

## Written Testimony of Hugh Chancy, RPh

### United States House Committee on Oversight and Accountability

#### Hearing: “The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part II: Not What the Doctor Ordered”

September 19, 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 Hugh Chancy, and I am a pharmacist and co-owner Chancy Drugs, which is celebrating more than 50 years of service. It specializes in compounding, specialty packaging, and enhanced clinical services. I am the president of the National Community Pharmacists Association, have been a member of NCPA since 2000, and have served as chairman of its board. I am also past president of the Georgia Pharmacy Association.

My family has three generations of pharmacists. My parents Hubert and Sue Chancy opened Chancy Drugs in 1966 in Hahira, Georgia. Chancy Drugs has since expanded under the leadership of me and my brother Bert, and my son Patrick has also now taken on a leadership role. Chancy Drugs is now made up of six full-service community pharmacies, with locations in Hahira, Adel, Lake Park, Moultrie, and Valdosta. A seventh pharmacy, also in Hahira, serves as a closed-door site specializing in long-term care. Chancy Drugs currently employs approximately 100 people across south Georgia. Chancy Drugs also operates the only compounding pharmacy in the south Georgia/north Florida region to hold accreditation by the Pharmacy Compounding Accreditation Board and the Accreditation Commission for Healthcare.

The outsized role pharmacy benefit managers play in pharmacy has caused many problems for our patients and our practice. The three largest PBMs (Caremark owned by CVS Health which also owns Aetna, Evernorth/Express Scripts owned by Cigna, and Optum owned by UnitedHealthcare) control 80 percent of the market today.<sup>1</sup> These three PBMs are vertically integrated with their own retail and/or mail-order pharmacies, which means patients are oftentimes forced into using the PBM-affiliated pharmacy. Patients have almost no choice in the matter and may be pushed to get their drugs through the mail even though they prefer a pharmacist face-to-face in their community (See Exhibit A). According to a recent survey, “some 18% of mail-order customers say they ‘definitely will’ or ‘probably will’ switch pharmacies in the next 12 months, up from 14% in 2022. Top reasons for switching include employer insurance requiring a change (31%); medication is too expensive (24%); and want flexible pick-up options

---

<sup>1</sup> Fein, Adam. “The Top Pharmacy Benefit Managers of 2022: Market Share and Trends for the Biggest Companies.” *Drug Channels*. May 23, 2023. <https://www.drugchannels.net/2023/05/the-top-pharmacy-benefit-managers-of.html>.

(21%).”<sup>2</sup> A recent report from MedPAC and studies from several states have found that vertically integrated PBMs appear to be reimbursing their affiliated pharmacies more than they reimburse non-affiliated pharmacies. This is leading to higher costs to the government in the Part D program and higher costs for many state programs (See Exhibit B).

There is a need to level the playing field between community pharmacies and PBM-affiliated pharmacies to protect the government and patients from paying too much. The vertical integration of PBMs into monoliths with affiliated upstream insurance providers 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, with no regard for the patient’s preference on where they receive care. PBMs use a variety of methods to steer patients away from unaffiliated pharmacies. They create differential cost-sharing structures and arbitrary lists, such as specialty and aberrant drug lists, among other schemes, to limit independent pharmacies’ access to patients.

PBMs also contribute to artificially inflated drug costs, requiring expensive name-brand medications via formulary placement when less expensive generic alternatives are available. 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. Patients and their doctors have virtually no say in what drugs are used, since the PBM essentially forces which drugs can be prescribed – not because a drug is better or worse, but because the PBM can make more money from it. As PBM compensation is directly linked to the cost of medications, PBMs are benefiting from ever increasing list prices and rebates.

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.”

PBMs claim they save money for state-funded health plans like Medicaid managed care yet report after report shows something very different: excessive amounts of taxpayer dollars remain with PBMs. Examples compiled by NCPA include:

- In Kentucky, a state report found that state PBMs keep \$123.5 million in spread annually, in addition to the other fees they were paid.
- In Michigan, drug price manipulation allowed PBMs to overcharge Medicaid by at least \$64 million.
- In Virginia, a state-commissioned report on Medicaid found PBMs pocket \$29 million in spread pricing alone.

---

<sup>2</sup> “Retail Pharmacy Customer Satisfaction Surges as Digital Engagement Keeps Rising, J.D. Power Finds,” *JD Power*. <https://www.jdpower.com/sites/default/files/file/2023-07/2023079%20U.S.%20Pharmacy%20Study.pdf>.

