July 11, 2019

Representative David Linksy, Chair
Representative Dan Ryan, Vice Chair
Honorable Members
Massachusetts House Post Audit and Oversight Committee
Massachusetts Statehouse
24 Beacon Street
Boston MA 02133

Re: Post Audit Committee Review of Health Policy Commission Report on Pharmacy Benefit Managers

Dear Chair Linsky, Vice-Chair Ryan, and Honorable Members:

On behalf of the Pharmaceutical Care Management Association (PCMA), I am writing to provide information relevant to your hearing today on the Health Policy Commission's report on pharmacy benefit managers (PBMs). PCMA is the national association representing PBMs, which administer prescription drug plans for millions of Americans with health coverage provided through large and small employers, health plans, labor unions, state and federal employee-benefit plans, and government programs.

The Health Policy Commission (HPC) issued its report, "Cracking Open the Black Box of PBMs," at its meeting on June 5, 2019. Even the title of the report indicates the HPC's clear negative value judgment about PBMs. In the meeting presentation and in the report, there were significant leaps to arrive at unsupported negative conclusions about PBMs, and a failure to do a true analysis of the underlying data, the complex relationships involved in the pharmacy supply chain, or the purchaser (plan sponsor) perspective. We believe it is important to provide additional context and background on these issues.

PBMs Help Save Massachusetts Billions of Dollars.

PBMs are hired by plan sponsors (large employers, unions, health insurers, government programs such as Medicare, TriCare and Medicaid) to maximize the value of prescription drug benefits and will help patients and payers save $941 per enrollee per year in prescription drug costs[1], equaling $654 billion over 10 years[2]. Plan sponsors use these savings to benefit patients by lowering premiums or deductibles. Over the next decade, the use of PBM tools will save consumers in Massachusetts $14.7 billion, including $8.23 billion for commercial and private insurance, $5.4 billion for Medicare part D, and over $1 billion for Medicaid.[3]

[1] Visante, Inc. "The Return on Investment (ROI) on PGM Services, "Prepared by Visante on behalf of PCMA, November 2016. https://www.pcmanet.org/wp-content/uploads/2016/11/ROI-on-PBM-Services-FINAL.pdf
[2] Visante, Inc. "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers," Prepared for PCMA, February 2016, https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf.
[3] "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan sponsors and Consumers, "Visante, February 2016 https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

PBMs serve many different types of health care programs in Massachusetts, including the Group Insurance Commission (GIC).[4] In 2017, the GIC selected PBMs to manage its pharmaceutical coverage programs, and in doing so, indicated that it expected significant savings. In its annual report to the Legislature in 2018, the GIC reported that "[w]ith the high cost of prescription drugs adversely impacting our members' ability to pay for them, GIC conducted an extensive and competitive procurement process for a new Pharmacy Benefit Manager (PBM)…..GIC standardized its prescription drug access, ensuring all members have access to the same drugs at the same prices. In addition to achieving benefit consistency, this approach leverages the GIC's purchasing power and is projected to save the Commonwealth $500-$750 million in averted cost increases over three years, and was instrumental in achieving a zero aggregate premium increase for many members in FY2019."[5]

While there has been discussion of the concept of "spread" in plan sponsor-PBM contracts, ultimately, contractual relationships between plan sponsors and PBMs are unique to each plan sponsor's needs and goals. Plan sponsors may choose to compensate PBMs through a "spread" arrangement, administrative fees, or some combination thereof. It is always up to the plan sponsor to decide how it wants to contract with the PBM, including the services being provided and the compensation for the services being performed. PBMs can be hired to assist plans with things like formulary and utilization management, claims processing, pharmacy network contracting, drug utilization review, audit services, manufacturer rebate negotiations, enrollee coverage appeals, and more.

The Health Policy Commission's Report on PBMs Is Flawed.

Enclosed is a response to the HPC's report done by research firm Visante, which provides a detailed analysis about the flaws in the primary data sources used by HPC and the erroneous conclusions the HPC drew based on these data sources. In short, Visante found the following:

- HPC's report cherry picked selected data to support its arguments, but ignored data that did not support its argument. The HPC found that there were some *individual drugs* where expenditures were higher in managed care than they were in the fee-for-service (FFS) program during the time period examined (Q4 2018). However, Vistane points out that if all drugs had been examined during that time period, the HPC would have found that MCOs spent *less* than FFS overall. In fact, if MCOs had reimbursed at FFS levels for all drugs during that time period, *total state expenditures would have increased by more than $1.2 million*.

