Written Statement of Dr. Jonathan Grider, PharmD

United States House Committee on Oversight and Reform

"Reviewing the Role of Pharmacy Benefit Managers in Pharmaceutical Markets"

November 17, 2021

Ranking Member Comer and Members of the Committee:

Thank you for conducting this forum reviewing the practices of pharmacy benefit managers (PBMs) and for the opportunity to share my perspective on the impact that PBM practices have on prescription drug affordability to my patients and the operations of small business pharmacies, like mine.

My name is Jonathan Grider, and I am a third-generation pharmacist. My grandfather opened an independent pharmacy in 1968, and my uncle entered the family business around 1990. After receiving my Doctor of Pharmacy from the University of Kentucky College of Pharmacy, I opened Lake Cumberland Pharmacy in 2011, which today has two locations in Russell Springs, Kentucky. In 2016, I became a partner with St. Matthews Specialty Pharmacy, located in Louisville, Kentucky. My retail pharmacies serve a rural county with a population of roughly 15,000 with limited access to care as there are only two other independent and two chain pharmacies county-wide. Additionally, through St. Matthews, I provide services to vulnerable populations focused on improving access to both Hepatitis C and opioid misuse treatment options throughout Southcentral Kentucky. I am a member of the National Community Pharmacists Association (NCPA) and the Kentucky Pharmacists Association, and I serve on the Board of Directors for EPIC Pharmacies, Inc. I also serve as the Board Chairperson of Faith Healthcare, a Federally Qualified Health Center Look-Alike, located in Monticello, Kentucky which opened in 2020 during the COVID-19 pandemic.

NCPA represents America's community pharmacists, including nearly 19,400 independent community pharmacies. Almost half of all community pharmacies provide long-term care services (LTC) and play a critical role in ensuring patients have immediate access to medications in both community and LTC settings. Together, NCPA's members represent a $67.1 billion health care marketplace, employ approximately 215,000 individuals, and provide an expanding set of health care services to millions of patients every day. Its members are small business owners who are among America's most accessible health care providers, often serving as the only pharmacy in many rural and urban medically underserved areas.

Formed in 1982, EPIC Pharmacies is a buying group of over 1,500 independently owned pharmacies across the country. EPIC Pharmacies works to help independent pharmacies thrive by entering into contracts with third-party payers, help navigate and prepare for the harmful effects of pharmacy direct and indirect remuneration (DIR) fees, and to map out positive opportunities in the ever-changing pharmacy landscape. EPIC Pharmacies also helps to manage

the reimbursement relationships between PBMs and health plans and independent pharmacies, to include verifying accurate claim data is received from PBMs free of error and acting as a payment facilitator to ensure funds are remitted from PBMs to their pharmacy clients. Lastly, EPIC Pharmacies assists its pharmacy clients with responding to PBM audits.

PBMs play an oversized role in federal healthcare programs as large corporate middlemen. PBMs determine which pharmacies patients may choose by creating provider networks, they determine which drugs patients can be prescribed by creating drug formularies, and they determine how much patients pay at the pharmacy counter for their medications. As one state government investigation found, with their unique position in the pharmacy supply chain, "PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies." [1]

Because of their anticompetitive practices and our nation's ever-increasing drug costs, greater scrutiny over PBM business practices is imperative. Approximately 80 percent of my patients are covered under Medicare and/or Medicaid. The disproportionate share of my business revenue coming from federal healthcare programs is not uncommon for pharmacies like mine in underserved communities nationwide.

Unfortunately, my concerns with PBMs have been exacerbated because of the COVID-19 pandemic, both short-term and long-term. Independently owned pharmacies have long served as lifelines, as essential businesses before and during the pandemic. Pharmacists like myself have provided testing and vaccines to many patients during the pandemic. Along with vaccines, Lake Cumberland Pharmacy offers free home delivery county-wide to ensure elderly and vulnerable patients have convenient access to the medications they need. We also work with our local providers to support medication therapy management programs to help cut down on out-of-pocket prescription expenses. As an independent pharmacy owner, I strive to always be accessible to those in my community, so that a single mother who needs an emergency supply of antibiotics for her child knows that I will answer the 3:00 a.m. call to help, for instance. Countless examples like this demonstrate why community pharmacies are among the most trusted health care providers in their local areas. The threats facing me from PBM middlemen, however, threaten my ability to remain viable and keep the pharmacy doors open.

