THE ROLE OF PHARMACY BENEFIT MANAGERS

HEARING

BEFORE THE

SUBCOMMITTEE ON THE ADMINISTRATIVE STATE, REGULATORY REFORM, AND ANTITRUST

COMMITTEE ON THE JUDICIARY

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

WEDNESDAY, SEPTEMBER 11, 2024

Serial No. 118–98

Printed for the use of the Committee on the Judiciary

Available via: *http://judiciary.house.gov*

U.S. GOVERNMENT PUBLISHING OFFICE

56–838 WASHINGTON : 2024

COMMITTEE ON THE JUDICIARY

JIM JORDAN, Ohio, *Chair*

DARRELL ISSA, California
MATT GAETZ, Florida
ANDY BIGGS, Arizona
TOM MCCLINTOCK, California
TOM TIFFANY, Wisconsin
THOMAS MASSIE, Kentucky
CHIP ROY, Texas
DAN BISHOP, North Carolina
VICTORIA SPARTZ, Indiana
SCOTT FITZGERALD, Wisconsin
CLIFF BENTZ, Oregon
BEN CLINE, Virginia
KELLY ARMSTRONG, North Dakota
LANCE GOODEN, Texas
JEFF VAN DREW, New Jersey
TROY NEHLS, Texas
BARRY MOORE, Alabama
KEVIN KILEY, California
HARRIET HAGEMAN, Wyoming
NATHANIEL MORAN, Texas
LAUREL LEE, Florida
WESLEY HUNT, Texas
RUSSELL FRY, South Carolina
MICHAEL RULLI, Ohio

JERROLD NADLER, New York, *Ranking Member*
ZOE LOFGREN, California
STEVE COHEN, Tennessee
HENRY C. "HANK" JOHNSON, JR., Georgia
ADAM SCHIFF, California
ERIC SWALWELL, California
TED LIEU, California
PRAMILA JAYAPAL, Washington
J. LUIS CORREA, California
MARY GAY SCANLON, Pennsylvania
JOE NEGUSE, Colorado
LUCY MCBATH, Georgia
MADELEINE DEAN, Pennsylvania
VERONICA ESCOBAR, Texas
DEBORAH ROSS, North Carolina
CORI BUSH, Missouri
GLENN IVEY, Maryland
BECCA BALINT, Vermont
Vacancy

SUBCOMMITTEE ON THE ADMINISTRATIVE STATE, REGULATORY REFORM, AND ANTITRUST

THOMAS MASSIE, Kentucky, *Chair*

DARRELL ISSA, California
MATT GAETZ, Florida
DAN BISHOP, North Carolina
VICTORIA SPARTZ, Indiana
SCOTT FITZGERALD, Wisconsin
CLIFF BENTZ, Oregon
BEN CLINE, Virginia
LANCE GOODEN, Texas
JEFF VAN DREW, New Jersey
HARRIET HAGEMAN, Wyoming
NATHANIEL MORAN, Texas
KELLY ARMSTRONG, North Dakota
Vacancy

J. LUIS CORREA, California, *Ranking Member*
HENRY C. "HANK" JOHNSON, JR., Georgia
ERIC SWALWELL, California
TED LIEU, California
PRAMILA JAYAPAL, Washington
MARY GAY SCANLON, Pennsylvania
JOE NEGUSE, Colorado
LUCY MCBATH, Georgia
ZOE LOFGREN, California
STEVE COHEN, Tennessee
GLENN IVEY, Maryland
BECCA BALINT, Vermont

CHRISTOPHER HIXON, *Majority Staff Director*
AARON HILLER, *Minority Staff Director & Chief of Staff*

C O N T E N T S

WEDNESDAY, SEPTEMBER 11, 2024

OPENING STATEMENTS

WITNESSES

LETTERS, STATEMENTS, ETC. SUBMITTED FOR THE HEARING

THE ROLE OF PHARMACY BENEFIT MANAGERS

Wednesday, September 11, 2024

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON THE ADMINISTRATIVE STATE, REGULATORY REFORM, AND ANTITRUST

COMMITTEE ON THE JUDICIARY

Washington, DC

The Subcommittee met, pursuant to notice, at 2:20 p.m., in Room 2141, Rayburn House Office Building, the Hon. Thomas Massie [Chair of the Subcommittee] presiding.

Members present: Representatives Massie, Jordan, Bishop, Spartz, Fitzgerald, Bentz, Cline, Gooden, Van Drew, Hageman, Moran, Correa, Nadler, Johnson, Scanlon, Lofgren, Ivey, Balint, and Ross.

Mr. BISHOP. [Presiding.] The Subcommittee will come to order.

Without objection, the Chair is authorized to declare a recess at any time.

We welcome everyone to today's hearing on the role of Pharmacy Benefit Managers.

The Chair of the Subcommittee, Mr. Massie, is on the floor, and in the interest of time and everyone else's presence here, I'm going to proceed until he is able to join us.

In light of that, I will now recognize myself for an opening statement.

Today's hearing will examine the role of pharmacy benefit managers, known as PBMs, in the healthcare industry, including the ability of PBMs to control access to, and the pricing of, pharmaceutical products.

PBMs serve as one of a handful of intermediaries between the pharmaceutical manufacturers that make prescription drugs and the patients who consume them. While PBMs are just one link in the pharmaceutical distribution chain, we have all heard of their alleged outsized influence in the market.

According to some estimates, the largest three PBMs account for nearly 80 percent of the market for pharmacy benefit services. The top three PBMs are members of vertically integrated companies that also own insurance companies, provider groups, and pharmacies.

In some cases, a patient can purchase insurance, see a doctor, and buy prescription drugs from three companies that are all owned by the same parent company. Many claim that this level of vertical integration is highly beneficial for patients. By reducing administrative fees and leveraging their sheer size, large vertically integrated conglomerates are often able to operate more efficiently than disaggregated companies. Additionally, having a vast network of options for patients ensures that patients are likely to face the same treatment options, regardless of where they are in the country.

However, vertical integration is not without potential harms to patients. Because vertically integrated PBMs control so much of the supply chain, and because there are so few competitors in the market, PBMs have almost complete control over a patient's access to medications. PBMs have the ability to control which pharmacies are available to fill prescriptions, sometimes steering patients to PBM-owned pharmacies. PBMs also have the ability to control which medications are available under a patient's healthcare coverage.

Even if a medication is covered, patients often do not know how much a prescription drug will cost until they get to the register. For most other products, a consumer can research the price of a good well in advance of the point of purchase. However, a lack of price transparency has, unfortunately, become the norm in the healthcare industry.

We are holding a bipartisan hearing today because across the board we are hearing the same things from our constituents. When we go home to our districts, we hear about the high cost of prescription drugs; we hear about the confusion people face in regard to the price of healthcare, and we hear about the lack of access to community-based independent pharmacies.

While pharmacies run by vertically integrated conglomerates can save patients money, some patients want the option of using their local pharmacist. However, for independent pharmacists, the take-it-or-leave-it contracts they sign with large PBMs trap them into inflexible arrangements that leave little room for innovation.

Also, for many independent pharmacists, operating outside of a large PBM's network, effectively, means closing shop. Without a PBM's patients, there isn't enough business to go around.

Today, we have the opportunity to hear from experts in this field who have been studying the healthcare supply chain for decades. These experts are at the forefront of academic scholarship on health policy and are prepared to help us better understand the operations of the market and the costs and benefits of PBMs more broadly. This information will better inform us, as we work on possible solutions and consider the proposals that have already been introduced.

I want to thank the witnesses for appearing before us today, and I look forward to hearing what each of you has to say.

I now recognize the Ranking Member, Mr. Correa, for an opening statement.

Mr. CORREA. Thank you, Mr. Chair.

I want to thank our witnesses for being here today. I appreciate you being here today.

Today, we are going to examine the role of pharmacy benefit managers, or PBMs, and their impact on our healthcare system and the pharmaceutical drug delivery market. Nothing is so simple about this topic, but one thing is certain: Things just ain't right.

As the late, great Justice Louis Brandeis would say, "Sunshine is the best disinfectant." So, I hope that today the sun will shine brightly as we work to lift the veil on the PBMs and their role on drug pricing and the drug delivery market.

Until recently, most people didn't even know that PBMs existed, and now, we see their handiwork everywhere. While some of us Americans with good health plans and low deductibles may secure our medications at reasonable rates, there are too many hard-working Americans who can't afford medications. There are too many heart-wrenching stories of families having to choose between medications that they need to survive and food or housing, and that is not right.

Decisions, life-and-death decisions, are being made today for Americans in closed, backroom deals; instead, they should be made by the medical providers, and that is also not right.

We need to find solutions to these problems, like we did when Congress and the Biden–Harris Administration passed the Inflation Reduction Act, capping the monthly price of insulin and other critical drugs for Medicare beneficiaries.

We have a responsibility to all Americans to ensure that they can fairly access the medications they need. I hope today we will learn more from the witnesses on how to achieve this goal.

Let me call your attention to this chart. Nothing is simple about this chart. See here, point of payments from manufacturers to PBMs. It says, "Payments for manufacturers to PBMs," well, there isn't just one payment made that applies to everyone. There are many payments, depending on the drug, the PBM, the manufacturer, and the deal that is reached.

What each consumer pays for his medication is even more complicated, and this payment is only the first step. Understanding how the system works, partially because of the complexity and partially due to the lack of transparency, requires an advanced degree in engineering design.

Which drugs are included on PBM-created formularies or the list of drugs in the healthcare plan? How much people pay following a convoluted process involving a number of entities: The PBMs, the wholesalers, the aggregators, or group purchasing organizations, pharmacy service administrative organizations, health plans, pharmaceutical companies, pharmacists, and even the employers. Everyday Americans are at their mercy, relying on all these entities to do the right thing.

The complexities appear integral to the design. It's an enigma wrapped in a mystery, hidden in a riddle, in a conundrum. The average American and many small businesses can't solve this alone.

Of course, on Main Street, I'm concerned with the stories I'm hearing about pharmacies closing, pharmacies receiving payments that don't cover the costs, or pharmacies having to face payments being clawed back by PBMs. If these stories are true, this is both unsustainable and unacceptable.

Let's be clear. The PBMs have and will continue to play an important role in this market, and any suggestions to do away with them are misplaced.

Over the years, the role of PBMs in the marketplace has expanded from simply processing claims to having involvement in almost all aspects of the pharmaceutical drug market. In fact, there are numerous studies showing that PBMs have lowered prices of drugs for their clients.

It should never be the case that a person with insurance should pay more at the pharmacy using insurance than off-insurance, but that appears to be happening in some cases, and that, also, is not right.

As *The New York Times* reported in its recent investigation, the job of the PBMs is to reduce drug costs. Instead, they frequently do the opposite; they steer patients toward pricier drugs, charge steep markups on what would otherwise be inexpensive medications, and extract billions of dollars in hidden fees.

Another mechanism that PBMs may be utilizing is to raise costs and reap profits through mail order pharmacies. As *The Wall Street Journal* reported, PBMs encourage employers to use mail order pharmacies with the promise of cost savings, but, instead, they are increasing costs.

Specifically, *The Wall Street Journal* article explained,

> Branded drugs filled by mail order were marked up an average of three to six times higher than the cost of medicines dispensed by chain and grocery store pharmacies and roughly 35 times higher than those filled by independent pharmacies.

This Subcommittee has jurisdiction over antitrust matters, and we need to understand how this market operates. According to the FTC's recent released Interim Report on PBMs, the top three PBMs control almost 80 percent of the prescription drug market—something that came into play over the years of mergers with competitors.

I can show you the chart: The left, where it was before; to the right is what exists today. This chart shows the extent of how the number of large competitors consolidated over the last two decades, and it appears now that the PBM market is overly concentrated. Is that causing an anticompetitive result? The FTC seems to say yes.

The extent of vertical integration in the market is also astonishing, and quite frankly, as you see on this chart, every major health plan is connected to a PBM, specialty and mail-in pharmacies, and even one owns retail pharmacies. Some are now producing their own drugs for the market. While vertical integration can yield important efficiencies and benefits for customers, it appears that these deep connections are harming independent pharmacists, driving up costs, and harming consumers, while enriching corporations.

The FTC's Interim Report included many worrisome allusions and conclusions that PBMs are harming competition and consumers. Some of their conclusions: The PBM market is highly concentrated.

PBMs, due to their consolidation and integration, exercise a significant power over Americans' access to drugs and the price they pay.
PBMs may be steering patients to their own pharmacies and extracting additional profit, while harming unaffiliated pharmacies.
PBMs are using their market power to force pharmacies to enter into unfair contracts.
PBMs are limiting access to more reasonably priced alternative drugs through contract terms benefiting themselves.

Finally, I would say to the FTC: It's time to fish or cut bait. If PBMs are engaging in anticompetitive activities outlined in your report, do something. Either bring an action or explain why you're not bringing action.

Mr. Chair, finally, I ask that the following documents be included for the record:

First, the FTC Interim Report: Pharmacy Benefit Managers.
Second, the 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers.
Third, a Brief Look at Current Data bases about Pharmacy Benefit Managers.
Fourth, the Opaque Industry Secretly Inflating Prices for Prescription Drugs.
Fifth, Mail Order Drugs Were Supposed to Keep Costs Down; It's Doing the Opposite.
Sixth, PhRMA Response to the Joint DOJ–FTC–HHS Consolidation of Health Care Markets.
Seventh, PBMs and Prescription Drug Distribution.
Eighth, California Life Science and California Pharmacists Association joint letter on PBM reforms.

Thank you, Mr. Chair. ith that, I yield.

Mr. MASSIE. [Presiding.] Without objection.

Mr. CORREA. Thank you.

Mr. MASSIE. I now recognize the Chair of the Full Committee, Mr. Jordan, for his opening statement.

Chair JORDAN. Thank you, Mr. Chair, and I will be brief.

I appreciate putting this hearing together.

The Ranking Member just talked about the FTC needs to do something. Maybe if they weren't so busy harassing Elon Musk, they would have a chance to actually look at this issue in a real way. You've got three companies that have 80 percent of the market, and the FTC wants to send letters to Elon Musk asking what journalists he is talking to. That might be a problem, instead of dealing with the issue in front of us.

So, I appreciate the Chair calling in these experts, working the other party to agree to the four witnesses, and having this important hearing on something that impacts every single one of our constituents in a real way.

With that, I would yield back.

Mr. MASSIE. I thank the Chair.

I now recognize the Ranking Member of the Full Committee, Mr. Nadler, for his opening statement.

Mr. NADLER. Thank you, Mr. Chair.

Mr. Chair, the price of prescription drugs is out of control, and it is directly affecting the health and safety of our constituents. Over nine million adults have skipped medications prescribed to them because they could not afford them—with women, people with disabilities, and the uninsured most affected.

Prices are skyrocketing and people are dying or not getting the care they need, while healthcare giants reap massive profits, merge with other companies to entrench their dominance, and obscure critical information from Congress and regulators about their practices.

One reason that prescription drugs have become unaffordable for so many people is the growing dominance in the healthcare market of pharmacy benefit managers, or PBMs, who serve as middlemen between drug manufacturers, health insurers, healthcare providers, and pharmacies.

As a recent FTC report found, the PBM market is highly concentrated with the largest PBMs vertically integrated with the Nation's largest health insurers and specialty and retail pharmacies. As a result, the leading PBMs exercise significant market power over consumers' access to drugs and the prices paid for those medicines. This includes steering contracts to their own affiliated businesses and away from local independently owned pharmacies. They also have the ability to negotiate higher drug prices, while limiting access to potentially lower-cost generic alternatives. Because of their dominance, they are able to keep their practices largely shrouded in secrecy.

To address these concerns, we must act to increase competition in the PBM market. To be clear, the problem is bigger than the pharmacy benefit managers. It is true that only three PBMs control 80 percent of the market, but PBMs play just one part in our overly concentrated healthcare system.

I urge my colleagues on both sides of the aisle not to lose sight of the forest for the trees. If we truly want to address the rising cost of prescription drugs and healthcare, we must address consolidation industrywide rather than just focusing on one class of middlemen.

For example, 90 percent of all drugs are distributed through just three drug wholesalers; 95 percent of all health insurance markets are highly concentrated, and approximately 50 percent of all generic drug markets are dominated either by monopoly or duopoly drug manufacturers, when controlling for volume.

Not only does this lack of competition lead to higher prices, but it also allows the dominant companies to avoid transparency. An environment in which a handful of companies control Americans' access to and prices for critical medications means that we all lose.

We lose out on a more innovative healthcare market. We lose money paying exorbitant prices for drugs. We lose time fighting with our insurance provider for access to the drug our doctor prescribed. We lose knowledgeable counseling from our local independent pharmacist. In the worst cases, we lose a loved one who could not access or afford the medicines they need.

Although interest in PBMs has ramped up this Congress, their market dominance and their role in driving up drug prices is not news. This Subcommittee addressed the issue five years ago under

a Democratic majority. We did not just talk about it; we took action.

It is time for this Republican majority to act as well. We do not need another rehash of known issues with no goals or plans in mind to fix them.

Democrats have taken action to rein-in high drug costs and to make medication more affordable and accessible. Last Congress, over unanimous Republican opposition, Democrats passed the Inflation Reduction Act, which expanded Medicare benefits, lowered drug costs, and strengthened Medicare for the future.

This Committee also passed three bipartisan bills that would have addressed drug pricing: The Stop Stalling Access to Affordable Medications Act, the Affordable Prescriptions for Patients Through Promoting Competition Act, and the Preserve Access to Affordable Generics and Biosimilars Act. Republicans have failed to advance any of these bills during this Congress.

It is my hope that, as we continue our work to diagnose the problems associated with consolidation and anticompetitive conduct in healthcare markets, we will also work together in finding meaningful solutions that would provide a better deal for Americans on prescription drugs and other healthcare costs.

I thank our witnesses for appearing today, and I yield back.

Mr. MASSIE. I thank the gentleman. Without objection, all other opening statements will be included in the record.

I want to say, before I introduce today's witnesses, that I want to thank my Ranking Member, Mr. Correa, for making this a bipartisan hearing. This is one of those hearings that doesn't quite frequently happen in Congress. We don't know what the answer is. That is why we are having the hearing.

A lot of times, I'm not a lawyer, but the lawyers say, "Don't ask a question unless you know the answer." I'm going to ask questions I don't know the answer to today.

I'm also very appreciative of the witnesses who came here and the Ranking Member for making this a bipartisan panel. Oftentimes, you get some Republican witnesses and some Democrat witnesses. I don't know your political affiliations; don't need to know them. That is because we are working for the people here today.

Thank you, Mr. Correa, for—

Mr. CORREA. Mr. Chair, thank you very much. I think you have just outlined the heavy burden that these witnesses have in educating the Committee on where to go from here.

Thank you.

Mr. MASSIE. That is a heavy lift: To educate Congressman.

So, with that, I will now introduce today's witnesses.

Dr. Richard—oh, I'm sorry, we are going to start from right to left, I believe.

Dr. Anthony LoSasso. Dr. LoSasso is a Professor, Driehaus Fellow, and the Chair of the Department of Economics at the Driehaus College of Business at DePaul University. His research focuses on health and labor economics, health policy, and health services and outcomes.

Dr. Joey Mattingly, II. Dr. Mattingly is an Associate Professor and Vice Chair of Research at the University of Utah, College of Pharmacy. He has worked in pharmacy for over 20 years, both as

a pharmacist and, more recently, as an academic focusing on drug pricing policy.

Dr. Richard Frank. Dr. Frank is the Director of the Center on Health Policy and a Senior Fellow in Economic Studies at the Brookings Institution. He is the emeritus Margaret T. Morris Professor of Health Economics at Harvard Medical School, and previously served as the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

Dr. Karen Van Nuys. Dr. Van Nuys is the Executive Director of the Value of Life Sciences Innovation Program and a Senior Scholar at the USC Schaeffer Center. Her research focused on the pharmaceutical distribution system and the impact of intermediaries' business practices on prescription drug utilization and cost.

We welcome our witnesses and thank them for appearing today.

We will begin by swearing you in. Would you please rise and raise your right hand?

Do you swear or affirm under penalty of perjury that the testimony you are about to give is true and correct to the best of your knowledge, information, and belief, so help you God?

Let the record reflect the witnesses have answered in the affirmative.

Thank you and please be seated.

Please know that your written testimony will be entered into the record in its entirety. Accordingly, we ask that you summarize your testimony in five minutes.

Dr. LoSasso, you may begin.

STATEMENT OF DR. ANTHONY LoSASSO

Dr. LOSASSO. Thank you, Chair Massie and Ranking Member Correa, and Members of the Committee. I appreciate the opportunity to be here with you today to be part of this conversation on this really important topic.

My name is Tony LoSasso. I am the Chair of the Economics Department at DePaul University in Chicago and have been studying the healthcare system for about the last 30 years.

PBMs are an important, but widely misunderstood—and I believe wrongfully maligned—part of the pharmaceutical supply chain. I like to point out to people that no less than ancient philosopher Plato had serious misgivings about middlemen. So, you're in good company when you express skepticism and concern about the role of middlemen.

However, we're going to talk a lot today, I hope, about nuances. We'll talk about spread pricing and a lot of other pharmacy networks, lots of details. At heart, what PBMs do is force pharmaceutical companies to compete on price. Competing on price, generally speaking, is the last thing that pharmaceutical companies want to do.