- In Maryland, a state Medicaid report found PBMs pocket \$72 million annually in spread pricing alone.
- In Louisiana, PBMs retained \$42 million that was incorrectly listed as “medical costs.”
- In Pennsylvania, the state auditor found that between 2013 and 2017, the amount that taxpayers paid to PBMs for Medicaid enrollees more than doubled from \$1.41 billion to \$2.86 billion.
- In Ohio, the state auditor found that, of the \$2.5 billion that is spent annually through PBMs on Medicaid prescription drugs, PBMs pocketed \$224.8 million through the spread alone during a one-year period.
- In New York, a legislative committee investigated PBM practices and found “PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies.”
- In Florida, a report on Florida’s Medicaid managed care program found PBMs steered patients with high-cost, high-profit prescriptions to their own pharmacies and charged higher prices, revealing that “when it comes to dispensing brand name drugs, [managed care organization]/PBM-affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy.”<sup>3</sup>

In Medicaid, over the last two and a half years, Centene, the largest Medicaid managed care organization in the United States, has entered into settlements with at least 17 states for overcharges to the state Medicaid program, totaling around \$900 million. In 2021, Centene had put aside \$1.25 billion for settlements with states.<sup>4</sup> Centene has already paid settlements in Arkansas (\$15.2 million), California (\$215 million), Illinois (\$56.7 million), Indiana (\$66.5 million), Iowa (\$44 million), Kansas (\$27.6 million), Louisiana (\$64.2 million), Massachusetts (\$14 million), Mississippi (\$55 million), Nebraska (\$29.4 million), Nevada (\$11.3 million), New Hampshire (\$21.1 million), New Mexico (\$13.7 million), Ohio (\$88.3 million), Oregon (\$17 million), Texas (\$165.6 million), and Washington state (\$33.3 million). Additionally, 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.

PBMs also wreak havoc on independent pharmacies’ financial health, and this is especially true with increased stress from egregious PBM practices, including pharmacy direct and indirect remuneration (DIR) fees. These DIR fees have allowed PBMs to pay pharmacies for the prescriptions they have dispensed to patients, and then later take back thousands of dollars from those payments. According to the MedPAC March 2023 Report to Congress, pharmacy DIR fees reached \$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. While pharmacies like mine were busy helping fight the

---

<sup>3</sup> <https://ncpa.org/sites/default/files/2022-08/NCPA-MMC-Consequences-08-2022.pdf>.

<sup>4</sup> Maya T. Prabhu, Atlanta Journal-Constitution and Andy Miller, “Centene Gave Thousands to Georgia Leaders’ Campaigns While Facing Medicaid Overbilling Questions.” October 18, 2022. *Kaiser Family Foundation*. <https://kffhealthnews.org/news/article/centene-georgia-settlement/>.

pandemic, PBMs were even charging us DIR fees on the vaccines we administer to Part D patients.

Harmful DIR trends are only getting worse. We continue to see take-it-or-leave-it Medicare Part D contracts for 2024 where the reimbursement rates are significantly below our cost to purchase drugs. I appreciate that the Centers for Medicare & Medicaid Services is requiring Part D plans and PBMs to pass through all DIR fees to the point of sale starting in 2024 so my patients pay lower prices at the pharmacy counter, but pharmacies like mine struggle to survive when we are losing money on Part D prescriptions because the PBM payment is less than our cost to acquire the drug. Looking at recent claims from one major PBM, approximately 6 percent of my Part D claims were being reimbursed below my drug acquisition costs, and the reimbursement was below my operating costs for over 50 percent of the claims. Underwater reimbursements coupled with year-over-year double-digit increases in DIR fees will make the first few months of 2024 unbearable for independent pharmacies, as they continue to pay PBMs the DIR clawback fees from contract year 2023. Several NCPA members have expressed that these financial pressures have caused them to apply for lines of credit. The intended effect of these PBM actions appears to 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 patients and independent pharmacies.

Part D pharmacy payment reform is absolutely necessary and must include reasonable reimbursement coupled with standardized pharmacy performance metrics and transparency in payments. The convoluted pharmacy performance metrics PBMs assess on my pharmacies are anything but quality related. Some metrics have even contributed to NCPA members having been penalized for a dead patient not being adherent.

