Written testimony of Joe Moose, PharmD

United States House Committee on Ways and Means Health Subcommittee Hearing:
"Why Health Care is Unaffordable:
Anticompetitive and Consolidated Markets"

May 17, 2023

Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee:

Thank you for conducting this hearing and for the opportunity to testify on my experiences as a pharmacist with firsthand knowledge dealing with pharmacy benefit manager (PBM) practices and their effects on patients and taxpayers.

My name is Joe Moose. I am a pharmacist and co-owner of Moose Pharmacy and its seven locations in North Carolina. Moose Pharmacy was started by my great-grandfather in 1882 in Mt. Pleasant, North Carolina and is still there today in the same location, where I practice with my brother as fourth generation pharmacists. I am a member of the National Community Pharmacists Association (NCPA), which represents America's community pharmacists, including the owners of more than 19,400 independent community pharmacies. Additionally, I serve as the director of strategy and luminary development with CPESN® USA, America's first clinically integrated network of pharmacy providers with more than 3,500 community pharmacies participating in 49 local networks in 44 states.

Over the past 141 years, our community pharmacy in rural North Carolina has been the first stop for those in need of health care. In many of the communities where we are located, our pharmacy is the only pharmacy for miles. This is now being jeopardized by PBMs, which determine who has access to our pharmacy under the guise of lower-priced drugs. If the anticompetitive practices and consolidation continue to go unchecked, you run the risk of putting businesses like Moose Pharmacy and thousands of other community pharmacies out of business. If these pharmacies that operate in underserved areas are forced to close, patients will be left without access to care, which ultimately will drive up costs for patients because of delays in care. It will also result in a less competitive marketplace with higher prices where both the patients and taxpayers lose.

Independent pharmacies and the patients we serve have long had concerns about PBMs, their anticompetitive practices, and the role they play in ever-increasing drug costs. These concerns have been further exacerbated because of the COVID-19 pandemic's effects on small businesses. Independently owned pharmacies have served as lifelines as essential businesses during the pandemic. However, PBM practices are causing these small businesses to struggle to remain viable and keep doors open to provide continued access and care.

Pharmacies have faced significant closures in recent years. From 2012 to 2019, over 1,000 independent pharmacies closed, going from approximately 23,000 to less than 22,000. Although chain and independent pharmacy closures contribute to creating pharmacy shortage areas, in

most states, independent pharmacy closures create greater patient access issues than chains.[1] Independent pharmacies are at greater risk of closure than chains in urban and non-urban areas. Additionally, pharmacies serving disproportionately low-income and uninsured populations are at greater risk of closure.[2] *Kaiser Heath News* cited a Rural Policy Research Institute study showing that 630 communities are without a pharmacy due to over 1,000 pharmacy closures since 2003.[3]

NCPA and the University of Southern California School of Pharmacy and Leonard D. Schaeffer Center for Health Policy and Economics have collaborated to develop a web tool that generates information on pharmacy closures and populations affected and shows pharmacy shortage areas at the neighborhood level. This collaboration has demonstrated that 25 percent of the U.S. population (81,203,948) lived in pharmacy shortage areas across urban, suburban, and rural areas in 2020. Only one-third of pharmacy shortage areas calculated within the web tool carry the Health Resources and Services Administration designation of Medically Underserved Areas, or MUAs. This means that two-thirds of pharmacy shortage areas are unaccounted for when considering low access to health care in geographical areas under the MUA definition. The populations with the highest pharmacy shortage areas were Black (37.1 percent), Medicaid (33.2 percent), and low-income (36.7 percent). States with the highest percentage of census tracts calculated as pharmacy shortage areas are Alaska, Mississippi, Montana, New Mexico, North Dakota, South Dakota, and Wyoming. Independent pharmacies were the most dynamic factor in terms of creating and resolving pharmacy shortage areas.

Today, the top three PBMs (Caremark, Express Scripts and Optum) control 80 percent of the market.[4] PBMs determine which pharmacies will be included in a prescription drug plan's network and how much said pharmacies will be paid for their services. PBMs, which are vertically integrated with the largest Part D plan sponsors, entice those same plan sponsors to incentivize beneficiaries to use a mail-order, retail or specialty pharmacy – often one owned and operated by the PBM.

Independent pharmacies have one mission and that is to serve patients, but they are at an inflection point with increased stress from egregious PBM practices, including pharmacy direct and indirect remuneration (DIR) fees. According to MedPAC's March 2023 Report to Congress, pharmacy DIR fees were $12.6 billion for 2021, which represents a $3.1 billion or 33 percent increase in just two years. That kind of financial stress is unsustainable, especially when it comes to providing health care to seniors. Harmful DIR trends are only getting worse. We continue to see take-it-or-leave-it Medicare Part D contracts where the reimbursement rates are significantly below our cost to purchase brand drugs. Rates such as this coupled with year-over-year double-digit increases in DIR fees will make the first 3-6 months of 2024 unbearable for independent pharmacies, as they continue to pay DIR fees from contract year 2023. The intended effect of

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[1] Data from 2018 to 2020, from University of Southern California School of Pharmacy and Leonard D. Schaeffer Center for Health Policy and Economics.

