



February 28, 2019

The Honorable Eugene A. DePasquale
Auditor General
Department of the Auditor General
Harrisburg PA 17120-0018

Re: Report on Drug Pricing and Pharmaceutical Rebates

Dear General DePasquale:

PCMA has received a copy of your report on pharmaceutical rebates, and provides this response to express concerns about statements and conclusions therein. PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug benefits for more than 266 million Americans with health coverage through large and small employers, health insurers, labor unions, Medicare, Medicaid, and other programs. PBMs are the primary advocates for consumers in the fight to lower prescription drug costs. By leveraging marketplace competition, PBMs effectively negotiate savings which are used to lower enrollee premiums and reduce costs for consumers at the pharmacy. Access to medical innovation is essential for America's patients, but there is no access without affordability.

We are surprised and discouraged to see the significant imbalance in the discussion in your report, especially after providing information about rebates to your office, speaking at each of your listening tour stops in the Commonwealth last fall, testifying before a Senate committee on PBM issues, and working to educate your office and the public on the value of PBMs in the health care system, how PBMs work with other entities in the pharmacy supply chain, how PBMs serve Medicaid, and how the existing mechanisms of PBM oversight work in Pennsylvania. It is essential to set the record straight on the misinformation and imbalances in this report.

1. Drug manufacturers alone set the price of drugs.

The report fails to make the very simple—and obvious—observation that drug makers alone have the power to set prices for their products. Contrary to the narrative promoted by some, manufacturer pricing strategies are unrelated to the rebates they negotiate with PBMs. The report seemingly attempts to describe a complex system, but in doing so, fails to see the forest for the trees. The solution to high list prices is very simple: Just cut the price.

Industry and market experts know that prices drive profits for manufacturers, and 100% of manufacturers' profit is reaped through increased list prices.¹ Because of this, we know that manufacturers will not just cut the prices of their drugs. Without something forcing

¹ Global Pharma and Biotech, Credit Suisse, April 2017, available at: https://research-doc.credit-suisse.com/docView?language=ENG&format=PDF&sourceid=em&document_id=1073763651&serialid=%2FoS2%2F%2Buhfn1K9jHaHOw40qPqJMxew63e%2F6kudOybyhM%3D.



manufacturers to compete and provide price concessions, there is no mechanism to drive down the net cost of drugs.

2. Rebates are the only tool to drive down net cost of pharmaceuticals.

Payers (health plans and PBMs) do not control the prices of drugs, but they are always actively working to reduce the net cost of drugs, through price concessions called rebates. Rebate agreements are made between PBMs and drug manufacturers, and monies are paid, based on utilization, after a drug is dispensed. Most—if not all—of these funds get passed to the payer to help reduce the cost of providing the pharmacy benefit.

The impact of rebates was illustrated most notably and publicly when drugs to treat hepatitis C were first introduced in 2013. Upon introduction, the list price was \$84,000 for a course of treatment. By 2015, when multiple drugs in the class were on the market, PBMs were able to harness competition and force manufactures to offer price concessions. The cost of covering the drugs in this class was reduced by about 40%.

These price concessions can have a positive impact on access, as well. When cholesterol drugs PCSK9 inhibitors were introduced, they had a list price of \$13,000 annually (net cost of \$10,000), and few people were able to access the drug. When rebates were driven higher and net cost reduced to around \$7,000, payers could afford to cover the drugs, providing access to hundreds of thousands of people.²

Not all drugs dispensed are eligible for rebates. Close to 90 percent of all drugs dispensed are generic drugs, and these drugs are not generally eligible for rebates. In Medicare where there are no statutorily-mandated rebates (like in Medicaid), *nearly 40 percent of branded pharmaceuticals are not rebated*,³ yet prices on those drugs also continue to increase. In Medicare Part B, drugs are not eligible for rebates and PBMs do not play a role in negotiation or coverage, but commonly used drugs have risen in price between 16 and 74 percent over the period between 2012 and 2017.⁴

With no analysis or evidentiary support, the report simply recites manufacturer talking points that they are increasing list prices 30 percent to pay for rebates. The report fails to ask crucial—and simple—follow up questions, such as: with only a portion of branded drugs that are rebated, how are payers to get price concessions on the others? What is the cause for increased list prices in drugs that do not have rebates? What is the cause of generic drug price increases, since there are no rebates for generic drugs? This report fails to examine even slightly below the surface of this manufacturer price-blame deflection tactic. Without rebates, manufacturers will have carte blanche to increase prices on all products (as they currently can), but with no reason to compete on price. There is no evidence to suggest that drug manufacturers will keep their own prices in check.⁵

² Visante analysis of data from SSR Health for Praluent and Repatha (non-Medicaid market).

³ Increases in Reimbursement for Brand Name Drugs in Part D, US Dept. of Health and Human Services, Office of Inspector General, <https://oig.hhs.gov/oei/reports/oei-03-15-00080.asp>, June 2018.

⁴ Visante analysis of data from CMS and SSR Health, 2018.

⁵ After President Trump indicated that drug manufacturers had agreed they would not increase their prices in 2018, some drug makers still did, and a significant number of commonly used drugs increased in price at the start of 2019, see: <https://www.reuters.com/article/us-usa-drugpricing/drug-companies-greet-2019-with-u-s-price-hikes-idUSKCN1OW1GA>,

3. There is no correlation between rebates and drug list price increases or launch prices.

Although manufacturers—and your report—cite with no evidence, rebates as the cause of higher prices, analyses of actual data tell a different story. A study of list prices and rebates for top 200 most prescribed drugs between 2011 and 2016 indicated that there is no correlation between rebates and list price increases or launch prices for individual drugs.⁶ Of these drugs, there were prices that increased significantly, some that increased slightly, and some rebates that were high, and some that were low. Top brand drugs that offered little to no commercial sector rebate during this time period still increased their prices, and manufacturers are increasing drug prices regardless of rebate levels negotiated by PBMs. Among the top 200 brand drugs by 2016 sales, the launch prices for drugs introduced from 2012 to 2016 were double the launch prices for those introduced prior to 2012. There was no correlation found between the prices and rebates.