PBMs' Vertical Integration

Today, the three largest PBMs control 77 percent of the health plan pharmacy benefit market. [2] A PBM, as part of a vertically integrated entity with a health plan and mail-order/specialty/retail pharmacies, has power in most of the markets in which community pharmacies try to

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[1] New York Senate Committee on Investigations and Government Operations, *Final Investigative Report: Pharmacy Benefit Managers in New York*, (May 31, 2019), *available at* https://www.nysenate.gov/sites/default/files/article/attachment/final_investigatory_report_pharmacy_benefit_managers_in_new_york.pdf.

[2] Fein, Adam. "The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation." Drug Channels. April 6, 2021. https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html

compete.[3] With their growing market share and limited regulation, PBMs set the rules that pharmacies must follow, have the upper hand in negotiations, and can force pharmacies into take-it-or-leave-it contracts. With their vertical integration, PBMs can steer patients to their affiliated retail, mail-order, and specialty pharmacies, and can mandate that patients in certain plans only utilize the PBM affiliated pharmacies, therefore depriving patients of any choice. These ownership interests raise conflict of interest questions, and the ever-growing mergers in this sector continue to lead to decreased competition and fewer choice for patients.

Congress should pass S. 1388, the *Prescription Pricing for the People Act of 2021*, which would require the Federal Trade Commission to study PBMs and how their actions are affecting patients and small independent pharmacies. This legislation would shed light on how PBMs are affecting prescription costs and patient choice and would bring needed transparency to the pharmacy benefit space. Advancing this legislation this year will empower the FTC to review the consolidated PBM industry and their anticompetitive practices, which would provide relief to patients. The bill would bring further transparency to PBMs through retrospective reviews from the FTC and support Congress as it crafts evidence-based solutions to address the anticompetitive role PBMs play as pharmaceutical costs continue to rise.

Pharmacy Direct and Indirect Remuneration (DIR) Fee Reform

Pharmacy direct and indirect remuneration (DIR) fees are post point-of-sale clawback fees assessed on pharmacies months after Medicare Part D prescriptions are filled instead of being deducted from claims at the point of sale. The Centers for Medicare & Medicaid Services (CMS) documented an extraordinary 91,500 percent increase in DIR fees paid by pharmacies from 2010-2019. By comparison, if a gallon of milk increased by 91,500 percent over that same period, it would cost $366 today. Gas would be over $2,700 per gallon. These fees, which lead to higher costs for beneficiaries at the pharmacy counter, impose ever-increasing challenges on struggling seniors, putting them at risk for reduced medication adherence and poorer health outcomes.

Pharmacy DIR fees also make it harder for pharmacies to continue operating and providing seniors and special needs populations with the medications and services they desperately need. Many pharmacies have closed over the past few years and have cited pharmacy DIR fees as a primary cause. Over the last five years, 24 independent pharmacies have closed across Kentucky. Since 2019, EPIC Pharmacies has reported a total of 129 pharmacy closures nationally. A total of 52 closures in 2019, 45 closures in 2020, and currently 32 as of today, respectively. These pharmacy closures reduce access to vital healthcare services; especially in rural and underserved areas where healthcare options are already limited. An October 2019 NCPA member survey showed that 58 percent of independent pharmacies – representing over

[3] https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf, *see e.g.,* Table 1 (in 92% of markets, at least one insurer with PBM has 30% market share; in 50% of the MSAs, one insurer has at least 50% market share).