I find it somewhat amazing that rebates have been made into some sort of nefarious practice. This, to me, is testimony to, apparently, a reality distortion that the pharmaceutical industry is capable of pulling off. Rebates are a good thing because they represent price decreases, and price competition is a good thing for consumers.

So, the effort to regulate, and I fear neuter, the impact of PBMs only plays into the hands of the pharmaceutical industry and strengthens their bargaining power vis-à-vis PBMs. Now, make no mistake, I am a fan of the pharmaceutical industry. They are an engine of innovation that truly improves lives, and I want them to succeed. I want us all to live to be 120 and be happy and healthy.

That does not mean that pharma should get a hall pass from competition. Pharma has very rich profit margins, monopoly privilege that comes with patent protection, and they are, by and large, firmly in the driver's seat when it comes to pricing power.

There's a lot of talk about concentration in the PBM industry, rightfully so. However, the flip side of that is, with that market concentration, which is again is not monopoly, 70–80 percent, that is big; that is significant. That does not mean that there is not entry in that industry, the PBMs industry, that is. With that concentration does come bargaining power and an ability to push back and against what I just mentioned as the pricing power of the pharmaceutical industry.

Complaints from pharmacies, which I'm sure we'll discuss, I think distract from the key issues around getting drugs efficiently to patients. Many pharmacies, independent and otherwise, have lived off high dispensing fees for many years. Pushback against that is a good thing. It's a good thing for consumers. It may not be a good thing for independent pharmacists, but the market is tough, and I think we want to be in the business of encouraging competition that pushes entities toward being more efficient.

Doctors, and I mean the real doctors that help people, they know that, for people with chronic disease, adherence is an enormous factor when it comes to drug delivery. Mail order has been proven to be a mechanism to improve adherence to a drug regime.

So, to wrap up, I think it's essential that we recognize the value of PBMs and support their continued role in the healthcare system. So, we should focus on enhancing, wherever possible, market mechanisms in the pharmaceutical supply chain.

So, I just simply urge this Committee to carefully consider the broader implications and potential for unintended consequences of any legislation or regulatory efforts that might weaken the role of PBMs.

Thank you.

[The prepared statement of Dr. LoSasso follows:]

Statement of Anthony T. LoSasso[1]
To the Subcommittee on the Administrative State, Regulatory Reform, and Antitrust of the Committee on the Judiciary, US House of Representatives
On "The Role of Pharmacy Benefit Managers"
September 11, 2024

Chairman Massie, Representative Correa, and members of the Committee, I thank you for the privilege of appearing before you today. I believe that today's topic is an incredibly timely and salient one, given the legislative and regulatory efforts presently under consideration. With every passing day, the decisions made regarding the regulation of PBMs will directly affect the cost and availability of medications for millions of Americans.

The Essential Role Intermediation and PBMs

Throughout history, intermediaries in economic transactions have been viewed with suspicion. From the ancient Greek philosopher Plato to modern-day critiques, middlemen have often been seen as unnecessary actors who add costs without adding value. This perspective, while understandable, is deeply flawed when applied to the role of PBMs in the pharmaceutical supply chain. In reality, PBMs are indispensable in managing the complexities of the drug market, negotiating lower prices, and ensuring that patients have access to the medications they need at affordable prices. Policies that eliminate, weaken, or overly constrain PBMs would ultimately lead to higher drug prices and reduced access to essential medications, playing directly into the hands of pharmaceutical manufacturers. Far from being a source of higher drug prices, PBMs represent one of the few mechanisms to inject true price competition into the market for drugs with the direct aim of lowering drug prices.

The Misunderstood Role of PBMs

The narrative that PBMs are unnecessary middlemen has gained traction in recent years, fueled by concerns over rising drug prices and the perception that PBMs contribute to these increases. Critics argue that PBMs raise costs and create barriers to life-saving treatments. This perspective is not only misguided but also dangerous, as it threatens to undermine one of the few entities with both the goal and the ability to actively work to contain drug costs.

PBMs negotiate with drug manufacturers on behalf of health insurers, Medicare Part D plans, large employers, and other payers. Through these negotiations, PBMs secure

[1] Professor and Chair, Department of Economics, DePaul University, Chicago IL.

significant discounts and rebates that directly reduce the cost of prescription medications. These savings are passed on to insurers and, ultimately, to consumers in the form of lower premiums and out-of-pocket expenses. This role is crucial, especially in a market where pharmaceutical companies can exercise significant pricing power due to patent protections. It is important to note that the pharmaceutical industry is known for high profit margins in the range of 15% to 30%[2], while PBMs operate in a low-margin industry with margins in the range of 2% to 5%.[3]

PBMs and Cost Containment

One of the most important functions of PBMs is cost containment. By leveraging their purchasing power, PBMs are able to negotiate substantial discounts with drug manufacturers. These discounts come in the form of rebates, which are often misunderstood as merely a way for PBMs to increase their profits. In reality, rebates are price reductions that benefit consumers by lowering the overall cost of drugs.

For example, a comparative analysis of the Medicaid programs in Michigan and Illinois illustrates the value of PBMs in cost containment.[4] Michigan chose to centralize its purchasing of specialty pharmacy products, while Illinois relied on PBMs to manage these purchases. The results were stark: Illinois, through its use of PBMs, was able to switch rapidly to cheaper generic alternatives as they became available, saving taxpayers as much as $50 million per year. In contrast, Michigan's centralized approach led to higher costs, as the state continued to pay for more expensive brand-name drugs even when cheaper generics were available. This stark contrast highlights the crucial role PBMs play in ensuring that states, and by extension taxpayers, do not overpay for necessary medications.

This example underscores the agility of PBMs in responding to market changes and their ability to secure lower prices for high-cost medications. The ability to respond to changing dynamics in the marketplace is an often-overlooked aspect of the value PBMs provide to payers. Without the negotiating power of PBMs, states and other large purchasers would likely pay much higher prices, which would ultimately be passed on to taxpayers and patients.

---

[2] https://csimarket.com/Industry/industry_Profitability_Ratios.php?ind=803
[3] Carlton, D. PBMs and Prescription Drug Distribution: An Economic Analysis of Criticisms Levied Against Pharmacy Benefit Managers. Compass Lexicon Working Paper July 2024.
[4] Brannon, Ike and Anthony T. Lo Sasso, "The Myth that the State can do Better: Medicaid Drug Prices and Managed Care Organizations," May 26, 2021. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3852446.

Addressing Short-Sighted Policy Proposals: The Reality of PBM Operations

Despite the clear benefits of PBMs, they are not without their critics. One of the most common criticisms is related to the use of spread pricing and rebates. Spread pricing refers to the difference between what a PBM pays for a drug and what it charges the insurer. Critics argue that this practice is a way for PBMs to generate profit at the expense of patients. However, spread pricing is a standard practice in many industries and serves as an incentive for PBMs to negotiate the lowest possible prices for drugs. Moreover, payers typically have the option of spread pricing or administrative fee-based payment and most choose spread pricing. The reason for the choice is clear: it generates the greatest incentives to reduce prices paid to pharmaceutical manufacturers, which is in turn shared between the payer and the PBM. Eliminating spread pricing leads to one winner: the pharmaceutical industry.

Similarly, rebates are often portrayed as a mechanism that drives up drug prices. However, rebates function as price reductions that benefit consumers by lowering their out-of-pocket costs and reducing insurance premiums. The use of the rebate mechanism represents an awkward work-around to the Robinson-Patman Act of 1936 which prohibits "price discrimination" where a seller charges different prices to different buyers. Allowances are, however, made for volume discounts.[5] Arguments that a PBM would prefer a high-cost drug because the manufacturer offers a larger rebate make no sense because what matters is the net price the PBM must pay. It will always make sense to pay a lower net price for a drug because the PBM will be able to offer lower premiums and lower cost-sharing to payers. Indeed, a recent GAO study found that more than 99 percent of rebates were passed on to plan sponsors.[6]

Additionally, proposals to mandate the pass-through of rebates directly to consumers may seem beneficial on the surface, but they risk undermining the negotiating power of PBMs, ultimately leading to higher drug prices for everyone. Specifically, when PBMs, payers, and consumers have their incentives aligned they are in the best position to negotiate with pharmaceutical companies; requiring full pass-through of the rebated amount removes the incentive for the PBM to fight for price concessions from pharmaceutical manufacturers. Again, efforts to de-link PBMs from incentives to negotiate lower prices benefit the pharmaceutical industry first and foremost.

A related lament is the lack of "transparency", which is typically meant to imply that PBMs craft nefarious secretive deals with pharmaceutical companies to solely benefit PBMs. This

---

[5] See https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/price-discrimination-robinson-patman-violations.
[6] https://www.gao.gov/assets/gao-19-498.pdf.

ignores the reality that PBMs must compete for business by offering lower premiums, lower cost to patients, and higher quality service because these are the factors that ultimately matter to payers and patients. As an analogy, if a grocery store obtains excellent prices for high quality apples, the consumer is the beneficiary despite being none the wiser about the "shadowy" deals between orchards, wholesalers, and distributors. Moreover, transparency is not a panacea; the experience of the Danish cement market shows that in some cases, transparency can lead to tacit collusion and higher prices rather than competitive outcomes.[7] Obviously, the supply chain for drugs is complicated by third-party payment and other factors, but the end consumer still has a voice and, in a market economy, can vote with their feet.

Mail-Order Pharmacies: A Success Story

Mail-order pharmacy services, supported by PBMs, provide a compelling example of how these intermediaries improve both convenience and patient adherence. By negotiating bulk purchasing agreements and leveraging their extensive networks, PBMs can offer lower prices for medications through mail-order programs. These services are particularly beneficial for patients with chronic conditions, who require a steady supply of medications.

Studies have shown that mail-order pharmacies improve medication adherence,[8] [9] which is crucial for managing chronic diseases such as diabetes and hypertension. Higher adherence rates lead to better health outcomes and lower overall healthcare costs, as patients are less likely to require emergency care or hospitalization.

Efforts to limit mail-order pharmacy services, whether through regulation or legislation, would have the unintended consequence of increasing costs for patients and reducing their access to necessary medications. Additionally, limiting mail-order pharmacy services could force patients, particularly those with chronic conditions, to pay more and potentially experience disruptions in their medication regimens, leading to worse health outcomes. It is essential that policymakers recognize the value of these services and support the continued role of PBMs in facilitating access to affordable medications. Efforts to curtail the direct delivery of drugs do not benefit patients.

---

[7] Albæk, S., Møllgaard, P., & Overgaard, P. B. (1997). Government-Assisted Oligopoly Coordination? A Concrete Case. *The Journal of Industrial Economics*, *45*(4), 429–443. http://www.jstor.org/stable/2950610.
[8] Do D, Geldsetzer P. Trends in Mail-Order Pharmacy Use in the U.S. From 1996 to 2018: An Analysis of the Medical Expenditure Panel Survey. Am J Prev Med. 2021 Aug;61(2):e63-e72. doi: 10.1016/j.amepre.2021.02.017. Epub 2021 May 3. PMID: 33958237; PMCID: PMC8319048.
[9] Lloyd JT, Maresh S, Powers CA, Shrank WH, Alley DE. How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program? Med Care. 2019 Mar;57(3):218-224. doi: 10.1097/MLR.0000000000001067. PMID: 30676355.

Enhancing Market Efficiency

Beyond cost containment, PBMs play a critical role in enhancing market efficiency. The pharmaceutical supply chain is complex, involving manufacturers, wholesalers, pharmacies, and payers. PBMs streamline this process by managing formularies, conducting drug utilization reviews, and processing prescription claims. This centralization reduces redundancies and errors, ensuring that medications are delivered promptly and accurately to patients.

Preferred pharmacy networks are another tool used by PBMs to enhance efficiency and reduce costs. By negotiating selective contracts with pharmacies, PBMs are able to secure better pricing for medications. Research has shown that the use of preferred pharmacy networks can reduce drug prices by 2.3 percent in Medicare Part D, which translates into significant savings for both patients and the healthcare system.[10] This reduction could save the healthcare system millions of dollars annually, translating to lower costs for both taxpayers and patients.

Moreover, PBMs provide valuable market information and analytics to insurers and healthcare providers, aiding in better decision-making and resource allocation. This data-driven approach allows for more effective management of drug benefits, leading to improved patient outcomes and more efficient use of healthcare resources.

The Future of PBMs in Healthcare

PBMs have been a vital part of the healthcare system for decades, balancing the dual objectives of cost containment and high-quality patient care. They reduce drug prices, improve market efficiency, foster innovation, and ensure that patients have access to the medications they need. The current legislative efforts to constrain the role of PBMs are misguided and could have serious adverse consequences for consumers.

It is essential that we recognize the value of PBMs and support their continued role in the healthcare system. Rather than dismantling the mechanisms that serve to counter-balance high drug costs, we should focus on enhancing wherever possible market mechanisms in the pharmaceutical supply chain. Improving market competition through preserving PBMs' ability to negotiate lower prices remains the best way to both lower cost and improve patient access to care.

I urge this committee to carefully consider the broader implications of any legislation that would weaken the role of PBMs. The stakes are high, not just for the healthcare system, but

---

[10] Starc, Amanda, and Ashley Swanson. 2021. "Preferred Pharmacy Networks and Drug Costs." *American Economic Journal: Economic Policy*, 13 (3): 406-46.

for every American who depends on affordable access to medications. The decisions made here will determine whether we continue to have a healthcare system that prioritizes patients or one that places undue burdens on them.

Thank you for your attention, and I look forward to your questions.

Mr. MASSIE. Thank you, Dr. LoSasso.
Dr. Mattingly, you may begin.

STATEMENT OF DR. JOEY MATTINGLY

Dr. MATTINGLY. Chair Massie, Ranking Member Correa, and the Members of the Subcommittee, thanks again for this opportunity.

My name is Joey Mattingly. I'm a pharmacist and a health economist on the faculty at the University of Utah. I study drug pricing policy, pharmacy supply chain dynamics, and just ways to improve our healthcare system. I also support our university human resources team that's responsible for managing the benefits for 30,000 beneficiaries.

I have worked in this field for 20 years, starting as a pharmacy technician in my hometown of Bardstown, Kentucky, then becoming a pharmacist and a district manager for a large grocery store chain.

The past 10 years has been focused on drug pricing research, academic research, specifically, talking about what we're getting into today.

While the increase in interest in regulating PBMs allows us to have a really rich discussion on how we pay for pharmaceuticals, my fear is that advocacy efforts by all stakeholders involved who stand to win or lose from the regulation, it just distracts us from facts. I've had the pleasure of working with all stakeholders involved in these policy fights, and I genuinely empathize with all the stakeholders.

In my written testimony, I've tried to detail several key issues in the same way that I would teach my students, which I just want to give a quick shoutout to the University of Utah, my students, for helping prepare for this testimony.

To kick things off, I just want to highlight three key areas I'd like the Committee to consider.

(1) We need a process to balance the individual patient goals with the population goals. When I get sick, I can talk to my doctor about a variety of treatment strategies. If that strategy involves a medication, I'm also free to go to any pharmacy I want.

However, as an employee of the University of Utah, if I wish to go at the University of Utah, if I wish to use my prescription insurance to pay for that medication, the decision is no longer just a patient-doctor decision because I'm, essentially, asking all my coworkers to pay or contribute for my benefits. So, now, my healthcare goals have to align with my employer's goals. So, we need to work on developing a fair process that finds a win/win for both the patient and the employer, as well as how to settle disagreements.

(2) If you remove the PBM from the equation today, who or what steps in to fill that void? PBMs have been around since the 1960s, and while they have substantially evolved, many of their core functions have remained constant for the past 60 years. PBMs, typically, gain customers from a process where they respond to competitive bids, Requests for Proposals, from plan sponsors, like employers and governments, who are requesting for help developing formularies, managing a pharmacy network. So, when we remove the PBM, we just have to know, OK, then what? Who steps in and who stands to gain from this new environment?

(3) Our pharmaceutical supply chain is riddled with anticompetitive business practices by design. We have to grapple with the fact that we made a tradeoff in the 1960s to, essentially, by incentivizing the development of new pharmaceuticals, we decided we would grant innovators temporary monopoly power or market exclusivity. We, the U.S. citizens, would get this massive investment from the business community, which we have, and then, we would have to pay higher prices initially. Forty years of celebrating the Hatch-Waxman Act, now we've got a rich generic manufacturing community as well for the last 40 years.

PBMs, along this time, have evolved to leverage large populations to gain price concessions from these pharmaceutical manufacturers that we grant those exclusivity rights. Additionally, they use their size and their scale to capture price concessions from pharmacies as well.

On one hand, this is good if the savings are passed on to the health plans. On the other hand, the price concessions from these, that these pharmacies give make once profitable pharmacies no longer sustainable.

So, as this Subcommittee deliberates whether PBM practices require additional regulation, I would just simply ask the Members, walk through the same mental exercise as I try to ask my students to walk through. Eliminate the PBM from the equation, and then, play out the scenario for each of these different stakeholders—what happens with patients and their caregivers; what happens with the health plan sponsors; what happens to pharmacies; and what happens to drug manufacturers?

Thank you all and I look forward to answering your questions.

[The prepared statement of Dr. Mattingly follows:]

Pharmacy Benefit Managers and Pricing in the Pharmaceutical Supply Chain

Statement of T. Joseph Mattingly II, PharmD, MBA, PhD

Associate Professor and Vice Chair for Research
Department of Pharmacotherapy
University of Utah College of Pharmacy
Email: joey.mattingly@utah.edu

Before the

Subcommittee on the Administrative State, Regulatory Reform, and Antitrust
of the House Committee on the Judiciary

September 11, 2024, 2:00pm
Room 2141 of the Rayburn House Office Building

SUMMARY OF REMARKS

Chairman Massie, Ranking Member Correa, and members of the Subcommittee, thank you for this opportunity to discuss the role of Pharmacy Benefit Managers (PBMs) in the pharmaceutical supply chain and the potential impact these entities have on drug prices for Americans.

My name is Joey Mattingly and I am a pharmacist and PhD-trained health economist on the faculty at the University of Utah College of Pharmacy. I study drug pricing policy, pharmacy supply chain dynamics, and ways to improve our health care system. I also support the University's human resources team responsible for the benefits of approximately 30,000 beneficiaries. I have worked in this field for more than 20 years, from pharmacy technician in my hometown (Bardstown, Kentucky) to pharmacist and district manager of a large pharmacy chain. For the past 10 years, my academic research has specifically focused on the topics we will discuss today.

While the increased interest in regulating PBMs allows us to have a rich discussion on how we pay for pharmaceuticals, my fear is that advocacy efforts by all stakeholders who stand to win or lose with new regulation can distract our attention from facts.

I have had the pleasure of working with all of the stakeholders involved in these policy fights and I genuinely empathize with the arguments made by all sides. In my written testimony, I have detailed several key issues in the same way I would teach these issues to my students – which I would like to thank my students for helping me prepare for this testimony.

To kick things off, I would like to highlight 3 issues I believe the Subcommittee should consider:

1. We need a process to balance Individual Patient Goals vs. Population Goals.

When I get sick, I can talk with my doctor about a variety of treatment strategies. If that strategy involves a medication, I am also free to pick whatever pharmacy I want. However, as an employee of the University of Utah, if I want to use my prescription insurance to pay for that medication, this decision is no longer a patient-doctor decision because I am essentially asking ALL of my coworkers and the taxpayers of Utah to contribute to my care. Now my health care goals must be aligned with my employer's goals. We need to work to develop a fair process to find a win-win for the patient and the employer and we need a process to settle disagreements.

2. If you remove the PBM from the equation today, who or what steps in to fill that void? (And who benefits from a weakened or completely eliminated PBM scenario?)

PBMs have been around in the US since the 1960s and while they have evolved substantially, many of their core functions have remained constant over the past 60 years. PBMs typically gain customers through a relatively transparent process, responding to a competitive bid process developed by plan sponsors (e.g., employers, governments) who are requesting their help with things like developing and managing a formulary or managing the pharmacy network for the plan. When we remove the PBM, who will be best to fulfill these services? And who stands to gain from this new environment.

3. Our pharmaceutical supply chain is riddled with anticompetitive business practices, mostly by design. How will the actions that focus solely on PBMs impact the other actors in the supply chain?

We have to grapple with the reality that we made a tradeoff in the 1960s. Essentially, to incentivize the development of new pharmaceuticals, we decided that we would grant innovative pharmaceutical companies a temporary monopoly to reward the successful companies for all their research investments.[1] The US would get a massive investment in this innovation from the business sector, but we would need to

[1] Conti RM, Frank RG, Cutler DM. The Myth of the Free Market for Pharmaceuticals. *N Engl J Med.* 2024;390:1448-1450. DOI: 10.1056/NEJMp2313400

pay higher prices initially. PBMs have evolved to leverage large populations to gain price concessions from pharmaceutical manufacturers with this government-approved monopoly power. Additionally, PBMs have used their size and scale to capture price concessions from pharmacies. On one hand, this is good for health plans, assuming the savings are passed on. On the other hand, these price concessions from pharmacies could make "once profitable pharmacies" no longer sustainable.

As this Subcommittee deliberates whether PBM practices require additional regulation, I simply ask that the Members work through the same mental exercises I would ask my students to walk through. Remove the PBM from the equation and then play out a scenario for each of the following stakeholders: the patient, health plan sponsor, pharmacy, and drug manufacturer.

