Questions for the Record for Dr. Hugh Chancy, PharmD

United States House Energy and Commerce Subcommittee on Health hearing:

"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients."

April 4, 2025

Questions from The Honorable Troy Balderson

1. Over the past few years, we have seen pharmacy benefit managers (PBMs) and their affiliated group purchasing organizations (GPOs) increase the use of service fees, for instance requiring manufacturers to pay for access to necessary information or data. The rapid rise in these so-called service fees is just an example of the onerous challenges PBMs and GPOs are inflicting on manufacturers. These fees are designed for profits, they are not designed to reduce costs for patients. How should we ensure that these fees are truly bona fide?

Answer: One solution to ensure PBMs receive "bona fide" fees for their services is the Protecting Pharmacies in Medicaid Act," currently reintroduced in the Senate as S. 927. This bill has not yet been reintroduced in the House but passed the House floor last Congress as H.R. 1613, the "Drug Price Transparency in Medicaid Act." This legislation ends the abusive practice of "spread pricing" in Medicaid programs and limits PBM compensation to administrative fees.

Another solution to ensure that PBMs receive bona fide fees for their services is the "Delinking Revenue from Unfair Gouging (DRUG) Act," recently reintroduced as H.R. 2214. This bill tackles commercial compensation by de-linking the compensation PBMs receive from the price of the drug; instead of receiving a percentage of the drug's price (a perverse incentive which encourages PBMs to promote higher-priced drugs) PBMs would receive a flat service fee.

Additionally, oversight of these laws and their implementation is necessary. PBMs have proved that they try to evade the very laws that Congress passes through deceitful tactics. This can be seen when last year Express Scripts (ESI) created their "bonus pool fees" in violation of the Medicare Part D final rule on DIR fees that went into effect in January 2024. In the wake of the final rule, pharmacists immediately noticed the overall lower reimbursement on medications, as well as new fees. It was rapidly apparent that the new ESI bonus pool fees were not being calculated at the point of sale and these retroactive fees violated the new rule. After several months of reporting into the Centers for Medicare and Medicaid Services (CMS), they stated ESI was violating the rule, and within two weeks, ESI announced they would be discontinuing the program and paying back these fees. However, I have heard that ESI may still be in violation of the rule, with questions as to if they ever reimbursed pharmacies. While pressure from the agencies did force ESI to comply with the rule, the fact that it took six months of harm to

pharmacies is concerning. Therefore, it is imperative that Congress not only pass the laws that state exactly what constitutes a bona fide fee in definition, but that they explicitly use their oversight of these programs to make sure that all are playing fairly within the marketplace.

a. What do you predict PBMs and their affiliated GPOs will do next in their efforts to maximize profits at the expense of patients and taxpayers?

Answer: While I cannot predict exactly what their next tactic will be, as can be seen from my previous answer as soon as one area of anticompetitive tactics has been brought to light, the vertically integrated monoliths shift their plans or wording slightly try and continue in the same fashion. This is why not only are the bills before you essential, but strong Federal oversight and regulation of the market is needed to protect patients.

<u>Questions from The Honorable Diana Harshbarger</u>

1. Last Congress our committee marked up, advanced out of committee, and the House of Representatives passed without objection my bipartisan legislation that would increase competition for specialty drugs — the "Seniors' Access to Critical Medication Act" (H.R. 5526). This important legislation will allow independent community practices, especially oncology practices, to dispense a prescribed drug and deliver to a patient by mail or have a loved one pick up the prescription for them. This enables medication adjustments to be quickly addressed, reduces drug waste, and keeps a patient's course of treatment on track.

Enacting this legislation will not only allow Medicare beneficiaries in need to better maintain access to care and facilitate regular uptake of their prescribed medications, it should also improve competition and lower prices for Medicare and patients. Last year, a JAMA study found that point-of-sale prices for high-cost drugs filled by in-house pharmacies was 1.76 percent lower than other pharmacies, which are mostly owned and controlled by PBMs.

According to the study, on-site pharmacies, like those in community oncology practices, saved an average of $800 for high-cost drugs per patient annually.

• Link: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2815251

a. How have PBMs impacted the ability of independent, community pharmacies and practices to stay in business?

Answer: PBMs impact pharmacies like mine every day by the contracts they offer, which reimburse me less than I paid for the medications, when they force my patients to switch to their affiliated specialty or mail-order pharmacies after two refills, and when they refuse to fill prescriptions on drugs they lose money on and then send those patients to me instead. With

underwater reimbursements, untenable contracts, and patient steering, pharmacies are quickly losing ways to keep their businesses solvent, which leads to patient pharmacy deserts and overall, a lack of access to health care.

b. In your experience, what happens to the point-of-sale prices for drugs when an independent pharmacy is no longer able to compete with PBM-owned pharmacies to fill prescriptions?

Answer: PBMs often steer patients to the pharmacies of their choice, which are often pharmacies affiliated with those PBMs, and away from independent community pharmacies. Such steering can often negatively impact point-of-sale prices. These patients can be steered toward an affiliated brick-and-mortar pharmacy, but more and more are being forced to use mail-order affiliated pharmacies. A recent 3Axis Advisors study on Washington state's drug pricing found that when prescriptions are pushed outside the retail pharmacy channels PBMs are able to significantly mark up prices, with typical mail-order pharmacies making approximately 20-times more in their margins for brand name drugs and 1,000-times more for generics.

c. What is lost for patients when they no longer have access to community-based, independent practices, but instead have to rely on nationwide PBMs?

