NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Comments from the National Association of Chain Drug Stores in Response to the Federal Trade Commission's Solicitation for Public Comments on the Impact of Prescription Benefit Managers' Business Practices

May 19, 2022

The National Association of Chain Drug Stores (NACDS) thanks you for the opportunity to respond to the Federal Trade Commission's (FTC) February 24th Solicitation for Public Comments on the Business Practices of Pharmacy Benefit Managers (PBMs) and their impact on consumers and pharmacies. NACDS and its members have a strong interest in the PBM practices which are the subject of this solicitation, including PBM pharmacy contract terms, which impact all retail community pharmacies, including chains small and large, and, by extension, their patients. Therefore, NACDS provides the following comments for FTC's consideration.

NACDS is a non-profit, tax-exempt organization representing over 80 chain pharmacy member companies include regional chains, with a minimum of four stores, and national companies. Chains operate over 40,000 pharmacies, and NACDS' chain members employ nearly 3 million individuals, including 157,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and health care affordability.

A. PBM Practices Lacks Transparency, Stability, and Predictability in Pharmacy Reimbursement

NACDS and its members have a strong interest in initiatives that help to protect the health and safety of patients by promoting the economic viability of their trusted community pharmacies. The unregulated reimbursement practices of PBMs have caused numerous pharmacies to close, leaving many communities without front-line health care providers. Helping to ensure that PBMs' reimbursement rates cover pharmacies' costs of acquiring and dispensing prescription medications and associated services, and counseling is a critical factor for preserving and protecting patient access to needed care and services provided by pharmacies.

PBMs are third-party administrators that are utilized by most insurers, self-insured employer health benefit plans, union health plans, Medicare Part D plans, state government plans, Medicaid managed care plans, and other entities to manage pharmaceutical benefits for their employees or members. The PBM's role in prescription drug benefits made available through retail community pharmacies is dominant. Indeed, the market reality is that they negotiate discounts with drug manufacturers, work with health plans to design formularies, including tier placement and coverage criteria that correspond with patient cost-sharing for each drug, establish pharmacy networks, reimburse pharmacies on behalf of plans, process drug claims, and more.[1] Through a PBM's contract with a health plan, the beneficiaries covered by the plan's prescription drug program obtain access to the pharmacy networks established by the PBM, some of which include the PBMs own pharmacies. When a plan beneficiary fills a prescription, the plan and the beneficiary each pay a set amount determined under the PBM contract for the prescription.

[1] https://content.naic.org/cipr-topics/pharmacy-benefit-managers

Oftentimes, the PBM does not fully cover the pharmacy's cost related to dispensing the prescription or any supportive or related clinical services.

In addition to establishing the reimbursement rate for drugs that pharmacies dispense, PBMs also charge pharmacies fees, or price concessions, that are often collected from the pharmacy months after the transaction. The collection of fees after the point of sale results in a loss of revenue by pharmacies that is nearly impossible to predict, so pharmacies are frequently unsure of their final reimbursement due to their inability to ascertain if, and to what extent, additional price concessions will be recuperated at a future time. Moreover, this often causes losses in revenue that surpass the acquisition cost of the drug itself, regardless of the services provided. This situation arises from the practice of PBMs individually applying various undisclosed quality metrics to pharmacies against which their performance is measured either to provide incentives for high performance or to "claw back" payments for unsatisfactory performance. Additionally, PBM audit practices, which also can trigger pharmacy payments back to PBMs, often are unduly burdensome and unclear.

As described, PBM operations are opaque, and these types of reimbursement practices by PBMs harm consumers, pharmacies, and others. While some states have attempted to regulate PBM activities, these problematic practices persist as does the threat they pose. The current opaque PBM reimbursement model, with respect to price concessions and incentive payments tied to undisclosed and variable performance measures, does not allow pharmacies to make clear and fully informed decisions about PBM network participation, as well as how to optimize costs and care for patients. As a result, these opaque terms and lack of transparency are anticompetitive, as they bar a pharmacy from being able to properly assess where the best terms for its services, including both reimbursement concessions and incentives, may be found.

Further, negotiation of these opaque terms is heavily influenced by the unmatched market predominance of PBMs. Failure of pharmacies to secure contracts with the PBMs would result in pharmacies being unable to care for large portions of their patient population. Consequently, pharmacy dependence on these opaque PBM contracts to provide patient care, especially on those of PBMs with the largest market share, creates an unfair and anticompetitive imbalance in the negotiation process. As a result, pharmacies find themselves forced to accept terms that are not fully disclosed that may impose below-cost reimbursement, unfavorable reimbursement benchmarks, undisclosed fees, invisible performance metrics, lack of standardization of favorable terms across network pharmacies, and patient steering that ultimately limit patient access to the pharmacy of their choice. Ultimately, the anticompetitive nature of both PBM contracts and related negotiations have negative consequences not only on the market well-being but more importantly on patient access to needed health care services.

