

Written Testimony of Kevin J. Duane, PharmD

United States House Committee on Oversight and Accountability

Hearing: “The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part I: Self-Interest or Health Care?”

May 23, 2023

Chairman Comer, Ranking Member Raskin, and members of the committee:

I appreciate the opportunity to speak to you today regarding my experience as a pharmacist and pharmacy owner, and about how the current marketplace distortions from pharmacy benefit managers (PBMs) have negatively impacted my ability to care for my community.

My name is Kevin Duane, and I am the pharmacist and owner of Panama Pharmacy in Jacksonville, Florida. I am a member of the National Community Pharmacists Association and the Florida Pharmacists Association.

Panama Pharmacy is one of the oldest community pharmacies in Jacksonville, having served patients in the area for over 100 years. Our patient base is largely from a poor and underserved community, with over 70 percent of patients on a government-funded health plan. I am a first-generation pharmacist and the first in my family to attend any kind of post-high school education. I have always considered small business ownership to be an “American dream,” but the experience in my field could better be described as a nightmare, and the monster in that nightmare is a PBM.

The outsized role PBMs take in the pharmacy space has caused many problems for our patients and our practice. The three largest PBMs (Caremark owned by CVS Health which also owns Aetna, Express Scripts owned by Cigna, and Optum owned by UnitedHealthcare) control 80 percent of the market today,¹ which means patients are forced by PBMs into using a certain pharmacy, often one owned and operated by the PBM, or they may be forced to get their drugs through the mail even though they want a pharmacist face-to-face in their community (See Exhibit A). Patients and their doctors have virtually no say in what drugs are used, since the PBM essentially forces which drugs can be used – not because a drug is better or worse, but because the PBM can make more money from it.

With vertical integration both upstream and downstream, there is a need to level the playing field between community pharmacies and PBM-affiliated pharmacies to protect patients from paying too much at the counter. The vertical integration of PBMs into monoliths with an affiliated upstream insurance provider and downstream mail-order, specialty, and retail pharmacies has only increased the incentives for PBMs to disfavor independent pharmacies and steer patients to their own affiliated pharmacies. PBMs use a variety of methods to steer patients away from unaffiliated pharmacies. They create differential cost-sharing structures and arbitrary lists, such

¹ Fein, Adam. “The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger.” Drug Channels. April 5, 2022. <https://www.drugchannels.net/2022/04/the-top-pharmacy-benefit-managers-of.html?m=1>.

as specialty and aberrant drug lists, among other schemes, to limit independent pharmacies' access to patients.

PBMs contribute to artificially inflating drug costs using expensive name-brand medications when less expensive generic alternatives are available. To do this, PBMs claim that they secure large rebates from the manufacturer to bring the net cost of the product down to below the cost of the generic. Even if this were true (which would require complete transparency and a 100 percent pass-through of all monies that flow from a pharmaceutical manufacturer to a PBM), it does not negate the consumer harm that exists to patients when they are in the deductible phase and are paying more out of pocket for their medication costs. PBMs blame these formulary placements on plan sponsors, but plan sponsors like others in this industry are at the mercy of PBMs and their constant threats of rate hikes.

Another harmful, anticompetitive tactic employed by PBMs is spread pricing, which refers to the difference between how much a PBM reimburses the pharmacy for a drug and the higher price they turn around and charge the plan for the same prescription. For years, community pharmacists have said that PBMs have been playing spread pricing games, contributing to higher drug costs to the detriment of patients and the taxpayer-funded programs the PBMs are supposed to serve. Studies of multiple state Medicaid managed care programs have indicated that PBMs are overcharging taxpayers for their services in Medicaid managed care, reimbursing pharmacies low for medications dispensed, billing the state Medicaid program high for the cost of those medications, and retaining the difference, called "spread." Over the last two years, Centene has entered into settlements with 17 states for overcharges to the state Medicaid program, totaling almost \$1 billion. Arkansas, Georgia, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Texas, and Virginia now prohibit spread pricing in their Medicaid managed care programs.

