NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement of:
Steven C. Anderson, FASAE, CAE, IOM
President and Chief Executive Officer
National Association of Chain Drug Stores (NACDS)

For:

United States House
Committee on Oversight and
Accountability

On:

"The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part II: Not What the Doctor Ordered"

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National Association of Chain Drug Stores
(NACDS)
1776 Wilson Blvd., Suite 200 Arlington, VA
22209
703-549-3001
www.nacds.org

Introduction

The National Association of Chain Drug Stores (NACDS) thanks Chairman Comer and Ranking Member Raskin for the opportunity to submit a statement for the record for the House Committee on Oversight and Accountability hearing on "The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part II: Not What the Doctor Ordered." NACDS appreciates the Committee's ongoing, bipartisan work to expose the tactics of pharmacy benefit managers (PBMs) that are increasing healthcare costs for Americans and harming patient care.

We applaud Chairman Comer's investigation into PBMs' role in rising healthcare costs, and into how PBM practices distort the pharmaceutical market and limit high quality care for patients. PBMs' opaque and self-serving business practices, including their abuse of pharmacy performance measures in the Medicare Part D program, lead to inflationary effects on drug prices, restrictions on patient access, and unfair and below-cost pharmacy reimbursement. The ability of pharmacies to provide prescription medications and related care to patients is often controlled and manipulated by the three largest vertically integrated PBM insurers, which threatens pharmacies' viability and the patients who rely on them for care and access.

Retail pharmacies are critical healthcare access destinations for patient and population health. The nation called on pharmacies to deliver COVID-19 testing, vaccinations, and other critical care services to communities during the pandemic. Pharmacies seamlessly rose to the challenge, in large part due to more than a decade of pandemic preparedness and collaborative planning. Consider, the nation's pharmacies have so far administered over 300 million COVID vaccines, performed more than 42 million tests, dispensed nearly 7 million antiviral courses, and were the top provider of over-the-counter COVID tests in CMS' demonstration program. Using conservative estimates, pandemic interventions by pharmacists and pharmacy personnel averted more than 1 million deaths, more than 8 million hospitalizations, and $450 billion in healthcare costs. Notably, a poll of adults conducted March 4-6, 2022, by Morning Consult and commissioned by NACDS found that retail pharmacies received the highest ratings for ease of access among the destinations tested. Moreover, 79 percent of those surveyed also support pharmacists helping patients prevent chronic diseases.

America's pharmacies have been struggling with reimbursement challenges for over a decade, due to or exacerbated by the absence of oversight and understanding of the competition-eroding practices of PBMs that impact timely patient access, pharmacy sustainability, and pharmacy's innovative vision to empower patients' total health and wellness. As illustrated by MedPAC, Medicare Part D's direct and indirect remuneration (DIR) fees, or fees that PBMs claw back from pharmacies weeks or months after they pay pharmacy claims, skyrocketed from $8.7 billion (11%) in 2010 to $62.7 billion (29%) in 2021, which is in part due to the expanded market leverage of PBM-insurers and a non-transparent pharmaceutical supply chain.

NACDS applauds Chairman Comer and Ranking Member Raskin for prioritizing this bipartisan issue of PBM reform this Congress and for your continued commitment to fight for transparency and competition to lower costs for Americans. Comprehensive PBM reform is needed to instill increased transparency and accountability for PBMs, to help ensure the economic viability of

pharmacies, and to foster increased access to care and improved health outcomes for the patients they serve.

The Pharmacy Benefit Manager Marketplace and Impact on Pharmacies

Prescriptions filled by patients who are paying cash without any form of insurance or discount card account for only about 3% of the total volume of prescriptions.[1] While approximately 91% of prescriptions filled have a payment component coming from Medicare Part D, Medicaid, or a commercial insurance plan, these plans are ordinarily administered by PBMs. The top three PBMs manage about 80% of prescription drug volume.[2] Five of the top six PBMs are owned by large national health insurers. This business environment makes it very difficult for pharmacies to negotiate fair business practices and transparency because the PBMs and health insurers have more commercial market power and leverage in the relationship due to their size and scale. This creates a one-way street with negative consequences for patients, pharmacies, employers, taxpayers, and communities – seemingly for all but the PBMs and payers.

