Oppose H.R. 244

The MAC Transparency Act

The so-called "MAC Transparency Act" (H.R. 244) would increase costs for government and Medicare Part D, TRICARE, and FEHBP enrollees alike, by tying the hands of plan sponsors trying to keep the costs of prescription drugs low. Specifically, the legislation would require that plans disclose their pricing methodologies and reward inefficient pharmacies by removing incentive for them to operate and purchase more effectively for patients enrolled in Federal programs. The bill also prohibits plan sponsors from sharing patient information or requiring patients to use retail, mail service, or specialty pharmacies in which the plan has an ownership stake, even when it lowers costs for the beneficiary. The bill would increase the cost of drugs solely to benefit pharmacies.

H.R. 244 Would Increase Costs and Disincentivize the Use of Generic Drugs in Federal Programs.

- Maximum allowable cost (MAC) lists are the maximum reimbursement allowed by pharmacy benefit managers (PBMs) for a particular generic drug that is available from multiple manufacturers and sold at different prices. The bill would effectively end the use of these lists, which plans and pharmacy benefit managers (PBMs) have successfully used for years to standardize payments for generic drugs with multiple manufacturers.
- MAC lists are based on wholesale prices, reasonable profit margins, and other factors. Publishing the methodology would allow pharmacies and wholesalers to undermine the system by hiding discounts or devising other ways around it, which would raise costs to consumers.
- Use of MAC lists give pharmacies an incentive to shop for the lowest-cost generic drug. Tying reimbursement to a reference price based on the overall market encourages pharmacies to manage inventories efficiently and leverage buying power to get the lowest possible cost. These lower costs are passed along to consumers, payers and the federal government.
- MAC lists are used by Part D plans, private-sector sponsors, union health and welfare funds, and Medicaid. Four out of five private employer prescription drug plans use MAC lists for retail generic prescriptions. A recent analysis from the HHS Office of Inspector General (OIG) recommended that states strengthen MAC programs given "the significant value MAC programs have in containing Medicaid drug costs."

H.R. 244 Would Increase Enrollee Costs by Eliminating Preferred Cost Sharing for Most Mail Pharmacies.

- The bill would make it more difficult for plans to offer enrollees lower cost sharing for certain more efficient pharmacies, including mail service pharmacies.
- Anti-mail service legislation that works against the appropriate use of mail-service for long-term prescriptions amounts to nothing more than special-interest legislation that will raise costs for consumers.
- Moreover, provisions of the bill governing plan-pharmacy negotiations and ownership interests are misplaced. The Federal Trade Commission found accusations of "self-dealing" that might arise when PBMs both administer a pharmacy benefit and ship drugs via their own mail-order pharmacy are "without merit."

H.R. 244 Contains Provisions That Violate Medicare Part D's Noninterference Statute.

- The legislative architecture of the successful Part D program states that "to promote competition" in Part D, the government "may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors.…"
- H.R. 244 would require the Centers for Medicare and Medicaid Services (CMS) to enforce provisions governing the private negotiations between sponsors and pharmacies, including the widely used MAC pricing tool.

H.R. 244 Raises Costs for Enrollees and Taxpayers Solely to Benefit the Retail Pharmacy Lobby.

- Given Medicare Part D's track record of success, including high beneficiary satisfaction and lower-than-expected costs, such serious changes to the program are unnecessary, unwarranted, and unwise.

Federal Law Already Requires Disclosure of Updated MAC Prices to Pharmacies.

- 42 U.S.C. 1395w–112(b)(6) as amended by PL 110-275 (MIPPA) reads: *"If the PDP sponsor of a prescription drug plan uses a standard for reimbursement of pharmacies based on the cost of a drug, each contract entered into with such sponsor under this part with respect to the plan shall provide that the sponsor shall update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the drug"*