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Subcommittee on Consumer Protection, Product Safety, and Data Security

"Ensuring Fairness and Transparency in the Market for Prescription Drugs"

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Introduction

Good morning, Chairman Blumenthal, Ranking Member Blackburn, and members of the Subcommittee on Consumer Protection, Product Safety, and Data Security.

My name is JC Scott. I am the President and CEO of the Pharmaceutical Care Management Association (PCMA).

PCMA is the national association that represents America's Pharmacy Benefit Managers (PBMs), which administer prescription drug plans and operate specialty and mail-order pharmacies for more than 266 million Americans who have health coverage from a variety of sponsors, including through employers, labor unions, health insurers, Medicare Part D plans, state government employee plans, Medicaid plans, the Federal Employees Health Benefits Program, TRICARE and others.

PBMs are proud of the work they do to reduce prescription drug costs, expand affordable access to medications, and improve patient outcomes. PBMs negotiate with drug companies to lower prescription drug costs. PBMs work with pharmacies to create networks of pharmacies that provide the best value. PBMs facilitate home delivery of prescription drugs to patients safely and seamlessly, and PBMs help patients stay on their prescription drugs to live healthier lives. PBMs advocate for patients in the fight to keep prescription drugs accessible and affordable.

On behalf of PCMA’s member companies, I appreciate the invitation to testify before the subcommittee today as it seeks to understand better the role PBMs play in the drug supply chain and our impact on consumers, small businesses, and drug costs.

Drug pricing and affordability are a challenge for too many patients in America. We can and should talk about what is driving that affordability challenge and how we solve it, which begins with an understanding of the entirety of the prescription drug supply and payment chain, from manufacturer to wholesaler to pharmacy to those providing health coverage.

Today, the subcommittee is focused on just one piece of that ecosystem—understanding the work done by our companies, PBMs.

During your time in the Senate, you have met with many people representing the health care industry.

With respect to prescription drugs, you have heard from retail pharmacies, which are essential to serving patients and providing access to medications, and which, generally speaking, argue for higher payments, which lead to higher drug costs.

Representatives of drug manufacturers, those responsible for both the amazing innovations that benefit patients and for setting prices, generally seek to justify their price-setting decisions and argue for higher, not lower, prices.

Understandably, stakeholders in the supply chain want to be paid more for their services and products. That is the way the market functions. But those paying the bills need a balancing force to push for lower costs and better access, and that is where PBMs come in.

The PBM industry is the only stakeholder in the chain dedicated to seeking lower costs. PBMs do that work for the employer, union, health plan, and government clients who hire them, and, most

importantly, the patients for whom those health plans provide coverage.

PBMs return $10 in savings for every dollar spent on their services. As a result, PBMs will lower the cost of health care by $1 trillion this year alone.[i] For many of us, that can be a hard number to get our heads around, but it comes down to saving about $962 per person per year.

PBMs are able to negotiate for lower drug costs when they can bring competition between pharmaceutical manufacturers and between pharmacies to bear. PBMs lower prescription drug costs by using these negotiations to deliver discounts and rebates, promoting the use of generic medications, encouraging better pharmacy quality, and offering things like home delivery for those on chronic medications.

Simplifying the Consumer Experience

People with insurance filled more than 6.4 billion prescriptions in retail pharmacies in 2021.[ii] Every day, that amounts to nearly 15 million prescriptions, so it is critical that patients can pick up their prescriptions as quickly as possible at the pharmacy counter to establish and maintain medication adherence. PBMs perform many essential functions that combine disparate information and expertise, as well as advanced technology to facilitate and streamline getting a prescription filled as seamlessly as possible.[iii]

To achieve optimal PBM-patient coordination, once a pharmacy enters a prescription into the system, it is sent electronically to the patient's PBM, which checks the pharmacy benefit information to confirm the patient's insurance status and cost-sharing amount, as well as the patient's medication history for any errors and possible harmful dangerous drug interactions. While pharmacies have

records of prescriptions filled by them or a fellow chain pharmacy, they do not have records of prescriptions filled in other pharmacies. However, PBMs do, as long as the patient has used insurance. Given that information and the technology, in real-time and almost instantaneously, the PBM can determine if the prescribed drug should not be taken by that patient and can alert the pharmacist to any dangerous interactions before the patient pays any cost sharing and receives any medication. All of this happens rapidly, seamlessly, and behind the scenes to improve patient safety and care.

