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Committee on Energy and Commerce
Subcommittee on Health

AN EXAMINATION OF HOW REINING IN PBMS WILL DRIVE COMPETITION AND LOWER COSTS FOR PATIENTS

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Chairman Carter, Ranking Member DeGette, and members of the subcommittee: It is an honor to speak to you today on behalf of the National Alliance of Healthcare Purchaser Coalitions (National Alliance). The National Alliance is the only nonprofit, purchaser-led coalition with a national and regional reach. We are the voice for more than 40 regional and local employer/purchaser coalitions, which together represent more than 12,000 employers with more than 45 million covered lives, spending over $400 billion annually on healthcare in the commercial market. I am here to provide the experience of self-funded employers and purchasers that pay for healthcare on behalf of their employees and families.

As I will discuss below, the high and rising cost of prescription drugs in the commercial market is one of the most pressing concerns for employers and purchasers across the country. We believe that the consolidation, opacity, and market distortions in the pharmacy benefit manager (PBM) market are among the most significant drivers of high and rising costs for employers, purchasers, and working families. While the National Alliance broadly supports PBM legislation affecting the Medicaid and Medicare programs (included in Sections 113 and 227 of the original version of H.R. 2, the *Further Continuing Appropriations and Disaster Relief Supplemental Appropriations Act* released in Nov. 2024), my testimony will focus on provisions in that bill that directly impact the commercial market, namely Sections 901 and 902.

My testimony will cover four key areas:

- Understanding the PBM market related to self-funded employers and purchasers
- How employers have sought to navigate this distorted market
- Continued struggles for employers as they engage PBMs
- How legislation under discussion will begin to transform the commercial market

Understanding the PBM Market Related to Self-funded Employers and Purchasers

Handing Over the Credit Card: PBM Contracting with Self-Insured Employers and Purchasers

All told, roughly 165 million people in the United States receive healthcare coverage through their employers.[1] Of those, roughly 60% are people covered by self-insured employers regulated at the federal level by the Employee Retirement Income Security Act of 1974 (ERISA).[2] Self-insured employers contract directly with PBMs to manage the employer's pharmacy benefit – a role that is often "carved out" or contracted separately from third-party administrators that manage the employer's medical benefit. Serving as contractors for the self-insured employer, PBMs play many roles, including negotiating rebates and discounts on behalf of the employer, establishing contracts with pharmacy networks, establishing formulary designs, and providing support to plan beneficiaries as they navigate this complicated system. Given that self-funded employers directly pay for the costs of their pharmacy and medical benefits and are financially responsible to any fluctuations in plan spending,[3] decisions made by the PBMs directly impact purchaser plan assets.[4] Essentially, employers hand PBMs their credit card and said, "go out and spend our money wisely."

Fiduciary Responsibility of Self-Insured Employers and Purchasers

Since ERISA's creation in 1974, self-insured employers and purchasers – and key employees working for those entities – have been held to a fiduciary standard to oversee plan assets set aside by the employer on behalf of covered individuals. The Consolidated Appropriations Act of 2021 (CAA), enacted in 2020, raises the bar for self-funded health plans requiring them to pay fair prices for services provided. Employers and other plan sponsors that are unable to determine if they're paying reasonable prices could face a heightened risk of lawsuits and considerable fines. Indeed, since passage of the CAA, at least two large self-funded employers have been sued by plan beneficiaries alleging the employer failed to adequately oversee their health plan assets as they relate to PBM services.