PBMs steer patients to PBM-owned and -affiliated retail and mail-order pharmacies, increasing costs and limiting choices for patients. There are countless stories of how patients are negatively impacted by these PBM practices. Just last month, the *Pittsburgh Post-Gazette* wrote about a patient who heard about a pharmacy that offered her prescriptions at a lower cost than the PBM's specialty pharmacy was charging. This patient faced "a monthly battle" to go to the pharmacy of her choice as her doctor's electronic prescriptions were automatically sending her prescriptions to the PBM's more expensive specialty pharmacy. Another patient discovered that they were being billed \$2,000 for medication using their insurance benefit, but the cash price for the same drug at a pharmacy was only \$29.95.<sup>5</sup>

Chancy Drugs has three stores near Moody Air Force, which means we have many military retirees and veterans who are our customers. When ExpressScripts implemented changes to the TRICARE pharmacy network last year, many of our patients were negatively impacted. We had one patient who called in tears. She is blind, and we were using specialty packaging to help her take the right meds at the right time and we were hand delivering it to her. With the TRICARE changes, she was going to be forced to get her medication through the mail without the specialty packaging she needed with our personal touch, or her elderly husband was going to be forced to

---

<sup>5</sup> Kris B. Mamula, "A Bitter Pill to Swallow: Getting out-of-network specialty prescriptions can be a headache." August 31, 2023. *Pittsburgh Post-Gazette*. Available at: [pge.post-gazette.com/pf/showstory/202308240126/3](https://www.post-gazette.com/pf/showstory/202308240126/3).

drive 20 minutes to a pharmacy in Valdosta to pick up her medications. Our service members and veterans deserve better than this hardship being inflicted on them by a PBM.

Many of my patients who are required to use the PBM-owned mail-order pharmacy receive them damaged or do not receive their medications in a timely manner. The PBM-owned mail-order pharmacy will rarely allow an override for the independent pharmacies to fill these medications, and the amount of time needed to get an override is not cost effective for any business. NCPA members have seen examples of this happening with Eliquis (blood thinner), insulin, and many other drugs PBMs classify as “specialty,” all to inflate their bottom line. Independent pharmacies are forced by PBMs to give these patients solutions that are far from ideal, telling them to either pay cash, which is expensive, or to go to the emergency room to receive their medication in an inpatient setting.

We cannot negotiate any aspect of our contracts with PBMs in a 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, and we are rarely paid for the actual cost to dispense the medication. CMS says that in Georgia, the professional dispensing fee for Medicaid is \$10.63,<sup>6</sup> but it is not unusual to get maybe a nickel from PBMs for our cost-to-dispense, and oftentimes zero dollars in Part D. 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 filled.

To reform PBMs, there are several important bipartisan pieces of legislation that I urge members of the committee to support. First, the House will soon be considering H.R. 5378, *the Lower Costs, More Transparency Act*. This health care package contains several key provisions that are vital to lowering prescription drug costs and bringing transparency to anticompetitive practices of PBMs. Among the provisions included in the package is H.R. 1613, *the Drug Price Transparency in Medicaid Act*, which is sponsored by Reps. Buddy Carter (R-Ga.) and Vicente Gonzalez (D-Texas). This provision prohibits the use of spread pricing in Medicaid managed care programs and would move to a fair and transparent pharmacy reimbursement system based on average acquisition costs plus the state’s Medicaid fee-for-service dispensing fee. It requires all pharmacies to respond to the Centers for Medicare & Medicaid Services’ National Average Drug Acquisition Costs survey, which would provide more transparency on drug pricing. The Congressional Budget Office estimated this provision would save taxpayers over \$1 billion.

Another proposal under consideration is H.R. 2880, *the Protecting Patients Against PBM Abuses Act*, which was introduced by Reps. Buddy Carter (R-Ga.), Lisa Blunt Rochester (D-Del.), Nicole Malliotakis (R-N.Y.), and Jake Auchincloss (D-Mass.). H.R. 2880 would protect patients, taxpayers, and pharmacies from harmful PBM practices that make high-quality health care inaccessible and unaffordable. Among other things, this legislation prohibits PBMs from reimbursing non-affiliated pharmacies at a rate less than they reimburse their own pharmacies (thus removing incentives to steer patients) and prohibits spread pricing in the Medicare Part D program. Additionally, it delinks PBM compensation from the cost of medications so that PBMs

---

<sup>6</sup> <https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/medicaid-covered-outpatient-prescription-drug-reimbursement-information-state/index.html>.

are no longer benefiting from ever-increasing list prices and rebates. It also increases transparency by requiring PBMs to publicly report all rebates and fees they receive from drug manufacturers.

