



The Honorable Earl L. “Buddy” Carter
United States House of Representatives
Washington, D.C. 20515

June 4, 2018

Dear Mr. Carter:

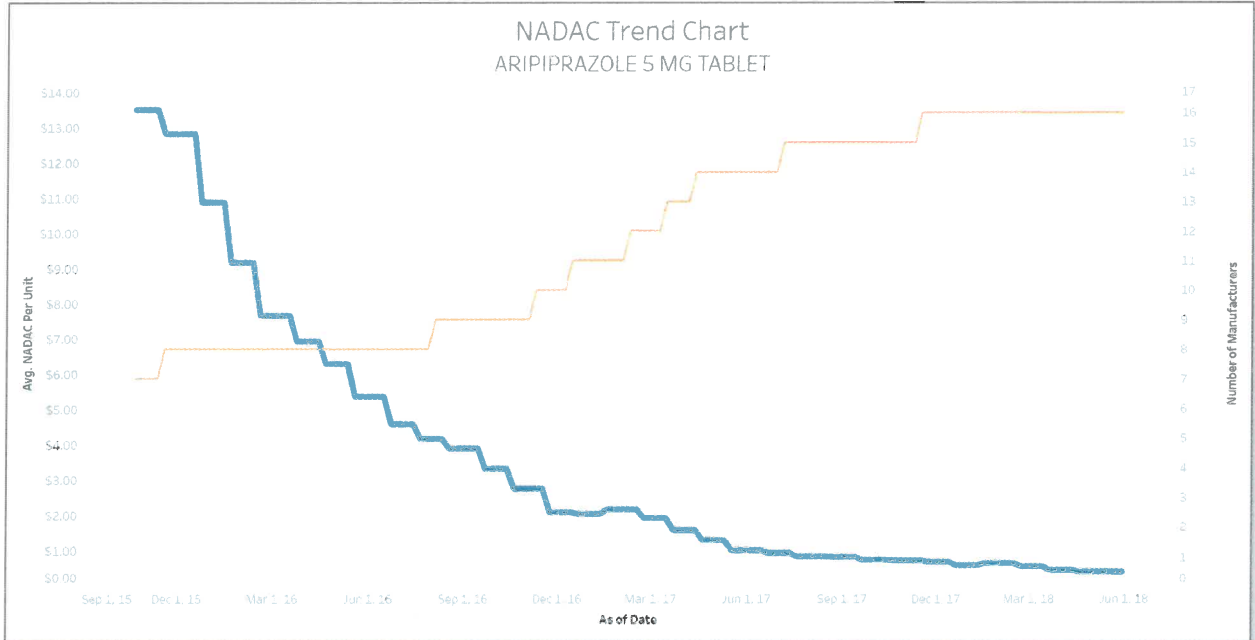
One of the largest profit drivers within the PBM industry is its ability to exploit the “spread” between the price set for a given drug and what is paid out to providers (i.e. pharmacies) for this drug. Non-transparent contracts entered into with payors provide the PBM with the ability to hide true market deflation on drug pricing, and instead manage to “target performance,” which in an extreme deflationary environment on generics affords the PBM ample opportunity to keep the preponderance of cost savings on multi-source generic drugs.

The problem with identifying spread is that in a system designed and dominated by PBMs, there is no transparency around drug pricing. This lack of transparency allows the PBM to charge the payor one price and reimburse the provider a completely different price. Anecdotes of egregious gaps between the two have been leaked to the media over the past few years – but to our knowledge there has never been a comprehensive study measuring the abuse of spread pricing by the PBM – *until now*.