More specifically, the lack of drug price transparency in PBM contracts can drive up both market and consumer costs as well. For example, the opaque practice of payment clawbacks from pharmacies after the point of sale can mean that patients are subject to cost-sharing tied to inflated price benchmarks (as opposed to net drug costs). Consequently, a common practice for patients is to look for discount pricing to circumvent traditional pharmacy benefits which often leads to higher costs in the long run due to failure to meet deductibles or out-of-pocket spending caps. Worse yet, consumers often fail to take their medication as prescribed, or discontinue therapy, due to challenges related to inflated costs leading to

nonadherence and ultimately increased medical complications and overall costs to the health care system. In fact, experts agree that medication non-adherence leads to undue and preventable suffering for patients, suboptimal health outcomes, increased total cost of care, and wasted spending. Specifically, patients not taking their medications as prescribed by their health care provider contribute to $100 billion to $290 billion in unnecessary health care expenditures every year as a result of increased hospitalizations and other avoidable, expensive medical services.[2]

Not only is consumer drug price transparency hindered by these PBM practices, but also pharmacy quality transparency, of obvious significance to consumers, is as well. As described, that is clouded by the non-standardized and inconsistent PBM quality measures applied to pharmacies. Quality metrics currently being used are neither consistent across PBMs nor transparent by PBMs, so pharmacies do not know what metrics they are trying to satisfy to obtain a reward for high performance or to avoid a claw back for poor performance. Further, without a standard set of pharmacy metrics, and measurement and ranking criteria, consumers, are unable to make direct comparisons of pharmacy quality. As a result, there is not an effective means for consumers to compare plans and pharmacies within government and certain commercial plans, undercutting the overall market competition. Additionally, the continual downward push on pharmacy reimbursement threatens beneficiary access to pharmacy services.

B. PBM Practices Jeopardize Patient Access to Valuable Pharmacists-Provided Services

Pharmacies not only dispense medications, but also provide front-line health care like immunizations, tobacco cessation counseling, hormonal contraceptive therapies, blood pressure testing, glucose testing, flu shots, and customer education on a variety of health-related matters. Throughout the global COVID-19 pandemic, community pharmacies have been vital health care destinations, especially to those often underserved, helping to ensure patients' uninterrupted access to critical medications and providing critical community-based COVID-19 testing, life-saving vaccines, and most recently beneficial treatment therapies. For example, recent government reports show:

- Pharmacies have administered more than 248 million COVID-19 vaccinations to date.[3]
- Today, 2 of every 3 COVID-19 vaccine doses are provided at a pharmacy[4]
- More than 40% of those vaccinated at pharmacies were from racial and ethnic minority groups.[5]
- More than 40% of children ages 5 to 11 who received a COVID-19 vaccination did so at a pharmacy.[6]
- Half of pharmacy COVID-19 vaccination sites are located in areas with high social vulnerability[7]

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[2] *See* Rosenbaum L, Shrank WH, Taking Our Medicine - Improving Adherence in the Accountability Era, New England Journal of Medicine, Aug. 22, 2013; Network for Excellence in Health Innovation, Bend the Curve: A Health Care Leader's Guide to High Value Health Care, 2011, available at https://www.nehi.net/writable/publica-tion_files/file/health_care_leaders_guide_final.pdf

[3] CDC, Federal Retail Pharmacy Program, *available at* https://www.cdc.gov/vaccines/covid-19/retail-pharmacy-program/index.html.

[4] White House, *available at* https://www.whitehouse.gov/briefing-room/statements-releases/2021/12/02/fact-sheet-president-biden-announces-new-actions-to-protect-americans-against-the-delta-and-omicron-variants-as-we-battle-covid-19-this-winter/.

[5] GAO, Federal Efforts to Provide Vaccines to Racial and Ethnic Groups, *available at* https://www.gao.gov/assets/gao-22-105079.pdf.

[6] Biden Administration, *COVID-19 Vaccine for Children 6 Months – 4 Years Old Preliminary Considerations for Pediatric Planning*, Feb. 2022, *available at* https://www.aha.org/system/files/media/file/2022/02/covid-19-vaccine-for-children-6-months-4-years-old-preliminary-considerations-for-pediatric-planning.pdf.