Recently, Express Scripts, the Cigna-owned pharmacy benefit manager that administers the TRICARE benefit on behalf of the Department of Defense, instituted pharmacy network changes that impact 400,000 TRICARE beneficiaries by shrinking the retail network by almost 15,000 pharmacies. Most of the pharmacies excluded from the network are independent community pharmacies located in underserved rural and urban areas. On top of that, Cigna/Express Scripts made the unilateral decision to make these changes effective Oct. 24, 2022, surprising and confusing patients. This decision was not communicated directly to many impacted pharmacies. Instead, they only learned about their removal from the network from patients bringing in letters they received from Cigna/Express Scripts saying their pharmacy was "leaving" the network.

Now, our servicemembers and families covered by TRICARE can no longer get most name-brand medications at regular pharmacies, instead being forced into using the mail-order or on-base pharmacy. In Jacksonville this leads to days-long waits and delays in treatment of weeks or more. The Naval Air Station Jacksonville base is attempting to service more than three times the patient load that they are staffed and equipped to serve. People are being harmed, and it is because of PBM greed. TRICARE beneficiary access to pharmacy is such a dire issue in Jacksonville that a local news outlet recently reported on it (See Exhibit B).

Without access to small-business pharmacies, TRICARE patients will suffer. Several patients have gone public with their frustrations with the changes and their experiences, including:

- Cigna/Express Scripts hindering access to necessary cancer medications that they initially denied to patient and were ultimately provided by the local community pharmacy²
- Cigna/Express Scripts providing unacceptable alternatives to their independent pharmacy³
- Cigna/Express Scripts giving very short notice to affected patients to find a new pharmacy given the accelerated effective date⁴

Additionally, many independent pharmacies serve long-term care facilities and offer services such as compliance packaging for the residents. Even though TRICARE does not have a long-term care pharmacy benefit, TRICARE beneficiaries in facilities served by an independent pharmacy receive this level of care. Under the Cigna/Express Scripts changes, residents in these facilities are now left to fend for themselves.

PBMs also wreak havoc on our independent pharmacies' financial health, and this is especially true with increased stress from egregious PBM practices, including pharmacy direct and indirect remuneration (DIR) fees. According to the Medicare Payment Advisory Commission's (MedPAC) March 2023 Report to Congress, pharmacy DIR fees were \$12.6 billion for 2021, which represents a \$3.1 billion or 33 percent increase in just two years (See Exhibit C). That kind of financial stress is unsustainable, especially when it comes to providing health care to seniors. Harmful DIR trends are only getting worse. We continue to see take-it-or-leave-it Medicare Part D contracts where the reimbursement rates are significantly below our cost to purchase brand drugs. Rates such as this coupled with year-over-year double-digit increases in DIR fees will make the first 3-6 months of 2024 unbearable for independent pharmacies, as they continue to pay DIR fees from contract year 2023. The intended effect of such contracts and discriminatory pricing can only be to force independent pharmacies to opt out of the Medicare Part D networks or stay in them only to face financial ruin. The end result is the strengthening of PBM-affiliated mail-order, specialty, and retail pharmacies at the expense of independent pharmacies.

We cannot negotiate any aspect of our contracts with PBMs in any meaningful fashion – it is truly take-it-or-leave-it. Some of the most basic yet most life-sustaining medications – drugs to prevent heart attacks, blood clots, or transplant rejections, for example – are commonly underpaid compared to the true market cost. I could shop 50 different wholesalers of medications and not find one I can buy from that would break even from what the PBM is providing for payment. That does not even cover the actual cost to dispense the medication. The Centers for Medicare & Medicaid Services says that in Florida it costs about \$12 to dispense a given medication, but it is not unusual to get maybe a nickel from PBMs for our cost-to-dispense. Some PBMs do not pay a single cent for it. There is no other industry where the service you

² [Tricare to reduce number of network pharmacies for its beneficiaries this month | Stars and Stripes](#)

³ [TRICARE network leaving local pharmacies | Journal Record \(myjrpaper.com\)](#)

⁴ [Richmond Hill Pharmacy patients losing coverage after 30 years \(wjcl.com\)](#)

provide can mean the difference between life and death for the person you are caring for, while the payment for that same service is a total of less than a dollar – pennies compared to our break-even. It is madness. Meanwhile, the PBMs pay themselves more for prescriptions at their own mail-order, specialty, and retail pharmacies, with some of the newer drugs paying out hundreds or thousands of dollars to the PBMs per prescription fulfilled. A recent report from MedPAC as well as studies from several states have found that vertically integrated PBMs appear to be reimbursing their affiliated pharmacies more than they reimburse non-affiliated pharmacies (See Exhibit D).

