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Introduction

Good morning, Chairman Good, Ranking Member DeSaulnier, and other members of the Subcommittee. My name is JC Scott, and I am the President and Chief Executive Officer of the Pharmaceutical Care Management Association (PCMA). PCMA appreciates the opportunity to testify at today's hearing on competition and transparency in health care. PCMA is the national association representing America's pharmacy benefit companies, which administer prescription drug plans and operate home delivery and specialty pharmacies for more than 275 million Americans with health coverage through public and private employers, labor unions, retiree plans, Medicare, Medicaid, the Federal Employees Health Benefits (FEHB) program, and the exchanges established by the Affordable Care Act (ACA). Our members work closely with health plans and health insurance issuers to secure lower costs for prescription drugs and achieve better health outcomes for patients.

Health plan sponsors, including employers, voluntarily hire PCMA's members primarily to secure savings and provide choice and specialized expertise on pharmacy benefit design, coverage, and delivery. PCMA's diverse membership works closely with health plans and health insurance issuers to secure lower costs for prescription drugs and achieve better health outcomes. These savings allow employers and labor unions to keep offering quality drug benefits to their employees and retirees across America – ensuring that premiums are affordable, and patients have choices and access to pharmacies where they can get the drugs they need at a price they can afford.

Pharmacy benefit companies lower prescription drug costs for patients and a wide range of health plan sponsors – specifically by:

- Negotiating rebates from brand drug companies and discounts from pharmacies to reduce costs for patients, their families, and health plans – saving plan sponsors and patients an average of $1,040 per patient per year across the private sector and government programs.[i]
- Encouraging the use of more affordable alternatives to brand drugs, such as generics and biosimilars.
- Offering services that benefit patients, such as home delivery, which saves patients time and money while increasing access and care coordination.
- Managing and helping patients access high-cost specialty medications.
- Reducing waste, preventing potentially harmful drug interactions, and improving adherence.
- Providing clinical support in the form of services to plan enrollees, internal clinical expertise to support business operations, and assembling clinical experts to evaluate drug therapies and make coverage recommendations to plan sponsors.

Pharmacy benefit companies support a competitive market for prescription drugs. Today I will review the policies PCMA members support to encourage a competitive market for prescription drugs, as competition is the most effective way to drive down high drug prices. I will also discuss ways pharmacy benefit companies work to generate value for the U.S. health care system.

As an industry, pharmacy benefit companies welcome any opportunity to discuss and advance ways to improve the prescription drug marketplace so Americans can better afford their prescription drugs, and we believe any attempt at understanding the factors driving drug costs must include an examination of the entire supply chain, including drug companies, large pharmacy collectives known as Pharmacy Services Administrative Organizations (PSAOs), wholesale

distributors, employer benefit consultants, pharmacies, and all others with impact on the cost of prescription drugs. For instance, there is irrefutable evidence of certain drug companies repeatedly abusing the patent system to keep more affordable alternatives from entering the marketplace, which allows those companies to increase prescription drug prices for far longer than Congress contemplated when it established patent and exclusivity periods. We encourage the committee to review all these entities and potential anticompetitive practices as it assesses how to improve the prescription drug market.

Pharmacy Benefit Companies Support Policies to Encourage Competition as the Best Way to Lower Prescription Drug Costs

Pharmacy benefit companies encourage use of the most affordable drugs for patients by providing prescribers with information about less expensive generic alternatives, setting performance standards for pharmacies to encourage generic fills and adherence, and ensuring patients are aware of lower-cost alternatives. Due in large part to these efforts by PBMs, 90 percent of prescriptions are filled with generics.[ii] Pharmacy benefit companies also support increased uptake of biosimilars by preferring both the brand and a biosimilar to ensure patients and providers have the incentive to choose lower-cost options and the choice to continue with a drug from which they may be reluctant to switch.

Pharmacy benefit companies offer programs to keep out-of-pocket costs low and work with those providing insurance to encourage patients, through formulary design and cost-sharing incentives, to use the most affordable drugs, which are usually generics. 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.[iii] PBMs also employ other tools designed to deliver high-quality drug benefits while bringing down costs.[iv] For many brand drugs, PBMs negotiate directly with drug manufacturers, who compete for formulary placement by offering a type of discount called rebates.[v] For drugs on a preferred tier of a plan's formulary (list of covered drugs), patients typically have lower cost sharing.[vi] As competing products enter the market, PBMs gain the flexibility to leverage competitor products to negotiate deeper drug discounts for patients and employers.[vii]

To enhance competition and enable pharmacy benefit companies to further drive down drug costs, PCMA encourages policymakers to do the following:

1. **Stop patent abuse.** Addressing drug companies' abuses of the patent system that allow them to block competition by extending monopoly pricing well beyond their products' original patent expirations would increase access to lower-cost generics and go a long way toward reducing drug costs for patients and families.
2. **Reserve market exclusivities for true innovation.** Addressing overlong exclusivity periods for biologics and orphan indications will create more competition and lead to lower overall drug costs for patients.
3. **Ensure drugs can compete fairly.** Preventing practices like "shadow pricing" and abuses of the U.S. Food and Drug Administration's citizen petition process will improve the competitive market.
4. **Promote generic and biosimilar competition.** The most effective way to reduce prescription drug costs is to increase competition in the marketplace.

Pharmacy Benefit Companies Reduce Costs for Employers

Employers need choice and flexibility when designing prescription drug benefits that meet the health and affordability needs of unique employee populations. Employers vary dramatically in size, resources, and function, serving diverse populations. No plan sponsor, public or private employer, union, retiree health plan, pension fund, or other health plan is required to hire or use a pharmacy benefit company, but virtually all do. Each of those plan sponsors knows more about their financial resources and plan participants than any other entity, and they need the ability to design plans tailored to the unique needs of their participants. As health plan sponsors strive to create accessible, affordable benefits that meet the needs of the populations they cover, policymakers should avoid mandates that could increase costs and decrease quality.

PBMs have an established record of negotiating price concessions from drug manufacturers (through formularies and other tools) and pharmacies (via networks) to reduce drug costs. Pharmacy benefit companies will save employers and patients a collective $124 billion over the next ten years.[viii] Health plan sponsors choose PBMs through a transparent and highly competitive bidding process. With 73 full-service PBMs in the market, including regular new entrants, health plan sponsors have diverse options, allowing them to select the PBM that best meets their unique needs.[ix]

Recent findings from the PricewaterhouseCoopers (PwC) 2021 "Health and Well-being Touchstone Survey" of 368 companies explains why employers, including small and mid-sized businesses, voluntarily hire pharmacy benefit companies to help them provide affordable, quality prescription drug coverage for their health plan enrollees.[x] PBMs offer their expertise in pharmacy benefits by recommending formulary design options, and employers decide how their plan will function. The survey states, "To help manage overall drug cost trends, over 80% of employers told us that they continue to look to their pharmacy benefits manager (PBM) for solutions, supported by traditional management strategies," demonstrating the value employers derive from the advice of their PBM. However, highlighting the importance of employer choice, another survey of employers from the Pharmaceutical Strategies Group shows just 15 percent of survey respondents said their PBM had the most influence on their drug benefit design.[xi]

For health plan sponsors, it is important to maintain a competitive market that provides choice among PBMs and the ability to decide how to set up drug benefits to best serve their unique populations. Some may choose a PBM based on its scale and its 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 both lower drug costs and provide cost predictability, enabling them to stretch their benefit dollars even further.

Plan sponsors should have the option of determining how they would like to pay the pharmacy benefit company they select for their services. Employers can choose "pass-through" contracting, in which the plan sponsor pays whatever the pharmacy charges, or "spread pricing." Today, 34% of employers choose "spread pricing," [xii] which is a risk-based contracting model in which employers choose to let the pharmacy benefit company hold the risk that plan participants may use more expensive pharmacies to fill their prescriptions. In exchange, the pharmacy benefit company keeps the savings when a patient uses a less expensive pharmacy, and takes a loss when they use costlier pharmacies. While larger employers may select pass-through contracts, as they have the scale to deal with the variability of pharmacy charges, smaller employers may choose spread contracts because of the pricing predictability and savings they derive.

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.[xiii] 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.[xiv] One economist estimates that without PBMs, employers and other plan sponsors would pay 40 percent more to undertake themselves the services currently provided by pharmacy benefit companies.[xv]

The PBM Market is Diverse and Competitive

Savings from pharmacy benefit companies benefit health plans, employers, retirees, and patients directly. Pharmacy benefit companies save health plans and their enrollees an average of $1,040 per person per year.[xvi] The PBM market is dynamic, diverse, and growing. In 2019, there were 66 full-service pharmacy benefit companies active in the market.[xvii] As of March 2023, there are 73 full-service pharmacy benefit companies in the U.S., with six new PBMs entering the market since 2021.[xviii] In addition to these full-service companies, there are many companies that provide narrower PBM services to customers, with some catering to specific sectors, such as workers' compensation.