Reducing Health Benefit Costs for Businesses

PBMs have an established record of negotiating with drug manufacturers and pharmacies to reduce drug costs. PBMs work to bring drug prices down to the lowest net cost for employers, both large and small, and others who provide health insurance.

No employer, union, pension fund, or health plan has to hire or use a PBM. But virtually all do choose to hire a PBM to lower the cost of providing health care coverage and to better serve the patients they represent.

PBM clients choose their PBMs through a transparent and highly competitive bidding process. With more than 70 full-service PBMs in the market, including regular new entrants, unions, and employers, health plans have a tremendous diversity of opportunities to contract with the PBM that best meets their unique needs.[iv]

Some may choose a PBM based on its scale, ability to negotiate deep discounts or manage the risk of price changes. Others choose to hire PBMs based on their innovative care management programs or different levels of service. For small employers, many

of whom may struggle to provide health insurance to employees, PBMs lower drug costs and provide cost predictability, enabling them to stretch their benefit dollars even further.

For all those sponsoring health insurance, it is important that there is choice among PBMs and the ability to decide how to set up their drug benefits to best serve their unique populations.

PBMs typically develop a basic preferred drug list, or formulary, under the guidance of their pharmacy and therapeutics (P&T) committee. P&T committees are comprised of independent physicians, pharmacists, and other clinical experts who consider the most recent data on prescription drugs and tell the PBM what drugs it must include, must not include (for safety reasons), and may include on its formulary. The drugs it "may" include are typically for conditions or diseases for which there are competing therapeutically equivalent treatments, and for which the PBM may leverage competition between drug manufacturers to negotiate lower costs. Once the PBM has concluded its negotiations and devised its formulary, it then recommends it to those sponsoring health insurance, who may choose to utilize it, customize it, or go with another approach.[v] PBMs create formularies of clinically appropriate drugs, preferring ones that are the most cost effective, including generic drugs, biosimilars, and lower-cost alternative brand drugs.

One method that PBMs use to lower drug costs is incentivizing the use of lower-cost generic alternatives to name-brand drugs. Indeed, generic dispensing has grown over the past decade as more generics have entered the market and patients have responded to health plan designs encouraging their use, so that now roughly 90 percent of prescriptions filled in the United States are for generic drugs, at a fraction of the cost of their brand-name equivalents.[vi] PBMs also sometimes, for some conditions, require

patients to try generic drugs before trying more expensive brand drugs, and employ other tools designed to deliver high-quality drug benefits while bringing down costs.[vii]

As a result, PBMs have a pro-competitive influence on the prescription drug marketplace, and PBM services provide a significant and measurable benefit for businesses and others providing health insurance. Without PBMs in the marketplace, those organizations would be left to negotiate drug costs on their own or pay the full costs of these drugs.

Lowering Drug Costs for Consumers

As mentioned earlier, PBMs, working with those providing insurance, encourage patients through formulary design and cost-sharing incentives to use the most affordable drugs, which are usually generics. For many brand drugs, PBMs negotiate directly with drug manufacturers who compete for formulary placement by offering a type of discount called rebates.[viii] For drugs on the preferred tier of a plan's formulary, consumers typically have lower cost sharing.[ix] As competing products enter the market, PBMs gain the flexibility to leverage competitor products to negotiate deeper drug discounts for patients and payers.[x]

PBMs have also led the industry in creating contracts that account for the value of specialty and high-cost medications.[xi] Value-based arrangements are at the forefront of new drug payment designs and will be critical to managing the costs of next-generation therapies like cell and gene therapies, orphan drugs, and ultra-expensive specialty drugs. Value-based contracts will better allow plans to manage these high costs, and health plans will need broad flexibility to craft and employ value-based contracts.

