House Committee on Education and The Workforce
"Competition and Transparency: The Pathway Forward For A Stronger Health Care Market"
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Chairman Good, Ranking Member DeSaulnier, and distinguished members of the House Subcommittee, I would like to thank you for the invitation to speak with you on the necessity of increasing competition and transparency in health care.

My name is Greg Baker. I, first and foremost, am a pharmacist. I am also the CEO of AffirmedRx which is a transparent PBM I founded, headquartered in Louisville, KY. I have spent the past 30 years working in different areas of pharmacy with the past 11 years dedicated to collaborating directly with jumbo self-funded employers to help define and develop their pharmacy programs. Our goal at AffirmedRx is to partner with employers to deliver patient-centric pharmacy benefits with a mission to improve health care outcomes by bringing clarity, integrity and trust to pharmacy benefit management.

With my expertise in pharmacy benefits, I will focus my comments on competition and transparency within this industry. While there are around 70 PBMs currently doing business in the United States, only three large PBMs control up to 80% of the market in the USA. These PBMs are not constrained by any obligation to be transparent on their pricing and what they pay their own pharmacy versus what they pay other community pharmacies. They are not transparent in what their corporately owned and newly conceived group purchasing organizations (GPOs) receive in total manufacturer revenue versus what they pay back out to employers to help drive down the total cost of care.

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They do not share global claims data or per claim level rebate amounts. They are not transparent on why they prefer branded medications over lower-cost generic medications which, for the 55% of self-funded patients with high deductible or co-insurance plans, increases their out-of-pocket costs at the pharmacy counter.

Additionally, over the past 5 years, through mergers and acquisitions, these PBMs have become part of large, vertically integrated systems. We have been told for years how this vertical integration will improve outcomes and lower the cost of health care. It is our view that instead of helping they have used their significant market position and profit-focused business practices to secure outsized margins for the services they provide. This has led to higher costs, lower medication adherence, lower condition control and has increased morbidity and mortality of U.S. citizens.

Let us consider these facts on the state of the pharmaceutical industry today:

- Medications can be a key component to reduce health risk, control chronic disease and treat illnesses. In the U.S., illness and death from non-optimized medication therapy cost $528.4 billion annually – equivalent to 16% of total U.S. healthcare expenditures.
- Patients starting new prescriptions as prescribed by their physicians abandoned 94 million prescriptions at pharmacies in 2022 with increasing frequency as costs rise.
- A JAMA article published in June 2021 suggest that while drug manufacturers may increase list prices in order to offer larger rebates to insurers, such increases were associated with increased out-of-pocket costs to patients:
    - This study found that between 2014-2018 list prices from manufacturers grew 13.3% while rebates paid to PBMs increased 24.4%.
    - With the manufacturers raising list prices they also found that every $1 increase in list price equated to an increase of $2.09 in patient out-of-pocket costs. While we have had much debate over the list

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price increases by pharmaceutical manufacturers, these numbers clearly show how PBMs are retaining the most value and the American public continues to suffer greater drug affordability issues.
- Finally, the report sadly pointed out that every $10 increase in patient out-of-pocket costs led to lower adherence rates. This is particularly concerning amongst individuals with lower incomes and older adults as increasing prescription cost sharing can be associated with increased emergency department use, more frequent hospitalizations and other poor health outcomes.

These numbers illustrate at a high level how current market behaviors are having negative impacts on the system. PBMs operate in the middle of the entire distribution chain for prescription drugs and control all the rules. For example, they decide what pharmacies are allowed to fill medications for their members. Many times, for specialty and chronic medications, PBMs are mandating prescriptions be filled by pharmacies they own. In these situations, they get to decide what they pay themselves and, as we pointed out in our House Oversight and Accountability written testimony from May 23, 2023, that number can drive significant corporate profits while increasing costs for plan sponsors and their members.

Beyond this, they decide what medication a physician can and cannot prescribe and are increasingly excluding more and more medications from their formularies as called out by a January 10, 2023 article in Drug Channels. This article appropriately calls out the fact these exclusionary formularies are used "as a powerful tool for PBMs to gain additional negotiating leverage against manufacturers."

Additionally, there has been discussion about rebates and the relationship between the pharmaceutical manufacturers and PBMs. I am not here to defend or hold manufacturers harmless when we are talking about why we have a drug affordability issue in our country. They are by no means innocent, but the PBMs

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bear a significantly larger responsibility for the problem than they do. There are hundreds of brand manufacturers and only three main rebate aggregators. These three aggregators are each owned by one of the "big three" PBMs. They not only negotiate rebates for those traditional PBMs, but they now provide these rebate services to almost every other PBM in the industry. These aggregators are Ascent - created in Switzerland by Express Scripts in 2019 and now owned by Cigna, Zinc - created by CVS in 2020 and Emisar - started in Ireland in 2022 and owned by United Health Care. Ascent and Zinc each contract for over one hundred (100) million American lives and Emisar contracts for sixty five (65) million. They use their scale to create competition between manufacturers.