I mentioned TRICARE earlier. Last year we had to make the difficult decision to opt out of participation in that network. Jacksonville is a proud military town with two large Navy bases, and so this decision was a really tough one for us. I have family who have served in the Navy, and many of our friends and neighbors have too. Dropping out of the network to no longer be able to care for those people was especially tough, but the contract was unsustainable. We would have lost tens of thousands of dollars per year. Small businesses should not be asked to subsidize any plan, let alone a taxpayer-funded program. Yet we are, time and time again. And all the while, three of the largest PBMs are in the top 12 of Fortune's 500 richest companies.

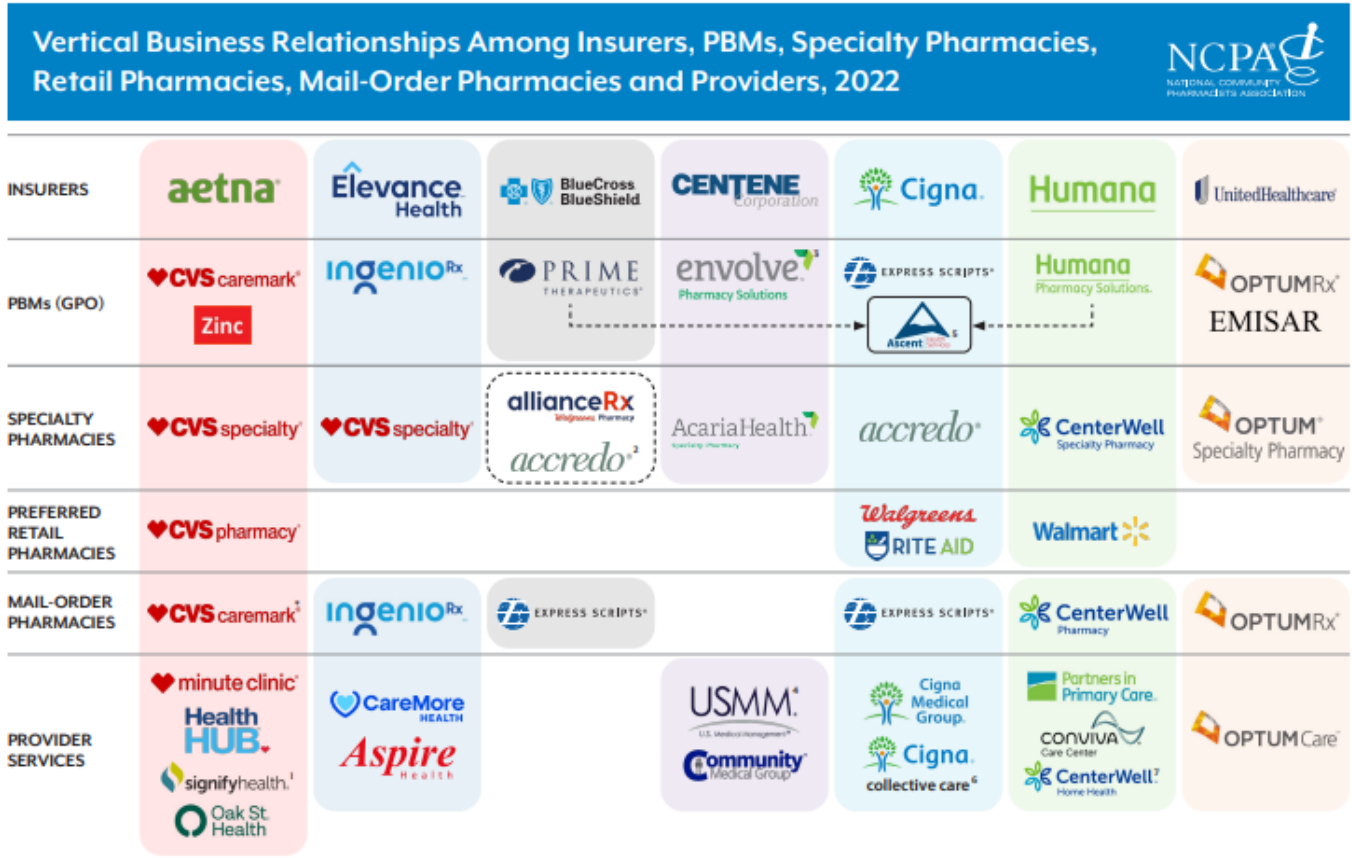
When companies are forced to compete, the consumer wins. The problem is, in our industry, free and fair markets do not exist. There is no competition – the game is rigged. PBMs own health insurers, they own drug stores, they are buying doctor's offices, and they are the largest purchasers of prescription drugs. A small business like mine cannot hope to compete when the deck is stacked against us. We are not asking for handouts or special exceptions, just the ability to compete on fair ground. Patients should always be able to choose what pharmacy they want to go to. Patients are not made of money. These games where a drug is priced high and then a hefty kickback is paid to the PBM have to go away. The patient should not be shouldering the phantom burden of high prices while the middlemen profit.