The Medicare Part D program, where older Americans and those

living with disabilities can choose among private plans to get their drug benefits, is a great example of PBM value. PBMs support Part D plans by negotiating rebates and discounts and promoting better pharmacy quality, passing 99.6 percent of those savings from those negotiations to the Part D plans, which in turn use them to enhance drug benefits and keep premium costs reliably low for beneficiaries.[xii]

As another cost-saving measure, PBMs offer prescription home delivery through highly efficient, virtually error-free mail-service pharmacies. As with many other products, patients can safely access prescription drugs through home delivery. Mail-service pharmacies are convenient, dependable, and affordable. Patients will often fill the first few prescriptions at a retail pharmacy if the prescription is for a chronic condition. Patients may then choose to use a mail-service pharmacy for home delivery once they are stabilized on the medication(s). On 90-day supplies of medicines, mail-service pharmacies result in lower copayments for consumers and improved medication adherence overall.[xiii]

Savings from PBMs benefit health plans, employers, and consumers directly. Prescriptions cost health plans and employers an average of $1,315 per person per year, with consumers paying an average of $180 for their prescriptions, or 14 percent.[xiv] Without PBMs and the savings they generate, drug costs could be $2,000 per person per year.[xv]

The Value of Pharmacy Networks

PBMs lower pharmacy costs by negotiating with pharmacies to establish competitive rates at which the PBM will reimburse for each prescription that a pharmacy fills, which enables the PBM to form preferred pharmacy networks. Through these pharmacy negotiations, pharmacy networks enable PBMs to maximize

accessibility, choice, and quality of service, as well as hold down costs for patients enrolled in health plans, including, among others, Medicaid, Medicare Part D, state employee plans, and employer-sponsored plans.

Pharmacies have been willing to negotiate price concessions, some based on proven volume, to ensure they have access to the plans and PBMs with the largest and fastest-growing membership bases. Often, but not always, independent pharmacies participate in preferred networks through contracts negotiated and administered by their Pharmacy Service Administration Organizations or PSAOs. As of 2019, all but one major PSAO chose to negotiate for the pharmacies they represent to participate in PBMs' preferred networks and fill prescriptions for patients served by plans utilizing those networks.[xvi] Some 83 percent of independent pharmacies contract with a PSAO.[xvii] Between 2011 and 2021, the number of independent pharmacies nationwide increased by approximately 13 percent (or by 2,645), whereas chains lost around 80 stores (0.2 percent) on average.[xviii] Today, there are more retail pharmacies in the U.S. than Starbucks, McDonald's, Burger Kings, and Subways combined.

By creating preferred networks, PBMs are able to negotiate savings that reduce Medicare Part D premiums by $63 per member per year. One study estimated that preferred networks created by PBMs for Part D health plans save federal taxpayers at least $870 million annually.[xix]

When patients present a prescription to be filled, the pharmacies in a PBM's network dispense prescriptions for them using prescription drugs that they have purchased directly from wholesalers or manufacturers. Before dispensing a drug, the pharmacy checks with the PBM to confirm the applicable plan design for the patient to determine eligibility, coverage, and cost-sharing information.

After the prescription is filled, the PBM reimburses the pharmacy at a contractually agreed-upon rate minus any applicable cost-sharing collected by the pharmacy from the patient. The PBM then separately bills the health plan at the rate negotiated between the PBM and the health plan.

Patients recognize potential savings and, as a result, most prefer plans with preferred networks. For plan year 2021, 99 percent of Part D beneficiaries chose Part D plans with preferred pharmacy networks—an increase from 92 percent in 2020. In a survey, 85 percent of Medicare Part D beneficiaries reported satisfaction with their preferred network plan, and nearly 80 percent said they would be disappointed if their plan were eliminated.[xx] These examples demonstrate that PBMs are delivering value to patients through intense competition amongst pharmacies for access to preferred networks.

