March 13, 2017

Ms. Sarah Huchel, Consultant
Business and Professions Committee
California State Senate
California State Capitol
Sacramento CA 95814

Re: Draft Pharmacy Benefit Managers Background Paper

Dear Ms. Huchel:

On behalf of the Pharmaceutical Care Management Association (PCMA) I am writing to submit our comments regarding the Pharmacy Benefit Managers Background Paper shared with stakeholders for fact checking on March 8, 2017. PCMA is the national trade association for America's Pharmacy Benefit Managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage through large employers, health insurers, labor unions, and federal and state-sponsored health programs.

PCMA appreciates the opportunity to review the document before it is finalized. We had hoped to have more time to review, given the number and detail of comments we would have liked to provide had there been more time. Overall, we are concerned that the paper seems to paint PBMs in an unbalanced negative light, and in some cases, makes broad factual assertions with no sources. While this letter will not be an exhaustive discussion of the issues, we attempt to provide some additional background and clarity to a few of items below. PCMA supplied brief comments in the margins on the background paper draft, as well.

Role of Payer Clients

In the background paper, payers seem to be passive players in the system. For example, there is no mention that the ultimate decisions on formulary, network, and reimbursement are made by PBM clients, not PBMs. PBMs compete with each other for large employer, health plan, labor union, state government, and other client contracts. Clients outline what they want the PBM to provide, and the PBM builds a contract that meets the unique needs of the client. Everything a PBM does is providing service based on what the client has asked for in its contract.

Conflicts and Competition

The background paper's analysis on competition is simply based on the number of PBMs operating, not a market analysis. There are over 80 PBMs in the United States,[1] though the largest few make up a significant majority of the market. However, there is no mention in the paper of the Federal Trade Commission's conclusions that there is vigorous competition in the PBM space. For example, the FTC allowed Express Scripts to purchase Medco several years ago, and did not object to the more recent Catamaran-OptumRx acquisition. The FTC has

[1] PBMI Data, Prepared for PCMA (2017).

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looked at the issues of mergers in the pharmacy benefit management industry comprehensively and determined that there are not conflicts of interest between PBMs and mail/retail pharmacies and that despite consolidation, competition still exists.[2] PBMs are evaluated by plan sponsor clients based on service and savings for their payers and consumers, among other items, and if clients want to make a change at the end of their contract period, they can, and at times, do, because there is healthy competition in the PBM marketplace. For example, recently CalPERS made a change in the PBM used for California state personnel health care.

PBM Licensing and Registration

The paper states that several states require licensure or registration with insurance departments or boards of pharmacy. To be clear, there is only one state—Mississippi—that has enacted a statute requiring licensure by the board of pharmacy, and this was despite Federal Trade Commission warnings that "giving the pharmacy board regulatory power over PBMs may create tensions and conflicts of interest for the pharmacy board,"[3] and that 'there is a real danger that regulatory boards composed of market participants may pursue their own interests rather than those of the state."[4] PCMA has grave concerns about any sort of regulatory oversight by a board controlled by market participants—pharmacists—who work for pharmacies that sit on the opposite end of the negotiating table with PBMs. Additionally, the report indicates that there is a chart detailing other states' PBM statutes and regulations; however, there was no chart of other states' PBM statutes to review.

Independent Pharmacies

The background paper on page 7 makes a sweeping statement about independent pharmacies, claiming that "independent pharmacies are being phased out or are largely relegated to rural areas," yet provides no source for this assertion. Adam Fein's Drug Channels analysis of the 2016 Cardinal Pharmacy Digest points out that the number of independents has stayed relatively stable over the last five years or so.[5] Furthermore, there can be any number of reasons why any given independent pharmacy might go out of business, and can of course include the choice to retire or sell the business to another entity. PCMA member companies report that their pharmacy networks have grown over these years, as well. The paper provides no discussion on these points.

[2] See, U.S. Federal Trade Commission, PBM Ownership of Mail-Order Pharmacies, August 2005, available at: https://www.ftc.gov/reports/pharmacy-benefit-managers-ownership-mail-order-pharmacies-federal-trade-commission-report, and FTC Letter to Larry Good, ERISA Advisory Council, 2014, available at: https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-erisa-advisory-council-u.s.department-labor-regarding-pharmacy-benefit-manager-compensation-fee-disclosure/140819erisaadvisory.pdf.
[3] FTC Staff Letter to The Honorable Mark Formby Re: SB 2445, March 21, 2011, available at: https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-mark-formby-mississippi-house-representatives-concerning-mississippi/110322mississippipbm.pdf.
[4] Id.
[5] Adam Fein, New Data Show Prescription Profits Under Pressure at Independent Pharmacies, at http://www.drugchannels.net/2016/12/new-data-show-prescription-profits.html