PBM games are occurring during a larger crisis in pharmacy. Both independents and chains are closing stores, as thousands of pharmacies represented by NCPA have gone out of business over the last decade.<sup>7</sup> Kroger cut ties with ExpressScripts last year.<sup>8</sup> Winn-Dixie announced it will be closing their in-store pharmacies in the wake of an acquisition of its grocery stores by ALDI.<sup>9</sup> Walmart is cutting its hours and pay.<sup>10</sup> Rite Aid is heading towards bankruptcy.<sup>11</sup> Walgreens has just lost its CEO<sup>12</sup> and is cutting thousands of pharmacists' pay and hours.<sup>13</sup> CVS is also cutting pharmacists' pay and hours.<sup>14</sup> If these large national chains and grocers are having difficulty maintaining their retail pharmacy operations, it is no surprise that small business independent pharmacies are struggling to survive. Pharmacies are going under while PBMs are getting fatter and fatter.

CVS/Caremark/Aetna, UnitedHealthcare/Optum and Cigna/Express Scripts are all in the Fortune 500 top 20 or higher. If Medicare Part D, Medicaid, and commercial plans continue to reimburse pharmacies below the cost to acquire and dispense medications, more pharmacies will close, creating greater obstacles for patients to access their prescription medications and other pharmacy care. Community pharmacy supports common-sense legislative reforms to end PBMs' harmful practices to pharmacy and patients alike. I applaud this committee's bipartisan efforts to shine a light on PBMs through this investigation, and I am happy to answer any questions.

---

<sup>7</sup> <https://ncpa.org/news#digest>

<sup>8</sup> <https://www.winsightgrocerybusiness.com/kroger/krogers-contract-dispute-express-scripts-cost-grocer-100m>.

<sup>9</sup> <https://www.villages-news.com/2023/09/05/winn-dixie-will-be-closing-pharmacies-in-wake-of-sale-to-aldi/>

<sup>10</sup> <https://www.cnn.com/2023/08/29/walmart-cuts-pharmacist-pay-hours-while-workload-piles-up.html>.

<sup>11</sup> <https://www.forbes.com/sites/willskipworth/2023/08/25/rite-aid-reportedly-preparing-for-bankruptcy-amid-opioid-lawsuits-and-33-billion-debt/?sh=17db68f06a6c>.

<sup>12</sup> <https://www.msn.com/en-ca/money/topstories/walgreens-ceo-brewer-abruptly-steps-down-after-less-than-three-years-in-role/ar-AA1g6eHh>.

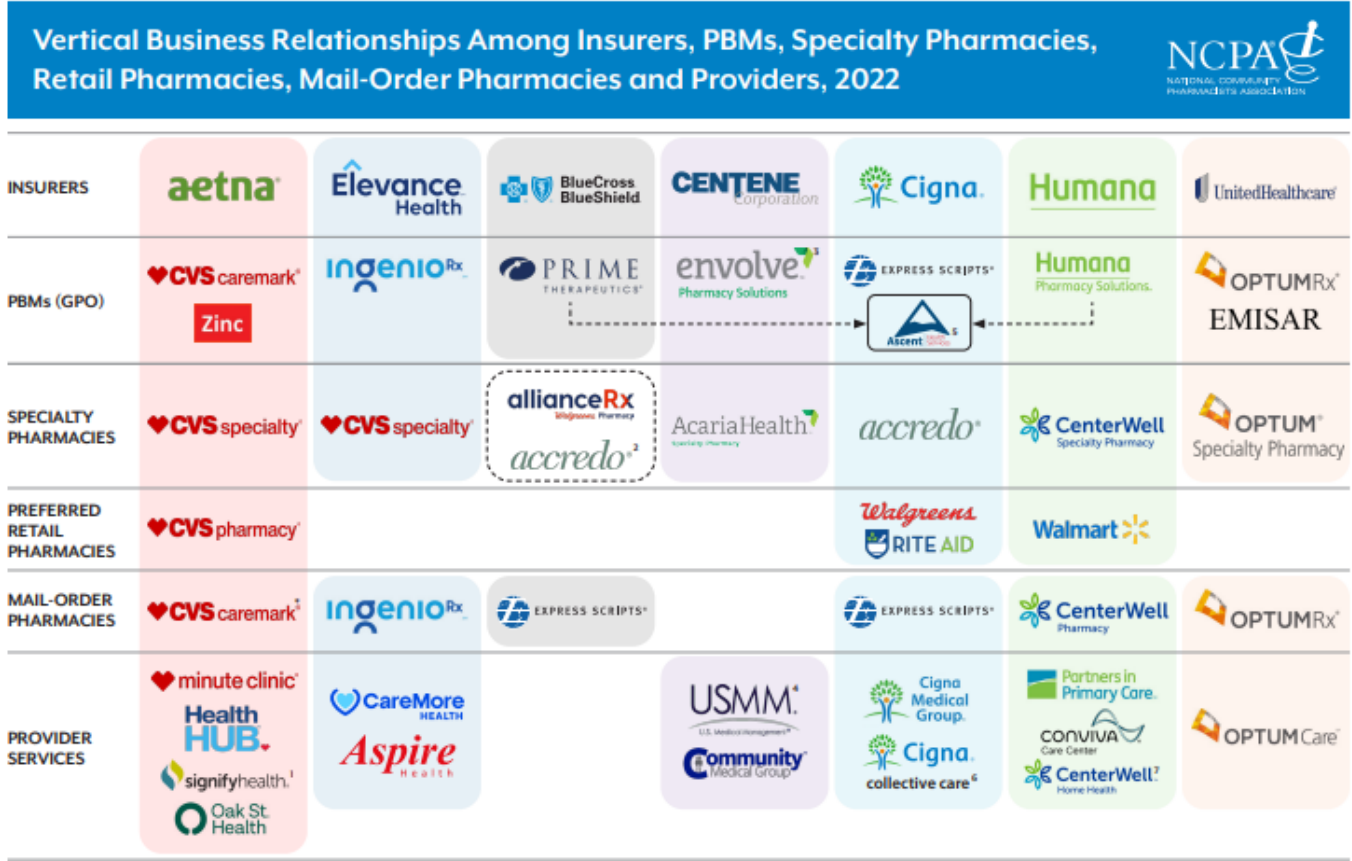
<sup>13</sup> <https://www.reuters.com/business/healthcare-pharmaceuticals/walmart-cuts-pharmacist-pay-hours-while-workload-piles-up-2023-08-29/>.