12,000 pharmacy small businesses – are somewhat or very likely to close in the next two years without relief from pharmacy DIR fees.[4]

In 2019, Lake Cumberland Pharmacy had to pay back a total of $92,661 in pharmacy DIR fees, a total of $137,007 in 2020, is and currently projected to pay $132,725 in 2021 with a month and a half left to finish off the year. St. Matthews Specialty Pharmacy paid back more than $1.1 million in pharmacy DIR fees in 2020 alone. In comparison, EPIC Pharmacies members paid a grand total of $66,329,196 in 2019, a total of $67,523,509 in 2020, and are projected to pay more than $86,000,000 in 2021.

Retroactive pharmacy DIR fees that Part D plan sponsors and their PBMs claw back from pharmacies months after prescriptions have been filled should be assessed at the point of sale to protect small business pharmacies and stop PBMs from artificially raising out-of-pocket drug costs for our nation's sickest seniors, pushing them into the donut hole at an accelerated rate. Congress must take action to address DIR fees by passing the *Pharmacy DIR Reform to Reduce Senior Drug Costs Act (*H.R. 3554 / S. 1909). By enacting this bipartisan legislation, Congress could provide out-of-pocket savings for Medicare beneficiaries between $7.1 and $9.2 billion over the next decade.

Medicaid Managed Care Spread Pricing Prohibition

For years, PBMs have been playing spread pricing games, contributing to high drug costs to the detriment of patients and the taxpayer-funded programs the PBMs are supposed to serve. Studies of multiple state Medicaid managed care programs have indicated that PBMs are overcharging taxpayers for their services in Medicaid managed care, reimbursing pharmacies low for medications dispensed, billing the state Medicaid program high for the cost of these medications, and retaining the difference; this difference being the "spread".[5] In 2020, Kentucky passed SB 50, which I worked on with Senator Max Wise, former Medicaid Pharmacy Director Dr. Jessin Joseph, PharmD, and many others. The law now requires the state to regulate and contract with a single PBM to administer Medicaid managed care benefits. It also allows the state to authorize the Medicaid department to establish pharmacy reimbursement methodologies and dispensing fees. In addition to Kentucky, Arkansas, Georgia, Louisiana, Maryland, New Hampshire, New York, Ohio, Pennsylvania, and Virginia now prohibit spread pricing in their Medicaid managed care programs. Federally, CMS has issued guidance prohibiting managed care organizations in Medicaid managed care programs from counting the "spread" towards medical costs in the medical loss ratio. Congress should ban the use of spread pricing by PBMs.

[4] https://ncpa.org/newsroom/news-releases/2019/10/16/local-pharmacies-pushed-to-brink-by-pharmacy-benefit-monopolies

[5] National Community Pharmacists Association summary of state Medicaid managed care reforms https://ncpa.org/sites/default/files/2020-05/medicaid-managed-care-reform-one-pager.pdf

To do this, Congress should require that state Medicaid managed care programs implement a "pass-through" model, which includes a transparent benchmark based on National Average Drug Acquisition Cost (NADAC) and a dispensing fee like those in Medicaid fee-for-service programs, which on average is $10.64 per prescription. Under a pass-through pricing model, PBMs are paid an administrative fee, which is the only source of revenue under the contract, thus avoiding any costly PBM spread. The Congressional Budget Office (CBO) has estimated this reform, which was included in both House and Senate drug pricing reform proposals last Congress, would save $1 billion over 10 years.

Conclusion

On behalf of community pharmacies across America, I appreciate the diligent work of this committee to examine the anticompetitive practices of PBMs and their impact on patients and pharmacies. Congress should continue to examine how PBMs are steering patients into their own affiliated pharmacies to the detriment of consumers, taxpayers, and small business pharmacies. Further action is needed to stop these harmful practices and review how vertical integration has fueled these behaviors. Congress should also pass the legislation and policies that I have detailed, including pharmacy DIR fee reform and a spread pricing prohibition in Medicaid managed care, to ensure patients' drug costs are lowered and that small business pharmacies can survive. Without action, pharmacies will continue to close at an alarming rate in underserved communities leaving more and more patients deprived of health care access.