Foundational Flaws in PBM Commercial Market

Unfortunately, as the committee knows well, over the past several decades, the PBM market has become highly dysfunctional, to the detriment of employers, purchasers, and working families. Today, I identify four foundational flaws in the PBM commercial market:

1) Horizontal consolidation – reducing employer choice
2) Vertical consolidation – allowing conflicts-of-interest and self-dealing
3) Distorted formulary placement – more money for PBMs at the expense of employers and families
4) Opacity – the foundational flaw

Horizontal Consolidation

Today, three large corporations control roughly 80% of the PBM market.[5] While smaller PBMs have sprung up in recent years, they continue to operate at a disadvantage compared to the "Big 3." Because of their massive size and small number, giant PBMs serve as an oligopoly, leading to reduced price competition, rigidity in prices, and abuse of non-affiliated actors in other stages of the pharmaceutical chain.[6] Given their massive size – the "smallest" of the Big 3 PBMs manages 22% of all pharmacy claims in the country – even a jumbo employer with hundreds of thousands of covered lives has scant leverage in negotiations with PBMs.

Vertical Consolidation

Each of the dominant PBMs is itself part of a larger vertically integrated company that also owns its own medical plans, retail, mail-order, and specialty pharmacies and group purchasing organizations (GPOs) or "rebate aggregators" that often serve as the first purchaser of prescription drugs from drug manufacturers before they are purchased by PBMs.[7] Such significant vertical integration enables many opportunities for "self-dealing" within a single corporate entity. Indeed, today, a single prescription drug could pass through at least four different hands within a single company before ultimately being paid for by a self-insured employer and the plan beneficiary. By way of example, a physician working at Oak Street Health – a wholly owned subsidiary of CVS Health – could prescribe a drug to a patient, requiring the patient to use CVS Specialty Pharmacy, which would have purchased the drug from CVS

Caremark, the company's PBM, which itself purchased the drug from Zinc, the company's GPO. CVS is not unique, of course – the example could work for each of the largest PBMs.

Wasteful Formulary Placement

While clearly against the best interest of employers, purchasers, and patients, PBMs will sometimes place drugs with limited clinical value and higher net costs at preferred tiers of an employer's formulary. Wasteful drugs placed on formularies may include:

- Brand name or higher-priced generic drugs offered when a lower cost generic or biosimilar alternative is available in the same class and with similar efficacy
- Overpriced "combo" drugs, which combine two other therapeutics that would be cheaper if purchased separately
- Prescription drugs that may be purchased at a lower price over the counter
- "Me too" drugs in which manufacturers made an immaterial tweak to the product and seek to sell it at a much higher price than the equally effective original drug, often in an attempt to extend patent protection

Wasteful formulary placement occurs when the PBM is able to extract higher discounts or fees – not passed onto employers – from manufacturers seeking to expand the market of the wasteful drug.[8]

Opacity

Perhaps the most pernicious flaw in the PBM market is the level of opacity between PBMs and their plan sponsor clients. In general, plan sponsors are unable to determine the initial price for a drug paid by the GPO, the extent to which negotiated rebates are passed on to them, whether there is differential pricing between wholly owned pharmacies and those owned by other entities, or other critical information that would allow them to ensure they are getting the best possible deal on the prescription drugs they are purchasing on behalf of their employees and families. The lack of transparent information affects employers' finances and imposes real legal risks to employers. As noted by Russell DuBose, VP of Human Resources at Pfifer, Inc. in testimony before the Education and the Workforce Committee on behalf of the National Alliance:

> *"Without full access to all information, self-funded insurers cannot reasonably act as prudent fiduciaries in their own right. Put simply, how can I – as the named fiduciary of our health plan – ensure that plan assets are being used solely in the interest of participants and beneficiaries and that expenses are reasonable if I do not have access to critical data and contracting terms? I cannot."*[9]

How Employers Have Sought to Navigate this Distorted Market

Despite operating in a dysfunctional market, self-funded employers and purchasers have sought innovative solutions to bring down prescription drug costs and enhance transparency. I offer two examples:

Family-Owned Timber Company Reduces Wasteful PBM Spending by Three Quarters

Neiman Enterprises, a family-owned timber operation for four generations, opened its first sawmill in 1936 in Upton, Wyoming. It now runs five sawmills in Colorado, Oregon, South Dakota, and Wyoming. Its commitment to forest-first decisions ensures the long-term stability of the company and to future resources though a cycle of renewal. According to Sherri Stimson, a company owner who manages benefits, "We've undertaken several initiatives to control costs without sacrificing the richness of our benefits. One of my easiest successes was removing wasteful drugs from our coverage policy."