<sup>14</sup> <https://www.usatoday.com/story/money/2023/01/27/cvs-pharmacy-hours-reduced/11132743002/>.

# Appendix

## Exhibit A

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



<sup>1</sup> In September 2022, CVS Health announced its acquisition of Signify Health. The transaction is expected to close in 2023.  
<sup>2</sup> 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.  
<sup>3</sup> 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.  
<sup>4</sup> In 2021, Centene sold a majority stake in its U.S. Medical Management to a group of private equity firms.  
<sup>5</sup> 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.  
<sup>6</sup> Cigna also partners with providers via its Cigna Collaborative Care program.  
<sup>7</sup> 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.  
<sup>\*</sup> CVS Pharmacy is owned by CVS/Caremark.

## Exhibit B

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

MEDPAC

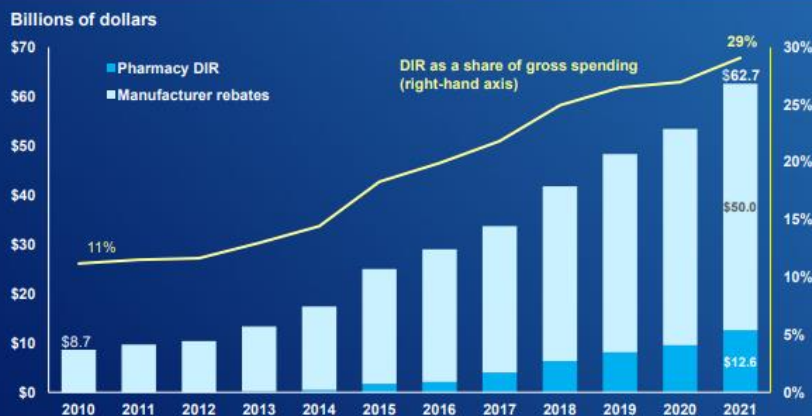
Note: VI (vertically integrated). From the analysis of four PBMs (CVS Caremark, Express Scripts, Humana Pharmacy Solutions, and Optum Rx) and six categories of drugs (disease-modifying anti-rheumatoid drugs, multiple sclerosis agents, two categories of antineoplastics, antiretrovirals, and pulmonary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

17

## Exhibit C

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

### DIR expanded rapidly in Part D, 2010-2021



Note: DIR (direct and indirect remuneration). Gross spending includes enrollee cost sharing and plan (and any other) payments to the pharmacy at the point of sale. Pharmacy DIR consists of net postsale payments from pharmacies to plan sponsors and their pharmacy benefit managers. Data are preliminary and subject to change. Totals may not sum due to rounding.

Source: MedPAC analysis of prescription drug event data and DIR data.

MEDPAC

5