FULL WRITTEN TESTIMONY

SECTION I: PAYING FOR PHARMACY SERVICES

In the United States (US), hypothetically speaking, every patient has the freedom to purchase any medication prescribed by his or her doctor and that patient can go to any pharmacy of his or her choosing to purchase that medication. This, of course, assumes that the patient can pay for these services without using health insurance. The moment the patient elects to use insurance for the purchase of these services, the patient is asking all the members of a larger population to help with this purchase. This fundamentally changes this health care decision from a "patient-focused" one to a decision that impacts an entire group of people. The concept of having insurance pay for prescription drugs did not develop in the US until the 1960s, but by 1980 more than 30% of the prescriptions in the US were covered by a third-party insurance.[2] Today, the US Department of Health and Human Services (DHHS) Office of Disease Prevention and Health Promotion estimates that more than 84% of patients under age 65 have prescription drug insurance[3] and the Centers for Medicare and Medicaid Services (CMS) estimates more than 80% of Medicare enrollees are also enrolled in Medicare Part D (Medicare's outpatient prescription drug benefit).[4] In other words, prescription drug benefits are now the norm in the US and patients using their benefits must consider how their decisions impact all other beneficiaries of their health plan.

Any discussion of prescription benefits begins with the ***Insurance Premium Equation*** **(Eq. 1)** that is a fundamental concept in health economics.

Equation 1. The "Insurance Premium Equation" in health economics.[5]

$$\boldsymbol{Premium = (1 + L_D)(1 - c)px}$$

The pharmacy benefit premium (e.g., monthly or annual payment amount to enroll and maintain the benefit) is a function of other important variables including the price of drugs (p), the total utilization or prescriptions covered over the period (x), the coinsurance rate (c), and the loading factor or costs to administer the plan including any return on investment (L_D). When I teach this equation, I ask my

[2] Mattingly TJ, Hyman DA, Bai G. Pharmacy Benefit Managers: History, Business Practices, Economics, and Policy. *JAMA Health Forum*. 2023;4(11):e233804. doi:10.1001/jamahealthforum.2023.3804
[3] Office of Disease Prevention and Health Promotion. Healthy People 2023. Accessed September 2, 2024. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-prescription-drug-insurance-ahs-03
[4] Centers for Medicaid & Medicare Services. Medicare Monthly Enrollment. Accessed September 2, 2024. Available at: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment
[5] Sloan FA, Hsieh CR. Health Economics. 2012. MIT Press: Cambridge, MA.

students to focus on the direction of the relationship in the equation and imaging holding all other variables constant – then consider what happens to the premium.

So, why does the premium equation matter for this Congressional Hearing? Nearly, everything we discuss today will come back to this equation and how different entities in the pharmaceutical supply chain influence each variable.

SECTION II: EVOLUTION OF THE PHARMACY BENEFIT MANAGER (PBM)

2.1. Early PBMs and Pharmacy Owner Opposition

As the pharmaceutical industry evolved midway through the 20th century, a new demand for prescription monitoring and "prepaid" health insurance plans that included drug expenses. In 1958, a group of pharmacists in Ontario, Canada established Prescription Services, Incorporated (PSI) which offered a prepayment plan for drugs.[6] By 1964, PAID Prescriptions (originally "California Pharmaceutical Services, Inc."), emerged thanks to pharmacists and was viewed as a pharmacy "Blue Shield" (drawing comparisons to the growing Blue Cross and Blue Shield health insurance plans).[7] By 1968, PAID Prescriptions began setting reimbursement rates for pharmacies wishing to enter its pharmacy network. In addition to these new reimbursement rate limits, pharmacists were upset about these newly formed pharmacy benefit manager (PBM) entities because of recordkeeping provisions, variability in coverage, and the methods in which these reimbursement rates were to be calculated.[8] ***Sound familiar?*** In 1969, Nick Avellone, former Chairman of the National Association of Retail Druggists (Now called the National Community Pharmacists Association or NCPA) called third-party payment for prescription drugs "the number one concern in pharmacy today."[9]

2.2. Vertical and Horizontal Integration of PBMs

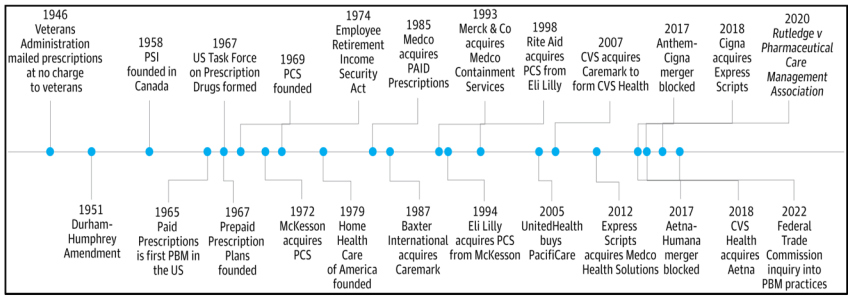
The newly formed PBM entities were ripe for integration with other entities in the pharmaceutical supply chain. Beginning in the 1970s, McKesson (one of the largest wholesale distributers of drugs) acquired Pharmaceutical Card System (PCS), becoming one of the first instances of "vertical integration"

---

[6] Morgan JP. Watching the monitors: "PAID" prescriptions, fiscal intermediaries and drug-utilization review. *N Engl J Med*. 1977;296(5):251-256. doi:10.1056/NEJM197702032960505
[7] Ibid.
[8] Campbell NA, Hammel RW. Development of the third-party payment concept for medical and pharmaceutical services. *Pharm Hist*. 1973;15(3):117-123.
[9] Ibid.

of the pharmaceutical supply chain.[10] A few years later, a large home infusion company entered the PBM market, was renamed "Caremark" and subsequently sold to Baxter International – one of the largest manufacturers of hospital supplies in the US.[11] The strategic mergers and acquisitions (M&As) of PBMs with other supply chain entities has continued for fifty years **(Figure 1)**, but not all have been welcomed and some have been stopped by the US Department of Justice.

Figure 1. Key Events in the Evolution of the Pharmacy Benefit Manager (PBM) Industry by Mattingly et al., published in *JAMA Health Forum* in 2023.[12]



2.3. Modern Functions of a PBM

While the PBM industry has evolved substantially since the 1960s, the business still revolves around core functions that ultimately focus on managing the variables in our "premium equation" discussed previously. At a high level, modern PBMs focus on key activities that include: 1) ***formulary development***; 2) ***utilization management***; 3) ***drug price negotiation***; 4) establishing and managing a ***pharmacy network***; and 5) providing ***mail order pharmacy*** services.[13]

The formulary specifies which drugs will be covered and how much patients will pay "out-of-pocket" (OOP) when they purchase these drugs, often discussed as different "Tier" levels (e.g., lower OOP for generic drugs or preferred brand drugs, higher OOP for non-preferred brands or specialty).[14] Formularies are typically developed by a committee that is made up of clinicians, often called a pharmacy

[10] Mattingly TJ, Hyman DA, Bai G. Pharmacy Benefit Managers: History, Business Practices, Economics, and Policy. *JAMA Health Forum*. 2023;4(11):e233804. doi:10.1001/jamahealthforum.2023.3804
[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Grabowski H, Mullins CD. Pharmacy benefit management, cost-effectiveness analysis and drug formulary decisions. *Soc Sci Med*. 1997;45(4):535-544. doi:10.1016/S0277-9536(96)00394-2

and therapeutics (P&T) committee, who will review the clinical evidence to determine the appropriateness of formulary inclusion.[15]

Utilization management encompasses all the actions that typically frustrate patients and clinicians, because as the name implies, it puts limitations on the types of therapies approved, quantities approved, or additional clinical evidence documentation prior to approval. Actions include prior authorization, step therapy requirements (sometimes referred to as "fail first"), day supply or dosage limits, and various financial incentives to encourage the patient to change therapies or steer patients to preferred network providers.[16] Prior authorization policies are widely used in managed care, however there may be some variation or inconsistency across health plans and across plan sponsor types (e.g., private vs. government).[17] The expansion of utilization management policies has caused some concern, especially for patients and clinicians who experience the increased burdens of these policies.[18]

One of the more controversial roles in recent years has been the PBM's role in drug price negotiation. A PBM negotiates on behalf of a health plan with two very important groups: 1) brand pharmaceutical manufacturers and 2) pharmacies. When a pharmaceutical manufacturer launches a new drug onto the market, it may offer a rebate to PBMs as part of the negotiation to obtain a preferred placement on the PBM's formulary in relation to its competitors.[19] This rebate offer can distort the actual price, or "net price", that is ultimately paid for drug utilization, but there are some pricing benchmarks that have been used to estimate this net price such as the Veterans Affairs Federal Supply Schedule (FSS)[20] and net prices reported by SSR Health.[21] On the other end, PBMs negotiate with pharmacies for the price they are willing to accept in order to be included in the PBM's pharmacy network (a strategy dating back to the 1960s). Because of these private negotiations, commonly used compendium prices such as Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) are almost useless in cost analyses for prescriptions.

---

[15] Goldberg RB. Managing the pharmacy benefit: the formulary system. *J Manag Care Spec Pharm*. 1997;3(5):565-573. doi:10.18553/jmcp.1997.3.5.565

[16] Howell S, Yin PT, Robinson JC. Quantifying the economic burden of drug utilization management on payers, manufacturers, physicians, and patients. *Health Aff (Millwood)*. 2021;40(8):1206-1214. doi:10.1377/hlthaff.2021.00036

[17] Gupta R, Fein J, Newhouse J, Schwartz AL. Comparison of prior authorization across insurers: cross sectional evidence from Medicare Advantage. *BMJ* 2024;384:e077797. DOI: 10.1136/bmj-2023-077797

[18] Resneck JS. Refocusing Medication Prior Authorization on Its Intended Purpose. *JAMA*. 2020;323(8):703–704. doi:10.1001/jama.2019.21428

[19] Dusetzina SB, Bach PB. Prescription Drugs—List Price, Net Price, and the Rebate Caught in the Middle. *JAMA*. 2019;321(16):1563–1564. doi:10.1001/jama.2019.2445

[20] Mattingly TJ, Levy JF, Slejko JF. *et al.* Estimating Drug Costs: How do Manufacturer Net Prices Compare with Other Common US Price References? *PharmacoEconomics*. 2018;36:1093–1099.

[21] Ippolito B, Levy J. Best Practices Using SSR Health Net Drug Pricing Data. *Health Affairs Forefront*. March 10, 2022. DOI: 10.1377/forefront.20220308.712815

Finally, the PBM also develops and manages an extensive network of community pharmacies along with mail-order and specialty pharmacy access for health plan members. The US is home to more than 60,000 outpatient pharmacies, including a mix of large national retail chains, mass merchandiser stores, regional chains, and independently owned small businesses.[22] One area of concern that has been raised by policymakers and pharmacy advocates is the business relationship between PBMs and pharmacies within the preferred pharmacy network.[23]

2.4. How PBMs get their customers

In recent months, two high profile examinations of PBMs were published (by the *New York Times*[24] and the Federal Trade Commission or FTC[25]) that both claimed to be based on significant investigation and examination of these entities – but both failed to explain how PBMs actually earn business or acquire customers. The process by which PBMs gain business is relatively simple. A plan sponsor (e.g., self-funded employers, insurers, managed care organizations, state and federal governments) begins by determining whether or not they wish to offer pharmacy benefits to their employees. If they do wish to offer pharmacy benefits to plan members, then the sponsor needs to determine whether or not they have the expertise to manage these benefits or whether they need to contract out these services to a PBM. If a plan sponsor determines it needs to contract out, then it will typically begin a formal **request for proposals (RFP)** process to seek bids from PBMs.[26] In this structured process, PBMs competitively bid on business from the plan sponsor by addressing specific points outlined in the RFP. In many cases, these bids are private, but for municipal governments these RFP documents are publicly available and can be used to help us understand what services plan sponsors typically request from PBMs. In the case below, you can see that a city government explicitly asks PBMs to submit proposals that meet several minimum requirements.

---

[22] Berenbrok LA, Tang S, Gabriel N, Guo J, Sharareh N, Patel N, Dickson S, Hernandez I. Access to community pharmacies: A nationwide geographic information systems cross-sectional analysis. *JAPhA*. 2022;62(6):1816-22.
[23] Federal Trade Commission. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. July 2024. Available at: https://www.ftc.gov/reports/pharmacy-benefit-managers-report
[24] Robbins R, Abelson R. The Middlemen: The opaque industry secretly inflating prices for prescription drugs. *New York Times*. June 21, 2024. Available at: https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html
[25] Federal Trade Commission. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. July 2024. Available at: https://www.ftc.gov/reports/pharmacy-benefit-managers-report
[26] Johnson A, Anderson BN. PBM Best Practices Series: RFP process. *Milliman White Paper Series.* September 2016. Available at: https://www.milliman.com/-/media/milliman/pdfs/articles/best-practices-pbm-rfp-process.ashx

Case Study: City of Buffalo, New York (RFP Issued March 1, 2023)

In spring 2023, the Department of Human Resources for the City of Buffalo published an RFP for PBM services.[27] At the time of this RFP, the City of Buffalo served approximately 12,045 plan members.

As part of this RFP, the City of Buffalo outlined minimal proposal requirements including:

1. Member Copay - Members will pay the lowest of the following: plan copay, plan price plus dispensing fee, usual & customary (U&C), or retail cash price.
2. Rebates - Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons. Rebates should be proposed with a percentage share of the total rebate paid by the manufacturer along ***with a minimum floor guarantee***.
3. Rebates are guarantees on the greater of, percentage of the total rebates paid by the manufacturer to the PBM based on the City utilization or minimum floor guarantees (i.e., not fixed) basis whichever is greater.
4. If your claim payment to pharmacies is other than a percent off AWP, please describe your approach and estimate what the expected savings off AWP will be.
5. Please provide a specific, concise line by line listing of ALL available formulary options, Utilizations Management options, and/or clinical programs or tools and their associated fee. Be sure to specify fees if there are various levels or tiers of a program. Be sure to specify fees for both a la carte and bundle/package options.

The selected items above were chosen to demonstrate how an employer can write in specific requests to PBMs and clearly state that if the PBM submitting a bid for the contract doesn't include these items that they will likely not be selected. This context is important because many of the items under scrutiny (e.g., rebates, spread pricing, fees) can be laid out in a very transparent way in the contracting process. For example, if an employer wants to work with a PBM without "spread pricing" they can simply request all proposals include that language.

[27] Department of Human Resources, City of Buffalo. Request for Proposals for: Pharmacy Benefit Management Services. March 1, 2023. Available at: https://www.buffalony.gov/DocumentCenter/View/11585/2023-Pharmacy-Benefit-Management-Services-RFP?bidId=

2.5. Rebate Guarantees and Role of Employer Benefit Consultants

Recently, a survey of 110 organizations with self-insured pharmacy benefits highlighted a few important issues that should be considered in our discussion of how PBMs earn customers and responds to these RFPs. Specifically, the researchers found that 62.7% of employers reported having rebate agreements with rebate guarantees for specialty drugs.[28] Even more concerning, employers reported a high reliance on benefits consultants and a process (referred to as "spreadsheeting") where consultants present employers with models comparing the rebate guarantees across the received proposals in an aggregated form, potentially obscuring the net prices paid for specific drugs or other fees.[29] These findings call into question all the interactions and relationships of expert consultants who contract with employers to facilitate the RFP process or help an employer evaluate the performance of the winning PBM. Especially if these consultants receive any other benefits or have any potential conflicts of interest with existing PBMs.[30]

SECTION III: PBM IMPACTS ON DRUG PRICING

3.1. Which "drug price" are we referring to?

All drug pricing policy discussions must be very clear when defining which price is the focus of the conversation. This is often the most confusing, but it critical for our ability to assess how PBMs impact drug pricing. Often when you read a newspaper article referring to a drug price, they are using a "list price" from the manufacturer – not considering the final net price paid for insured patients or considering any markups along the supply chain after the manufacturer. Additionally, most news and academic journal articles on "patient affordability" only focus on out-of-pocket costs for the patient being treated and fail to account for the annual premiums paid by all beneficiaries for the plan.

In the case of prescription drugs, the complexity of the pharmaceutical supply introduces many new terms and when we write new policy using different price definitions there is the potential for unintended consequences **(Table 1)**.

---

[28] Henderson R, Patterson J, O'Brien JM. Prescription Rebate Guarantees: Employer Insights. *Am J Manag Care*. 2024;30(11). In Press. Available at: https://www.ajmc.com/view/prescription-rebate-guarantees-employer-insights
[29] Ibid.
[30] Herman B. 'It's beyond unethical': Opaque conflicts of interest permeate prescription drug benefits. *STAT News*. June 20, 2023. Available at: https://www.statnews.com/2023/06/20/pbms-consulting-firms-investigation/

Table 1. Select drug pricing terms with additional context and commentary.

Drug Price Term	Place in Supply Chain	Expert Commentary
Wholesale Acquisition Cost (WAC)	The manufacturer's list price and meant to serve as a proxy for the price a wholesale company pays to acquire the drug.	This is a compendium price listed in databases such as MediSpan and Redbook. This price is commonly used in news articles as it is easily accessible, but it is incredibly misleading.
Average Wholesale Price (AWP)	This is a compendium price meant to be a proxy for the price a pharmacy pays to acquire the drug from a wholesale distributor.	This is a compendium price listed in databases such as MediSpan and Redbook. For brand name drugs, the AWP is typically around 20-23% higher than WAC. However, for generic drugs this AWP has substantial variation and is not reliable.
Usual & Customary (U&C)	This represents a pharmacy's "cash price" without insurance. It is a common term in retail businesses.	Pharmacies have advertised low U&C prices to gain market share for decades. Famous cash-based pricing schemes for generic drugs include things like the Walmart "$4 list" or other pharmacies advertising a low price without the use of insurance.
Out-of-Pocket (OOP) Cost	This represents the patient's amount owed to the pharmacy at the time of dispensing. It can include obligations such as a deductible and/or copayment based on benefit design.	This is the amount most important to an individual patient trying to make a decision at the pharmacy counter. While OOP costs limits have become more popular in policy circles, all OOP discussions should include total cost and premium cost impacts.
National Average Drug Acquisition Cost (NADAC)	This is a pharmacy cost estimate based on a national "Retail Price Survey" conducted by Myers & Stauffer, LC through a contract with CMS.	The NADAC has grown in popularity to more accurately represent pharmacy acquisition costs, however survey methods create potential reporting biases and does not include any off-invoice price discounts or rebates from wholesalers to pharmacies.
Dispensing Fee	This represents a flat prescription-level fee for the pharmacy's professional services.	Dispensing fees are meant to account for the cost to dispense the drug without any relationship to the actual price of the drug itself. Dispensing fees have traditionally been minimal (e.g., <$1) in most contracts, but have increasingly become more common in "cost+" benefit designs.
Net Price	This is meant to represent the final price paid by a health plan or PBM after all rebates or discounts are accounted for.	While we have more sophisticated ways to estimate the size of rebates for some brand name drugs, there are still substantial challenges with the full accounting for all price concessions at a prescription-level.

3.2. How drug price definitions can impact prices paid

The definitions listed above are critical when we want to understand the impacts of certain policies or how these prices are actually implemented into PBM contracts. For example,

when the FTC released its interim staff report on PBMs, it selected 2 drugs (imatinib mesylate and abiraterone acetate) for a case study to compare reimbursement rates for unaffiliated pharmacies, PBM-affiliated pharmacies, and with the prices found in the NADAC survey.[31] They concluded that both unaffiliated and PBM-affiliated pharmacies were reimbursed significantly more than NADAC and that PBM-affiliated pharmacies were paid more than pharmacies not affiliated with the PBM – concluding that vertically integrated PBMs have an incentive to prefer their own pharmacies and increase prescription drug costs.1 Unfortunately, the FTC failed to explore possible explanations of how this phenomenon could occur regardless of the PBM, which could be more informative for policy solutions. For example, in August 2024 these 2 drugs had AWP prices published in Redbook that varied from 20% markups over AWP to more than 5,000% for abiraterone acetate and over 8,000% for imatinib **(Table 2)**.

Table 2. Selected imatinib and abiraterone acetate drug prices in Redbook 2024.

Product	Manufacturer	WAC (per unit)	AWP (per unit)	Suggested Markup (%)
Abiraterone Acetate, 250mg tablets, 120-count bottle				
	Wockhardt USA	1.88	97.21	5,084
	5 different manufacturers	1.88	97.08	5,077
	Northstar Rx	1.88	93.53	4,888
	Hikma Pharmaceuticals	5.00	92.09	1,742
	Apotex	8.33	92.09	1,005
	Mylan Pharmaceuticals	14.17	97.21	586
	Teva Pharmaceuticals	29.16	97.21	233
	Patriot Pharmaceuticals[a]	76.57	91.88	20
	CivicaScript[b]	1.33	1.60	20
Imatinib mesylate, 400mg tablets, 30-count bottle				
	Upsher-Smith Laboratories	4.17	364.41	8,646
	3 different manufacturers	4.33	364.41	8,309
	2 different manufacturers	5.04	394.66	7,731
	Teva Pharmaceuticals	14.57	364.41	2,401
	Chartwell Rx	18.00	394.66	2,093
	Apotex	19.18	364.40	1,800
	Hikma Pharmaceuticals	45.61	364.41	699
	Northstar Rx	78.52	376.95	380
	Mylan Institutional[c]	11.70	14.04	20
	Major Pharmaceuticals	66.67	80.00	20

a) Patriot Pharmaceuticals is a wholly owned subsidiary of Janssen Pharmaceuticals, the brand manufacturer for Zytiga® (abiraterone acetate)
b) CivicaScript is a sister company to CivicaRx, formed in partnership with Blue Cross Blue Shield organizations
c) Mylan & Mylan Institutional are subsidiaries of Viatris, formed in 2020 through the merger of Pfizer's Upjohn division and Mylan. They produce imatinib products with different prices for institutional use.