Sherri and her team evaluated several and settled on a PBM designed with a separation of powers to eliminate the misaligned incentives that result in chasing rebates and spread pricing. The new PBM took over on August 1, 2019, one month after the new plan year began. In addition to taking wasteful drugs off the formulary, the Neiman family agreed to switch all appropriate prescriptions to lower cost therapeutic equivalents. Since then, the cost of non-specialty pharmacy claims dropped 20% for the company. Because the plan allowed for a three-month transition to the new, non-wasteful medications, their spend on wasteful drugs was down 75.8% one year after the switch.[10]

Manufacturing Company Switches to a Transparent PBM

Frustrated by high and rising prescription drug costs, a medium-sized manufacturing company with 5,000 covered lives, decided to rethink its pharmacy benefit. In 2018, the benefits team, along with the company president and chairman of the board, attended a National Alliance member healthcare purchasing coalition meeting on PBM misalignment and the effect on employers. While the organization was already considering revising the employee healthcare strategy, the project became more urgent when they began uncovering, for example, a brand-name prescription that was four times higher than the equivalent generic. When asked to explain the pricing gap, the organization's PBM responded simply, "pharma plays games with pricing."

The company's executive leaders and benefits professionals were ready to push beyond the status quo after learning about common PBM strategies that worked against them and how they could best advocate for employees and their families. This led to site visits with transparent PBMs that were willing to provide data and to satisfactorily answer a host of complex questions. Having the opportunity to see the facilities and meet with those who might be providing PBM services proved invaluable when it came time to compare and choose a partner.

Beginning January 2020, the employer switched to a transparent PBM. Ultimately, plan design, network, and formulary all underwent changes, with very little pharmacy network disruption, even in rural locations. Plan design went from a high-deductible health plan to reference-based pricing. This enabled a clear copay plan to set expectations for members at the point of care. The company instituted a $0 copay for the Affordable Care Act (ACA) preventive care list. Savings from having a transparent PBM were reinvested into the care of members to lower out-of-pocket costs. Over the succeeding four years, the employer has experienced only a 6% increase in pharmacy costs – far below industry averages.[11]

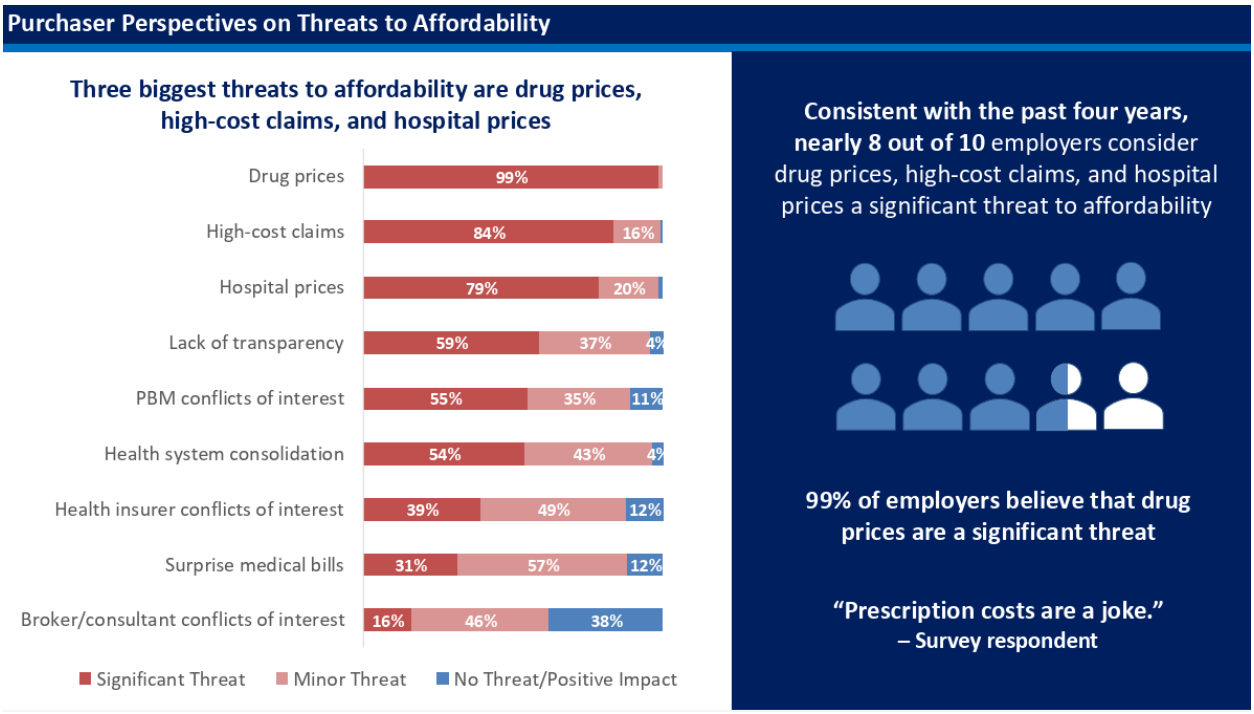
Continued Struggles for Employers as they Engage PBMs