Answer: When community pharmacies like mine are forced to close down due to PBM practices, patients not only lose access to a front-line medical provider but are more exposed to sudden price increases in their medication – local pharmacies are often able to find solutions for the latter scenario and ensure patients can afford their prescriptions, where nationwide PBMs and their affiliated pharmacies are not. Nonadherence to medication is also more likely without the presence of a local brick-and-mortar pharmacy the patient trusts, as are adverse outcomes due to drug interactions. Finally, and perhaps most crucially, patients find themselves in pharmacy deserts when their independent, community-based pharmacy closes. This problem is particularly acute for those in rural areas, lower-income Americans, and for seniors with limited mobility.

The Federal Trade Commission's second interim staff report, published in January 2025, focused on PBMs' influence on specific generic drugs. The report found, among other things, that the Big 3 PBMs – Caremark Rx, Express Scripts, and OptumRx, all owned by or affiliated with big insurance companies – control 44 percent of the commercial specialty generic 30-day market, and 72 percent of those drugs were marked up more than $1,000 per prescription. These dispensing patterns suggest that the big health insurers and the PBMs they own may be steering highly profitable prescriptions to their own affiliated pharmacies and away from

unaffiliated pharmacies to the detriment of costs to patients. The report looked at a range of critical drugs for chronic illnesses, including treatments for cancer and HIV.

d. Do you see waste and unused drugs because PBMs force patients to receive large, 90-day supplies of medication?

Answer: Yes, we see it all the time. Patients are often auto-enrolled in 90-day supply programs, but the problem is that prescriptions get mailed out too soon—sometimes well before the 90 days are up. This leads to unnecessary medications piling up and allows PBMs to bill for more prescriptions than needed.

I'll never forget one woman who came in after her husband passed away. She brought two full grocery bags of his unused medications—about $18,000 worth. The worst part? She had been trying to stop two of the prescriptions he no longer needed. She told us she called multiple times to cancel but eventually gave up because, luckily, she wasn't being charged extra for the copays. It just shows how wasteful and frustrating this system can be for patients and their families.

e. Is there a noticeable difference to the patient between the medication counseling received from an independent pharmacist and a nameless, faceless PBM?

Answer: Yes, absolutely. We hear it all the time—patients call us because they won't even pick up the phone when a PBM tries to reach them. They tell us they don't trust them and would rather get advice from someone they know. That's exactly why community pharmacies are so important. It's not just about filling prescriptions; it's about real relationships. People trust those who genuinely care about them, and that's what keeps the "care" in health care.

2. In Tennessee, several of our closed-door pharmacies, serving individuals with severe and persistent mental illness — which were historically categorized as Long Term Care (LTC) pharmacies — have recently been reclassified by Express Scripts as "a combo pharmacy." Meaning that Express Scripts can now reimburse at a lesser rate, often below acquisition cost, for many of the medications filled at these pharmacies.

A specific example of medication being reimbursed below acquisition costs are long acting injectables for the treatment of schizophrenia; which is considered the gold standard of care.

This puts our independent pharmacies in a difficult position — either lose tens of thousands of dollars per month to continue to serve this population — or send these patients elsewhere, which is likely to result in medication nonadherence as well as a higher health care spend if patients end up in the ER, psych beds, or in jail.

Despite multiple efforts by myself and my colleagues to encourage PBMs to extend their LTC definition, we continue to run into these barriers for our most vulnerable citizens.

Mr. Chancy, with this as background, please answer the following:

a. In order to ensure PBMs, such as Express Scripts, continue to recognize these Long Term Care mental health pharmacies as Long Term Care pharmacies, do you have thoughts on what steps CMS can take?

Answer: There is a significant disparity in the level of payments from PBMs to pharmacies for LTC pharmacy services provided to Medicare beneficiaries living in the community who require LTC pharmacy at home services compared to those who reside in a skilled nursing facility. This is the case even though many in the community have the same level of care needs. In December 2021, CMS acknowledged that Part D enrollees requiring LTC pharmacy services can reside in various settings, including assisted living facilities and their homes. The agency also recognized that Part D prescription drug plans (PDPs) could pay higher reimbursement fees to pharmacies providing LTC pharmacy services to these beneficiaries, reflecting the additional costs that pharmacies incur when delivering such enhanced care. However, despite this guidance, PDPs still do not provide adequate reimbursement for LTC pharmacy at home services, significantly impeding access to these specialized services for individuals residing at home. We urge CMS to utilize its existing authority to take action to address the complex needs of this vulnerable population.

b. How can Congress help ensure that patient access to necessary medicines, like long-acting injectables for the treatment of schizophrenia, will not be hindered by arbitrary reclassification of LTC pharmacies?

Answer: Patients living in communities other than skilled nursing facilities face barriers accessing critical services, even though their care needs are comparable to those residing in skilled nursing facilities. As the trend toward home-based care continues to grow, it is important, now more than ever, that CMS takes action to improve access to LTC pharmacy services for all Medicare beneficiaries with complex medical conditions, regardless of where they reside. We would ask Congress to strongly urge CMS to exercise their authority to close the gap in LTC and ensure that Medicare beneficiaries with complex medical conditions receive the high-quality, comprehensive pharmacy care they need to live safely no matter where they reside.