3.3. Concept of Spread Pricing

Pricing differentials established by a PBM between the contract established with a health plan and the actual price paid to a pharmacy for the service has also garnered recent attention from policy makers

[31] Federal Trade Commission. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. July 2024. Available at: https://www.ftc.gov/reports/pharmacy-benefit-managers-report

with spread pricing prohibitions introduced in bills such as the PBM Transparency Act or PBM Reform Act.[32] This differential price, also referred to as "risk mitigation pricing" by the Pharmaceutical Care Management Association (PCMA)[33], has been offered by PBMs to employers where the PBM guarantees the price at the initiation of the contract and takes on any risk associated with price inflation or benefits with price deflation.

Table 3. Example of spread differences on two manufacturers of Atorvastatin 10mg.

Drug Name & Strength	NDC	Manufacturer	NADAC	WAC	AWP	AWP – 70% (PBM-Plan)	AWP – 80% (PBM-Pharmacy)	PBM "Spread"	Pharmacy "Spread"
Atorvastatin 10mg	43598-0830-90	Dr. Reddy's Laboratories	0.96	2.49	115.52	34.66	23.10	11.55	22.14
	00093-5056-10	Teva Pharmaceuticals	0.96	3.82	225.00	67.50	45.00	22.50	44.04

AWP-based contracts create major incentives for both PBM and pharmacies to strategically purchase specific NDCs

In the case example of Atorvastatin 10mg, when you model hypothetical contracting scenarios between the PBM and the health plan (e.g., "AWP – 70%") and the pharmacy (e.g., "AWP – 80%"), you can see that in some cases an AWP-based formula could create disincentives to use the lowest price generic. PBMs have understood this phenomenon for many years and for many common generic drugs, they have created a "maximum allowable cost" (MAC) list that functions as a price ceiling for these drugs – preventing pharmacies from being incentivized toward the higher AWP product. However, to my knowledge, health plans do not have an equivalent MAC list for PBMs.

In any case, the concept of spread pricing has some benefits for employers, particularly those who may be price sensitive to potential price inflation throughout the year. Additionally, allowing PBMs to profit from spread pricing creates an incentive to put downward pressure on pharmacy costs in its network, which could be disastrous for small businesses with little negotiating power. However, it does create weird incentives that may be difficult for any single health plan to manage.

3.4. National Average Drug Acquisition Cost (NADAC) Plus Pricing Models

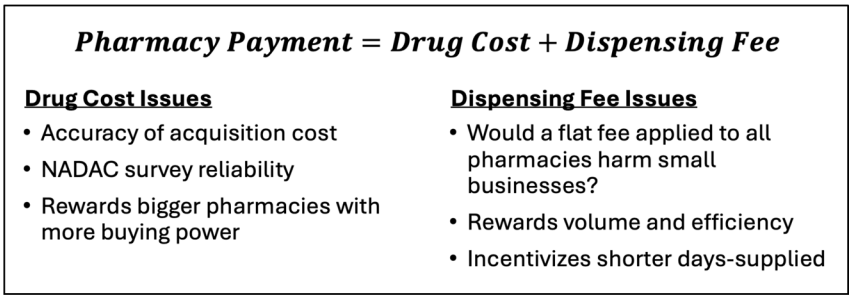
In recent years, the "NADAC plus a dispensing fee" pharmacy price model has gained in popularity with several states implementing this approach and with support from the largest independent

[32] Mattingly TJ, Ben-Umeh KC, Bai G, Anderson GF. Pharmacy Benefit Manager Pricing and Spread Pricing for High-Utilization Generic Drugs. *JAMA Health Forum.* 2023;4(10):e233660. doi:10.1001/jamahealthforum.2023.3660
[33] Pharmaceutical Care Management Association. Small And Mid-Sized Employers Rely On Spread Pricing For Predictable, Fixed Pricing. PCMA Blog. May 31, 2023. Available at: https://www.pcmanet.org/pcma-blog/small-and-mid-sized-employers-rely-on-spread-pricing-for-predictable-fixed-pricing/05/31/2023/

pharmacy organization.[34] While on its face, this approach seems pretty straightforward and offers a much better solution when compared to using an AWP- or WAC-based pricing methodology, there are still issues when using NADAC that members of Congress should consider.

First, NADAC is based on a monthly survey of a relatively small number of outpatient pharmacies in the US conducted by a national accounting firm contracted by CMS.[35] The survey is voluntary and focuses on independent and chain pharmacies – excluding closed door pharmacies such as mail order or specialty pharmacies.[36] In April 2024, generic drug prices in the NADAC survey dropped by approximately 19% and the NCPA reported that the drop was not related to the updated survey methods but that CMS reported the changes were due "to a meaningful increase in pharmacy participation"[37] – in other words, a large number of pharmacies with substantial pricing discounts reported low enough prices to bring the national average down. This raises significant concerns regarding the acquisition cost data collection and analysis process.

Figure 1. Summary of key issues with "Cost-Plus" or "NADAC-Plus" pricing models.



Second, a cost-plus model requires a professional "dispensing fee" to be applied to all prescriptions. While this sounds simple, setting an appropriate dispensing fee rate can actually be challenging. If the fee is uniformly applied to all prescriptions regardless of day supply quantities, pharmacy type, or medication type, then the fee will likely "overpay" for relatively simple prescriptions,

[34] National Community Pharmacists Association. News around the states. Published February 26, 2024. Accessed September 6, 2024. Available at: https://ncpa.org/newsroom/qam/2024/02/26/news-around-states
[35] Levy J, Rosenberg M, Vanness D. A Transparent and Consistent Approach to Assess US Outpatient Drug Costs for Use in Cost-Effectiveness Analyses. *Value in Health.* 2024;21(6):677-684.
[36] Centers for Medicare & Medicaid Services. Methodology for Calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid Covered Outpatient Drugs. February 2024. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/ful-nadac-downloads/nadacmethodology.pdf
[37] National Community Pharmacists Association. What's going on with NADAC? June 5, 2024. Available at: https://ncpa.org/newsroom/qam/2024/06/05/whats-going-nadac

shorter durations, and for high-volume pharmacies. A flat rate would also "underpay" for more complex prescriptions that require more pharmacy staff time or for small pharmacies that have a very low volume of prescriptions. Additionally, we would need a plan to adjust the fee annually with inflation to account for pharmacy operation cost increases over time. We would also need to prevent pharmacies from switching patients from longer durations (e.g., "90-day-supply") to shorter durations to increase total prescription volume.

3.5. Insurance coverage influences demand for prescription drugs

Most US consumers have health insurance that includes some form of pharmacy benefit as part of the insurance design. When a drug is covered by insurance, the patient is not exposed to the full cost of the drug – distorting our classical supply-demand models taught in introductory economics courses. Health care providers (e.g., doctors, clinics, hospitals) may be rewarded for using more expensive drugs[38] if they are compensated based on the drugs sales price or if they are 340B covered entities.[39] Additionally, PBMs and insurers may have incentives to cover higher priced drugs based on rebate arrangements.[40] All of these factors influence the demand for pharmaceuticals – particularly the demand for high cost drugs.

SECTION IV: DRUG PRICINGS ISSUES UNRELATED TO THE PBM

4.1. Temporary Monopoly Power – The Tradeoff for Innovation

In the late 1950s / early 1960s, the Senate Subcommittee on Antitrust and Monopoly conducted several months of hearings on the administered prices for prescriptions. Led by Senator Estes Kefauver, these hearings ultimately led to draft legislation called the "Drug Industry Antitrust Act" in 1961 which focused on amending the Food, Drug, and Cosmetic Act (FDCA), Sherman Antitrust Act, and existing patent laws.[41] Senator Kefauver specifically wanted to reform the intellectual property rights for pharmaceutical companies – however, his bill did not have the votes. Around that same time, the thalidomide scare increased the priority for President Kennedy's administration to get a bill through Congress and Kefauver's bill was essentially overhauled to focus on "safety, effectiveness, and reliability" of drugs and stripped the bill of Kefauver's drug pricing components.[42] Despite the bill being

[38] Conti RM, Frank RG, Cutler DM. The Myth of the Free Market for Pharmaceuticals. *N Engl J Med*. 2024;390:1448-1450. DOI: 10.1056/NEJMp2313400
[39] Conti RM, Bach PB. Cost Consequences of the 340B Drug Discount Program. *JAMA*. 2013;309(19):1995–1996. doi:10.1001/jama.2013.4156
[40] Mattingly TJ, Hyman DA, Bai G. Pharmacy Benefit Managers: History, Business Practices, Economics, and Policy. *JAMA Health Forum*. 2023;4(11):e233804. doi:10.1001/jamahealthforum.2023.3804
[41] Mattingly TJ. Kennedy, Kefauver, and Castro: A historical lesson on the politics of drug pricing reform. *Health Affairs Forefront*.
[42] Ibid.

named for him and receiving the first ink pen President Kennedy used to sign the bill into law, Senator Kefauver was furious about the Senate politics involved and even described the event as the "first time in my 23 years in Congress that an administration has emasculated a bill without letting its sponsor and chairman know."[43] What ultimately resulted from the 1962 Kefauver-Harris Amendments to the FDCA was a more robust regulatory system for new drugs to enter the market that would require more clinical trial testing prior to approval. While this was arguably one of the most impactful pieces of legislation in terms of efficacy and safety for our drugs, it would increase the costs for manufacturers to bring drugs to market. In exchange for these increased costs, pharmaceutical manufacturers would maintain the monopoly powers granted through their patents that would enable the companies to both recoup their costs and make a substantial return on investment for shareholders.

To this day, the value of the intellectual property for pharmaceuticals has provided an enormous incentive for the research, development, and commercialization of drugs. When comparing to other S&P 500 companies outside of the pharmaceutical industry, pharmaceutical company profitability from 2000 to 2018 was 13.8% compared to nonpharmaceutical company earnings of 7.7%.[44] And as part of this tradeoff for monopoly power and increased profitability, a patient who contracts the Hepatitis C virus (HCV) can now be cured, a newborn child with Cystic Fibrosis (CF) can expect to live more than 20 years longer than that same child born in the 1990s[45], and we may be closer to slowing down the progression of Alzheimer's disease than ever before.

4.2. Pros and Cons of Out-of-Pocket Limits

One policy solution that has gained favor in recent years has been "out-of-pocket caps" for patients. This policy type is great to limit the risk exposure for people when they become sick and need to use their insurance to pay for health services, however these caps simply shift the cost to the monthly premium everyone in the health plan must pay (see Insurance Premium Equation in Section I). Historically, different out-of-pocket costs have been used at the pharmacy counter to encourage patients to use preferred drug products on the pharmacy formulary. The PBM works with each health plan to establish different price levels or tiers, with the most preferred (often lowest cost, like generic drugs) drugs placed with a very small or no copayment. For many medications, these lower tiers are typically affordable for most families and research on recent insulin out-of-pocket caps in Colorado demonstrated that the caps did not change insulin utilization for Type 1 and Type 2 diabetics using insulin, likely

[43] McFadyen RE. Estest Kefauver and the Drug Industry. Emory University ProQuest Dissertations & Theses. 1973. Available at: https://www.proquest.com/docview/302719773?pq-origsite=gscholar&fromopenview=true&sourcetype=Dissertations%20&%20Theses

[44] Ledley FD, McCoy SS, Vaughan G, Cleary EG. Profitability of Large Pharmaceutical Companies Compared With Other Large Public Companies. *JAMA*. 2020;323(9):834–843. doi:10.1001/jama.2020.0442

[45] Ong T, Ramsey BW. Cystic Fibrosis: A review. *JAMA*. 2023;329(21):1859-1871. doi:10.1001/jama.2023.8120

because many commercial plans already had out-of-pocket copayments lower than the state-mandated cap.[46] When Congress evaluates proposals seeking to cap spending on prescriptions, it must evaluate both the current level of out-of-pocket spending and the potential impact on insurance premiums that would increase costs for all beneficiaries.

4.3. Understanding Drug Price Inflation and the Value of Innovation

One of the issues that arises when policy discussions center around drug pricing is that typically focus on an unadjusted "price" that fails to adequately account for the underlying value of all the technological advancements that have been achieved to make that drug and what benefits the drug offers. This concept of adjusting for quality improvements when we calculate price inflation is not new. What does this mean?

For most goods and services (e.g., televisions, computers, automobiles), quality adjustments are made for the Consumer Price Index (CPI) to ensure any price differential attributed to a change in product quality is removed from the equation.[47] Unfortunately for drug prices, we make no such adjustments to take into consideration the innovation occurring in the drug market. Additionally, current drug price indexes fail to account for new launches of drugs that may have a much higher price than other drugs currently on the market for the same condition. Last year, we demonstrated that for Hepatitis C virus (HCV) drug therapies, a product-level approach for measuring inflation likely underestimated price increases because they failed to capture the significant jump in price for the whole class of medications and that prescription-level analyses did not consider the innovations that allowed for shorter treatment durations (3-month vs. 12-month) actually overestimated price increases.[48] In other words, our current methods for comparing prices of pharmaceuticals over time are not actually helpful for consumers.

---

[46] Anderson KE, Chaiyakunapruk N, Gutierrez EJ, et al. State Out-Of-Pocket Caps On Insulin Costs: No Significant Increase In Claims Or Utilization. *Health Affairs*. 2024 43:8, 1137-1146.
[47] US Bureau of Labor Statistics. Consumer Price Index: Quality Adjustment in the CPI. Accessed September 6, 2024. Available at: https://www.bls.gov/cpi/quality-adjustment/home.htm
[48] Mattingly TJ, Anderson GF, Levy JF. Comparison of Price Index Methods and Drug Price Inflation Estimates for Hepatitis C Virus Medications. *JAMA Health Forum*. 2023;4(6):e231317. doi:10.1001/jamahealthforum.2023.1317

Mr. MASSIE. Thank you, Dr. Mattingly.

Dr. Frank, you may begin.

Oh, make sure your microphone is on and pull it near you. There you go.

STATEMENT OF DR. RICHARD FRANK

Dr. FRANK. OK. Chair Massie, Ranking Member Correa, the Members of the Subcommittee, thank you for inviting me here today to talk about the role of pharmacy benefit managers, or PBMs.

In my remarks here, I want to touch on three issues.

First, how PBMs are paid and what that implies for the market.

Second, market structure within which PBMs operate; specifically, vertical integration of PBMs and insurers on one hand, and highly concentrated horizontal markets for PBM services on the other.

Third, I want to talk about the circumstances facing independent retail pharmacies and the role that PBMs play in that.

So, let me start by noting that PBMs came to prominence by introducing procompetitive incentives to market prescription drugs. That resulted in price concessions that are estimated to be 10–28 percent.

Turning now to payment, PBMs are paid in several ways.

The first is service fees for performing specific functions like claims processing.

The second form of payment is to retain part of rebates that they negotiate. Estimates of retention rates fall in the 9–13-percent range. Rebate retention creates incentives for PBMs to bargain hard.

PBMs also earn revenues through a variety of fees charges to pharmacies, and some PBM revenues come about because they pay less to pharmacies than they charge the insurer or the employer. That's called spread pricing.

PBMs negotiate a mix of fees, retained rebates, and spreads with their customers. So, when larger retained rebates happen and spread prices are larger, in allowable contracts, service fees tend to be lower.

Now, let me turn to market structure. In 2022, the largest four PBMs accounted for 87 percent of sales. This is due to both scaled economies and horizontal mergers that we saw in that chart. This likely gives large PBMs the upper hand in negotiations with some payers and pharmacies, resulting in the ability to extract excess profits.

The market has also moved rapidly toward vertical integration. Each of the four top PBMs is integrated with a major insurer. Vertical integration, in theory, can create synergies by managing the drug and the medical benefits together. Those synergies can result in improved patient care and reduced costs.

Vertical integration can also have a less happy result, such as avoidance of regulatory rules. This stems from the ability to disguise profits as costs to avoid regulations that, for example, limit the margins of health insurers.

Another concern involves potential anticompetitive conduct. For example, insurers may choose to sell their PBM and health insur-

ance services to employers as a package or a bundle, and that would impede competition from insurers who don't have a PBM.

The evidence on these things is thin. There's little evidence showing that there are synergies, but there is emerging evidence suggesting that there is regulatory gaming linked to vertical integration.

Let me now turn to retain pharmacies. Steering of customers to PBMs, to preferred pharmacies, claim to disadvantage independent pharmacies. This is particularly troubling in rural America because of the greater potential for pharmacy deserts. Independent pharmacies face challenges, though, broad economic challenges, such as competition from mail order, smaller scale, and lack of robust purchasing arrangements.

The situation for pharmacies, independent pharmacies, is varied. The number of rural independent pharmacies declined 16 percent between 2003–2021, while urban chains, I mean, while rural chains grew about 4.5 percent. During that same period, metropolitan independent pharmacies grew 28 percent, while the chain pharmacies only grew 10.5 percent. So, it's a mixed picture. Gross margins were flat at around 21 percent over the recent history.

Then, there's scale problems. Independent pharmacies dispense about a third of the number of prescriptions that a chain pharmacy does on average. So, they just have a much smaller scale, and their purchasing arrangements leave them sort of 2–6 percent, with higher costs of about 2–6 percent.

So, in finalizing, let me just make one final comment that I concluded after undertaking, undertaking a view of the landscape; those efforts to improve competition and efficiency in PBM markets is a sensible way to go, but being successful in doing that will only make a small difference to the overall drug pricing problem.

Thank you for your attention.

[The prepared statement of Dr. Frank follows:]

Testimony of Richard G. Frank, Ph.D.
Director and Senior Fellow, Center on Health Policy
Economic Studies, Brookings Institution

Before the United States House of Representatives
Committee on the Judiciary
Subcommittee on the Administrative State, Regulatory Reform, and Antitrust

Congressional Hearing on
"The Role of Pharmacy Benefit Managers"

September 11, 2024

Introduction

Chairman Massie and Ranking Member Correa, thank you for inviting me to participate in this discussion of the role of Pharmacy Benefit Managers or PBMs. The cost of prescription drugs and the burden of those costs for individuals and families that need to be treated with prescription drugs involves the entire prescription drug supply chain. My testimony reflects my views and not those of any organizations with which I am affiliated.[1] I will focus on four themes. First, I will touch on the original promise of PBMs. I will then discuss the market structure and the incentives facing PBMs. My third theme will be directed at steering of demand for products and delivery mechanisms by PBMs. Fourth and finally, I will offer some observations on the forces affecting the fortunes of retail pharmacies.

In considering these four themes, I arrive at several conclusions. At a high level, they are as follows.

- Undertaking efforts to improve competition and efficiency in PBM markets is sensible, but success in doing so will only contribute modestly to making prescription drugs more affordable.
- Much of the unhappiness with PBMs traces back to the dynamics in health insurance markets that have become increasingly vertically integrated. This development likely has resulted in less competition and regulatory avoidance conduct.
- Rebates on brand-name prescription drugs are frustratingly opaque and are in some cases subject to the exertion of market power. But they also create incentives for PBMs to work hard to get payers lower prices. As a result, they are common features of contracts between PBMs and payers.
- Consumers are increasingly exposed to significant out-of-pocket costs for prescription drugs. Some of this stems from the gap between list prices and net prices but also from the choices by payers and insurers to be increasingly reliant on cost-sharing in the forms of deductibles and coinsurance.
- Retail pharmacies face an array of challenging economic conditions threatening the survival of some of those operating in rural America. Yet much of what threatens these enterprises is not tied to PBMs.

My perspective is that of a health economist who has long studied markets for prescription drugs. In that role, I have at once a strong appreciation of the benefits that competition can bring to health care markets generally and the prescription drug market specifically. I also see many instances of market failures in health care markets that can benefit from interventions by various levels (local, state, federal) and agencies

[1] The views I express in this testimony are my own and do not necessarily reflect the views of other Brookings staff members, officers, or Trustees of the Institution.

(regulatory and judicial) of government. My remarks today highlight market forces and incentives. Today's pharmaceutical markets and supply chains are very much creatures of public policy and so many of my observations will reflect the consequences of prior legislation, regulations, and litigation.

Background and Brief History

Origins and Economic Rationale for PBMs

The PBM industry is located at the center of the pharmaceutical supply and distribution chain. PBMs offer specialty management services of prescription drug benefits to health insurers and employers. Key functions of PBMs include claims processing, negotiation of drug prices, generic substitution programs, the development of drug utilization management processes, the creation and management of networks of pharmacies, and the reimbursement of pharmacies for the prescription drug products they dispense to insured individuals.

