July 17, 2018

The Honorable Buddy Carter
United States House of Representatives
432 Cannon House Office Building
Washington, DC 20515

Dear Representative Carter:

The National Community Pharmacists Association wishes to thank the House Energy and Commerce Committee's Subcommittee on Oversight and Investigations for conducting this hearing, "Examining State Efforts to Improve Transparency of Health Care Costs for Consumers." This is a vital hearing looking at health care price transparency that has emerged as a hot topic in state government and legislatures as a strategy for containing health costs for consumers and state governments. NCPA would like to share our experiences with states that have enacted legislation and initiated programs that aim to reduce costs and bring about increased transparency to the drug pricing system.

NCPA represents America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $80 billion health care marketplace and employ more than 250,000 individuals on a full or part-time basis. Independent community pharmacies are also typically located in traditionally underserved rural and urban communities, providing critical access to residents of these communities.

Community pharmacists have long been concerned with pharmacy benefit managers (PBMs) operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state.

State efforts to increase PBM transparency in the Medicaid program

Spurred by patient concerns, policymakers in several states have examined PBM practices and contract management in their Medicaid managed care programs. Those policymakers have found Medicaid managed care organizations (MCOs) that fail to hold their PBMs accountable, narrow networks that limit patient access to trusted community pharmacists, PBMs that often pay themselves much more than they pay community pharmacies, and spread pricing models

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that disadvantage taxpayers. Having examined the role of PBMs, policymakers in some states are implementing reforms in their Medicaid managed care programs to correct these abuses.

For example, in the summer of 2017, West Virginia carved pharmacy benefits out of its Medicaid managed care program. The state's Department of Health and Human Resources made the move after an actuarial study showed that Medicaid could save $30 million annually by administering the benefit directly, and that doing so would also put $34 million back into local economies in the form of pharmacy reimbursements. Anecdotal reports from Medicaid officials indicate that the actual savings thus far are in line with the projections.

In Kentucky, the state spends approximately $1.68 billion of taxpayer funds on the pharmacy benefit in the Medicaid managed care program. While testifying in front of legislative committees, the state Medicaid administrator could not explain where that money was going, other than it was going to MCOs. Data shows that as much as $380 million could be going directly into the pockets of the PBMs. This lack of transparency and accountability drew the ire of legislators who soon thereafter enacted some of the strongest Medicaid transparency language in the country. Under the new law, Kentucky's Department for Medicaid Services has the authority to review and approve contracts between an MCO and its PBM, contracts between a PBM administering Medicaid drug benefits and a pharmacy, and PBM reimbursement rates. The law also requires PBMs to disclose the difference between the amount the pharmacy is reimbursed for filling a prescription and the amount the PBM charges the MCO for administering the claim.

Kentucky is not the only state to take action and increase transparency by examining PBMs' spread pricing models. Virginia and Georgia have also passed legislation requiring PBMs to disclose the difference between the amount the pharmacy is reimbursed for filling a prescription and the amount the PBM charges the MCO for administering the claim. Similarly, in Ohio and Pennsylvania, the state auditors have announced plans to review PBM practices in those states' Medicaid managed care programs and investigate potential wrongdoing after realizing that community pharmacies' reimbursements have been decreasing, but overall state spending on prescription drugs continues to increase.

Conclusion

Members of this subcommittee should be just as concerned as state policymakers have been in realizing how harmful a lack of transparency is when it comes to PBMs' use of public tax dollars. MCOs have not been holding PBMs accountable, and states are beginning to take control. Those states have learned that constant vigilance and increased transparency is necessary to keep PBMs honest and ensure public funds are spent properly. These measures not only protect taxpayers' wallets, but they ensure that Medicaid beneficiaries can continue accessing the services of trusted community pharmacists. The success of these and similar initiatives have

been noticed by states and organizations across the country, including the National Council of Insurance Legislators, which is currently developing model PBM transparency legislation. While examining efforts to improve transparency of health care costs of consumers, the committee should pay close attention to the success that states have had by increasing PBM transparency.

Sincerely,

Karry K. La Violette
Senior Vice President
Government Affairs and Director of Advocacy Center