Retail pharmacies are in crisis, facing unsustainable financial pressures as they are increasingly reimbursed by payers below the cost of buying and dispensing prescription drugs. Dire financial pressures have forced an alarming number of pharmacies to take drastic steps, such as possibly paring back hours of operation and delaying innovative care services that otherwise could improve health outcomes. PBMs' retroactive fees and claw backs often occur weeks or months after a transaction closes, when the PBM arbitrarily decides to recoup a portion of the pharmacy's reimbursement. These fees and claw backs have made the economic viability of community pharmacies increasingly difficult, due to the unpredictability of reimbursement and the increased damage to bottom lines.

It is important to examine pre-COVID pharmacy closures. According to IQVIA, between December 2017 and December 2020, almost 2,200 pharmacies closed nationwide.[3] Some of the PBMs' abuse of pharmacies was abated during the pandemic, and the nation's reliance on pharmacies over the past three years further mitigated pharmacy closures. However, the ominous situation for pharmacies is worse than ever before.

The epidemic of pharmacy closures is reducing access to vital healthcare services, especially in rural areas where options are already limited. Communities across the nation depend on neighborhood pharmacies among all healthcare destinations. A recent study published in the Journal of the American Medical Association also found that pharmacy closures led to a significant drop in medication adherence for older adults taking cardiovascular medications, which has obvious implications for patient health and healthcare costs. Preserving patient access to robust pharmacy provider services and networks like health screenings, disease state management, vaccinations (e.g., flu, COVID-19), patient counseling, medication adherence, and

[1]Source: IQVIA, National Prescription Audit & RxInsight, June 2022; Approximately 5.4% of patients use a discount card to assist with payment.

[2]https://www.xcenda.com/insights/skyrocketing-growth-pbm-formulary-exclusions-concerns-patient-access

[3] IQVIA Data, 2020. Closures disproportionately impacted rural areas.

testing— all in addition to essential medication access — can help improve health outcomes and generate overall healthcare savings for Americans.

We look forward to continuing to work with the Committee and other Members of Congress to stop the manipulation by PBMs both domestically and internationally that increases patients' medication costs, limits patients' choice of pharmacies, restricts access to medicines that are right for them, and jeopardizes the pharmacies and pharmacy teams on whom patients rely.

To that end, please see below **NACDS' Principles of PBM Reform** to increase transparency and ensure comprehensive reform of harmful PBM tactics and practices:

I. Help to Preserve Patient Access to Pharmacies by Addressing PBM's Retroactive Pharmacy Fees

Retroactive DIR Fees/Claw Backs – Pharmacy access can be undermined when health plans and their middlemen, PBMs, arbitrarily "claw back" fees retroactively from pharmacies weeks or months after a claim has been adjudicated/processed. This manipulation of pharmacy reimbursements may diminish access to care *(e.g., pharmacies being forced to close their doors or pare back hours and healthcare services)* when PBMs are unpredictable, not transparent, and payment falls below a pharmacy's costs to acquire and dispense prescription drugs. Policymakers should consider enacting laws that prohibit payers or PBMs from retroactively reducing and/or denying a processed pharmacy drug claim payment and obligating them to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points of care for patient services.

II. Provide Fair and Adequate Payment for Pharmacy Patient Care Services

Reasonable Reimbursement & Rate Floor – Pharmacy access remains at risk when PBMs reimburse pharmacies below the cost to acquire and dispense prescription drugs. Pharmacy reimbursement that falls below the costs to acquire and dispense prescription drugs threatens future sustainability for pharmacies to continue providing valuable medication and pharmacy care services to communities. Policymakers should enact laws to adopt a reimbursement rate floor that requires PBMs to use comprehensive reimbursement models that are no less than the true cost to purchase and dispense prescription drugs to help maintain robust public access to pharmacies.

