relevant information. P&T Committees do not consider any information on drug rebates, discounts, or net prices/costs.

rebates are provided based on actual aggregated utilization by a specific population, they are paid several months after the drug has been prescribed and dispensed and all the data can be reconciled.

In designing their plan benefits and developing premium rates in advance of the upcoming coverage year, health insurance providers calculate an estimate of the aggregate rebates they expect to receive. Since drug costs comprise a significant portion of a health insurance provider's total costs, plans may use these estimated discounts to reduce the premiums they charge for the overall benefit and/or reduce co-payment amounts. Alternatively, health insurance providers may incorporate the estimates into lower point-of-sale pricing for individual drugs that generate the rebates.

By reducing the net price and cost of drugs, all consumers benefit when health insurance providers negotiate lower prices. The savings from discounts and rebates are passed on through improvements to benefit packages, reductions in premiums, and/or lower out-of-pocket costs. This represents a broad and direct benefit for millions of consumers whether they get their coverage through Medicare, on their own, or through their employer.

Market-Based Solutions for Reducing Drug Prices

There is no one silver bullet to reduce drug prices. A combination of bold legislative and regulatory steps is needed to hold drug makers accountable for high list prices and ensure that the American people have access to affordable medications.

In recent months, AHIP has submitted statements to the committee for several previous hearings in which we discussed our support for market-based solutions that put downward pressure on prescription drug prices. With solutions that deliver real competition, create more consumer choice, and ensure open and honest drug prices, we can deliver more affordable pharmaceutical products—while at the same time protecting and supporting innovations to deliver new treatments and cures for patients.

Below we briefly identify key areas where we see opportunities for Congress and the Administration to provide relief to the American people from out-of-control prescription drug prices:

- Stopping gaming by drug makers that limits the entry of new generic and biosimilar competitors—the "Creating and Restoring Equal Access to Equivalent Samples (CREATES)

Act" and a prohibition against pay-for-delay settlements, both of which the committee approved on April 3, would be important steps toward achieving this goal;

- Preventing the "evergreening" of patent protections—a scheme through which drug makers make minor changes to a drug's chemical composition or delivery mechanism to extend patents that otherwise would have expired;
- Shortening the exclusivity period for biologics to promote greater price competition and help alleviate cost pressure for payers, patients and consumers for biologics;
- Revisiting the incentives in the Orphan Drug Act to ensure that this law is used as intended by those developing medicines to treat rare diseases—not as a gateway to premium pricing and blockbuster sales and profits beyond orphan indications;
- Ensuring that federal rules promote the availability of interchangeable biosimilars;
- Providing more transparency and timely information about drug and biologic patents to promote greater generic drug and biosimilar competition;
- Requiring drug makers to publish true research and development costs and explain price setting and price increases;
- Mandating that drug maker coupons and/or co-pay cards cover a patient's entire out-of-pocket expenses for the duration of the drug therapy;
- Disclosing list prices in direct-to-consumer advertisements;
- Informing patients and physicians on the effectiveness and value of drugs;
- Eliminating barriers to value-based pricing; and
- Exercising HHS' authority to introduce market competition when manufacturers fail to engage in reasonable, good-faith negotiations with payers.

Conclusion

Thank you for considering solutions to address the pharmaceutical cost crisis. We look forward to working with the committee to make prescription drugs more affordable. Everyone deserves access to the medications they need at a price they can afford. We should not have to choose between innovation and affordability. With the right solutions and genuine collaboration, we can have both.