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Reviewing the Role of Pharmacy Benefit Managers in Pharmaceutical Markets

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Thank you for hosting the forum on "Reviewing the Role of Pharmacy Benefit Managers in Pharmaceutical Markets" and for the opportunity to discuss the important role of specialty pharmacy, and in particular address my experience working with Senderra Rx, an independent specialty pharmacy.

Specialty pharmacies support patients who have complex health conditions like rheumatoid arthritis, multiple sclerosis, hemophilia, cancer, and organ transplantation. The medications a specialty pharmacy dispenses are typically expensive. Historically, there are limited generic or biosimilar alternatives to brand specialty drugs. Specialty prescription medications are not routinely dispensed at a typical retail pharmacy because the medications are focused on a limited number of patients and require significant patient education and monitoring on utilization and adherence. Typical retail pharmacies are not designed to provide the intense and time-consuming patient care services that specialty medications require. Though many specialty medications are taken orally, still many need to be injected or infused in either a doctor's office or hospital. The services a specialty pharmacy provides includes patient training in how to use the medications, comprehensive treatment assessment, ongoing patient monitoring, and frequent communication with caregivers, physicians and other healthcare providers. A specialty pharmacy's expert services drive patient adherence, proper management of medication dosing and side effects, and ensure costly and complex drug therapies and treatment regimens are used correctly and not wasted. I represent Senderra Rx, an independent specialty pharmacy headquartered in Texas with services provided to specialty patients with such conditions as multiple sclerosis and rheumatoid arthritis throughout the U.S.

It's important to provide some perspective for this forum. While the number of specialty medications only comprises two percent of the total number of prescriptions dispensed in the US,

it represents nearly 50 percent of overall drug spend. Distribution for most specialty medications is limited, with payers working to keep them even smaller. The market is heavily dominated by the largest PBMs and the health insurers that own those PBMs. While the specialty market has grown, so has vertical integration in the market. The three largest PBMs—CVS Caremark (subsidiary of CVS Health, Inc.; 2019 revenue: $141.5 billion), Express Scripts (subsidiary of Cigna, Corp.; 2019 revenue: $96.4 billion), and OptumRx (subsidiary of UnitedHealth Group; 2019 revenue: $74.3 billion)—account for more than 80% of the PBM market.[1],[2] Insurers have more incentive to fill a specialty drug through their PBM-owned specialty pharmacy. The largest PBMs also dominate the specialty pharmacy market, having their own or an affiliation with three of the four largest specialty pharmacies in the United States: CVS Specialty (owned by CVS Health, Inc.), Accredo / Freedom Fertility (owned by Express Scripts), and Optum Specialty Pharmacy (owned by OptumRx).[3] The impact on pharmacy access for patients and cost to the overall health care system as vertical integration persists is dire. **Far more oversight through statute and regulation is necessary, with specific protections in place to ensure that: pharmacy networks include a robust network of specialty pharmacies for patients; the practice of patient steering is prohibited; and pharmacy DIR clawbacks on pharmacies are eliminated and prohibited.**

Pharmacy Networks

In many instances, my pharmacy – Senderra, has witnessed increased efforts by PBMs to limit the participation of independent specialty pharmacies in a given pharmacy network. Tactics such as demanding impossible terms for participation and non-negotiable reimbursement rates that do not cover the cost of the drug alone – let alone the services needed to go with the drug - are all too common. Impossible terms can include requiring a specialty pharmacy to stock non-specialty drugs that are outside the needs of its patient base and mandating that a pharmacy set up additional physical locations despite the PBM knowing that specialty pharmacies have a hub and spoke model where they successfully ship medications to patients as opposed to operating multiple physical facilities. Senderra and other specialty pharmacies must repeatedly work through state and federal law to get into provider networks.

Patient Steering

However, even if initially successful, too often, a large PBM will capture a prescription away from a network pharmacy – a practice referred to as patient steering. Vertically integrated PBMs can see a patient's insurance information and will use the information to call or send a letter to a patient or prescriber, instructing them to transfer their prescription to the PBM-owned specialty pharmacy or otherwise risk their drug's coverage. Extremely sick and vulnerable patients are threatened to lose their coverage for a drug they otherwise may not be able to afford or access if they do not comply with the PBM's demands. Without federal oversight, through such entities as the HHS Office of Civil Rights or Federal Trade Commission and the establishment of enforcement protections, network pharmacies continue to fall victim to these anti-competitive practices, and patient access to their pharmacies is suppressed.