PBMs are instrumental in ensuring that patients have good options for where to fill their prescriptions at reasonable prices, including at independent pharmacies. In Medicare Part D, PBMs and Part D plan sponsors use a form of value-based contracting referred to as "pharmacy DIR" to reward high-performing pharmacies, create high-quality pharmacy networks, promote quality access for beneficiaries, improve health outcomes, and reduce premiums. Pharmacies that help Medicare beneficiaries stay on their medications, increase generic dispensing, and improve overall patient access to care are rewarded through pharmacy DIR.

Meaningful, Actionable Transparency

Transparency that helps patients and payers is necessary across the entire prescription drug chain. PBMs support and practice actionable transparency that empowers patients, their physicians, those sponsoring health coverage, and policymakers, so that they

can make informed decisions that can lead to lower prescription drug costs. Actionable transparency encourages consumers to shop for coverage that best fits their health needs and budgets, and once covered, use the most cost-effective, highest-value healthcare goods and services. It enables prescribers and patients to avoid pharmacy-counter surprises and helps ensure that physicians can prescribe drugs that are affordable for patients. To that end, PBMs provide consumers and prescribers with real-time benefit tools (RTBTs), which provide real-time information on exactly where the patient is with respect to progressing through a deductible or another benefit phase, what drugs are on the patient's formulary, and exactly what cost-sharing to expect for a given drug at the pharmacy. PBMs also provide consumers with information on in-network pharmacies, premiums, general cost-sharing, and benefits for their prescription drug coverage.

PBMs provide health plans, employer plan sponsors, and consumers with a broad array of accurate, actionable information on price and quality to make efficient purchasing decisions. PBMs' customers are able to set the terms of the transparency and information they want to receive, as well as their audit rights, as part of their contracts.

In recent years, Congress has added more requirements for PBMs to report to federal agencies, as well as public reporting in more aggregated form, in both cases with appropriate protections for confidential data to avoid encouraging tacit collusion, efforts that we support. As the Federal Trade Commission has noted, there are limits to the benefits of transparency and unintended consequences that can result.[xxi] PBMs encourage Congress to focus its efforts on actionable transparency that reduces drug costs versus transparency that raises them.

Promising Policy Solutions

PCMA supports efforts to increase competition in the pharmaceutical market and increase patient access to needed medications. Generally, we support bills by several of the committee's members and others that would:

- Increase competition in the pharmaceutical market and eliminate patent system abuses that stifle competition.
- Prevent pay-for-delay patent settlements for patent infringement claims between brand and generic manufacturers.
- Put an end to abuses of the citizen petition process that may slow new competition by slowing applications seeking market approval.
- Improve Medicare's online pricing tools, allowing beneficiaries to compare costs across healthcare settings.
- Prohibit product hopping that would allow drug manufacturers to switch from an expiring patent on a reference drug to a later-expiring patent on a follow-on product.
- Reimagine and modernize Medicare Part D to allow for comprehensive benefit redesign and increased transparency while protecting sensitive proprietary pricing information and avoiding inadvertent price increases for patients and the federal government.

I want to thank Chairman Blumenthal and Ranking Member Blackburn and Senators Klobuchar, Cruz, Peters, and others for their work on these efforts. The PBM industry looks forward to working with the committee's members on these policy concepts.

Conclusion

PCMA and the companies we represent are committed to working with the subcommittee and all stakeholders to continue improving the affordability of prescription drugs for patients. While I have spoken a lot about the work we do for those who provide health coverage for consumers, the most important lens through which to judge these issues is not what will best benefit the plan sponsor, the PBM, the retail pharmacy, or the manufacturer; it should come down to what best serves the consumer—the affordability of their health care, the ease of their access, and ultimately their health care outcomes.

Through their work, PBMs are contributing to lower costs for health coverage, lower costs for medications, and better and more affordable access for patients, which means more people getting the medications they need to lead healthier lives.

I hope that this hearing is an opportunity for a continued conversation not only about the work done by PBMs but a look at the entire supply chain so that we can identify solutions for patients and consumers.

Thank you again for the opportunity to speak with you. I look forward to answering your questions.

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