Prior to the shift in focus of the Federal Trade Commission (FTC), which has recently moved away from consumer protection, the commission evaluated the PBM industry numerous times and found it to be appropriately competitive. In 2005, the commission issued a report showing that PBM ownership of pharmacies does not result in higher costs for consumers. The chair at the time noted, "Health insurers manage their drug costs by choosing among a variety of PBM services and service providers," and "Data in the report demonstrate that PBMs' use of owned mail-order pharmacies generally is cost-effective for plan sponsors."[xix]

Additionally, in 2012, the FTC completed an investigation evaluating the potential impact of a proposed merger between two PBMs, Express Scripts and Medco. As a result, the commission observed that the "market for the provision of full-service PBM services to health care benefit plan sponsors is moderately concentrated and consists of at least ten significant competitors," and further found that "competition for accounts is intense."[xx] Over the 11 years since that investigation, the market for full-service PBMs has grown, with 73 full-service pharmacy benefit companies of varying sizes operating across the nation in a variety of markets in 2023.

Preserving the competitiveness of the PBM market is as important as ensuring competitiveness in all other aspects of the prescription drug supply and payment chain.

Pharmacy Benefit Companies Support a Robust and Competitive Market for Pharmacies

The structure of a health plan's provider and participating pharmacy network is among the most important elements of health benefit design. Working with their PBMs, plans exercise careful judgment to construct pharmacy networks that meet beneficiary needs, balancing breadth of coverage, access, quality, and cost-efficiency, often on a multi-jurisdictional basis.

There are many types of pharmacies – retail, specialty, hospital, clinic, home care, mail-order, compounding, and assisted living or long-term care. These pharmacies offer different levels of expertise and services to ensure patients are getting what they need to secure the best health outcomes. In fact, there are more than 60,000 retail pharmacies in the United States, including 23,000 independent community pharmacies. Health plans with a variety of sites of care in their pharmacy networks promote access, affordability, and value. For example, the right mix of brick-

and-mortar retail, mail, and specialty pharmacies improves adherence to therapy and patient safety.

Pharmacists are skilled health care practitioners who are often more convenient to access than doctors in a hospital, private practice, or other clinical setting. To better contain drug costs and improve access to quality patient care, pharmacy benefit companies support laws and regulations that allow pharmacists to "practice at the top of their license," based on their specific expertise. Pharmacy benefit companies continue to call on policymakers to enact legislation enabling pharmacists, where appropriate, to perform diagnostic testing, prescribe indicated medication, and administer vaccines to expand access to care.

Pharmacies large and small are important partners in delivering care to patients, and where a patient acquires a drug can impact its cost significantly. Pharmacy benefit companies negotiate with pharmacies to establish networks that support consumer choice while offering high quality care at competitive prices. Most pharmacy networks provide patients with a variety of options allowing them to get the drugs they need where they need them. Policies that restrict pharmacy benefit companies' ability to develop such networks drive costs up, while well-managed networks offer savings to both plan sponsors and enrollees. For instance, some states have passed laws constraining pharmacy networks, to the detriment of employers and union plan sponsors. Such regulation sometimes even seeks to intrude into ERISA despite federal pre-emption, which should prohibit states from acting on exclusive areas of federal regulation. These pharmacy network restrictions could lead to a patchwork of inconsistent state laws, creating administrative burdens for plan sponsors offering benefits across state lines and boosting costs for employers, which can result in higher patient cost-sharing and premiums.

Understanding the Role of Wholesalers and PSAOs is Critical

As the committee considers the factors impacting the competitiveness of the drug supply chain, it is important to understand the role of PSAOs. PSAOs negotiate pharmacy network contracts with PBMs and perform fundamental back-office operations for the pharmacies they contract with, and the relationships between large wholesaler-owned PSAOs and independent pharmacies are complex and worthy of scrutiny.

The largest PSAOs are subsidiaries of the three largest wholesalers, which also typically operate the equivalent of networks of pharmacy franchises, providing branding, organizational support, and back-office support. The significant role large wholesalers play in the prescription drug supply chain and the often-symbiotic relationship wholesalers have with independent pharmacies is just beginning to be explored. Shining a light on this relationship is exposing potential areas of concern, underscoring the need for Congress to examine all players in the supply chain that have a direct impact on the price of prescription drugs. For example, the PSAO marketplace is dominated by the "Big Three" wholesalers, AmerisourceBergen, Cardinal Health, and McKesson. Unlike pharmacy benefit companies, PSAOs operate with no state or federal regulation or oversight, and according to PBM reporting data, negotiate higher rates than PBMs typically pay non-independent retail and chain pharmacies. Approximately 83 percent of independent pharmacies use PSAOs to negotiate favorable contracts with pharmacy benefit companies.[xxi]

