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The Honorable Maureen K. Ohlhausen
Acting Chairwoman
U.S. Federal Trade Commission
Washington D.C.

Initiative Name: Understanding Competition in U.S. Prescription Drug Markets: Entry and Supply Chain Dynamics

As a career pharmacist with over 30 years of experience, I have witnessed the creation and evolution of pharmacy benefit managers (PBMs). Since the 1980s, PBMs have evolved from fiscal intermediaries who adjudicate prescription drug claims to companies that manage pharmacy benefits, negotiate drug discounts with pharmaceutical companies, and require patients to use preferred providers and products to treat medical conditions. This evolving business model has resulted in fewer choices in care for patients and restricted access to community pharmacists. Without action, consumers and independent health care providers, alike, will suffer from the consolidation of an under-regulated market that has continued to funnel consumers into a system stifling choices for Americans.

I believe there are three essential elements that must exist for the creation of a competitive market: transparency, choice, and a level playing field for patients and providers alike that is devoid of conflicts of interest. Without these elements, patients will see fewer choices and higher costs as providers are not forced to compete by offering fair prices and better services. Without transparency, consumers would not be able to evaluate products, make informed choices, and participate in the full range of services the market could offer. The lack of transparency of PBMs continues to make it difficult for consumers and pharmacists to take part in the benefits they deserve. While well intentioned at their inception, Pharmacy Benefit Managers (PBMs) have transformed from a market disruptor to a market dominator. Today they increase costs, decrease choice, drive consolidation throughout the health care system, and erode the quality of care for patients. Their rapid consolidation – both vertically and horizontally – is dramatically expanding the deleterious nature of their role in American health care.

Due to their lack of transparency and under-regulated market, PBMs have grown substantially since 2003. In just over ten years, the two largest PBMs have increased their profit

margins by almost 600%. This increase alone is impressive without considering that within those 10 years the U.S. suffered the worst financial crisis since the Great Depression. To varying extents, PBMs impact the treatments, pharmacies, and health outcomes for 253 million American patients. The three largest PBMs control nearly 80 percent of the prescription drug market. All three companies are listed in the top 25 of the Fortune 500. In 2016, total revenue for CVS Health alone was greater than that of McDonald's, Coca Cola, and Pfizer combined.

While revenues and profits have continued to skyrocket for PBMs, the Pharmaceutical Care Management Association, the PBM industry's lobbying group, claims that PBMs will save health plans \$654 billion over the next decade. If past proves precedent, that claim will prove false and American patients will pay the price. According to data from the Centers for Medicare and Medicaid Services (CMS), between 1987 when PBMs first formed and 2014, expenditures on prescription drugs have jumped 1,100 percent. Employers have seen a 1,553 percent increase in per-employee prescription drug benefit costs since 1987. Meanwhile, Express Scripts' adjusted profit per prescription has increased 500 percent since 2003, and earnings per adjusted claim for the nation's largest PBM went from \$3.87 in 2012 to \$5.16 in 2016. In effect, PBMs tax American patients billions upon billions of dollars while delivering no value to the health care system.

A system that rewards middle men over those who research and develop new treatments runs contrary to the needs and concerns I've heard from people across the country. There is little data proving PBMs add of value to the drug supply chain. A new report released on January 19, 2017 by CMS finds that drug companies and pharmacies are paying increasingly larger rebates to PBMs and insurers, but those savings aren't translated into lower costs for government health care programs and consumers. CMS data shows that since 2010, the growth in rebates paid by drug companies or pharmacies to PBMs (in addition to the lump sum payment plans received from Medicare) after the point of sale (called Direct and Indirect Remuneration or DIR) has outpaced the growth in Part D drug costs. The fact that rebate growth has continued to outpace drug price inflation should be reviewed as it correlates to PBM pressure on the manufacturers to increase rebates so that they can keep more of the "spread" between the price the PBM pays the manufacturer and the price the plan pays for the drug.

The PBMs use a host of tactics to hide the ways that they are causing prescription drug price inflation, and this lack of transparency leads directly to higher out-of-pocket costs to consumers and taxpayers. PBMs reimburse pharmacies for generics based on a schedule called the maximum allowable cost (MAC), but the actual number is hidden until the point of sale. PBMs charge health plans higher rates, but reimburse pharmacies at the MAC cost – a practice known as "spread pricing." The damage "spread pricing" can cause was evidenced in a case involving Meridian Health Systems.

In 2008, Meridian Health Systems (Meridian) was experiencing surging medication costs for its employees. In turn, they hired a PBM to help reduce their costs. In the beginning, the

PBM projected that they would save Meridian at least \$763,000. However, just three months into the contract with the PBM, Meridian was on pace to spend an additional \$1.3 million more than previously spent before hiring the PBM. On the brink of the largest medication bill Meridian had ever experienced, the officer in charge of Meridian's medication spending began to investigate where all the money was going. After a review of Meridian's employee prescription data, he was shocked to find that the PBM was inflating their bills to play "the spread" (billing the company for larger amounts than what it costs to actually fill the prescription). Rather than the PBM acting as a fiduciary for Meridian, the PBM padded its profits by taking advantage of a complicated and opaque system. The damage caused by "spread pricing" is not limited to those with employer-sponsored insurance coverage.

For seniors with Medicare Part D plans requiring coinsurance payments, PBM spread pricing increases out-of-pocket costs. The full price of drugs would be credited against the patient's limit of coverage, rather than the lower price impacted by rebates. This bait-and-switch tactic leads to seniors entering the Part D "donut hole" at an accelerated pace. Without reflecting the true cost of the drug, seniors continue to be penalized at the expense of higher profits for the middle men.

Additionally, PBMs have begun acquiring their own pharmacies. Rather than creating efficiencies, this vertical consolidation creates negative incentives for negotiation and increases costs to patients as well as the system as a whole. This sort of vertical integration and collusion causes further consolidation in the health care industry and is toxic to competition. Recently, CVS Health announced that it is in negotiations to buy Aetna Inc. for more than \$69 billion. The deal, if approved, would result in a single company controlling every transaction from payment by the insurer to dispensing to the patient. As competitors try to adjust to changing market conditions, this could lead to more acquisitions in the health care space, reducing choices for patients.

Consolidation also limits the ability of patients and payers to understand contracts and maintain leverage in negotiations. PBMs have used their size to create a niche industry of increasingly complex and confusing contracts. Many companies are forced to accept them without understanding them because they lack a firm negotiating position. Thus, PBMs line their pockets at the expense of payers and patients. By contrast, limiting the extent of PBMs in the drug supply chain, we can improve outcomes and reduce costs. While much of the country has seen drug prices spiraling upward, some larger companies have found savings by bringing these benefits in-house. Unfortunately, too many smaller companies, or those without the expertise, are forced to place their trust in PBMs and see their costs go up.

The key to creating sustained efficiencies in the drug supply chain is to demand accountability and transparency from the PBMs. The FTC must address the vertical integration and potential market domination that could result from continued mergers, such as the proposed acquisition of Aetna, Inc. by CVS Health. Moreover, health plan sponsors must be given more

information about the difference between the list and net prices for prescription drugs. Too often, plans simply do not know the amount of the rebates paid to PBMs by the manufacturers. A lack of transparency is the root of concern and hinders efforts to improve our health care system. In order to bend the cost curve for prescription drugs, we must see greater transparency around the net price paid for prescription drugs and enhanced scrutiny of further mergers and acquisitions by PBMs.

Sincerely,

Earl L. "Buddy" Carter
Member of Congress