[7] GAO, Federal Efforts to Provide Vaccines to Racial and Ethnic Groups, *available at* https://www.gao.gov/assets/gao-22-105079.pdf.

- Pharmacies have provided more than 11,000 mobile COVID-19 vaccination clinics across the country[8]
- Pharmacies provide more than 20,000 COVID-19 testing sites nationwide, and 70% of such sites are in areas with moderate to severe social vulnerability[9]
- Pharmacies and retail health clinics provide access to COVID-19 antivirals at thousands of locations nationwide.[10]

Despite continuing to step up heroically during the pandemic and beyond, pharmacies are facing a crisis that poses a genuine health care threat to Americans: the rampant closure of pharmacies, especially in rural areas. Independent data sources have reported that the number of retail pharmacies in the United States declined in number by almost 2,000 in recent years.[11] Moreover, several pharmacy chains have announced plans to close hundreds of additional pharmacies.[12] Pharmacy closures have disproportionately affected rural areas. 630 rural communities that had at least one pharmacy in March 2003 had no retail pharmacy in March 2018.[13]

Pharmacy closures are harmful to patients because pharmacies serve as front-line health care providers. As described above, in addition to providing medications, pharmacies offer immunizations and a range of other patient services on a variety of health-related matters. When a pharmacy closes in a rural area, the frequent result is that the rural area no longer has a front-line health care provider. Thus, if a patient that resides in such an area wishes to obtain medications or basic health care testing, the patient, who may or may not have a reliable mode of transportation, may need to take time off from work or travel a great distance to access such care. If the patient is unable to do so, this will likely lead to poorer medication adherence or delayed medication fills, possibly resulting in negative changes to clinical outcomes and increasing overall health care costs.[14]

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[8] *Id.*

[9] White House, FACT SHEET: Biden Administration Announces Historic $10 Billion Investment to Expand Access to COVID-19 Vaccines and Build Vaccine Confidence in Hardest-Hit and Highest-Risk Communities, available at https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/25/fact-sheet-biden-administration-announces-historic-10-billion-investment-to-expand-access-to-covid-19-vaccines-and-build-vaccine-confidence-in-hardest-hit-and-highest-risk-communities/

[10] Also, the Administration has announced a pharmacy-based Test-to-Treat initiative to help enhance access to COVID-19 antivirals through hundreds of pharmacy-based co-located clinics. Unexpectedly, the emergency use authorizations (EUAs) issued by FDA for the two COVID-19 oral antiviral medications needlessly omitted pharmacists as authorized prescribers. NACDS continues to advocate against this undue barrier and for pharmacists to be leveraged in the full end-to-end patient journey to help ensure those who need access to these vital medications have it in a timely manner. Still, in addition to those pharmacy locations able to participate in the Test-to-Treat initiative, thousands of pharmacies are also providing important access to COVID-19 therapeutics by providing a dispensing access point, and are also providing patient and prescriber education, coordinating with prescribers on appropriate use, initiation within the 5-day symptom window, dosing adjustments, infection control procedures, and more.

[11] National Association of Chain Drug Stores, *The Pharmacy Reimbursement Crisis* (last visited Feb. 24, 2020)), *available at* https://www.nacds.org/pdfs/pharmacy/2020/Pharmacy-Reimbursement-2020.pdf (showing the number of U.S. retail pharmacies dropped from 58,706 in December 2017 to 56,788 in December 2019 according to IQVIA, an industry group that collects pharmacy data, and a net 995 pharmacy profiles closed in 2018 and net 695 pharmacy profiles closed in 2019 according to the National Council for Prescription Drug Programs, a national group that assigns identification numbers to pharmacies for billing purposes).

[12] Chains Closing Stores, Opening Fewer, https://www.drugtopics.com/latest/chains-closing-stores-opening-fewer.

[13] Center for Rural Health Policy Analysis, Rural Policy Brief, https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf

[14] Dima M. Qato, et al., *Association Between Pharmacy Closures and Adherence to Cardiovascular Medications Among Older US Adults*, Journal of the American Medical Association (Apr. 19, 2019) (finding "pharmacy closures are associated with persistent, clinically significant declines in adherence to cardiovascular medications among older adults in the United States."). *See also,* fn. 2, *supra* (including additional source with details on cost of patient non-adherence).

NACDS appreciates being given an opportunity to share the above information and concerns with the FTC as it examines PBM business practices. Should you have any questions, please contact Christie Boutte, Senior Vice President, Reimbursement, Innovation & Advocacy at 703-837-4211 or cboutte@nacds.org.