Community pharmacies, and especially small business pharmacies like mine, represent the forefront of health care in this country. COVID showed us that. Urgent legislative action is needed before providers like me go extinct. I applaud the committee for holding this important hearing looking at the black box of PBM middlemen and their anticompetitive tactics that are contributing to increased health care costs for patients and taxpayers while harming small businesses. I look forward to the outcome of this committee's investigation and future congressional action to rein in the PBM industry, and I am happy to answer any questions you may have.

Appendix

Exhibit A

PBM Vertical Integration. Source: [NCPA](#).



¹ In September 2022, CVS Health announced its acquisition of Signify Health. The transaction is expected to close in 2023.
² Since January 2021, Prime's Blue Cross and Blue Shield plans have had the option to use Express Scripts or AllianceRx Walgreens Prime for mail and specialty pharmacy services. On Dec. 31, 2021, Walgreens purchased Prime Therapeutics' 45% interest in AllianceRx Walgreens Prime, so this business has no PBM ownership in 2022. Effective June 2022, the company has been known as AllianceRx Walgreens Pharmacy.
³ In 2021, Centene has announced its intention to consolidate all PBM operations onto a single platform and outsource its PBM operations to an external company.
⁴ In 2021, Centene sold a majority stake in its U.S. Medical Management to a group of private equity firms.
⁵ Since 2020, Prime has sourced formulary rebates via Ascent Health Services. In 2021, Humana began sourcing formulary rebates via Ascent Health Services for its commercial plans.
⁶ Cigna also partners with providers via its Cigna Collaborative Care program.
⁷ In 2022, Humana announced an agreement to divest its majority interest in Kindred at Home's Hospice and Personal Care Divisions to Clayton, Dubilier & Rice. In 2022, Kindred at Home was rebranded as CenterWell Home Health.
Sources: Drug Channels Institute research and Nephron; Companies are listed alphabetically by insurer name.
^{*} CVS Pharmacy is owned by CVS/Caremark.

Exhibit B

Screenshots of news story: “INVESTIGATES: Veterans forced to wait for hours in long lines at NAS Jax pharmacy” (May 10, 2023). *Action News JAX*. Available at:

<https://www.actionnewsjax.com/news/investigates/investigates-long-lines-nas-jax-pharmacy/DMB26JZDQJELHGBI3RRP4ARMT4/>.



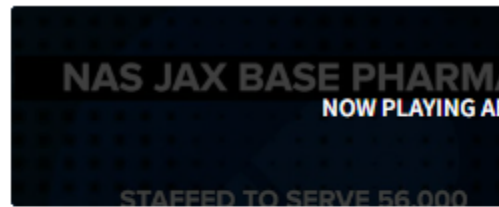
ANJ INVESTIGATES

INVESTIGATES: Veterans forced to wait for hours in long lines at NAS Jax pharmacy



By [Jake Stofan, Action News Jax](#)

May 10, 2023 at 5:22 pm EDT



JACKSONVILLE, Fla. — Military veterans and their families are waiting in line for hours just to pick up their prescriptions at NAS Jax.