[2] Jenny S. Guadamuz, MS, G. Caleb Alexander, MD, MS, Shannon N. Zenk, PhD, and Dima M. Qato, PharmD, MPH, PhD. "Assessment of Pharmacy Closures in the United States From 2009 Through 2015." JAMA Internal Medicine. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6806432/.

[3] Markian Hawryluk. "How Rural Communities Are Losing Their Pharmacies." Kaiser Health News. Available at: https://kffhealthnews.org/news/article/last-drugstore-how-rural-communities-lose-independent-pharmacies/.

[4] Fein, Adam. "The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger." Drug Channels. April 5, 2022. https://www.drugchannels.net/2022/04/the-top-pharmacy-benefit-managers-of.html?m=1.

such contracts and discriminatory pricing can only be to force independent pharmacies to opt out of the Medicare Part D networks or stay in them only to face financial ruin. The end result is the strengthening of PBM-affiliated mail-order, specialty, and retail pharmacies at the expense of independent pharmacies.

PBMs are not transparent about the rebate process and their profit margins. To achieve real transparency in government programs like Medicare Part D, we need greater clarity on: complicated and opaque methods to determine pharmacy reimbursement; methods to steer patients towards PBM-owned or affiliated pharmacies; fees and clawbacks charged to pharmacies; potentially unfair audits of independent pharmacies; the prevalence of prior authorizations and other administrative restrictions; the use of PBM-defined specialty drug lists and associated specialty drug policies; and the effect of rebates and fees from drug manufacturers on formulary design and the costs of prescription drugs to payers and patients. Moreover, there is little to no insight into how much PBMs make on administrative service fees and spread pricing (the difference between how much they reimburse the pharmacy and the higher price they charge the plan for the same prescription).

For years, community pharmacists have said that PBMs have been playing spread pricing games, contributing to higher drug costs to the detriment of patients and the taxpayer-funded programs the PBMs are supposed to serve. Studies of multiple state Medicaid managed care programs have indicated that PBMs are overcharging taxpayers for their services in Medicaid managed care, reimbursing pharmacies low for medications dispensed, billing the state Medicaid program high for the cost of those medications, and retaining the difference, called "spread." Arkansas, Georgia, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Texas, and Virginia now prohibit spread pricing in their Medicaid managed care programs.

PBMs protect profits at the expense of competition and consumer welfare. With vertical integration both upstream and downstream, there is a need to level the playing field between community pharmacies and PBM-affiliated pharmacies to protect patients from paying too much at the counter. The vertical integration of PBMs into monoliths with an affiliated upstream insurance provider and downstream pharmacies has only increased the incentives for PBMs to disfavor independent pharmacies and steer patients to their own affiliated pharmacies. PBMs use a variety of methods to steer patients away from unaffiliated pharmacies. They create differential cost-sharing structures and arbitrary lists, such as specialty and aberrant drug lists, among other schemes, to limit independent pharmacies' access to patients. The arbitrary lists require patients to obtain certain drugs from a PBM-affiliated pharmacy.[5]

PBMs operating in the Medicare Part D, Medicaid, and commercial spaces alike contribute to artificially inflating drug costs using expensive name brand medications when less expensive generic alternatives are available. To do this, PBMs claim that they secure large rebates from the manufacturer to bring the net cost of the product down to below the cost of the generic. Even if this were true (which would require complete transparency and a 100 percent pass-through of all monies that flow from a pharmaceutical manufacturer to a PBM), it does not negate the

[5] Fein, A. (2022). *Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?* Drugchannels.net. Retrieved 11 May 2023, from https://www.drugchannels.net/2019/12/insurers-pbms-specialty-pharmacies.html.

consumer harm that exists to patients when they are in the deductible phase and are paying more out of pocket for their medication costs. PBMs blame these formulary placements on plan sponsors, but plan sponsors like others in this industry are at the mercy of PBMs and their constant threats of rate hikes.

I am glad this committee recognizes the black box within which PBMs operate. Community pharmacies are eager to work with the committee to discuss the anticompetitive practices and the consolidated PBM market that has worsened with vertical integration. Given the above, NCPA hopes the committee and Congress will consider legislation to address PBM practices in Medicaid and Medicare. Prescription drug prices continue to grow at an alarming rate, while transparency and competition are decreasing. As I have described, vertically integrated PBMs acting as "middlemen" that employ a litany of anticompetitive practices are contributing to increased health care costs for patients and taxpayers, while threatening access to local community pharmacies that patients depend on. I applaud the committee for holding this hearing and look forward to congressional action to reform PBM practices in a way that will lower drug prices at the pharmacy counter for our patients.