While some claim otherwise, the independent pharmacy market is stable and profitable. Data shows that over the last ten years, the number of independent retail pharmacies nationwide increased by 1,638 stores or 7.5 percent.[xxii] Over the last five years, the number of independent pharmacies has increased 0.5 percent, indicating a stable marketplace. In fact, independent

pharmacies' financials have also been stable. From 2016 to 2020, the average per prescription gross profit margin for independent pharmacies ranged from 20.8 percent to 21.1 percent, showing little fluctuation.[xxiii]

Data from the lobby group for independent pharmacy, the National Community Pharmacists Association (NCPA), agrees that the independent pharmacy market is stable, growing 0.4 percent over the last year,[xxiv] and it is the only sector of retail pharmacy that has experienced growth over the last 10 years. The same report finds that between 2020 and 2021, the average independent pharmacy location dispensed ten percent more prescriptions, gross profit margins increased to 23.3 percent, and average sales per location were up more than $570,000 – in excess of $4 million. As noted, by leveraging the power of large pharmacy collectives to negotiate with pharmacy benefit companies on their behalf, independent pharmacies can secure favorable contract terms, and on average, higher reimbursements than chain drugstores.[xxv] PSAOs and PBMs also provide pharmacies with software, such as Pharmacy Quality Solutions' Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP), which allows pharmacies to access their contracted pharmacy measures, track their own performance against those measures, and compare benchmark measures of their contracts across plans and against other pharmacies.

PBMs Support Meaningful, Actionable Transparency to Enhance Market Competition

Pharmacy benefit companies 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. As part of their requests for proposals when putting their pharmacy benefits out to bid, PBMs' customers lay out the terms of the transparency and information they want to receive, as well as their audit rights, and those terms are formalized in their contracts.

Transparency that helps patients and payers is necessary across the entire prescription drug chain. Pharmacy benefit companies support and practice actionable transparency that empowers patients, their physicians, those sponsoring health coverage, and policymakers, so that each of these actors 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 health care 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, pharmacy benefit companies provide patients and prescribers with real-time benefits 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 a patient should expect for a given drug at the pharmacy. PBMs also provide patients with information on in-network pharmacies, premiums, general cost-sharing, and benefits for their prescription drug coverage.

Pharmacy benefit companies also provide employers and plan sponsors with a broad array of accurate, actionable information on price and quality to make efficient purchasing decisions. Beyond this extensive information sharing, PBMs' customers have the ability to set their own terms for 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, these laws included appropriate protections for confidential data to avoid encouraging tacit collusion, and PCMA supported that approach. We have also supported legislation that is now law, which provides congressional support agencies, including the Congressional Budget Office (CBO), Government Accountability Office (GAO), Medicare Payment Advisory Commission (MedPAC), and Medicaid and CHIP Payment and Access Commission (MACPAC), with access to Medicare and Medicaid claims-level data to ensure that Congress is able to perform appropriate oversight.

PBMs support and practice transparency that empowers patients, their physicians and pharmacists, those sponsoring health coverage, and policymakers to make informed decisions that can lead to lower prescription drug costs. That is why the PBM industry supported legislation enacted in 2018 to empower pharmacists to share information with patients about lower out-of-pocket cost alternatives. As the committee considers how best to preserve the competitiveness of the PBM market, we encourage consideration of the administrative burdens extensive, unharmonized, duplicative reporting requirements create for smaller PBMs. While larger PBMs may be able to adapt, smaller PBMs may find these new regulations overly burdensome or wholly unworkable, forcing them to either close their doors or consolidate; effectively reducing the competitive market for PBMs. It is also important to note that these added reporting burdens on top of the existing requirements could lead to higher costs for people taking prescription drugs.

Exposing Proprietary Pricing Information Can Raise Drug Prices

More recently, in February of this year, the U.S. Department of Justice Antitrust Division withdrew three outdated antitrust policy statements related to enforcement in health care markets. As Principal Deputy Assistant Attorney General Doha Mekki remarked:

> *Courts have long recognized that the exchange of competitively sensitive information can subvert the competitive process and harm competition. …The Second Circuit explained in Todd that "[p]rice exchanges that identify particular parties, transactions, and prices are seen as potentially anticompetitive because they may be used to police a secret or tacit conspiracy to stabilize prices." …Where competitors adopt the same pricing algorithms, our concern is only heightened. Several studies have shown that these algorithms can lead to tacit or express collusion in the marketplace, potentially resulting in higher prices, or at a minimum, a softening of competition."*[xxvi]

Tacit collusion, sometimes called conscious parallelism, happens when competing firms set their prices at a profit-maximizing level after recognizing their shared economic interests and interdependence related to pricing. It is done without an implicit or explicit agreement between the competing firms. It typically results in higher prices for consumers.