PBMs became prominent in response to concerns about prescription drug prices stemming from a combination of factors. They include increasingly generous insurance coverage for prescription drugs (covering 26% of drug spending in 1980, increasing to nearly 85% in 2022[2]), product differentiation in drugs treating the same conditions (think SSRI antidepressants in the 1990s), and market exclusivity due to patent protection or Food and Drug Administration (FDA) market exclusivity provisions. The confluence of these market features made individual product demand unresponsive (inelastic) to relative prices, resulting in little competitive pressure on prices. PBMs offered a solution through formulary design, product placement decisions, and other administrative mechanisms. Those mechanisms were used by PBMs to make demand for specific drug products more responsive to prices (price-elastic) that, in turn, reduce the market power of prescription drug manufacturers. Thus, the ability of PBMs to "move market share" among competing products based on price was viewed as key to saving payers' money. PBMs also negotiated with pharmaceutical manufacturers over products that were the sole products in their class. The savings they realized tended to be smaller than in the case of differentiated competition with multiple suppliers.[3]

PBMs also serve a few functions that affect access, cost, and safety of care with prescription drugs. Those services are designed to control utilization and limit the potential misuse of drugs; control the payments to retail outlets; ensure that lowest price generic drugs are used when they are available; provide consumers with convenient dispensing arrangements; and management of high-cost drugs that frequently involve special handling.[4]

How do PBMs Make Money: Revenue Sources

For many of the functions noted here, PBMs charge insurers and employers a service fee.

Another source of revenue is the retention of rebates. PBMs are typically responsible for negotiating price concessions from manufacturers in the form of manufacturer rebates that are typically percentage reductions off list prices. Rebates are paid retrospectively based on the ability of a PBM to "move market share" and deliver extra volume to manufacturers. PBMs and payer contracts commonly allow PBMs to retain a portion

[2] Center for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. (2024). National Health Expenditure Accounts, Historical Table 16. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

[3] Anderson-Cook, A., Maeda, J., & Nelson L. (2019). *Prices for and Spending on Specialty Drugs in Medicare Part D and Medicaid: An In-Depth Analysis, Working Paper 2019-02*. Congressional Budget Office. www.cbo.gov/publication/55011

[4] For some early background see: Sroka C.J. (2000, November 29). *Pharmacy Benefit Managers*. (CRS Report No. RL30754). https://www.everycrsreport.com/reports/RL30754.html

of rebates. One estimate put the share of rebates retained by PBMs at 9% in 2016.[5] Other estimates suggest a figure of 13% in 2021.[6] Contracts that permit the retention of rebates create an incentive for PBMs to bargain hard to lower prices. Details about rebates have been closely guarded by PBMs as competitive secrets. That makes the net prices quite opaque. Yet, the Centers for Medicare and Medicaid Services (CMS) Actuary and a 2009 commentary by the Federal Trade Commission (FTC) noted that revealing net prices resulting from rebate negotiations would likely result in increases in net prices.[7]

PBMs also earn revenues through so-called Direct and Indirect Renumeration (DIR) fees. The term DIR in the context of PBM interactions with pharmacies refers to payment reconciliations and various other forms of payment (a much broader definition than that used in Part D of Medicare). . Some of the additional fees include "pay for play" network participation fees because network participation is associated with increased customer volume to pharmacies resulting in greater sales of both drugs and other consumer products. Pharmacies view the DIR fees as a claw back. This type of fee arrangement is sometimes known as "drip pricing" in that it occurs after an initial set of fees are established (drip pricing is commonly found in airline price structures). Because of the after-the-fact reconciliations and fee adjustments, pharmacies may be paid less than the insurer or employer pays the PBM. That "spread" creates a revenue source for the PBM that is referred to as "spread pricing." The mix of PBM revenues are frequent features of negotiated contracts between PBMs and their clients (insurers and employers).

A common result is that payers will have reduced fees in lieu of allowances for PBMs to retain rebates and engage in spread pricings.[8] Finally, the larger PBMs all own mail order and specialty pharmacies that are reputed to be the largest sources of PBM profits.

PBM Spending Impacts

Early in their development PBMs' use of formularies to negotiate lower payer prices through rebates was shown to realize significant savings for payers relative to a benefit managed by the insurer.[9] One Government Accountability Office (GAO) study of the use of PBMs in the Federal Employees' Health Benefit Program showed savings for 14 brand-name drugs dispensed by retail pharmacies. The results showed savings of roughly 19% for the plans, while beneficiaries using those products experienced reduced out-of-pocket costs.[10] More recently, in a series of studies, Feng showed savings associated with PBMs. In

---

[5] Pew Charitable Trusts. (2019). *The Prescription Drug Landscape Explored.* https://www.pewtrusts.org/en/research-and-analysis/reports/2019/03/08/the-prescription-drug-landscape-explored

[6] Drug Channels. (2022, August 9). *Texas Shows Us Where PBMs' Rebates Go.* https://www.drugchannels.net/2022/08/texas-shows-us-where-pbms-rebates-go.html

[7] Centers for Medicare & Medicaid Services, Office of the Actuary. (2018, August 30). *Proposed Safe Harbor Regulation Impact.* www.regulations.gov/document?D=HHSIG-2019-0001-0004. A letter from the FTC to the New York State Legislature in 2009 makes a similar point about revelation of negotiated rebates, see: FTC NY Comment letter PBM leg.pdf. It is important to note that the FTC recently issued an opinion distancing itself from prior analyses and position with respect to PBMs.

[8] National Association of Insurance Commissioners (NAIC). (2023, April 16). *Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation.* (NAIC White Paper Draft). https://content.naic.org/sites/default/files/inline-files/AphA%20Comments.pdf

[9] For an example of an early study of savings see: Motheral, B., & Fairman K.A. (2001). Effect of a three-tier prescription copay on pharmaceutical and other medical utilization. *Med Care*, 39(12):1293-304. https://doi.org/10.1097/00005650-200112000-00005

[10] Available at: United States General Accounting Office (GAO). (2003, January). *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies.* https://www.gao.gov/assets/gao-03-196.pdf

a case study of statin drugs during the period 1996 to 2013, Feng and Maini reported savings of 28%.[11] In a more general analysis, Feng reported spending reductions associated with PBMs on the order of 15%.[12] Recent analyses also show some savings in (roughly 10%) out-of-pocket costs from preferred pharmacy networks.[13]

The PBM and its Market Context

The market structure within which PBMs operate has evolved over the past two decades. So too has the composition of brand-name prescription drug products on the market. The structure of cost-sharing for patients has changed along with changes in the insurance and PBM market segments. I discuss each of these below and how they can affect the conduct of PBMs in the marketplace. It appears that the changes in the market have been so significant that the FTC recently issued a statement distancing itself from earlier positions on the PBM industry.[14] In that statement they specifically cited changes in market structure and price determination as underpinning the Commission's altered position.

Market structure: Concentration and Vertical Integration

The main parties involved in the prescription drug market are prescription drug manufacturers, insurers, pharmacies (retail, mail order, and specialty), PBMs, and consumers. Historically each entity was owned and operated independently and there were varying levels of competition at each level, in some instances that took the form of price competition. Much has changed over the past several decades. In 2003, the top four PBMs accounted for about 68% of sales.[15] In 2022, the largest four PBMs accounted for 87% of sales.[16] The increased concentration over time is a product of both scale economies and horizontal mergers.[17] This structure indicates likely market power, giving large PBMs the upper hand in negotiations with some payers and pharmacies resulting in supra-competitive compensation and the ability to extract excess profits. It is also important to note that the entire prescription drug supply chain has become more concentrated.[18]

---

[11] Feng J., & Maini L. (2024, March) Demand Inertia and the Hidden Impact of Pharmacy Benefit Managers. *Management Science*. https://doi.org/10.1287/mnsc.2021.03331

[12] Feng, J. (2021). Pricing Intermediaries in Prescription Drug Markets: To Leverage or Replace? (Working Paper, University of Utah).

[13] Starc, A., & Swanson A. (2021). Preferred Pharmacy Networks and Drug Costs. *American Economic Journal*, 13(3): 406-446. https://www.aeaweb.org/articles?id=10.1257/pol.20180489

[14] Federal Trade Commission (FTC). (n.d.) Federal Trade Commission Statement Concerning Reliance on Prior PBM-Related Advocacy Statements and Reports that No Longer Reflect Current Market Realities. https://www.ftc.gov/system/files/ftc_gov/pdf/CLEANPBMStatement7182023%28OPPFinalRevisionsnoon%29.pdf

[15] Note that the entire supply chain has grown more concentrated include brand-name manufacturers, generic manufacturers, retail pharmacies, and wholesalers.

[16] Guardo J.R. (2023). *Competition in Commercial PBM Markets and Vertical Integration of Health Insurers with PBMs: 2023 Update*. American Medical Association. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi.pdf; Drug Channels. (2024, April 9). *The Top Pharmacy Benefit Mangers of 2023: Market Share and Trends for the Biggest Companies---And What's Ahead*. https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html

[17] Among the most notable horizontal mergers were Medco's acquisition of PAID (1985), Caremark's acquisition of Advance PCS (2004), and Express Scripts' acquisition of Medco (2012).

[18] The analysis of market power in the PBM context has varied. Traditionally market concentration was a key indicator of market power. An alternative view was advanced by the FTC in its analysis of the Express Scripts-Medco merger (see Shelanski H., et al. (2012, December). *Economics at the FTC: Drug and PBM Mergers and Drip Pricing, Review of Industrial Organization*. Federal Trade Commission. https://www.ftc.gov/sites/default/files/documents/reports/economics-ftc-drug-and-pbm-mergers-and-drip-pricing/shelanskietal_rio2012.pdf. That view focused on the degree of competitive discipline that would exist from remaining competitors. More recently the FTC and others have again focused on concentration indicators.

The market has also moved rapidly towards vertical integration. Each of the top four PBMs is integrated with a major health insurer. These PBMs all own mail order and specialty pharmacies. Specifically, CVS Health owns Aetna, Caremark, and CVS retail pharmacies. Cigna owns Express Scripts. United Health Group owns United and Optum Rx. Humana owns Humana Pharmacy Solutions. This is new, as data from 2018 showed that vertically integrated PBMs accounted for about 50% of the market. Recent estimates indicate that about 70% of insured individuals obtain coverage from a vertically integrated firm that combines an insurer and a PBM.[19] Lastly, several of these organizations have created so-called rebate aggregators, allegedly to negotiate and manage rebates.

Vertical integration incentives: There are a variety of incentives that drive the trend towards vertical integration of parts of the prescription drug supply chain. Some potentially lead to improved efficiency in supply chain management, while others have possible anti-competitive impacts or serve to avoid regulatory provisions enacted by the government.

Among the impulses for integration that may improve efficiency and health outcomes is the promise of improved alignment of medical and pharmaceutical care delivery thereby realizing synergies beneficial to the health of insured individuals. Another benefit is reduced costs associated with "double marginalization" that results from a multi-layered supply chain. That is the traditional efficiency gain associated with vertical integration that is also present in this case. Relatedly, it has been argued that redundancies in functions would be reduced with vertical integration.[20]

Vertical integration along the supply chain also offers opportunities to engage in practices that serve to avoid the impact of regulatory rules. One example is the Medical Loss Ratio (MLR) regulation that aims to limit profits in insurance. In the Medicare Advantage program, the MLR requires Medicare Advantage plans to spend 85% of their premium dollar on services and quality improvement efforts. However, in a vertically integrated supply chain, an insurer and a PBM that are owned by the same parent entity can disguise profits as costs to avoid the MLR requirements. That is, the payments to the PBM from the related insurer are counted as a cost to the insurer but they serve to generate profits for the parent company. So, by charging the insurer higher fees, the PBM can move profits to the parent company out of the reach of the MLR regulation.[21]

Another concern related to vertical integration involves potential anti-competitive effects. A vertically integrated firm that links an insurer and a PBM can potentially raise a rival's costs by increasing fees charged or reducing rebates to rival nonintegrated insurers.[22] Such anti-competitive effects might be constrained in markets where there is a great deal of competition among PBMs. However, in a highly concentrated PBM market, the opportunities to find an alternative PBM are more limited. An extreme version of that phenomenon is the opportunity to impede competitors from using key goods and services thereby foreclosing markets. This might occur with access to pharmacy services (retail or specialty).

---

[19] Op. cit. see Guardo Note 15.

[20] Orzag P., & Rekhi R. (2020, April 15). The Economic Case for Vertical Integration in Health Care. *NEJM Catalyst*, 1(3). https://doi.org/10.1056/CAT.20.0119

[21] For more complete discussion of this issue see: Frank, R.G., & Milhaupt, C. (2022). Profits, medical loss rations, and the ownership structure of Medicare Advantage plans. *Brookings Institution*. https://www.brookings.edu/articles/profits-medical-loss-ratios-and-the-ownership-structure-of-medicare-advantage-plans/; and Frank R.G., & Milhaupt, C. (2023). Medicare Advantage spending, medical loss rations, and related businesses. An initial investigation. *Brookings Institution*. https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/.

[22] U.S. Department of Health and Human Services, Office of Inspector General. (n.d.) *Audit of Vertically Integrated Medicare Part D Sponsors*. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000849.asp

Insurers also may choose to sell their PBM and health insurance services to employers as a package or bundle that would impede competition from insurers without a PBM.

Finally, vertical integration may facilitate health insurer pursuit of existing incentives to enroll healthier people in their plans, because people who use high-cost drugs disproportionately also use other medical care. Thus, PBMs can design formularies and utilization management protocols in ways that would discourage sicker people from enrolling in the vertically integrated plan. This is a long-standing source of market failure in health insurance markets.

The empirical evidence on the potential impacts of vertical integration of PBMs, insurers, and pharmacies are very limited. Two of the FTC Commissioners made such an observation in response to the recently released FTC Interim Report, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs*.[23] MedPAC analyzed rebates in the context of the Medicare Part D drug benefit and found that vertically integrated plans obtained larger rebates than nonintegrated PBMs.[24] Yet at the same time MedPAC observed that for vertically integrated entities that included insurers, PBMs, and (specialty) pharmacies for "a limited number of drugs" (six categories), net prices were more likely to be higher than those at non-integrated pharmacies.[25]

Earlier I noted the potential for improved incentives to coordinate care in the interest of whole person health may lead integrated plans to offer more efficient health care.[26] In 2012, the Congressional Budget Office (CBO) outlined the synergy benefits of managing the prescription drugs and medical care together.[27] There is little direct evidence on the impact of synergies from PBM-insurer integration. One recent study of vertical integration between PBMs and insurers in the context of Medicare Part D standing Prescription Drug Plans or PDPs found an association between elevated premiums and insurers that owned PBMs.[28] That analysis does not allow for key synergies that have been proposed stemming from integrated management of both the medical and pharmaceutical benefits. In addition, the "natural experiment" studied is a horizontal change in market structure (a merger of PBMs). That means that one cannot easily make inferences about vertical integration impacts. As a result, the authors note that the estimated relationship may not offer causal or generalizable results on vertical integration. Finally, even though there is some support to suggest that integrated plans design coverage to take advantage of synergies, there is

---

[23] The report can be accessed at: Federal Trade Commission (FTC). (2024, July). *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf. Commissioner Holyoak dissented due to her concerns about evidence. Her statement is available at: Holyoak, M. (2024, July 9). *Dissenting Statement of Commissioner Melissa Holyoak*. Federal Trade Commission. https://www.ftc.gov/system/files/ftc_gov/pdf/Holyoak-Statement-Pharmacy-Benefit-Managers-Report.pdf. In addition, Commissioner Ferguson in a concurring statement raised concerns about available evidence. His statement is available at: Ferguson, A. N. (2024, July 9). *Concurring Statement of Commissioner Andrew N. Ferguson*. Federal Trade Commission. https://www.ftc.gov/system/files/ftc_gov/pdf/Ferguson-Statement-Pharmacy-Benefit-Managers-Report.pdf

[24] Medicare Payment Advisory Commission (MedPAC). (2023, June). Chapter 2: Assessing postsale rebates for prescription drugs in Medicare Part D. In *Report to the Congress: Medicare and the health care delivery system. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf*

[25] Ibid. pp. 95-98.

[26] Lavetti, K., & Simon, K. (2018). Strategic Formulary Design in Medicare Part D Plans. *American Economic Journal*, Economic policy, 10(3), 154–192. https://doi.org/10.1257/pol.20160248

[27] Congressional Budget Office. (2012, November 29) *Offsetting effects of prescription drug use on Medicare's spending for medical services*. https://www.cbo.gov/publication/43741

[28] Gray, C., Alpert, A., & Sood, N. (2023). *Disadvantaging rivals: Vertical Integration in the pharmaceutical market*. SSRN. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4533250

accompanying evidence to suggest that they also design their benefits and management structure to discourage enrollment by high-cost enrollees.[29]

While the systematic evidence is quite limited there are some observations that can be made about vertical integration and PBMs. The pass through of rebates, spreads, and discounts to insurers has been attenuated by the fact that such a large segment of the PBM market is now integrated with health insurers. Vertical integration has created new opportunities for anticompetitive conduct in the form of raising rival costs and local market foreclosures. Finally, the vertical structure serves to facilitate "gaming" of regulations such as the MLR.

Other Changes in the Market Environment

The composition of brand-name products offered has been shifting rapidly. Biological products have been accounting for a growing share of prescription drug spending in the U.S. In 2023, biological drugs accounted for about 51% of prescription drug spending and specialty drugs made up 54% of spending.[30] The corresponding shares for 2018 were 42% and 49% respectively. These drugs typically are distributed and managed quite differently than small molecule, oral solid products. This in part explains the growing role of specialty pharmacies.

The benefit design in insurance coverage of prescription drugs has also evolved in recent years. IQVIA reports that in 2013 54% of cost-sharing was in the form of co-payments that are not based on list prices. In contrast, by 2017 that figure had declined to 44% indicating greater exposure to list prices.[31] The trend in exposing patients to greater cost-sharing appears to have continued past 2017, where co-payments as a share of cost-sharing fell to roughly 40% in 2021.[32] Therefore health insurance designs for prescription drugs have been changed in ways that leave consumers more exposed to list prices.[33] The net effect of such changes on consumer out-of-pocket costs depend on the health plan choices of employers and consumers. There is strong evidence suggesting that consumers commonly have difficulties in making choices among complex insurance designs that may result in failures to make plan choices that avoid overly high levels of cost-sharing.[34] There is some evidence that supports an association between higher rebates and greater out-of-pocket costs.[35]

Steering

---

[29] See Lavetti and Simon Note 25.

[30] IQVIA. (2024, May). *The Use of Medicines in the U.S. 2024: Usage and Spending Trends, and Outlook to 2028*. https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-use-of-medicines-in-the-us-2024/the-use-of-medicines-in-the-us-2024-usage-and-spending-trends-and-outlook-to-2028.pdf.

[31] Devane, K., Harris, K., & Kelly, K. (2018, May 18). *Patient affordability part one: The Implications of Changing Benefit Designs and High-Cost Sharing*. IQVIA. https://www.iqvia.com/locations/united-states/library/case-studies/patient-affordability-part-one

[32] PhRMA Org. (2022, November 14) *Deductibles and coinsurance drive high out-of-pocket costs for commercially insured patients taking Brand Medicines*. Pg. 5. https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Report-PDFs/G-I/IQVIA-Report-High-OOP-for-Brand-Medicines_November-2022_v2.pdf#page=5

[33] Benefit design decisions are made by ERISA plan sponsors in for about two-thirds of employer sponsored insurance enrollment.

[34] Abaluck, J., & Gruber, J. (2011). Choice inconsistencies among the elderly: Evidence from plan choice in the medicare part D program. *American Economic Review*, *101*(4), 1180–1210. https://doi.org/10.1257/aer.101.4.1180

[35] Yeung, K., Dusetzina, S. B., & Basu, A. (2021). Association of branded prescription drug rebate size and patient out-of-pocket costs in a nationally representative sample, 2007-2018. *JAMA Network Open*, 4(6). https://doi.org/10.1001/jamanetworkopen.2021.13393

Earlier we noted how vertical integration may facilitate anti-competitive actions or strategies to avoid regulatory constraints. Here we address the incentives related to permitting PBMs to retain parts of rebates and price spreads. It is frequently claimed that paying PBMs through rebates and price spread retention creates incentives for PBMs to steer patients to higher list price drugs.

In assessing the incentives and claims about PBM conduct, several points are important. In the discussion of vertical integration, we noted that for 70% of the market, the insurer and the PBM are a single entity. The list-net price gap can lead patients to pay higher prices than the insurer or PBM does when the benefit design consists of deductibles and coinsurance.[36] A GAO study of Part D prices found that PBM pursuit of high rebates frequently leads to patients paying elevated out-of-pocket prices that are higher than the net price paid by the PBM and higher than the lowest out-of-pocket cost drug in a class.[37] In the extreme case, out-of-pocket prices can exceed to cost of goods sold to the pharmacy. Data presented earlier suggests that the changes in health insurance benefit designs for prescription drugs have contributed to many harms experienced by consumers.

Next, I examine the proposition that insurers and employers pay more because PBM fees are in part paid for through the retention of rebates and price spreads. To substantiate those claims, one needs to compare net prices for the high list price drugs and those with lower list prices. The evidence is limited but data from Medicare Part D suggests that Medicare benefits from lower net prices for highly rebated drugs relative to competitor products with lower list prices. Making similar comparisons in the larger context of commercial coverage is difficult because net prices are closely guarded secrets by PBMs.