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Pharmacy Services Administrative Organizations (PSAOs)

The paper did not include any discussion of PSAOs and the role they play in negotiating discounts and financial incentives for pharmacies, the fact the largest PSAOs are also owned by the three largest wholesalers—AmerisourceBergen, Cardinal Health, and McKesson (Fortune 21 companies[6]), their cost structure, role in the supply chain, or any discussion on their overall impact on the system as "middlemen." Eighty percent of independent pharmacies in the United States are represented by PSAOs in their dealings with PBMs.[7] PSAOs provide contract negotiation, communication, and help desk services for independent pharmacies. Joining a PSAO provides greater bargaining power for smaller pharmacies, allowing them to more effectively negotiate contract terms with large payers and the PBMs that provide services on payers' behalf.

Prescribers

The role of prescribers is not mentioned in the background paper, and the paper appears to imply that consumers and PBMs make decisions about drug coverage in the absence of prescribers. The paper states that "consumers tend to select drugs from manufacturers who obtain preferred status (and a lower tier [on the formulary]) for their products." In actuality, prescribers decide the best therapeutic option for their patients, and patients can discuss with the prescriber about product and channel options, but prescriber has the final say on what is prescribed.

Rebates and Discounts

The authors appear to condemn rebates and discounts to payers but do not acknowledge that manufacturers also provide rebates and discounts to other entities in the health care market, such as hospitals, wholesalers, insurers, clinics and "others."[8]

In addition, on page 3, the paper states that "actual costs of drugs are never disclosed to clients." PBM-payer contracts are unique and spell out all the terms regarding collection and pass-through or sharing of rebates. PBMs pass along an average of 90% of drug rebates to their plan sponsor clients,[9] but many PBM clients have 100% pass-through contracts, meaning they receive 100% of the rebates from the manufacturer. Rebate arrangements are spelled out in PBM-client contracts and plan sponsors can audit these contracts regularly to ensure that PBMs are complying with the contract terms. Though the paper highlights one instance of private litigation between a payer and PBM, it does not acknowledge the *thousands* of other payer-PBM contracts that have been negotiated and executed and haven't resulted in litigation.

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[6] http://beta.fortune.com/fortune500/list/

[7] U.S. Government Accountability Office (GAO), The Number, Role and Ownership of Pharmacy Services Administrative Organizations, Jan. 2013, available at: http://www.gao.gov/products/GAO-13-176.

[8] Adam Fein, Janssen Reveals and Explains Its List and Net Drug Pricing, available at: http://www.drugchannels.net/2017/03/janssen-reveals-and-explains-its-list.html#more.

[9] Solving the Mystery of Employer-PBM Rebates, Adam Fein, Drug Channels, http://www.drugchannels.net/2016/01/solving-mystery-of-employer-pbm-rebate.html

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Direct and Indirect Remuneration (DIR)

The background paper quotes PCMA's fact sheet on the Medicare DIR (Direct and Indirect Remuneration) program, but takes the information out of context. DIR is a Medicare program. There may be DIR-like programs in the commercial market, but they are not called DIR, and the PCMA fact sheet does not say that "the term 'DIR fees' has now evolved in pharmacy parlance" to encompass many charges…" PCMA disagrees with this statement and discourages the use of the term DIR to refer to any non-Medicare DIR program. Furthermore, PBMs do not profit from DIR. DIR is a financially neutral policy for PBMs.

Other

PCMA believes that an analysis of PBMs for a "PBM 101" hearing should include more discussion about the types of services PBMs provide their clients, the competitive RFP process within the PBM industry, safety measures like Drug Utilization Review that PBMs provide, cost savings achieved through using PBM services, and the value of services provide by PBM-affiliated mail service and specialty pharmacies, which have quality programs that improve healthcare outcomes, provide 24/7 pharmacist access, and provide care management programs that help patients manage their complex conditions and adhere to drug therapies.

Although the pharmacy supply chain can seem complicated, PBMs serve an important role. PBMs save 40-50% on drug costs, through unit cost savings, placing incentives for plan sponsors to achieve an affordable drug mix, and managing utilization. Researchers have found that PBMs help patients and payers save $941 per enrollee per year in prescription drug costs, equaling $654 billion nationally over the next 10 years, and 73.5 billion in California alone.[10] Plan sponsors use these savings to benefit patients by lowering premiums, deductibles, and cost sharing.

Thank you again for the opportunity to review the background paper. If you have any questions about our comments, please contact me at 202-756-5743 or our Sacramento advocate, John Caldwell, at 916-441-0702. Thank you.

Sincerely,

April C. Alexander
Senior Director, State Affairs

[10] Visante, "The Return on Investment (ROI) on PBM Services," prepared for PCMA, Nov. 2016, and "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers," prepared for PCMA, Feb. 2016.

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