PCMA Testimony – Oct. 16th Hearing

PCMA is the national trade association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through large and small employers, state governments, health insurance plans, labor unions, Medicaid managed care, Medicare Part D, Federal Employees Health Benefit Programs, and other public programs.

At the outset, it is important to note that no one is required to use a PBM, but most plan sponsors choose to use one because of the quality and cost savings PBMs can provide the pharmacy benefit. PBMs on average save 30% compared to an unmanaged pharmacy benefit. In Medicaid specifically, the use of PBM tools is expected to save the state of Pennsylvania $1.6 billion over a 10 year period.[1]

There are 80 companies providing PBM services in the United States.[2] Plan sponsors utilize an RFP process to solicit PBM services, and PBMs compete fiercely for this business. Though there are some large PBMs that serve a large part of the market, competition is robust and the market is always changing.

Issues Raised by Pharmacists: PCMA participated in every one of Auditor General DePasquale's listening tour stops across the state. We heard a number of comments that will likely be reiterated in this committee. We'd like to take a few minutes to dispel some of the myths.

1. **Myth**: Independent pharmacy industry is going under, and PBMs are the reason.

As of January 2018, independent pharmacies comprised 38% of the pharmacy market in Pennsylvania, one of the highest market concentrations in the region.[3] Between 2010-2017, the number of independent retail pharmacies in Pennsylvania grew from 932 to 1,077, an increase of 15.5%. Nationally, the number of independents grew 12% over the same period. During this same time period, the number of chain retail pharmacies has decreased 2.3%.[4]

Gross profits for pharmacy nationally remain high—hovering around 21% in 2016.[5] PBMs have an interest in the independent pharmacies being reimbursed fairly—we need all types of pharmacies, including independent pharmacies, to remain in the PBM network so PBMs can ensure health plan clients stay in compliance with network adequacy requirements.

2. **Myth**: Pharmacists don't have bargaining power against PBMs.

80% of independent pharmacies use Pharmacy Services Administrative Organizations (PSAOs). Most pharmacies don't contract directly with PBMs. PSAOs represent multiple

---

[1] Visante, Pharmacy Benefit Manager: Generating Savings for Plan Sponsors, Prepared for PCMA (2016), available at https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf.
[2] Pharmacy Benefit Management Institute(PBMI) Data
[3] "Region" includes Delaware (18.4%), District of Columbia (31.6%), Maryland (33.5%), (Virginia (23.4%), and West Virginia (42.9%).
[4] Quest Analytics analysis of NCPDP dataQ data, 2017.
[5] Based on 2018 Economic Report on US Pharmacies and PBMs - Drug Channels Institute.

pharmacies and negotiate contracts with PBMs on behalf of pharmacies. Contracts deal with issues such as reimbursement rates, payment terms, and audit terms. PBMs have no visibility into PSAO contracts with pharmacies.

PSAOs provide access to pooled purchasing power, negotiating leverage, and contracting strategies similar to those of large, multi-location chain pharmacies. A typical PSAO represents thousands of pharmacies and the largest are owned by some of the largest drug wholesalers.

Pharmacies in some *rural communities* actually have the upper hand with PBM contracting because of plans' need to meet network adequacy requirements and lack of pharmacy competition in the area.

3. **Myth**: PBMs aren't regulated.

PBMs are regulated directly and indirectly across the country and in Pennsylvania. In 2016, there was sweeping PBM legislation (SB 946) requiring PBMs to register with the Department of Insurance, comply with audit rules, and abide by new standards for the use of maximum allowable cost lists. These standards went into effect in May 2017.

4. **Myth**: PBMs pay their affiliates (or chains) more than they pay independents

While PCMA, as a trade association, does not have insights into actual contracts between PBMs and pharmacies, there are two public reports that looked at these sorts of allegations. In Washington State, the Office of the Insurance Commissioner found that most of the PBMs were paying chains less than independent pharmacies, and in Ohio, the Department of Medicaid found that the company alleged to have been paying its affiliate more than independents was actually paying independents more than its affiliate.

Pharmacists use anecdotal evidence—a handful of drugs out of thousands—where they've been reimbursed less than what they claim their costs are. But they never talk about the drugs they've profited from. The important thing is to look at the entire market basket—picking a few examples doesn't give an accurate picture.

5. **Myth**: PBMs don't have a positive impact on patients—local retail pharmacies provide superior care.

While we agree that small local pharmacies can provide great services to patients, sometimes these services are limited based on the capabilities of that individual pharmacy. PBM mail service and specialty pharmacies can provide 24/7 access to clinicians, they have staff and clinicians specially-trained in certain disease states so they can provide support to patients. On the administrative side, PBMs are performing services like sophisticated data analysis and are looking for drug-to-drug interactions, looking for outlier prescribers and watching for patients who are pharmacy- or doctor-shopping for opioids. These are brief examples; there are many other consumer-focused programs.

On the Issue of "Spread": There are a lot of misconceptions about spread pricing that should be cleared up.

Spread exists in every business, including for pharmacies. In the pharmacy context, the "spread" is the difference between the cost of a product from the wholesaler vs. the amount the pharmacy receives from cash paying customers (or third party payer reimbursements). In the PBM – plan sponsor context, "spread" is one way a PBM could get compensated for providing services to the plan.

A "spread" contract is one where the PBM retains the difference between a plan-PBM agreed-upon payment amount and a PBM-pharmacy agreed upon payment amount. That is, a plan may choose to tell PBM that it can keep the difference between what the plan pays it to cover a drug and what a pharmacy agrees to accept as reimbursement. Essentially, if a PBM drives a harder bargain with pharmacies than the amount the plan agrees to provide the PBM for covering the drug, the PBM keeps the difference. This is only the case in a "spread" contract. There are other types of contracts with different compensation methodologies. A plan may want the predictability of using a spread compensation arrangement because its costs are known ahead of time, rather than having its costs dependent on each individual claim retrospectively.

Some plans may want the full amount of the claim to be "passed-through" to them so there is no difference between what they pay the PBM and what the PBM pays the pharmacy. In these cases, the PBM typically receives an administrative fee for its services. These are called "pass-through" contracts.

Some plans choose "spread" and some plans choose "pass-through" arrangements. PBMs compete fiercely for business and plans choose the PBM and type of contract that fit their unique needs. The plan always retains the right to audit the performance of the contract to ensure that the PBM is complying with the terms.

At the end of the day, much of these discussions come down to payer-provider tension. There will always be tension in this relationship. Providers will always want to be paid more and the plans funding those payments will always be looking for ways to drive down costs.