Since the retention of rebates and price spreads is frequently part of a negotiated arrangement between insurers and other payers with PBMs, reducing the ability to retain rebates and price spreads would likely result in increased administrative fees. That might result in some attenuation in list price growth but would also reduce the incentive for PBMs to drive hard bargains. So, there is a trade-off between regulating how fees are set and the potential to limit PBM profits against incentives for cost control and supply of "extra services."

Spread pricing is mostly focused on generic drugs. This is because pharmacies have the most bargaining power with generic manufacturers in competitive markets. Generic drugs in this sense are commodities. This is what enables spread pricing. This applies to all pharmacies. Retail, mail order, and specialty pharmacies are all in positions to negotiate low prices with manufacturers and then charge insurers a price above the negotiated cost of goods sold. Vertical integration often makes the PBM the conduit of the price paid to the pharmacy. Yet non-integrated pharmacies, especially chain retail pharmacies, also have market power in price negotiations with generic drug manufacturers.

Steering and the Economic Status of Retail Pharmacies

Steering has also been associated with the disadvantaging of independent pharmacies. Such steering has been connected by some to the decline in the availability of independent pharmacies in rural America and the greater potential for pharmacy deserts. Independent pharmacies face a variety of economic forces that exert pressure on their revenues and ability to survive in the marketplace. These include competition from mail order pharmacies, smaller scale, less robust purchasing arrangements than chain pharmacies, and

[36] As discussed earlier this requires that coinsurance and deductibles are fixed, that is consumers do not switch to avoid what they view as excessive cost-sharing.

[37] U.S GAO. (2023, September 5) *Medicare part D: CMS should monitor effects of rebates on plan formularies and beneficiary spending.* https://www.gao.gov/assets/gao-23-105270.pdf.

pricing pressures. Steering directed by PBMs clearly affects the degree of competition from mail order pharmacies and the level of dispensing fees. The use of "drip pricing" in the form of so-called DIR adjustments post-transaction has been cited by the FTC and others as creating special difficulties for independent retail pharmacies.[38]

Despite the claims, the available evidence on the role of PBMs in affecting the fortunes of independent retail pharmacies is not clear. Specifically, independent pharmacy supply has declined in rural areas relative to chain pharmacies but has increased more than chains in metropolitan areas.[39] PBMs manage pharmacy benefits in both types of markets. Thus, the attribution of such changes in the fortunes of independent pharmacies is hard to establish. An analysis of the state of rural pharmacies in the U.S. reports that about 50% of rural pharmacies are independently owned and operated. That research shows that rural independent pharmacies declined 16.1% from 2003 to 2021; while rural chain pharmacies grew 4.6%. During the same time, independent pharmacies grew 28% in metropolitan areas compared to 10.5% for chain pharmacies. Data on gross margins for prescriptions dispensed by independent pharmacies shows that they have remained steady between 20.8% and 21.1% from 2016 through 2020.[40]

In considering the role of PBMs and other economic forces in affecting the supply of independent pharmacies one must acknowledge that there are some important scale differences between various types of retail pharmacies that are likely to affect the efficiency of pharmacy services. The average chain drug store dispenses about 138,000 prescriptions per year. Grocery store pharmacies dispense an average of about 91,000 prescriptions per year, while independent pharmacies dispense about 48,000 on average.[41] These differences likely create cost advantages for the larger chain stores. Finally, the purchasing power of chains has been estimated to result in margin advantages of 2% to 6%. This data makes sorting out the net impact of PBM policies on the financial status of independent pharmacies challenging.

Beyond the uncertain role of PBMs in the economic status of retail pharmacies is the fact that retail pharmacies like the rest of the supply chain have become more concentrated and as a result often have market power. Keeping the exertion of that market power in check serves to benefit payers and consumers alike.[42]

A Comment on Profitability of PBMs and Prescription Drug Affordability

The profits of PBMs (and in turn their parent companies) have been pointed to as being an important part of the prescription drug affordability problem. Estimates of operating margins of the largest PBMs have in recent years ranged from 4% to 6%. Those estimates include the PBM services, specialty pharmacy and

---

[38] See FTC report: Federal Trade Commission. (2024, July 9). *Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing Main Street pharmacies.* https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[39] Lazaro, E., Ullrich, F., & Mueller, K. J. (2022, August). Update on Rural Independently Owned Pharmacy Closures in the United States, 2003-2021. *Rural Health Research & Policy Center, University of Iowa.* https://iro.uiowa.edu/esploro/outputs/report/Update-on-Rural-Independently-Owned-Pharmacy/9984388646502771

[40] Fein, A. J. (2022, February 15). Five things to know about the state of Independent Pharmacy Economics. Drug Channels. https://www.drugchannels.net/2022/02/five-things-to-know-about-state-of.html

[41] Ladsariya, A., McLeod, A., Sahni, N., Tevelow, B., & Noh, G. (2023, March 17). Meeting changing consumer needs: The US retail pharmacy of the future. *McKinsey & Company.* https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/meeting%20changing%20consumer%20needs%20the%20us%20retail%20pharmacy%20of%20the%20future/meeting-changing-consumer-needs-the-us-retail-pharmacy-of-the-future-f.pdf

[42] See Starc and Swanson Note 12

mail order earnings.[43] The PBM trade association or Pharmaceutical Care Management Association (PCMA) commissioned a study by Visante that included a larger number of PBMs and excluded mail order and specialty pharmacy earnings. They reported accounting for 6% of the drug dollar and 2% due to profit.[44] Since much of what is counted as revenues for the PBM are pass throughs of payments made by insurers and employers, PBM profits only make up a small portion of the nation's prescription drug spending. As my colleagues and I have previously stated, PBMs may nevertheless be exercising market power and regulatory avoidance strategies to gain excess returns and reduce market efficiency.

Take Aways

Addressing the ills associated with PBMs noted here are well worth addressing, but it is important to recognize that successfully remedying those ills would have only a modest impact on the affordability of prescription drugs in the U.S. There are however meaningful benefits to individuals, public programs, and other payers from improving the competitive environment within which PBMs operate. In considering policy actions it is important to recognize that many of the troubling features of how the prescription drug supply chain is managed today are related to new and existing market dynamics in health insurance. Key among the changes is vertical integration alongside increased PBM concentration. The avoidance of regulation related to margins in health insurance like the MLR coupled with the ownership of related businesses by insurers and their parent companies, potential distortions in formulary and drug benefit designs motivated by insurer selection incentives, and the changing shape of cost-sharing arrangements, all have their origins in markets for health insurance.

A great deal of discontent has focused on rebates. Yet rebates are common features of negotiated contracts. And while it is important to be attentive to the exertion of market power in those negotiations, the incentives to drive hard bargains on behalf of payers created by rebates should be recognized. The lack of transparency associated with rebates is frustrating, yet private negotiations can also yield benefits to premium payers, taxpayers, and patients. Finding the right level and type of transparency to enhance the bargaining power of smaller purchasers where complex PBM contracts serve to disadvantage them while retaining the ability to get the best deals would improve matters but is very challenging to implement. One focal point might be the composition of products and utilization patterns offered under competing PBM contracts.[45]

The harms to patients are directly related to the cost-sharing arrangements in the insurance design. Self-insured employer health plans and health insurers each have a great deal of say about those arrangements. Reduced reliance on deductibles and coinsurance can go a long way toward mitigating the harms to patients associated with rebates.

Finally, the recent FTC report highlighted potential harms to retail pharmacies. There are important policy concerns about the appearance of pharmacy deserts, especially in rural America. It is also clear that independent pharmacies are what stand in the way of rural areas experiencing a larger number of pharmacy deserts. Pharmacy deserts disproportionately affect lower-income, non-white, and older adult populations.[46]

---

[43] See Fiedler M., Adler L., Frank R.G (2023, September 7). A brief look at current debates about pharmacy benefit managers. *Brookings Institution*. https://www.brookings.edu/articles/a-brief-look-at-current-debates-about-pharmacy-benefit-managers/ (4.0%+); author's calculation from CVS, Cigna, and United Health Group end of year 2023 10K filings (4.0%-5.1%), and 2018 Express Scripts filings (5.8%).

[44] Visante. (2023, January). *The return on investment (ROI) on PBM Services*. https://www.pcmanet.org/wp-content/uploads/2023/01/The-Return-on-Investment-ROI-on-PBM-Services-January-2023.pdf

[45] For a more extended discussion of this see: Fielder, Adler, Frank op cit. Note 42.

[46] Constantin J., Ullrich, F., & Mueller, K. J. (2022, August). Rural and Urban Pharmacy Presence—Pharmacy Deserts. *Center for Rural Health Policy Analysis, University of Iowa*. https://iro.uiowa.edu/esploro/outputs/report/Rural-and-Urban-Pharmacy-Presence/9984388644902771

There are, however, significant economic forces threatening the supply of independent pharmacies in rural America that are not the result of PBM conduct. There is little reason to believe that PBMs are the main economic force creating these risks. Moreover, there is market power in the supply chain, including in retail pharmacies. Consumers and payers benefit from institutions that constrain the exertion of that market power.

Mr. MASSIE. Thank you, Dr. Frank.

Dr. Van Nuys, you are now recognized for your statement.

STATEMENT OF DR. KAREN VAN NUYS

Dr. VAN NUYS. Chair Massie, Ranking Member Correa, and the honorable Members of the Subcommittee, thank you for the opportunity to testify about pharmacy benefit managers in our healthcare system.

I'm an economist and have been researching pharmaceutical distribution economics at the USC Schaeffer Center for the last decade. The opinions I offer here today are my own.

PBMs play a crucial role in our healthcare system. They are key intermediaries managing drug benefits, negotiating rebates, designing formularies, and processing claims. Their central role in the system affords them unique access to data about nearly every transaction in the value chain.

The industry's current structure and practices raise significant concerns about market power, pricing distortions, and misaligned incentives that may raise costs for patients, employers, and taxpayers while stifling competition.

Today, three PBMs handle about 80 percent of the U.S. retail prescription market. All three are vertically integrated with large insurers, specialty pharmacies, and other healthcare entities. Those three vertically integrated companies ranked 4th, 6th, and 16th in the Fortune 500, accounting for nearly a trillion dollars in revenue.

This concentration of market power combined with extensive vertical integration has enabled several concerning practices. I'll give some examples.

First, although PBMs are supposed to lower drug costs, we found that involving a PBM increases generic drug costs. We discovered that Medicare could have saved $2.6 billion in 2018 on the most common generic drugs if they had been purchased at Costo for cash. On average, Medicare overpaid by 21 percent.

Second, the current rebate system is driving up branded list prices. We found that between 2014–2018, insulin list prices rose 40 percent, while the net prices taken home by manufacturers fell 31 percent. Those 31 percent savings that PBMs were negotiating for manufacturers were not passed on. They were absorbed by the PBMs and other intermediaries. Over five years, the share of insulin spending captured by PBMs and other intermediaries more than doubled.

Third, we've seen PBMs steer patients to higher-cost drugs. They have given more favorable formulary placement to expensive brand-name drugs over lower-cost generics or biosimilars, likely due to the larger rebates offered on higher-priced products.

Fourth, spread pricing, where PBMs charge health plans more than they pay pharmacies and pocket the difference, enables PBM to hide their true compensation. A 2018 Ohio State audit found PBMs charged 31 percent average spreads for generic drugs in its Medicaid managed care system.

Finally, PBMs are increasingly restricting access to medications. Schaeffer researchers found that from 2011–2020, the share of drugs restricted in Medicare Part D plan formularies rose from 32–44 percent.

The impact of these inefficiencies in the PBM market is far-reaching. Federal programs like Medicare and Medicaid are overpaying for drugs, increasing costs for taxpayers. Employers are struggling to assess whether they're getting value for money from their PBMs. Consumers are facing higher out-of-pocket costs and restricted access to medications, and uninsured individuals are paying inflated cash prices that may put needed medications out of reach.

I recommend several policy options to address these market inefficiencies.

First, we need more transparency. This means requiring greater disclosure of rebates and true net pricing to PBM clients. CMS should be authorized to develop and publish high-quality average net price benchmarks by drug for key supply chain transactions.

Second, we need to reevaluate the current rebate system and develop alternatives that better align with patient and payer interests. We should ensure that patient out-of-pocket expenditures are based on post-rebate prices.

Third, we need to scrutinize vertical integration in the PBM industry more closely. This includes investigating practices that weaken standalone competitors. Finally, we must explore ways to align PBM incentives with the interests of patients and payers. This could involve changing how PBMs are compensated or imposing fiduciary requirements on them.

In conclusion, while PBMs play a crucial role in our healthcare system, the current industry structure raises significant concerns about the impact on drug prices, patient access, and overall health costs. By implementing these policy recommendations, we can better harness the potential benefits of PBMs for the benefit of patients, employers, workers, and taxpayers.

Thank you. I'm happy to answer your questions.

[The prepared statement of Dr. Van Nuys follows:]

USC Schaeffer
Leonard D. Schaeffer Center
for Health Policy & Economics

Testimony of Karen Van Nuys, Ph.D.

Senior Scholar and Executive Director of the Value of Life Sciences Innovation Program,
Leonard D. Schaeffer Center for Health Policy & Economics
University of Southern California

Before the

U.S. House Judiciary Subcommittee on the
Administrative State, Regulatory Reform, and Antitrust

The Role of Pharmacy Benefit Managers: Market Power, Pricing Practices, and Policy Implications

September 11, 2024

Key Points:

- **The PBM industry is highly concentrated and vertically integrated:** Three PBMs control about 80% of the market, raising concerns about limited competition and innovation. Major PBMs are part of conglomerates including insurers, pharmacies, and healthcare providers, creating potential conflicts of interest and opportunities for self-dealing.

- **This market structure allows for problematic drug pricing practices**: PBMs often increase costs for generic drugs, inflate brand drug list prices through the rebate system, steer patients to higher- rather than lower-cost drugs, and engage in opaque spread pricing. These practices obscure drugs' true costs and lead to higher drug expenditures.

- **PBMs' unique market powers can impact patient access to medications**: PBMs are increasingly restricting patient access to therapies through utilization management policies like prior authorization and formulary exclusions.

- **As a result, many stakeholders are negatively impacted**: These practices negatively affect federal programs, employers, consumers, and uninsured individuals by increasing costs and potentially reducing access to medications.

- **Policy recommendations**: Suggestions include increasing transparency, reevaluating the rebate system, scrutinizing vertical integration, and better aligning PBM incentives with patient and payer interests.

University of Southern California
635 Downey Way, VPD 312, Los Angeles, California 90089-3333 • Tel: 213 821 7940

Chairman Massey, Ranking Member Correa, and Honorable Members of the Subcommittee, thank you for the opportunity to testify today about the role of pharmacy benefit managers (PBMs) in our healthcare system. My name is Karen Van Nuys, and I am an economist and Senior Scholar at the Leonard D. Schaeffer Center for Health Policy & Economics, where I also direct the Value of Life Sciences Innovation research program. The opinions I offer today are my own and do not represent the views of the University of Southern California or the USC Schaeffer Center.

The central theme of my testimony today is that while PBMs play a crucial role in our pharmaceutical distribution system, the industry's current structure and practices raise significant concerns about market power, pricing distortions, and misaligned incentives. These issues ultimately lead to higher costs for patients, employers, and taxpayers, while stifling competition in the healthcare sector and impacting patient access to the medications they need.

Background on PBMs

PBMs emerged as simple claims processors in the 1960s but have evolved to become key intermediaries in the pharmaceutical supply chain. Today, they manage drug benefits for health plans and employers, negotiate rebates with manufacturers, design formularies, develop and maintain pharmacy networks, and process prescription claims. This evolution has been marked by significant consolidation and vertical integration with other parts of the healthcare value chain, fundamentally changing the industry's dynamics.

Over the last several decades, PBMs have dramatically increased their size and leverage. Today, just three PBMs handle about 80% of prescriptions filled in the U.S. (1), and all three are vertically integrated with large insurers, specialty pharmacies, mail-order pharmacies, rebate aggregators, and healthcare providers. (2) Some also include retail pharmacies and drug repackaging and marketing subsidiaries. In fact, the top three PBMs are part of companies that rank #4, #6, and #16 on Fortune's list of the largest public companies in America. (3) Together, they account for nearly $1 trillion in revenues, or 21% of US healthcare expenditures. (4)

This concentration of market power combined with extensive vertical integration raises significant concerns. While PBMs' scale helps them negotiate with drug manufacturers, and their integration could theoretically produce efficiencies, these characteristics also enable them to potentially suppress competition and discourage new, innovative market entrants. The implications of this market structure extend far beyond the PBM industry itself, affecting drug prices, patient access, and overall healthcare costs.

Key Concerns About PBM Practices

Our research at the Schaeffer Center has identified several concerning practices that stem from PBMs' market power and positioning:

1. Increasing generic drug costs

One might expect that PBMs' negotiating power would lead to lower drug prices across the board. However, our research finds this is not the case, with specific evidence from the generic drug market. A study we published in JAMA Internal Medicine in 2021 found that Medicare could have

saved $2.6 billion in 2018 on just 184 common generic drugs if they had been purchased at Costco cash prices instead of through Medicare Part D plans. Remarkably, involving the PBM and health plan increased average costs by 21%. (5)

This finding is particularly troubling because generic drug markets are intended to be a corner of our pharmaceutical system where competitive forces are harnessed to bring drug prices down. The Hatch-Waxman Act explicitly held out the promise of inexpensive generics to justify the patent protections it granted to brand-name drugs. If PBMs are inflating the cost of generics, it undermines this fundamental tradeoff in our drug pricing system.

2. Increasing brand drug list prices through the rebate system

For competitive classes of brand-name drugs, PBMs negotiate confidential rebates with manufacturers in exchange for preferred formulary placement. While this might seem like it would lower costs, in practice we've seen it create perverse incentives that lead to higher list prices: as manufacturers compete for better formulary positions by offering PBMs bigger rebates, list prices rise to accommodate those higher rebates.

Our research on insulin prices illustrates this dynamic. We found that between 2014 and 2018, insulin list prices rose 40% while net prices received by manufacturers fell 31%. Importantly, those savings that PBMs were negotiating from manufacturers did not translate into lower overall expenditures per unit of insulin – instead, they were absorbed by PBMs and other distribution intermediaries. During this period, the share of insulin spending captured by PBMs and other intermediaries more than doubled, from $31.29 out of every $100 spent on insulin in 2014 to $53.27 in 2018. PBMs' share alone grew 155%, from $5.64 to $14.36. (6)

This perverse dynamic doesn't just affect insulin. A 2021 study by my Schaeffer colleagues published in JAMA Network Open found that the most competitive drug classes feature the fastest growth in list prices. List prices grew 11.1% annually for off-patent drugs with multiple molecules in the same class, compared to 10.8% for on-patent drugs in single-molecule classes and 9.3% for on-patent drugs in multi-molecule classes. (7) This counterintuitive result – higher list price growth in more competitive markets – illustrates the perverse incentives created by the current system of confidential rebates.

3. Steering patients to higher- rather than lower-cost drugs

The rebate system not only inflates list prices but can also lead PBMs to steer patients to more expensive drugs through their coverage policies. There are numerous examples of PBMs giving more favorable formulary placement to expensive brand-name drugs over lower-cost generics or biosimilars, likely due to the larger rebates offered on the higher-priced products. Humira biosimilars provide a recent example: although biosimilars became available in early 2023, CVS Caremark did not exclude the originator Humira from most of its commercial formularies until April 2024.[1] (8) During that delay, the PBM was continuing to collect the rebates on the originator product. And such examples are not occasional anomalies: a study of Medicare Part D formularies found that 72% of them placed at least one branded product in a lower cost-sharing tier than its generic equivalent. (9)

[1] After excluding Humira, the preferred adalimumab options included Hyrimoz, a biosimilar version jointly marketed through its own subsidiary, Cordavis.

This practice can significantly increase costs for both patients and the healthcare system as a whole. It also undermines the cost-saving potential of generic and biosimilar competition, potentially discouraging investment in these lower-cost alternatives.

4. Hiding PBM compensation through spread pricing

Another practice that has received much attention is spread pricing. Spread pricing occurs when PBMs charge health plans more for a drug than they reimburse pharmacies, pocketing the difference. The health plan doesn't see what the pharmacy is paid, so does not know how much spread the PBM is pocketing. As a result, the plan lacks a clear understanding of the full amount it is paying for PBM services. In 2018, a state audit in Ohio found PBMs charged 31% average spreads for generic drugs in its Medicaid managed care system. (10) In response, the Ohio Department of Medicaid moved to a single PBM to administer managed care drug benefits, and eliminated the opaque practice of spread pricing. This practice not only increases costs for health plans and taxpayers but also puts financial pressure on pharmacies, especially smaller independent ones.

5. Collecting copayments exceeding the cost of the drug

While now somewhat restricted by federal gag clause legislation, the practice of copay clawbacks illustrates how PBMs have historically leveraged opaque pricing against patients' interests. We found that in 2013, 23% of prescriptions in a commercial claims dataset involved a patient copay that exceeded the total cost of the drug to the PBM, with the PBM keeping the overpayment. When an overpayment occurred, it averaged $7.69 per claim. (11) Before they were outlawed, gag clauses in contracts between PBMs and pharmacies would prohibit pharmacists from telling patients when their copayment was more than the cash price for the drug.