Standardized Performance Measures – A crucial part of comprehensive DIR fee reform is advancing pharmacy quality that improves outcomes for beneficiaries and drives value in care which are essential to controlling costs in the healthcare system. Arbitrary performance measures developed by PBMs assess the performance of the pharmacy without pharmacies' input and create a moving target for pharmacies to show value and improve health outcomes. Measures vary across the various plans and dictate DIR fees (or claw backs at the State level) imposed on pharmacies, as well as help create substantial system dysfunction and unnecessary spending in the Part D program. Policymakers should enact laws to standardize PBM's performance measures for pharmacies to help set achievable goals for pharmacies before signing a contract to promote harmonization in the healthcare system and improvements in health outcomes.

III. Protect Patient Choice of Pharmacies

Specialty – Some PBMs require patients with rare and/or complex diseases to obtain medications deemed "specialty drugs" from designated "specialty pharmacies" or mail-order pharmacies which impedes patient access to their convenient local neighborhood pharmacies where specialty drugs are filled as well. Prescription drugs should not be classified as "specialty drugs" based solely on the cost of the drug or other criteria used to limit patient access and choice—instead, should focus on clinical aspects such as requiring intensive clinical monitoring. Policymakers should enact laws to establish appropriate standards for defining and categorizing specialty drugs to ensure comprehensive and pragmatic patient care and access and prohibit PBMs from steering patients to only specialty pharmacies, including those owned by the PBMs, for their prescription needs.

Mail Order – Medication access and care can be weakened when PBMs manipulate the system by requiring patients to use mail-order pharmacies only. Some plans impose penalties such as higher copays or other financial disincentives for choosing a retail pharmacy instead of a mail-order pharmacy which is often owned by the PBM. Policymakers should support patient choice and access by enacting laws to prohibit PBMs from requiring or steering patients to use mail-order pharmacies.

Any Willing Pharmacy - Due to PBMs' network and contract barriers, pharmacies willing and ready to serve patients may be ineligible to provide important pharmacy services and patients may experience unnecessary delays and interruptions in patient care. Patients should have the choice and flexibility to utilize the pharmacy that best meets their healthcare needs. Policymakers should enact laws that require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM to help maximize patient outcomes, and cost savings and ensure patient access to any willing pharmacy of their choice.

IV. Enforce Laws to Stop PBM Manipulation and Protect Pharmacies and Patients

Audits – PBMs routinely conduct audits to monitor a pharmacy's performance and reverse or claw back pharmacy payments when there are alleged issues with a particular pharmacy claim. PBM audits interrupt the pharmacy workflow, can extend wait times, and detract attention from the quality of care patients receive. Policymakers should enact laws that support fair pharmacy audit practices to ensure timely patient care delivery at community pharmacies and bring efficiency, transparency, and standardization to the PBM audit process.

Oversight Authority – There are growing concerns that pro-pharmacy and pro-patient legislative successes might be undercut if PBMs fail to comply with such laws and/or states fail to fully enforce these laws. Such failure could significantly impact pharmacy reimbursement and overall patient access. Policymakers should establish and enforce laws already on the books to regulate harmful PBM reimbursement practices that may

harm patients and the healthcare system as we know it, especially at the pharmacy counter, and empower state regulators to do the same to enforce PBM transparency and fair and adequate pharmacy reimbursements.

Conclusion

NACDS thanks the Committee for the opportunity to provide our perspectives on PBM reform and our support for your dedicated work to rein in harmful PBM practices. For collaboration, questions, or further discussion, please contact NACDS' Christie Boutte, Senior Vice President, Reimbursement, Innovation and Advocacy at CBoutte@nacds.org or 703-837-4211.