It's the only pharmacy they can go to and not pay a co-pay.

[>>> STREAM ACTION NEWS JAX LIVE <<<](#)

Photos posted on Facebook show lines of cars around the corner at the NAS Jax pharmacy, which could rival what you'd see at a theme park.

Exhibit C

MedPAC details the expansion of DIR fees. Source: MedPAC April 2023 [presentation](#): “Assessing postsale rebates for prescription drugs in Medicare Part D.”

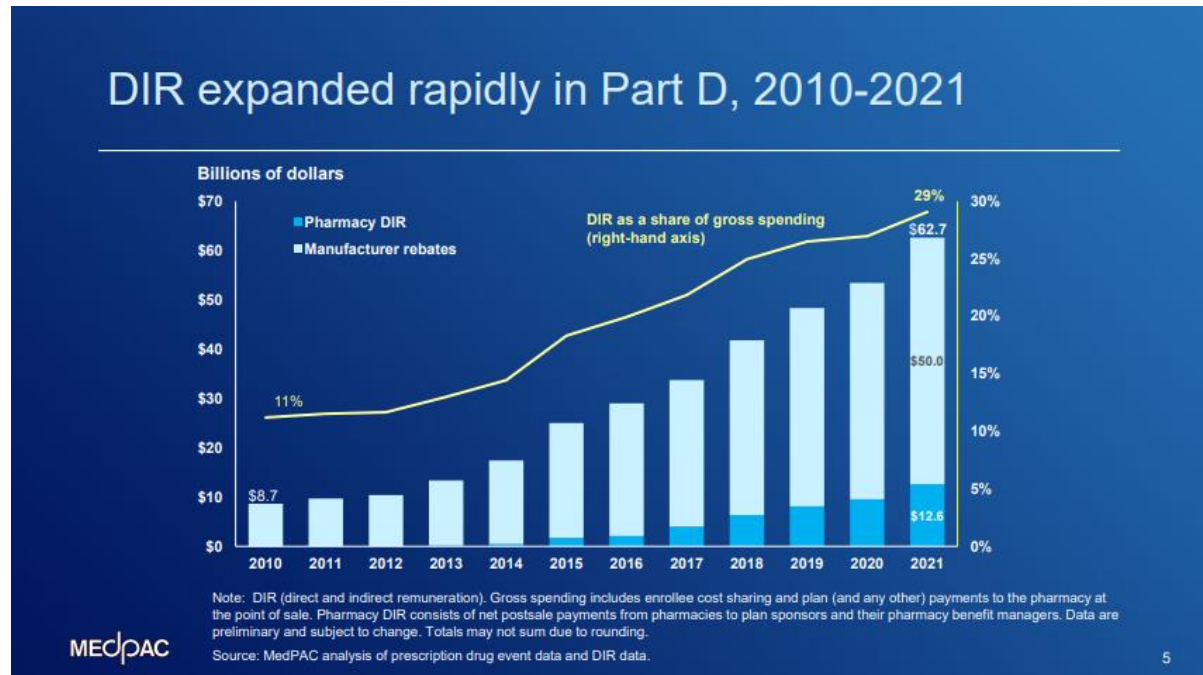


Exhibit D

MedPAC details the harm of vertical integration on Part D costs. Source: MedPAC April 2023 [presentation](#): “Assessing postsale rebates for prescription drugs in Medicare Part D.”

Vertical integration may have resulted in higher costs to Part D and their plan enrollees

- Gross payments to pharmacies and net-of-rebate costs were more likely to be:
 - Highest for VI pharmacies filling prescriptions for VI plans
 - Lowest for non-VI pharmacies
- Could indicate that a VI organization may financially benefit from higher payments to their (VI) pharmacies
- No visibility into prices between upstream and downstream entities

Note: VI (vertically integrated). From the analysis of four PBMs (CVS Caremark, Express Scripts, Humana Pharmacy Solutions, and Optum Rx) and six categories of drugs (disease-modifying anti-rheumatoid drugs, multiple sclerosis agents, two categories of antineoplastics, antiretrovirals, and pulmonary antihypertensive therapies).

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