6. Restricting access

Over the last decade, PBMs have increasingly restricted patients' access to therapies through utilization management policies like prior authorization, step therapy and formulary exclusions. In a recent study of Medicare Part D plan formularies, my colleagues and I found that the share of compounds restricted in non-protected classes rose from an average of 31.9% in 2011 to 44.4% in 2020. (12) Formulary exclusion, the most extreme form of utilization management, has been imposed especially aggressively: By 2020, Medicare plan formularies excluded an average of 44.7% of brand-name-only compounds. Interestingly, drug formularies for Medicare Advantage plans, which are also responsible for patients' hospital and other medical costs, were significantly less restrictive than those for standalone Medicare drug plans. While formulary management to encourage therapeutic competition makes sense, such aggressive utilization management may come at the expense of higher medical expenditures.

These practices, taken together, paint a picture of an industry that has used its market power and unique position in the pharmaceutical supply chain in a way that raises rather than lowers costs for patients, taxpayers, and other stakeholders in the healthcare system.

Horizontal and Vertical Integration

The concerns raised by PBM practices are amplified by the industry's high level of both horizontal and vertical integration.

Horizontal integration in the PBM industry has resulted in just three companies controlling about 80% of the market. (1) Using national retail prescription data from 2023, Schaeffer researchers found that market concentration levels exceed the Department of Justice's and Federal Trade Commission's threshold for "highly concentrated" markets overall and by payer type: commercial, Medicare Part D, and Medicaid managed care insurance. (13) This high level of concentration raises concerns about limited competition and innovation in the PBM market itself. Indeed, these concerns were raised in 2012 when the Federal Trade Commission investigated but ultimately declined to block the merger between two of the three largest PBMs, Express Scripts and Medco Health Solutions. (14) At the time, a dissenting opinion expressed one commissioner's belief that the merger would have anticompetitive effects, and called on the Commission to, in three years' time, "conduct a thorough analysis of this industry to determine if prices to employers in fact have gone down….I believe—with deep sadness and concern—that will not prove to be the case." (15) While no analysis was conducted after three years, that belief now seems prescient.

Vertical integration adds another layer of complexity. The largest PBMs are now part of conglomerates that include health insurers, specialty pharmacies, mail-order pharmacies, healthcare providers, and rebate aggregators. (2) In some cases, PBMs are part of corporate families that include retail pharmacy chains and subsidiaries that commercialize, market and distribute drug products. This integrated architecture creates many potential conflicts of interest and opportunities for anti-competitive behavior. For example:

- A vertically integrated PBM can steer the most profitable prescriptions to their affiliated pharmacies (16), or steer patients to their own mail-order pharmacy, as suggested by evidence in recently released reports from both the FTC and House Oversight Committee. (17,18)
- An insurer in a vertically integrated company can use spread pricing to shift profits into its affiliated PBM or pharmacy to avoid the medical loss ratio restrictions imposed by the Affordable Care Act. (19)
- A vertically integrated PBM can prefer the biosimilar marketed by its own subsidiary on its formularies over one that is lower cost, thereby blocking competition from other biosimilar manufacturers and raising overall costs. (8)
- A vertically integrated company may negotiate manufacturer rebates through its offshore GPO, thereby shielding those rebates from U.S. transparency requirements and regulatory scrutiny. (18)

Thus, both horizontal and vertical integration allows these companies to leverage their market power across multiple segments of the healthcare system. This can create barriers to entry for potential competitors and may enable anticompetitive practices that are difficult to detect due to the opaque nature of PBM contracts and pricing.

Impacts of Inefficiencies in the PBM Market

Our research suggests that excessive PBM market power has significant adverse impacts on various healthcare system stakeholders:

- Federal programs: Medicare and Medicaid are overpaying for drugs, particularly generics, due to PBM practices. (5) This increases costs for taxpayers and threatens the sustainability of these crucial programs.

- Employers: Lack of transparency in PBM contracts and misalignment of incentives between PBMs and their clients make it difficult for employers to assess whether they're getting value for money, potentially leading to higher healthcare costs for businesses and their employees.

- Consumers: Patients face higher out-of-pocket costs due to inflated list prices and unfavorable formulary designs, particularly in high-deductible plans. (20) They also face tightening restrictions on the drugs they can access through insurance. (12) Both can lead to reduced medication adherence and poorer health outcomes.

- Uninsured individuals: Those without insurance pay inflated cash prices that reflect inflated list prices and other markups, potentially putting necessary medications out of reach.

Policy Implications and Recommendations

The issues I've outlined today call for serious consideration of policy reforms. While PBMs can and do provide valuable services, the current structure of the industry has created misaligned incentives and opportunities for rent-seeking behavior that increase costs for patients, employers, and taxpayers.

I recommend the following areas for policy consideration:

1. **Increase transparency:** Require greater transparency to PBM clients of contract terms, rebates, and true net pricing, so that they can better assess the value that PBMs are offering. HHS should also develop and publish high-quality, public benchmarks for average prices, by drug, for key transactions in the supply chain. These benchmarks could be modeled on the existing, publicly-available National Average Drug Acquisition Cost series (NADAC) which was created to help Medicaid programs ensure they are getting fair prices for prescription drugs. A weekly survey is used to understand what pharmacies are paying, on average, to acquire drugs; these averages are published and used as inputs to determine Medicaid reimbursements. A similar process could be used to generate similar benchmarks of what PBMs are paying pharmacies, what they are charging plans, and what they are collecting from manufacturers in rebates and fees. These average benchmarks should be made widely available. Survey responses should be made mandatory to better ensure that data collected is representative and accurate.

Such benchmarks would provide important context for PBM clients to evaluate their PBMs' performance, facilitate price shopping, and intensify competitive pressure on PBM market players. They will also enable policymakers and researchers to identify potential abuses.

2. **Reevaluate the current rebate system:** The current system of confidential rebates drives up list prices, increases patients' out-of-pocket burden, and distorts market incentives. Policymakers should consider alternatives that better align with patient and payer interests. Patient out-of-pocket expenditures should be based on post-rebate prices.

3. **Scrutinize vertical integration:** The potential for anticompetitive effects from vertical integration in the PBM industry is significant, and warrants close antitrust scrutiny. Regulators should investigate practices that weaken standalone competitors, such as steering the most lucrative patients or prescriptions to affiliated pharmacies, or giving preferred formulary placement to one's own biosimilar product rather than a cheaper biosimilar from an unaffiliated manufacturer.

4. **Align incentives:** Explore ways to better align PBM incentives with the interests of patients and payers, including changing how PBMs are compensated, or imposing fiduciary requirements on PBMs.

Conclusion

The pharmaceutical distribution system, with PBMs at its center, plays a crucial role in delivering life-saving medications to patients. However, the current structure of the PBM industry, characterized by high concentration, vertical integration, and opaque business practices, raises significant concerns about its impact on drug prices, patient access, and overall healthcare costs.

Policymakers should consider reforms that will benefit patients and healthcare purchasers, including those that will promote competition, provide information that payers and patients need to make sound economic decisions, and improve patients' access to the treatments prescribed by their doctors. By doing so, we can better harness the potential benefits of PBMs – their ability to negotiate lower prices and manage complex drug benefits – for the benefit of patients and those who ultimately pay for their healthcare: US employers, workers, and taxpayers.

Thank you for the opportunity to testify. I would be happy to answer any questions.

SOURCES:

1. Fein AJ, Ph.D. The Top Pharmacy Benefit Managers of 2023: Market Share and Trends for the Biggest Companies—And What's Ahead [Internet]. [cited 2024 Sep 9]. Available from: https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html

2. Drug Channels: Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: A May 2024 Update [Internet]. [cited 2024 Sep 9]. Available from: https://www.drugchannels.net/2024/05/mapping-vertical-integration-of.html

3. Fortune 500 – The largest companies in the U.S. by revenue | Fortune [Internet]. [cited 2024 Sep 9]. Available from: https://fortune.com/ranking/fortune500/

4. National Health Expenditures 2022 Highlights | CMS [Internet]. [cited 2024 Sep 9]. Available from: https://www.cms.gov/newsroom/fact-sheets/national-health-expenditures-2022-highlights

5. Trish E, Gascue L, Ribero R, Van Nuys K, Joyce G. Comparison of Spending on Common Generic Drugs by Medicare vs Costco Members. JAMA Internal Medicine. 2021 Oct 1;181(10):1414–6.

6. Van Nuys K, Ribero R, Ryan M, Sood N. Estimation of the Share of Net Expenditures on Insulin Captured by US Manufacturers, Wholesalers, Pharmacy Benefit Managers, Pharmacies, and Health Plans From 2014 to 2018. JAMA Health Forum. 2021 Nov 5;2(11):e213409.

7. Lakdawalla D, Li M. Association of Drug Rebates and Competition With Out-of-Pocket Coinsurance in Medicare Part D, 2014 to 2018. JAMA Network Open. 2021 May 5;4(5):e219030.

8. Drug Channels: Humira Biosimilar Price War Update: Should We Be Glad that CVS Health and Express Scripts Are Using Private Label Products to Pop the Gross-to-Net Bubble? [Internet]. [cited 2024 Sep 9]. Available from: https://www.drugchannels.net/2024/09/humira-biosimilar-price-war-update.html

9. Socal MP, Bai G, Anderson GF. Favorable Formulary Placement of Branded Drugs in Medicare Prescription Drug Plans When Generics Are Available. JAMA Internal Medicine. 2019 Jun 1;179(6):832–3.

10. Yost D. Ohio's Medicaid Managed Care Pharmacy Services - Auditor of State Report [Internet]. Auditor of State; 2018 Aug [cited 2024 Sep 9]. Available from: https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf

11. Van Nuys K, Joyce G, Ribero R, Goldman DP. Frequency and Magnitude of Co-payments Exceeding Prescription Drug Costs. JAMA. 2018 Mar 13;319(10):1045–7.

12. Joyce G, Blaylock B, Chen J, Van Nuys K. Medicare Part D Plans Greatly Increased Utilization Restrictions On Prescription Drugs, 2011–20: Study examines Medicare Part D restrictions. Health Affairs. 2024 Mar 1;43(3):391–7.

13. Qato D, Chen Y, Van Nuys K. Pharmacy benefit manager market concentration for prescriptions filled at US retail pharmacies. JAMA. 2024 Sep 10;(Online).

14. FTC. Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc. [Internet]. Federal Trade Commission; 2012 [cited 2024 Sep 9]. Available from: https://www.ftc.gov/sites/default/files/documents/public_statements/statement-commission-concerning-proposed-acquisition-medco-health-solutions-express-scripts-inc./120402expressmedcostatement.pdf

15. Brill J. Dissenting Statement of Commissioner Julie Brill Concerning the Proposed Acquisition of Medco Health Solutions Inc. (Medco) by Express Scripts, Inc. (ESI) [Internet]. FTC; 2012 [cited 2024 Sep 9]. Available from: https://www.ftc.gov/sites/default/files/documents/public_statements/dissenting-statement-commissioner-julie-brill/120402medcobrillstatement.pdf

16. Three Axis Advisors. Understanding Pharmacy Reimbursement Trends in Oregon [Internet]. Three Axis Advisors; 2022 Oct [cited 2024 Sep 9]. Available from: https://oregonpharmacy.org/wp-content/uploads/2022/10/Oregon_Report_20221027-FINAL.pdf

17. Federal Trade Commission [Internet]. 2024 [cited 2024 Sep 9]. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. Available from: https://www.ftc.gov/reports/pharmacy-benefit-managers-report

18. Staff. The Role of Pharmacy Benefit Managers in Prescription Drug Markets [Internet]. House Committee on Oversight and Accountability; 2024 Jul [cited 2024 Sep 9]. Available from: https://oversight.house.gov/wp-content/uploads/2024/07/PBM-Report-FINAL-with-Redactions.pdf

19. Medicare Advantage spending, medical loss ratios, and related businesses: An initial investigation [Internet]. [cited 2024 Sep 9]. Available from: https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/

20. Mallatt J, Dunn A, Fernando L. Consumer Out-Of-Pocket Drug Prices Grew Faster Than Prices Faced By Insurers After Accounting For Rebates, 2007–20. Health Affairs. 2024 Sep;43(9):1284–9.

Mr. MASSIE. Thank you, Dr. Van Nuys.

I now recognize the—oh, sorry. We will now proceed under the five-minute rule with questions, and I now recognize the gentlewoman from Indiana for five minutes.

Ms. SPARTZ. Thank you, Mr. Chair. I appreciate having this hearing, and I hope we will have a good discussion. I know we had a lot of about—discussion about competition and consolidation, and since we talked about Plato, I have to mention Aristotle, about his oligarchs and oligopoly issues that he discussed when we have business controlling the government.

That is what is happening in healthcare. Unfortunately, we don't have the markets. We have oligopolies in each sector of healthcare fighting on committees and bankrupting the country and bankrupting the families. So, we need to have a serious discussion. It is going to be destruction of our country.

Healthcare became the biggest driver of our national debt and debt of American families, one of seven families on insolvency for medical debt. We right now have hyperinflation of price, and the system is going to blow up. A lot of my colleagues on the other side will offer complete government takeover, which is going to be a terrible solution.

We need to have a solution, as you know, I am glad that the Chair—the minority leader of the Committee mentioned about Affordable Care Act, Obamacare—but as you know, that actually drove consolidation hospitals. As you know, maybe not, it was a bad intent, but a lot of payments were to consolidate the market through Medicare. We have seen what's happening.

A lot of you know what site neutrality does with hospital overbilling, Medicare, roughly 300 billion effects our budget. Then Biden enslaved doctors. Let's talk about, recently, Inflation Reduction Act—we give a huge subsidy to big insurance and subsidize their profits. So, premiums—that is another 300 billion hit to the budget.

So, we now have a huge problem there. We need to have discussions, not look for the evils. There was a reason that PBMs were created. They are not doing their job, too. They are not passing along their rebates to consumer. We do not have competition in that market. Everyone is making a lot of money, and country is going bankrupt.

This is a big problem, whether it is through government—but it is a government-created monopoly. We are subsidizing through Medicare, through Medicaid, through all the bills, create barriers of entry, Affordable Care Act, even though physicians cannot own hospitals. Well, physicians can be owned by a hospital, but cannot own hospitals—and a lot of mandates and insurance in all the industry.

So, we need to have a serious discussion. I appreciate you being open-minded because we all have in it together. We need to get all the stakeholders to the table, not look who is evil, because it is like a balloon. It is going to pop-pop on the other side because we have enormous opportunity for innovation, and we have to have. This is what changed Americans' lives. It helps us to be a healthy country.

We have to have competition for value and outcomes, not wait until person gets so sick and keep them alive. As long as they are

not dead, they are very profitable. People serve a system. This became so corrupt. We have to have a bipartisan conversation, and I hope we can.

I hope people in your industries will be able to step up because it is very difficult to do it here. As I always say, there is no lobby for the people here, OK? We are supposed to be the lobby. So, appreciate a lot of my Republican colleagues bringing some transparency and conversation. So, I hope my Democrat colleagues will join in some of these discussions because we have to save healthcare.

So, my question that I want maybe goes from looking from a PBM perspective and some other ones, if you would look from some of the key issues including in—because I understand we are going to eliminate PBMs. Big pharma is going to do whatever they want. They were the ones that created it, right? What would you do to make sure that we don't create where we do is a lot of regulating PBMs more, giving insurance commissioners more power, create that—they just go lobby more State houses and write bigger checks in the State house. There will be oligopolies protected at the State level, OK?

So, this is not a solution. So, what can we do in that particular industry to make sure that we have a competition for value and help people have access to proper medication, that we have more choices for consumer, and be able to have innovative solution entering that, and how the PBM market can be more competitive?

So, Dr. LoSasso, I start with you. I think I have almost run out of time, so if you briefly can think quickly, sir, because you have a need to be very quick.

Dr. LOSASSO. Thank you, Congresswoman. Well, there's a lot there. I think that you definitely raised some important points there. I think we do want to have a system that allows for competition in the drug space that represents a meaningful counterweight to, as mentioned earlier, the monopoly privilege that pharmaceutical companies have with patent protection.

So, I guess I would say just be very cautious—in closing, be very cautious about how you go about trying to regulate it because we've seen many instances where well-intentioned regulation leads to terrible, unintended consequences.

Mr. MASSIE. The gentlelady yields back, and I will recognize the Ranking Member, Mr. Correa, for five minutes.

Mr. CORREA. Thank you, Mr. Chair.

Our witnesses I can see clearly now. This has clarified the whole picture. Like my colleague from Indiana said, though, PBMs don't work. The Inflation Reduction Act didn't work. Obamacare didn't work.

So, I was trying to legislate from the view that we don't want to do any harm. Do no harm. We want to be careful with the good intentions. There is a lot, a lot, of legislative proposals out there right now, too many of us to look at in this brief time period. I am going to talk about three of them right now, and if I can get some very quick opinions from the four of you as to some of these proposals.

Banning rebates, Ms. Van Nuys—Dr. Van Nuys—good or bad?

Dr. VAN NUYS. I can't give you—

Mr. CORREA. Complicated.

Dr. VAN NUYS. Yes. It's complicated. I'm sorry. It's full industry, but—

Mr. CORREA. Dr. Frank, banning rebates?

Dr. FRANK. I think rebates serve—

Mr. CORREA. Can't hear you.

Dr. FRANK. I think rebates serve a useful purpose. I think they have strong incentives. Coupled with market power, they can create problems.

Mr. CORREA. Banning rebates—yes/no?

Dr. FRANK. No.

Mr. CORREA. Dr. Mattingly, banning rebates?

Dr. MATTINGLY. No. I do think that rebates allow an opportunity to—you want the person negotiating the lower price to have some skin in the game, too. So, it's something we have to debate. Is it 100 percent pass-through that we want back to the health plan, or do we want the PBM to have—

Mr. CORREA. There is an incentive, skin in the game. Don't ban them is what you are saying.

Dr. LoSasso?

Dr. LOSASSO. Short answer, no. Longer answer, rebates themselves are a workaround, a bodge, if you will, that cropped up because—probably arguably Robinson–Patman Act. So, maybe eliminate Robinson–Patman.

Mr. CORREA. OK. Easier said than done. Second, spread pricing. Dr. Van Nuys, eliminate it? Yes or no?

Dr. VAN NUYS. Don't eliminate, but I think introduce transparency.

Mr. CORREA. Dr. Frank?

Dr. FRANK. Transparency is a good idea here.

Mr. CORREA. Was that a no, yes or no, on spread pricing eliminated? Yes/no?

Dr. FRANK. No.

Mr. CORREA. OK. Dr. Mattingly, spread pricing?

Dr. MATTINGLY. No. Same thing. I think there needs to be incentives along the supply chain.

Mr. CORREA. Would you also say transparency?

Dr. MATTINGLY. Absolutely.

Mr. CORREA. OK. Dr. LoSasso, spread pricing, eliminate? Yes/no?

Dr. LOSASSO. It's a no on eliminating spread pricing because it does align incentives, and as it stands right now, payers have the choice. They can offer spread pricing or do fees. They generally choose for spread pricing.

Mr. CORREA. Mr. Chair, I am on a roll here. I think we got some consensus. Let's try a third one here.

Transparency. Dr. Van Nuys, more transparency?

Dr. VAN NUYS. A hundred percent, yes.

Mr. CORREA. Dr. Frank?

Dr. FRANK. I'm a targeted yes. I think that there are private negotiations that have been where you get better prices because they're done privately, but there are a variety of places where transparency would be helpful.

Mr. CORREA. So, private negotiations are good because—

Dr. FRANK. So, for example, rebates are one of the places—the CBO and the Office of the Actuary in HHS both have scored positive costs if you make the rebates fully transparent.

Mr. CORREA. Dr. Mattingly?

Dr. MATTINGLY. I think we need to be very clear. Transparency to whom? Transparency is good, but to whom?

Mr. CORREA. Us. The world. Public.

Dr. MATTINGLY. Yes. So, if it's to the patient—so, often, the customer of the PBM—or the PBM is serving a health plan, like an H.R. director. So maybe we have to talk about, what's the transparency from H.R. to its employees on, like, a self-funded insurance plan or whatnot?

So, we just need to be clear what's the transparency, what we're talking about, as we're writing these regulations.

Mr. CORREA. Dr. LoSasso, transparency? Yes/no?

Dr. LOSASSO. Transparency is not an automatic no-brainer. Yes, I think there—I can go very far afield here and cite a famous study in economics of the Danish ready-mix cement market where prices for cement were mandated by the government to be transparent, and prices subsequently rose because—

Mr. CORREA. Thank you.

Dr. Frank, my 17 seconds left, the FTC interim report provided many examples of harm to healthcare market by PBMs. Can you quickly tell me what the FTC got right and what they got wrong in that report, Dr. Frank?

Dr. FRANK. They raised a lot of potential difficulties. However, the evidence presented is pretty thin.

Mr. CORREA. Out of time. Mr. Chair, thank you very much.

Mr. MASSIE. Thank you. The Member yields back.

Without objection, Ms. Ross will be permitted to participate in today's hearing for the purposes of questioning the witnesses if a Member yields the time for that purpose.

Now, I would like to recognize the gentleman from Wisconsin for five minutes.

Mr. FITZGERALD. Thank you, Mr. Chair.

In the 24 years I was in the Wisconsin State Senate, this issue was something that we worked on, and actually with President involved, and actually tried to move PBM legislation on a couple of occasions.