Pulse of the Purchaser Survey Results

The National Alliance conducts and publishes an annual survey of employers and purchasers covering issues from workforce strategies to public policy.[12] Our 2024 survey included 188 self-insured purchasers from across the country and ranging in size from relatively small employers (fewer than 1,000 employees) to jumbo purchasers (more than 50,000 employees).

When asked to describe the biggest threat to affordability, 99% of respondents said that drug prices were a significant threat. Further, 59% responded that lack of transparency (across the health system) is a significant threat. When asked about PBM conflicts of interest, 55% of respondents said it was a significant threat.

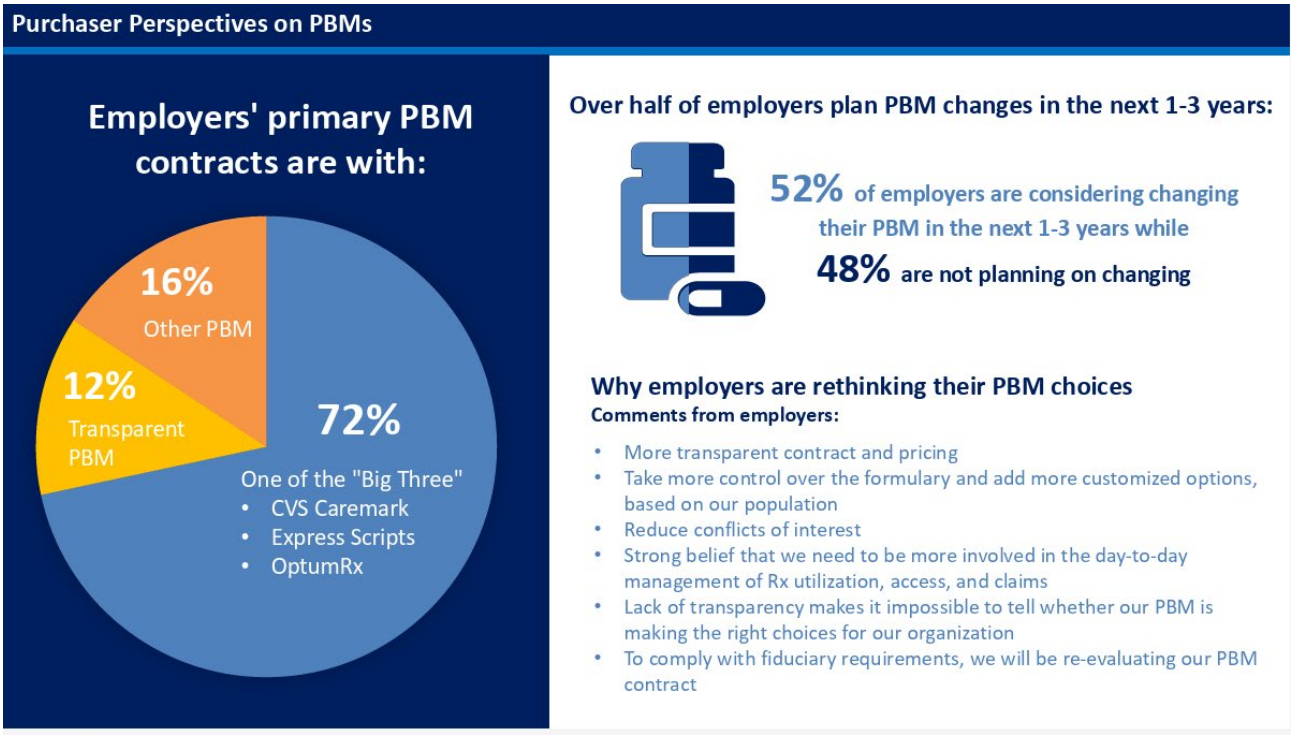
Figure 1



Source: National Alliance 2024 Pulse of the Purchaser survey

Looking more specifically at PBMs, while nearly three-fourths of surveyed respondents are currently contracted with one of the "Big 3" PBMs, more than half of respondents were considering moving to a different PBM in the next 1-3 years. When asked why respondents are considering changing PBMs, employers cited lack of transparency, concerns about fiduciary responsibility, and embedded conflicts-of-interest.

Figure 2



Source: National Alliance 2024 Pulse of the Purchaser survey

When asked about concerns related to compliance with ERISA fiduciary rules, half of respondents said they were not confident in the integrity and lack of conflicts-of-interest in PBM administration, and 47% were not confident in the reasonability of PBM direct and indirect compensation for services provided to their organization.

National Alliance PBM Misalignment Initiative

Over the course of the last year, the National Alliance has worked with member coalitions and employers to better understand employer concerns and educate member organizations about how to best engage in the PBM marketplace. The project's advisory committee, made up of employer benefits leaders, National Alliance member coalition directors, and subject matter experts identified key concerns by employers relating to their PBM contracts. Among these were:

- Promotion of higher-price drugs when lower-price drugs are available
- Coverage and/or preference of a brand drug when a generic or biosimilar is available
- Coverage of "off-label" use of drugs
- Redefining generics as brand drugs or vice-versa to influence guaranteed pricing discounts
- Narrow definition of "rebates" which allow PBMs to retain up to 50% of pharmaceutical discounts as they are defined as something else

Among the key outcomes of the project are a set of recommendations for employers to include in audits of their PBMs.[13] This includes asking the PBM vendor to answer several key questions:

- What are all the credits, incentives, and fees collected from third parties for the purchase of products, drugs, devices, and any other supplies required to administer the pharmacy benefit?
- What services or supports involve contracted third parties (e.g., drug manufacturers, providers, wholesalers, distributors, pharmacies)?
- Will you disclose all data elements in claim records, including all financial transaction data, for analysis?
- Do you compare financial data and pricing to publicly available pricing data (e.g., cash prices) to determine reasonableness of payments?
- Will you conduct a deep dive on high-cost claims involving the most expensive drugs?
- Will you provide a copy of the formulary and how decisions are made for drug placement in tiers?

Today, it remains exceedingly difficult for employers and purchasers to receive satisfactory answers to these questions.

How Legislation Under Discussion Will Begin to Transform the Commercial Market

The transparency requirements included in the legislation under discussion today ensure employers and purchasers will receive critical information on the questions described above. Further, the bill precisely targets misaligned incentives used by dominant PBMs to enrich themselves at the expense of employers, purchasers, and working families, including withholding rebates, hidden fees, conflicts-of-interest from vertical consolidation, wasteful formulary placement, and back-end deals to brokers and consultants.