If a manufacturer does not negotiate a high enough rebate and ends up on the ever-expanding list of medications found on the exclusionary drug list, they will lose access to be able to sell their medications to tens of millions of lives. For this reason, they are forced to pay higher and higher amounts in total revenue to these GPOs in order to maintain their formulary placement. The difference between list price increases as defined by manufacturers and the manufacturers' net revenues after paying all rebates and discounts has been coined the gross-to-net bubble by Drug Channels. In their April 4, 2023 article, they point out this difference has grown from $167 billion in 2016 to $223 billion in 2022. While I do agree that manufacturers are increasing their prices, this is only half of the story. We can publicly see list price increases from the manufacturer. It is time for PBMs and their GPOs to list how much total revenue they obtain from pharma to show what the total net prices should be to plan sponsors and patients, but the PBMs continue to fight against this level of transparency.

Two specific examples point to how PBMs influence manufacturer pricing decisions. These examples also show how the upcoming flood of new biosimilars may not have a significant impact in reducing pharmacy costs as plan sponsors have been hoping for. Semglee is the biosimilar to the blockbuster diabetes medication Lantus. When the FDA originally approved Semglee in July 2021, the manufacturer Viatris indicated it would price a vial at about $98 – much below

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the price of $285 a vial for Lantus at the time. By November 2021, Viatris changed their strategy by offering two versions - a branded version of Semglee priced at $270 per vial (with a rebate) and an unbranded version at $98 with no rebate. Amgen watched this play out and when they became the first biosimilar to hit the market for Humira earlier this year they followed the same pricing strategy to have one with a 5% discount to Humira with a higher rebate and another version at a 55% discount with a much lower rebate. If you look at most PBM formularies, they have picked up the higher priced, higher rebate version on their formulary. This negatively impacts plan sponsors – who are not getting claim-level data to ensure they are getting the lowest cost option – and patients who are having to pay a higher amount for a more costly medication.

Finally, it will be important in future policy to call out how the term "rebate" is defined. The industry has pushed this concept of passing through 100% of their rebate dollars over the past few years. While a portion of the funds they get from manufacturers is contractually called a "rebate," the GPOs are adding an ever-expanding list of fees which PBMs keep as profit. See the example below for a list of those fees and whether they are included or excluded in the monies shared with plan sponsors. This list is an example of 3 unnamed industry PBMs. All sources listed should be considered rebate revenue, yet many PBMs exclude them in the monies shared with plan sponsors.

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Pharma Revenue Streams Included in Rebate Offer			
Source	PBM #1	PBM #2	PBM #3
Administrative Fees	Excluded	Excluded	Excluded
Clinical Program Fees	Excluded	N/A	Excluded
Consulting Fees	Excluded	N/A	Excluded
Credits	Excluded	Included	Excluded
Discounts	Excluded	Excluded	Excluded
Education Program Fees	Excluded	N/A	Excluded
Financial Incentives	Excluded	N/A	Excluded
Formulary Placement or Access Fees	Excluded	Included	Excluded
Implementation Fees	Excluded	N/A	Excluded
Market Share Based Payments	Excluded	Included	Excluded
Price Concessions	Excluded	N/A	Excluded
Promotional Allowances	Excluded	N/A	Excluded
Pull Through Program Fees	Excluded	Included	Excluded
Rebates	Included	Included	Included
Rebate Submission Fees	Excluded	N/A	Excluded
Software Licensing Fees	Excluded	N/A	Excluded
AWP Inflation Coverage	Excluded	Excluded	Excluded
All Other Payments From Pharma	Excluded	Excluded	Excluded

In closing, I would like to point to the *Consolidated Appropriations Act, 2021* (CAA). As pointed out in a article from Pharmaceutical Commerce in May 2023, the CAA has been designed to level the playing field between PBMs and plan sponsors. It will ensure that as a fiduciary to the plan all PBM revenue is disclosed, all data for that plan is shared with the plan sponsors, all compensation – both direct and indirect – brokers receive is fully disclosed and we will have a health care system that is more transparent and allows for more competition to drive down costs while improving quality and the lives of all Americans.

Thank you, members of the committee, for the opportunity to speak today and I look forward to your questions.

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For more information, here are links to articles aimed at educating purchasers about the PBM industry:

https://affirmedrx.com/how-gpos-work/

https://affirmedrx.com/how-pbms-make-money/

https://affirmedrx.com/what-is-a-pbm/

https://affirmedrx.com/8-things-every-employer-should-know-about-their-pharmacy-benefit-manager/

https://affirmedrx.com/how-do-pharma-pbm-contracts-play-role-in-rebate-leakage-part-1/

https://affirmedrx.com/how-do-pharma-pbm-contracts-play-role-in-rebate-leakage-part-2/

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