There are numerous examples of tacit price collusion across multiple markets, including "airline tickets, gasoline, cellular phone text messaging and roaming rates, interest rates on bank accounts, credit card interchange fees, movie tickets, recorded music, breakfast cereals, real estate and travel agent commissions, electricity prices in deregulated markets, and air cargo fuel surcharges."[xxvii]

Given that, it is important to carefully protect data that helps to maintain a competitive market and ensure it is never released publicly. As Mekki warns, such information sharing would likely

damage the private market: “A softening of competition through tacit coordination, facilitated by information sharing, distorts free market competition in the process.”

In an environment where the DOJ feels compelled to pull back 30-year-old guidance because of increasing concerns about the anti-competitive impact of information sharing in the health care industry (including via tacit collusion), it seems imprudent to mandate increased information disclosures that could create the kinds of anti-competitive harms that the DOJ has identified, including tacit collusion amongst the drug companies.

In 2004, the Federal Trade Commission (FTC) spoke out against over-exposing information about private business dealings because such an approach is deeply damaging to a competitive marketplace, stating, “If pharmaceutical manufacturers learn the exact amount of the rebates offered by their competitors (either because the safeguards on subsequent disclosure by purchasers and prospective purchasers are insufficient or because the mandated disclosure to prescribers provides sufficient information for pharmaceutical manufacturers to calculate these amounts) then tacit collusion among manufacturers is more feasible. Consequently, the required disclosures may lead to higher prices for PBM services and Pharmaceuticals.”[xxviii] Likewise, in 2009 the FTC noted that there are limits to the benefits of transparency and unintended consequences can result.[xxix] And again in 2014, the commission noted it had conducted numerous reviews on state laws mandating transparency to evaluate their likely effect on competition. At that time, staff noted two main concerns, “(1) mandatory disclosure requirements may hinder the ability of plans to negotiate an efficient level of disclosure with PBMs; and (2) if such disclosures publicly reveal previously proprietary and private information about discounts negotiated with PBMs, disclosure may result in less aggressive pricing by, or even collusion among, pharmaceutical manufacturers.”[xxx]

Additionally, the CBO has framed the transparency and disclosure considerations clearly in this often-quoted statement:

> *The disclosure of drug rebates could affect Medicare spending through two principal mechanisms. First, disclosure would probably make rebates less varied among purchasers, with large rebates and small rebates tending to converge toward some average rebate. Such compression, for reasons discussed below, would tend to reduce the rebates that PDPs received and thus would raise Medicare costs. Second, for a range of medical conditions, drugs appropriate for treatment are available from only a few manufacturers; disclosure of drug-by drug rebate data in those cases would facilitate tacit collusion among those manufacturers, which would tend to raise drug prices.*[xxxi]

PCMA encourages the Committee, as it reviews how to improve the prescription drug market to help lower costs for patients, taxpayers, and businesses, to focus its efforts on actionable transparency and information disclosure that reduces drug costs, rather than the over-exposure of the type of proprietary information that raises drug costs.

Conclusion

Pharmacy benefit companies exist to reduce drug costs for plan sponsors and, most importantly, for the patients our companies serve. In doing this work, pharmacy benefit companies generate tremendous value for society, estimated at $145 billion annually,[xxxii] and save plan sponsors and patients an average of $1,040 per person per year.[xxxiii] Much of this value is generated by the savings pharmacy benefit companies negotiate with pharmaceutical manufacturers and

pharmacies. Pharmacy benefit companies also lower prescription drug costs by promoting the use of generic medications, encouraging better pharmacy quality, and offering things like home delivery of medications. Through their work, pharmacy benefit companies lower the cost of health coverage, reduce drug costs, and support better and more affordable prescription drug access for patients, which means more people can get on and stay on the medications they need. For many years, evidence has shown a return of 10:1 on investments in pharmacy benefit company services for their private sector and government partners.[xxxiv] As a result, pharmacy benefit companies will lower the cost of health care by $1 trillion over the next ten years.[xxxv]

On behalf of the industry, thank you for inviting me to testify. As I have indicated, PCMA welcomes the opportunity to further engage with the committee and looks forward to working collaboratively with Congress and other stakeholders to build on the existing private market framework to address prescription drug affordability challenges and improve functionality for patients.

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