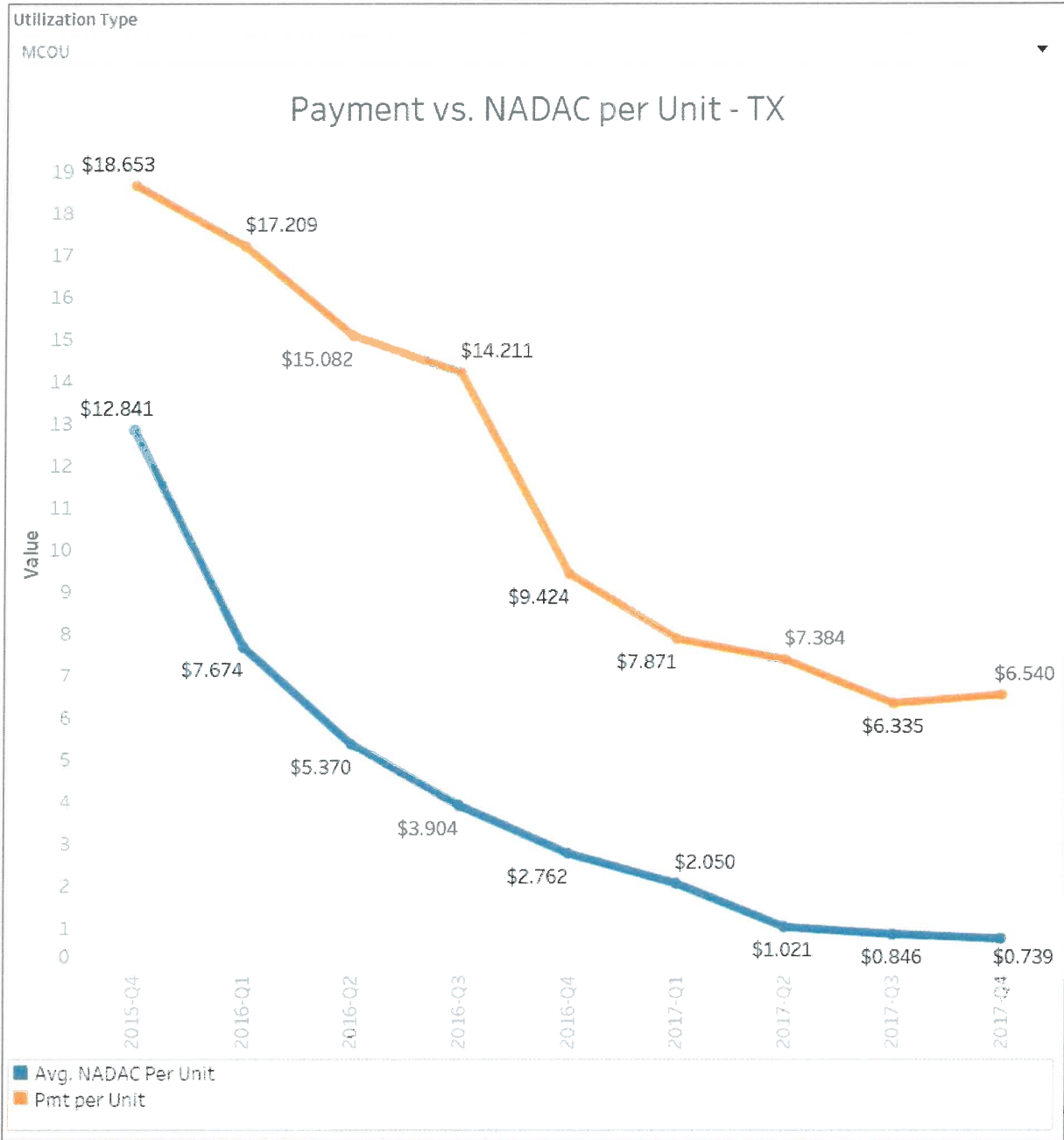
CMS has published Medicaid state utilization data for covered outpatient drugs available since the start of the Medicaid Drug Rebate Program. The state utilization database includes dispensing data for the entire Medicaid program, detailing usage and spend by quarter for both Managed Care and Fee for Service Medicaid programs. CMS also publishes a database of pharmacy drug acquisition costs (“NADAC”) each week. According to CMS, “NADAC is designed to create a national benchmark that is reflective of the prices paid by retail community pharmacies to acquire prescription and over-the-counter covered outpatient drugs.” Using advanced data visualization software, we have merged these two databases together into an interactive dashboard and analytical package, for the first time linking Medicaid drug spend with actual acquisition costs.

Our analysis has uncovered some good news, and some bad news. On a positive note, high profile generic drugs are deflating faster than they ever have before due to enhanced competition. The chart below shows the weekly acquisition cost of generic Abilify (Aripiprazole) – a heavily dispensed mental health medication. When the generic was introduced in late 2015, it was \$13.53 per pill. Fast forward a few years, and the price per generic pill has fallen 97% to \$0.41 as the number of manufacturers in the market rose to 16.