- While HPC demonizes the concept of "spread" in plan-PBM contracts because it argues that PBMs may be profiting unreasonably from the spread, the HPC fails to look at the drugs where PBMs had negative spread, i.e., where the PBMs paid the pharmacy *more than they received from the plans*. For example, looking at the MCO data, Visante found that negative spread in Q4 2018 was more than $2.5 million.

[4] Mass Retirees Newsletter, December 2017, available at: www.massretirees.com/article/issues/state-gic/gic-selects-cvs-express-scripts-pharmacy-management.
[5] GIC Report to Legislature, Sept. 2018, available at: https://www.mass.gov/files/documents/2018/10/12/GIC_Vendor%20Quality%20Improvement%20Report%20FY2018.pdf

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- The primary data sources (CMS' National Average Drug Acquisition Cost and State Drug Utilization Data) used for the analysis are unreliable for making broad conclusions about market distortions. The data varies significantly from quarter to quarter and selecting a limited time period to examine may lead to erroneous conclusions. Additionally, the data sources leave out key factors that impact net cost, including discounts and rebates that reduce the net cost to pharmacies for stocking pharmaceuticals and to plan sponsors (including Medicaid) for providing coverage of the pharmaceuticals. The sources also leave out cost data from specialty pharmacies, which handle drugs which are often very high cost.

- HPC takes a "tunnel vision" approach to pharmacy benefits by only looking at a few generic drugs, which are a small sliver of the overall cost picture (about 13%). Plan sponsors make decisions on the coverage programs based on overall costs, quality and outcomes associated with the entire benefit plan, not typically on individual drugs or payments.

- HPC implies that states and taxpayers are "paying more" because of spread on a few drugs. This is misleading at best, if simply not true. The states typically pay the Medicaid MCOs a capitated rate. If the price of a drug is much higher or lower than the amount that the Medicaid MCO pays the PBM, the MCO is at risk, not the state.

Finally, HPC's conclusion is unsupported by its analysis. HPC states, "[w]hile this analysis does not provide estimates of PBM margins from drug pricing, the results suggest that opportunities to lower drug spending through more transparent PBM practices exist for both public and commercial payers in Massachusetts." HPC admittedly did not examine PBM margins (which hover around 3%, the lowest in the pharmaceutical supply chain[6]), established no nexus between PBM spread or margins and overall costs or trends, and did not examine any existing transparency tools (such as the significant reporting requirements in Medicaid). Instead of looking at various ways the state is working with PBMs to help put downward pressure on rising costs (GIC, Medicaid), it focused the report on a singular issue to make a negative point about PBMs.

Ultimately, the HPC report is a distraction from the underlying issue, which is the rising cost of prescription drugs.[7] PBMs share policymakers' concerns about prices and cost, but encourage policymakers to take a holistic approach to the issues. Manufacturers alone set and raise the prices of the drugs they sell, and no discussion about expenditures on drugs is appropriate without manufacturers at the table. And despite HPC's negative opinions on PBM transparency, PBMs are open to transparency solutions that achieve real solutions to defined problems. While PBMs can attempt to put downward pressure on rising cost trends, they can do so only when they can use their tools to the fullest extent possible, and when there is competition among manufacturers and competition among pharmacies.

[6] The Flow of Money Through the Pharmaceutical Distribution System, USC Schaeffer Center, https://healthpolicy.usc.edu/wp-content/uploads/2017/06/USC_Flow-of-MoneyWhitePaper_Final_Spreads.pdf
[7] Drug Prices Persistently Rising Despite Trump Efforts, Sarah Owermohle, Politico, 7/1/19, available at: https://www.politico.com/story/2019/07/01/drug-prices-persistently-rising-despite-trump-efforts-1565892

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We respectfully request that you review with a critical eye the HPC report and consider the Visante comment in response, enclosed with this letter. We are happy to discuss further if you would like. Please contact me at 202-756-5743 if you have any questions. Thank you.

Sincerely,

April C. Alexander
Vice President, State Legislative and Regulatory Affairs

Enclosure: Visante Comment on HPC Report

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