The Office of the Inspector General recently reported that total reimbursement for all brand-name drugs in Medicare Part D increased 77 percent from 2011 to 2015, despite a 17-percent decrease in the number of prescriptions for these drugs, and even after accounting for manufacturer rebates, reimbursement for brand-name drugs in Part D still increased 62 percent during this time.⁷

On the issue of correlation, what we do know is that competition in a drug class is correlated with the availability of rebates. The more unique a drug is, the less likely there will be a rebate associated with it.⁸ The problem, then, is that when no competition exists in a drug class, there is no incentive for a manufacturer to offer a rebate as a price concession.

4. PBMs keep none of the rebates collected for Pennsylvania Medicaid.

The report incorrectly assumes that rebate dollars are retained by PBMs, when in fact, PBMs pass through to clients the significant majority of rebate dollars—and all rebate dollars in Pennsylvania Medicaid. Clients use the value of rebates to reduce the overall cost of providing the health care benefit, and in Medicaid, the value of rebates ultimately flows back to the state and federal governments. It is factually incorrect to state that PBMs retain manufacturer rebates in Pennsylvania Medicaid. The report acknowledges that PBMs do not keep rebates in Medicaid, yet makes the illogical conclusion that PBMs have a perverse incentive to drive up prices.

<https://www.cbsnews.com/news/drug-prices-oxycotin-predaxa-purdue-pharmaceuticals-boehringer-ingelheim/>,

<http://fortune.com/2019/01/02/dozens-drugmakers-celebrate-new-year-raising-prices-hundreds-drugs/>.

⁶ Increasing Prices Set by Drugmakers Not Correlated with Rebates, Analysis prepared by Visante on behalf of PCMA, Jan. 2017, available at: <https://www.pcmamet.org/wp-content/uploads/2017/04/Visante-Study-on-Prices-vs.-Rebates-By-Category-FINAL-3.pdf>.

⁷ Increases in Reimbursement for Brand Name Drugs in Part D, US Dept. of Health and Human Services, Office of Inspector General, <https://oig.hhs.gov/oei/reports/oei-03-15-00080.asp>, June 2018.

⁸ Global Pharma and Biotech, Credit Suisse, April 2017, available at: https://research-doc.credit-suisse.com/docView?language=ENG&format=PDF&sourceid=em&document_id=1073763651&serialid=%2FoS2%2F%2Buhfn1K9jHaHOw40qPqJMxew63e%2F6kudOybyhM%3D.



In addition, the report implies that PBMs could be keeping the vast majority of rebates, which is inaccurate. In fact, 90 percent of rebates are passed to plan sponsors, and plan sponsors audit the performance of these contracts to ensure that PBMs are complying. Regardless, agreements between private businesses providing private health care coverage should not be a focus of a report issued by an agency whose limited charge is to “ensure that all state money is spent legally and properly.”⁹

5. Rebate Sharing Arrangements Are Driven by Plan Sponsors

The report implies that agreements between PBMs and plan sponsors on rebate sharing are controlled by the PBM, when in fact, each plan sponsor determines how it wants a PBM to be compensated for its services and whether sharing in rebates will be a part of this. All PBM clients (e.g., large employers, health plans, insurance carriers, Medicaid managed care organizations) have 100% transparency into their contracts. PBMs compete vigorously for client business and clients dictate the terms of their contracts, including those relating to how pharmacies will be reimbursed and how a PBM will be reimbursed for its services. Clients retain the right to—and regularly do—audit their contracts with PBMs to ensure that PBMs are complying the terms, sharing rebates appropriately, and reimbursing pharmacies in accordance with law and contract.

While the report proposes to mandate plan sponsors to compensate PBMs through administrative fees, there is no basis for concluding that an administrative fee structure would reduce costs, change incentives in the system, or benefit consumers. The only guaranteed result this sort of mandate would have is eliminating flexibility for private employers and health care programs to design contracts in ways that fit their business goals and covered populations.

6. Pharmacies also benefit from price concessions.

The report references that pharmacies do not receive a share of rebate payments and leaves open the possibility that they should. This mischaracterizes the roles of payers, PBMs, and pharmacies in drug coverage programs. PBMs negotiate with manufacturers on behalf of payer clients to secure rebates that lower the net cost of covering or paying for drugs. Pharmacies also negotiate with drug manufacturers on their own behalf for discounts off the purchase of drugs, and these discounts are not necessarily passed through to patients or payers. There is no insight into discounts pharmacies receive from manufacturers or wholesalers that reduce pharmacies’ net costs, nor should there be necessarily. It is simply disingenuous to focus on only one discounting system in the entire supply chain, when there are many that exist.

PCMA remains concerned about the misrepresentations contained in the report and the unfair focus on one entity in the pharmaceutical supply chain. We also request that this response letter accompany the final version of the report. As you know, it is customary to include the response letter of any entity being audited as an attachment to the final report issued by your office.

⁹ Pennsylvania Department of the Auditor, “About the Department,” <https://www.paauditor.gov/about-the-department>.



Thank you for considering our comments, and please feel free to contact me at 202-756-5743 if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "April C. Alexander". The signature is fluid and cursive, with the first name being the most prominent.

April C. Alexander
Assistant Vice President, State Affairs