[1] https://www.acpjournals.org/doi/abs/10.7326/M17-2506?journalCode=aim
[2] https://docs.house.gov/meetings/JU/JU05/20151117/104193/HHRG-114-JU05-Wstate-BaltoD-20151117.pdf
[3] https://www.drugchannels.net/2020/04/the-top-15-specialty-pharmacies-of-2019.html

Pharmacy DIR Fees

An anti-market practice contributing to high drug costs under Medicare Part D that requires immediate action by Congress and the Biden Administration is the reform of pharmacy direct and indirect remuneration fees – called pharmacy DIR fees. DIR fees are monies received by PBMs and Medicare Part D health plans that include concessions pharmacies are forced by PBMs to pay long after the pharmacy dispenses medications to seniors. These fees are not used by PBMs or their affiliated health plans to reduce the cost of the drugs for seniors. Pharmacy DIR fees only result in profit for PBMs/payers, forcing pharmacies to fill Medicare prescriptions below cost. As reported by Drug Channels, in 2019, the total amount of pharmacy DIR was estimated to be approximately $9 billion.[4] The Centers for Medicare and Medicaid Services (CMS) reported to Congress in Spring 2021 that DIR fees on pharmacies have increased by 91,500 percent between 2010 and 2019. Senderra has had to pay millions of dollars in DIR fees per year. The consequence has been a reduction in staffing, litigation, and loss in patient access. Despite what many PBMs will say if asked, these fees are anything but transparent. If all pharmacy DIR fees were assessed, and assessed fairly and transparently at the point of sale, our patients would see an immediate reduction in their drug costs.

Also, because pharmacy DIR reduces the actual payment rate from PBMs to pharmacies, basing patient cost sharing on the rate referred to at the point-of-sale increases patients' financial burden, compared with basing cost sharing on the actual payment rate (with pharmacy DIR factored in). For example, assuming that the PBM-pharmacy contractually determined rate at the point-of-sale is $100 and a patient's coinsurance is 20%, the patient's cost sharing is $20 (20% of the point-of-sale price). Assuming also that the PBM charges $15 of pharmacy DIR, the actual payment rate becomes $85 (the point-of-sale price minus pharmacy DIR), and the patient cost sharing would be $17 (20% of the actual payment rate) should the cost sharing be based on the actual payment rate at the point-of-sale. However, in the current system, the patient cost sharing is based on the price at the point-of-sale and thus remains at $20, causing the patient 18% greater financial burden ($20 vs. $17).

Medicare Part D prescription drug plan sponsors report pharmacy DIR to CMS within six months after the close of the plan year.[5] Based on this data (publicly unavailable), CMS found that in recent years, plan sponsors have consistently received higher DIR than they initially estimated during the bidding process for contracting with the Medicare Part D program.[6] In other words, PBMs and plan sponsors have been underestimating DIR. This finding is important because it indicates that any DIR received by PBMs and plan sponsors above the projected amount factored into a plan's bid contributes primarily to plan profits, not lower premiums.

We are grateful for the leadership of Congressman Welch on committee to introduce H.R. 3554, the *Pharmacy DIR Reform to Reduce Senior Drug Costs Act*, and for the support of Ranking Member Comer, Congressman Krishnamoorthi, and so many other committee members for

[4] https://www.drugchannels.net/2020/02/pharmacy-dir-fees-hit-record-9-billion.html
[5] https://fas.org/sgp/crs/misc/R40611.pdf
[6] https://www.govinfo.gov/content/pkg/FR-2017-11-28/pdf/2017-25068.pdf

support of the bill on a bipartisan basis. This bill addresses pharmacy DIR reform that is needed this year.

We appreciate today's forum and effort to address the role and actions of PBMs in the pharmaceutical channel in which specialty pharmacy is part. Thank you for allowing Senderra to share some perspective on issues that contribute to challenges with market competition and also high drug costs for seniors in Medicare Part D. We are grateful for the opportunity to share recommendations through this forum and look forward to engaging more with the committee on these issues.