Among other provisions in Section 901 of H.R. 2, for the first time, self-insured employers and purchasers will have access to regular reports that detail:

- A list of prescription drugs prescribed by claim using national drug codes
- The contracted compensation for each drug
- The amount paid to the pharmacy for each unit
- The channel under which each drug was dispensed (retail, mail-order, or specialty pharmacy)
- For brand drugs, the Wholesale Acquisition Cost (WAC) for each unit
- For generic drugs, the Average Wholesale Price (AWP) for each unit
- The number of claims, participants, units, and days supply for each claim
- The net price of the drug (after accounting for all rebates, fees, and other discounts)
- The total out-of-pocket spending for each drug by claim
- The amount received by plan issues, PBM, and any amounts received from copay assistance, copay cards, or other renumeration offered by pharmaceutical manufacturers

Further, the bill would entitle plan sponsors to access, for each therapeutic class of drugs:

- Gross spending before rebates
- Net spending after accounting for rebates
- Amounts received by PBMs

- Number of patients receiving drugs in the therapeutic class
- A description and rationale of PBM formulary tiers
- Total out-of-pocket costs
- For high price drugs, a list of other drugs in the class, a description and rationale for formulary placement and a description of changes in formulary placement

The bill requires disclosure of vital details to curtail the inappropriate use of wholly-owned pharmacies, including:

- An explanation of benefit design
- The percent of drugs filled by wholly-owned pharmacies
- The amount charged for in-house pharmacies
- The median and interquartile-range for non-affiliated pharmacies
- The lowest cost for any pharmacy in which a drug was filled under the plan

Finally, the bill requires PBMs to disclose how much and to whom a PBM paid brokers and consultants, either directly or indirectly, for referrals, consideration, or retention. ***These transparency requirements hold the promise of transforming the commercial PBM market from one riven with conflicts of interest, misaligned incentives and outright obfuscation of information to one in which employers and purchasers can shop for better deals and demand more control over their pharmacy benefit.***

Section 902 of the legislation explicitly requires PBMs to pass through all rebates and discounts offered by drug makers through the complex drug channel, starting with the initial purchasers of the drug from the manufacturer – often the GPO or rebate aggregator – to the final sale of the drug to the patient.

Unlike related sections of the legislation that ban spread pricing to Medicaid plans and mandate "delinking" the price of a drug to PBM reimbursement for Medicare plans, bill drafters took a lighter touch to the commercial market. ***While the bill does mandate rebate pass-through, it allows PBMs and plan sponsors to engage in a more free and more transparent negotiation, continuing to allow for innovative plan designs including value-based purchasing arrangements and incentives for PBMs to deliver superior service at lower prices to plan sponsors and working families.***

Concluding Remarks

The previously mentioned Pulse of the Purchaser survey asked benefit leaders about the degree to which certain public policies would be helpful or harmful to their work. Fully 51% of respondents said that PBM reform would be very helpful with a further 38% saying reform would be somewhat helpful – a net support of 89% of respondents. The support for PBM reform was second only to protecting ERISA preemption and was higher than other top priorities for the National Alliance and its coalitions, including hospital price transparency, banning hospital anti-competitive practices, and HSA reforms.

Our strong support for the legislation under consideration is matched by support from other national employer organizations, including the American Benefits Council, the ERISA Industry

Committee, HR Policy Association, the Partnership for Employer-Sponsored Coverage, and the Self-Insurance Institute of America. Despite false claims from the PBM industry that employers are happy with their PBMs and do not support reform, it is our hope this testimony makes clear that the employer/purchaser community strongly supports your legislation and is clamoring for change.

By taking action now, Congress will ensure that the private healthcare market functions as intended, preventing companies from steering patients toward higher-priced medications and away from more affordable options. We strongly urge you to act swiftly and pass the bipartisan PBM transparency and accountability reforms that were agreed to by leadership in December. Employers, their workers, patients, and taxpayers all across America are counting on it to help mitigate their ever-growing healthcare costs.

Thank you for allowing me to provide the employer/purchaser perspective on this critical issue and I look forward to answering your questions.

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