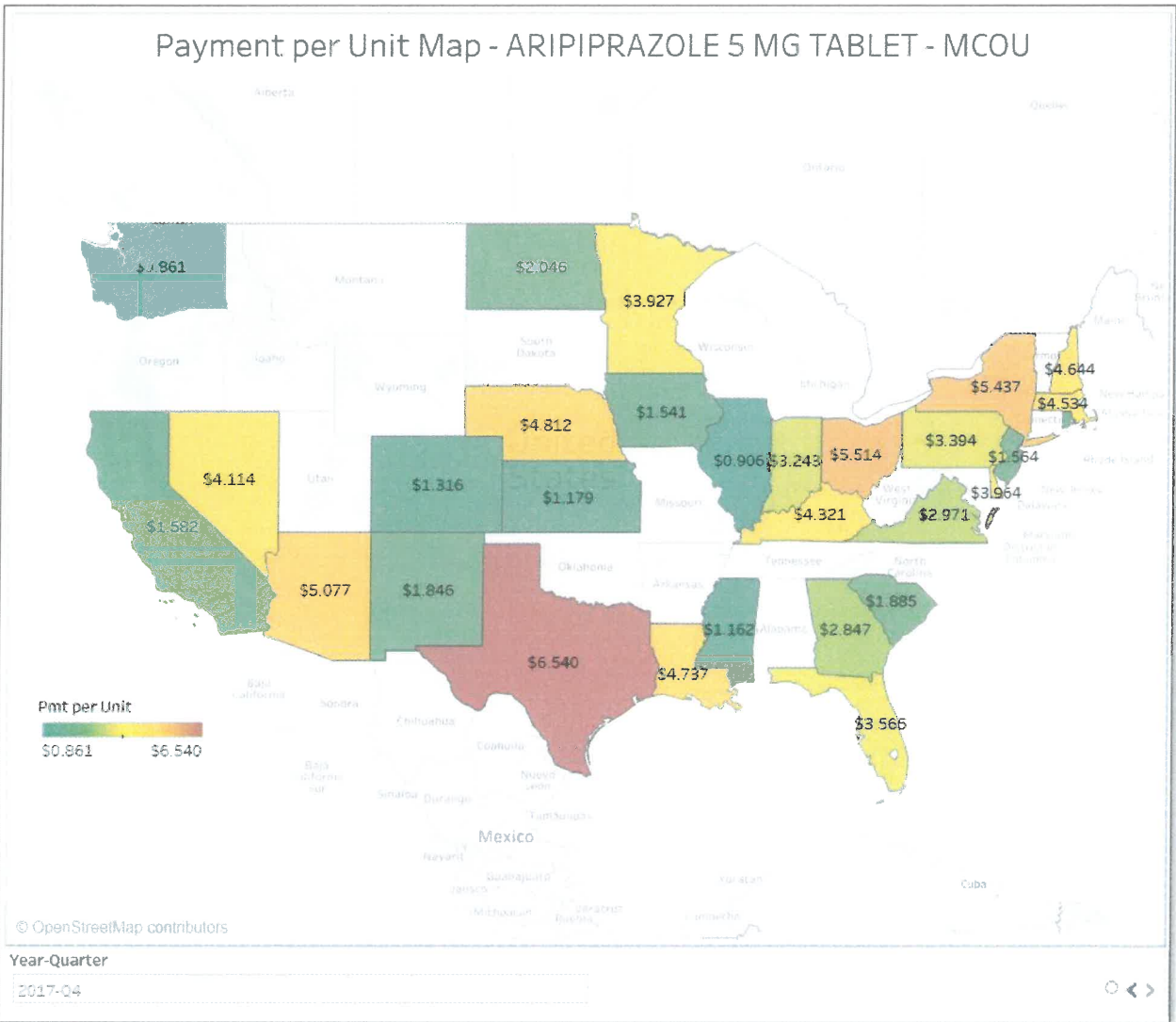
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The bad news is that what Medicaid pays for drugs is not necessarily linked to the actual acquisition cost. In other words, state and federal government are not consistently realizing the benefits of enhanced generic competition due to opaque PBM pricing practices. This is shown very strikingly in the chart below – which contrasts the actual acquisition cost of the same drug we studied above (Aripiprazole) with what CMS reports Managed Care (MCOU) Medicaid paid for this drug in Texas. In Q4 2017, Managed Care Medicaid in Texas paid \$6.54 per pill for this medication, nearly nine times the actual cost of the drug.



Unfortunately, this pricing disconnect is not isolated to one state. The map below shows what Managed Care Medicaid paid for this same drug (per pill) across the country in Q4 2017. Recall that the actual acquisition cost of this drug was \$0.73 per pill in Q4 2017.



Generic Abilify is just one example of a generic that has experienced substantial **actual** deflation, but comparatively modest **realized** deflation due to PBM spread pricing. There are dozens more that show a similar disconnect, suggesting that PBMs may be systematically exploiting the benefits of generic deflation instead of passing them along to taxpayers.

I would like for you to forward this information to appropriate Members, Committee's or the Administration in hopes of us presenting this information to them.

Thank You for all you do.

Bill Eley
 Bill Eley, Director of Legislative Affairs