Unfortunately, what we saw was—in Wisconsin—that there were many—I will call them hometown pharmacies, smaller, independent pharmacies, which—many of my constituents were customers of these pharmacies for many years, loved their pharmacist, right? Very comfortable with the advice they were being given, long-term plans that was integrated with their physicians.

Clearly, what was happening was that the PBMs started to skim. As that happened and they became larger and greater, we started to see pharmacies start to close in Wisconsin, and they ended up at one of the big three, right?

So, Dr. LoSasso, can you talk a little bit about the landscape and where we were maybe 20 years ago compared to where we are now on the vertical integration of PBMs and how they interact with the pharmacies that our constituents deal with all the time?

Dr. LOSASSO. Of course. Thank you, Congressman. So yes. As has been pointed out by folks on this panel and the Members of the Committee, there has been quite a great—quite a lot of vertical market integration going on in the PBM space. This is, again, as has been pointed out, not necessarily a bad thing. There are potential efficiency gains.

I guess I'll speak to this idea that you raise around what I guess I would refer to as contracting—creating selective networks of pharmacies were you could have a pharmacy that is on the outside, will not be part of the network created by the PBM. Selective contracting is a quite old concept in healthcare and other industries as well. What it does is it effectively allows for lower prices that are passed on to consumers, ultimately.

In other words, if a low-efficiency, high-cost pharmacist—pharmacy—cannot meet the terms that the PBM asks of them, they can't be part of the network. What do we do about—I don't know that we do anything about that, to be honest, because I think—do we want to have a system that props up the inefficient providers in markets? I would argue no, that's not a—that should not be a policy goal. So, I guess I'll pause there.

Mr. FITZGERALD. Very good.

In July 2024, the FTC released its Interim Staff Report on PBMs, which concluded that PBMs wield significant power of patients' ability to access affordable drugs. Unlike the 2005 report on PBMs, the report did not have the support of the entire commission.

In fact, Commissioner Holyoak dissented, arguing that the report failed to meet the standards of economic rigor expected of commission reports more generally. Chair Khan argued that the report lacked empirical evidence of a number of factors, including the State of competition in the prescription drug market.

Dr. Frank, you commented on the FTC report and the Commissioner Holyoak's dissent in your testimony. Do you think her concerns about the report were actually legitimate or not?

Dr. FRANK. I commented on her dissent as well as one of her colleagues' dissents to the report. There were multiple places that both commissioners pointed out that the evidence was pretty thin, and it is hard to draw conclusions about, sort of, some of the big points raised in the report. I think that my reading is consistent with that.

Mr. FITZGERALD. Very good.

Just really quick, the Trump-era price transparency rule—that required hospitals to post prices showing their average negotiated rates since 2021. Many of the hospitals that we worked in with Wisconsin have implemented tools on their own. They have kind of created a website so that there is transparency.

Dr. Mattingly, do you believe that a similar price transparency rule for PBMs would be a positive step? Do you think it is being utilized, and would it work?

Dr. MATTINGLY. Yes. I do want to—sorry. I do want to entertain something like that. I think it could be positive. I think it's really important to recognize that for some generic prices, it's maybe helpful. We can look and see what a price of a low-cost generic is,

but if it's a really high-cost-brand medication, knowing what the price is, isn't going to matter if you need that drug.

So, if it's a life-saving medication, it's not going no matter what the price is. You can tell it—you can post it everywhere you want, and I still need it. You know? So, I guess we just got to figure out, when is it actually going to help?

Mr. FITZGERALD. Yes. I yield back.

Mr. MASSIE. I thank the gentleman.

I now recognize the Ranking Member of the Full Committee, Mr. Nadler, for five minutes.

Mr. NADLER. Thank you, Mr. Chair.

Dr. Van Nuys, in your written testimony, you discuss the practice of spread pricing. Could you explain how this practice works and why it is concerning, especially in the context of government programs like Medicaid?

Dr. VAN NUYS. Yes. Spread pricing is the practice where a pharmacy benefit manager reimburses the pharmacy one rate for filling a prescription and then charges the health plan a different, higher rate for filling that same prescription. Then they keep the difference, and that's called the spread.

The health plan does not see what the pharmacy is reimbursed. As a result, the health plan doesn't know what they are paying. Part of what they are paying for pharmacy benefit services is that spread, and they don't know how big it is. Nobody can make a good, sound economic decision without knowing what prices they're paying.

The State of Ohio audited its Medicaid managed care program in 2018 and learned that they were being charged those spreads of 31 percent on average on generic drugs. As a result, they fired their PBMs, which suggests to me that they were very surprised to learn that the spreads were as high as they were. They would not have known about this if they had not done this audit.

So, I think that having spread pricing—the practice by itself is not as problematic as the fact that there's no transparency into it, and it actually masks prices and compensation levels for PDMs.

Mr. NADLER. Thank you. Dr. Van Nuys, how do PBM practices affect the uninsured?

Dr. VAN NUYS. The uninsured? Oh. So, when it comes to negotiating the prices of brand drugs, pharmacy benefit managers and drug manufacturers negotiate over the list price of the drug and the rebate. We've heard a little bit about rebates here, right?

So, in the process of negotiating that, the PBM wants a higher rebate because they get to keep a part of it, and the manufacturer wants to pay a higher rebate because that will get them preferred placement on the formulary. So, both of those agents are sort of working toward higher rebates, but what that tends to do is push up the list price of the drug because the rebate is taken out of the list price, and the net price is what remains.

Mr. NADLER. No one is pushing in the other direction.

Dr. VAN NUYS. No one's pushing in the—not on the list price. So, uninsured patients frequently face the list price of the drug, not that negotiated net price after the rebate, but the list price of the drug.

Mr. NADLER. So, the uninsured pay higher prices than the insured.

Dr. VAN NUYS. Yes.

Mr. NADLER. Dr. Frank, we have talked about a lack of competition in the PBM market contributing to high drug prices. Do you believe this is also a problem in other sectors of the healthcare industry?

Dr. FRANK. The concentration is problematic elsewhere, absolutely. I think we see it a bit in Medicare Advantage, for example. That would be one of the places that I think is a poster child for sort of high levels of concentration.

Mr. NADLER. What recommendations do you have for promoting competition in hospital and physician markets?

Dr. FRANK. Well, I'll give you one example. In Medicare Advantage, we have set things up so that the county is where competition happens, right? That's the way the markets are defined. That's fine in your borough. It's not so great in Nebraska.

What we could do to promote competition is make markets larger so that companies that enter can count on getting a lot of business. In New York, it's true—Nebraska, not so much.

Mr. NADLER. New York what?

Dr. FRANK. In New York, it's true that you go into that market; there are a lot of bodies for you to compete for. That's less true in Nebraska. So, by making the markets geographically larger, getting more people in, you create incentives for entering competition.

Mr. NADLER. Thank you.

Dr. Van Nuys and Dr. Frank, in order, what reforms do you recommend that Congress take to address the concerns related to PBMs?

Dr. Van Nuys, let's start with you.

Dr. VAN NUYS. I recommend creating greater transparency by developing and publishing pricing benchmarks that are true net pricing benchmarks so that the folks who are transacting in these markets can actually make better economic decisions, know what prices they're facing.

Mr. NADLER. Dr. Frank?

Dr. FRANK. I guess I would try to do things that promote competition from independent pharmacies—I mean independent PBMs—because, right now, you've got the three vertically integrated ones, and there is some midsize independent PBMs. To try to get them and others like them to be able to compete more effectively, doing things to encourage their entry into the market could go a long way to help.

Mr. NADLER. You mentioned the three vertically integrated PBMS. Do you think antitrust action should be taken against them?

Dr. FRANK. Well, no, let me tell you what my concern with taking antitrust action is. The areas of antitrust that are the hardest to make a case on, where the case law and the economics is messiest, is in vertical relations. I think you'd have to go after that. Because the process is a very long litigation, highly uncertain given the messiness of the area—I would try out something else first.

Mr. NADLER. Thank you.

My time has expired. I yield back.

Mr. MASSIE. The gentleman yields back.

I now recognize the Chair of the Full Committee, Mr. Jordan, for five minutes.

Chair JORDAN. Thank you, Mr. Chair, for this important hearing.

Dr. LoSasso, you started off our testimony—I think it was your second sentence you said even Plato doesn't like or didn't like middlemen, referring to the PBMs. The way I understand it—and again, just a country boy here, but PBMs work with insurance companies to negotiate prices with manufacturers and then dictate to the pharmacy what they get paid. If you are not in the network, look out. You are in trouble.

That doesn't sound like a middleman. That sounds like the dictator at the top. That sounds like a monopoly. That is the concern, and particularly when 80 percent of the market is vertically integrated, as the gentleman just pointed out, as the Ranking Member just pointed out.

So, I guess I am going to go back to the question the Ranking Member just asked Dr. Frank. Why isn't this an antitrust concern? I guess I will start with the guy who brought up the middlemen at the start of the hearing, Dr. LoSasso.

Dr. LOSASSO. Thank you, Congressman. So, yes, broadly speaking, the picture you paint is more or less accurate—

Chair JORDAN. Well, first, is the picture accurate? I am not trying to paint any special picture. I am trying to get to the facts. That is an accurate picture, isn't it?

Dr. LOSASSO. Well, it ignores some important aspects, which is that the payer ultimately—

Chair JORDAN. Three pharmacies, 80 percent of the market. Are three PBMs 80 percent of the market? Is that true?

Dr. LOSASSO. Estimates vary, but yes, 70–80 percent, 3–4.

Chair JORDAN. Three dominate, right?

Dr. LOSASSO. Three to four, yes, depending on—

Chair JORDAN. They work with insurance companies to negotiate prices with manufacturers and then tell pharmacists what you are going to get paid.

Dr. LOSASSO. So, remember the key part there is that pharmaceutical companies control list price, right? Pharmaceutical companies have a great deal of market power, given monopoly privileges.

The payer, on the other end, the person—the entity at—whether that's a labor union, whether that's a large employer—they are able to view options. They're able to say, "No, I don't want"—the first thing—I'm not a large employer, of course, but I would want to know, what is the average spread? You're offering me an alternative. The PBMs say I could do spread pricing. Here's an option. I can do spread pricing; I can do fees.

Well, what is the spread? Why didn't that Medicaid program—I think it was Ohio. That would have been one of the first questions I'd ask if I was an Ohio Medicaid Director. What is the average spread price for generics? I'd hate to find out with an audit down the road.

So, all I'm saying is that there are people with skin in the game that are able to push back, and that is the payers.

Chair JORDAN. Let me ask you this. Can a large PBM tell an independent pharmacy: If you work with some new innovative com-

pany to bypass our network, we will cut your pharmacy off from our network and subject you to fees and audits? Can that happen, Dr. Mattingly? We'll jump around a little.

Dr. MATTINGLY. I'm sorry. Can you repeat that scenario again?

Chair JORDAN. Could a large PBM tell an independent pharmacy: If you work with a new innovative company to bypass our PBM network, we will cut your pharmacy off from our network and subject your pharmacy to fees and audits? Can they do that?

Dr. MATTINGLY. I don't know, but they might be able to, yes.

Chair JORDAN. Dr. Frank, what do you think? Can they do that?

Dr. FRANK. I think that's certainly a risk that they can often have the market power—

Chair JORDAN. We think it is happening.

How about you, Dr. Van Nuys?

Dr. VAN NUYS. Yes, I think it probably happens.

Chair JORDAN. Yes. Is that—we got the manufacturer. We got the insurance company. We got the wholesale distributors. We got the pharmacists. We got the PBMs. If they can do that, that is probably not good for the one we should care about most, which is the patient, right?

Dr. VAN NUYS. Yes, particularly patients in rural areas or in underserved areas where, disproportionately, independent pharmacies are the ones who are serving those patients.

Chair JORDAN. Dr. LoSasso, I started with you. I will give you the last word here and my last few seconds. Anything you want to add?

Dr. LOSASSO. Well, I would—yes. I appreciate that. Thank you. I would just add that pharmacy networks, selective contracting, broadly speaking, as I pointed out earlier, that is a mechanism that can be used to ensure a high-performing set of pharmacies that can deliver drugs to patients. I can't speak to any of the sort of punitive measures that you mentioned. I don't know anything about that.

As a general matter, being able to create a high-performing network of pharmacies is a useful function because it can improve efficiencies. It can force the pharmacy that can't meet the objectives of the PBM, in this instance, to become more efficient or move on.

Chair JORDAN. I was going to yield my remaining time to the Chair, but as happens sometimes, there is nothing left. Thank you, Mr. Chair.

Mr. MASSIE. Thank you. The gentleman yields back.

I now recognize the gentleman from Georgia for his five minutes.

Mr. JOHNSON. Thank you, Mr. Chair, for this very important and bipartisan hearing.

With all due respect to my friend, the country boy from Ohio, I would point out there is a lot of city boys who would be interested in the same answers that you were trying to elicit. I will point out, too, the witness—

Chair JORDAN. Ah, it is great to see we are on the same page for a change, brother.

Mr. JOHNSON. I am happy about that.

Chair JORDAN. Yes. That is—amazing day.

Mr. JOHNSON. Now, typically, when a widget is manufactured, the widget manufacturer would manufacture the widget. The widget would then be placed with a distributor. The distributor would

then place the widget with a retailer, and the retailer would make it available to the customer. Correct? That is the normal supply chain or distribution channel.

It is much more complicated in the pharmaceutical industry. I would also point out the fact that drug prices in the United States of America, as it relates to pricing for the same drug in another industrialized Nation, the cost in the U.S.—like say insulin, for instance. Back in 2018, a vial of insulin in the U.S. cost $98.70, and you go right across the border to Canada and get that same vial for $12.

So, we see these kinds of price disparities across a broad range, in fact all, pharmaceutical drugs. We see that happening. We also know that 90 percent of the pharmaceutical drugs that are delivered to consumers—90 percent are generics. So, there is no exclusivity issue in terms of patents.

So, question I want to ask—the widget manufacturing process in the U.S. being as complicated as it is, does that same supply chain distribution process—is it employed in a place like Canada? Do—yes, Dr. Van Nuys.

Dr. VAN NUYS. I am not an expert on the Canadian drug distribution market, so I can't say for sure. I do believe that because of the very different healthcare system in Canada versus the U.S., we don't have the same kind of intermediaries.

Mr. JOHNSON. I guess what I want to ask is, do PBMs exist in any other market than the U.S.? Can you answer that, Dr. Mattingly?

Dr. MATTINGLY. Absolutely. Congressman, I love your example of the widget. I use that in my class all the time, so thank you for that.

Absolutely. So, in Canada—and I had this opportunity right after pharmacy school. I got to go spend about a month with the British Columbia Ministry of Health, so working with the province. So, this was for the government. So, I went and shadowed and worked there for four weeks, came back. I was like, "That was like a PBM." Right? So, their State level, province, is making the same decisions.

Mr. JOHNSON. Single-payer kind of model.

Dr. MATTINGLY. Well, and Canada has multiple provinces. So, it's not a single payer, as we like to think. It's even more complicated there.

Mr. JOHNSON. Well, single concept. Multiple payers, I guess, but same concept.

Dr. MATTINGLY. Right. Sure.

Mr. JOHNSON. A single payer among various provinces.

Dr. MATTINGLY. Well, instead of our premium payments going to function to a for-profit company that's set up to administer the benefits, it's maybe my tax dollars that are going through that way. So, it's just two different ways of handling it.

Mr. JOHNSON. How is it that the U.S. distribution channel for pharmaceuticals incorporated the PBM model as its distribution process? How did that come about, and why? Is it still useful?

Dr. MATTINGLY. Yes. It did start in 1958 in Canada and made its way over to the United States in the early 1960s. We started as prepaid pharmacy card systems. So, pharmacists actually helped us create these to begin with because we thought pharmaceuticals

were getting too expensive in the 1960s. So, a way to handle that was, "Let's pay ahead of time," and again, knowing that patients are going to have this spending.

So, it started, again, to address as the rising costs of drugs were coming along. Again, the rising cost of drugs to your widget—we put these widgets through many years of research and development that have to then meet a barrier that they are safe and efficacious to be distributed to our patients.

Mr. JOHNSON. That should have no bearing on the distribution process.

Dr. MATTINGLY. Oh, no, sir.

Mr. JOHNSON. OK. I have no further questions. I yield back.

Mr. MASSIE. Thank you. The gentleman yields back.

I now recognize the gentleman from Oregon for five minutes.

Mr. BENTZ. Thank you, Mr. Chair, and thank all of you for your testimony.

Dr. Mattingly, what exact part, if there is just one part, have PBMs played in the closing of the small pharmacies? Certainly, in my district back in Oregon, it is a huge, huge space—my district is bigger than the State of Washington, and we had at one time small pharmacies all over it. They are disappearing.

It is not just pharmacies that have disappeared. We have seen a wave of consolidation in the funeral homes, consolidated towing companies, and doctors have become hospitalists. The whole thing is collapsing into bigger spaces or perhaps more efficient, perhaps not.

So, tell me, though, what PBMs have done to cause this trend to continue, if anything.

Dr. MATTINGLY. Thank you. That is a great question. I absolutely—from my perspective, I feel like there is a major just scale difference and I talk about—again, to try to encourage my students because pharmacies close and pharmacies do open. So, there are pharmacists who seek out to start a new business.

If I want to open Joe's Pharmacy, my ability to negotiate with three companies that control 80 percent of the prescription drug market is quite limited. So, at the end of the day, it is often that size and scale thing. It is not just the independents, because I think we have seen large chains announce that they are closing stores, too, meaning that, is our retail market changing? It is something that we have to consider.

Even during the pandemic—I grew up working at a grocery store. I always loved to go to the grocery. During the pandemic, I had my groceries delivered a time or two, and it was like, that is pretty convenient. Maybe I don't need to go to the big box to get my groceries. I still do because I enjoy it, but my point is I don't know how much of it is also a function of the retail market changing that we have to evaluate.

Mr. BENTZ. Do you have a number of how much PBMs take out of the healthcare system? Cost the healthcare system? I heard at one point someone said it is a very small percentage of the total 3¼–4 trillion we spend.

Dr. MATTINGLY. Oh, that is a really good question, a really good research question, so thank you for that. I would say one of the things we are focused so much on the pharmacy market side of it,

and I think maybe what you are getting at is, too, is the pharmacy segment is still a small segment of the overall healthcare spend. I don't know if that is where you were headed.

Mr. BENTZ. No, no. My question simply is, PBMs are providing some sort of a service. How much of it is it costing?

Dr. MATTINGLY. No. So, I don't have that.

Do you have that, Richard? Please.

Dr. FRANK. Their margins are about 4–6 percent, and—what?

Mr. BENTZ. Four to six percent?

Dr. FRANK. Four to six percent. So, if you kind of look at that as part of the—in terms of the overall drug spend, it is actually, pretty small because—

Mr. BENTZ. So, when I was—the articles I read suggested that we were using PBMs as a whipping boy for a much larger problem, but that is why I am trying to get at how big a problem is this. If we get busy as a Congress, we are going to solve this problem. How much have we reduced the cost of medicine?

Dr. MATTINGLY. Right. So, that was a point I was trying to make at the end of my presentation, which was, even though there is good things that can happen by addressing the PBM market, but it is only going to do a small, modest amount to really bring down the cost of prescription drugs.

Mr. BENTZ. Right. Certainly, if someone has that number, I would love to see it.

Dr. Van Nuys, do you have reason to believe that PBMs are the worst of the middlemen? Or is there somebody worse? Or maybe they are not bad. Maybe they are good. Maybe they are the best of the middlemen. Where do they fit.

Dr. VAN NUYS. I don't think I have a way to rank order them. I will say to your question about, how much PBMs are costing the system, keep in mind that the three largest ones are vertically integrated with health plans and pharmacies, and so on, and because of that vertical integration they can shift revenues and profits into other sectors.

So, just because what we are reporting as PBM—the PBM share, it doesn't necessarily mean that this is the whole—

Mr. BENTZ. Right. You shifted to the entire supply chain, and we are selecting just one part of it. Are you saying that we should change our focus to that entire vertically integrated thing?

Dr. VAN NUYS. I think in the case of a vertically integrated company, yes.

Mr. BENTZ. Yes, Dr. Frank.

Dr. FRANK. Yes. I think that one of the important things that maybe we haven't brought out as much is that a lot of these issues are now insurance issues and not PBM issues, because in fact, as we said, they are all vertical—most 70 percent of Americans are in vertically integrated plans that have a PBM and an insurance policy. A lot of the things that are going on are driven by the dynamics of the insurance market as much as the PBM per se.

Mr. BENTZ. Right. Thank you all very much.

I yield back.

Mr. MASSIE. The gentleman yields back. I now recognize the gentlelady from Pennsylvania for five minutes.

Ms. SCANLON. Thank you, Mr. Chair. Thank you to our witnesses. It is always interesting trying to find the particular antitrust angle that we can bring to some of these issues that really kind of cross a broad swath of our country.

We know our healthcare system is becoming defined by concentration and a lack of competition, whether we are talking about insurers, providers, drug manufacturers, PBMs, or all the middlemen throughout the system. We see the impact of decades of mergers and acquisitions, the rise of private equity in our healthcare system, which is causing particular problems and lacks antitrust enforcement.

I am kind of interested in the suggestion we used. What is it? Robinson–Patman, was that—yes. That was your suggestion? We will get to that in a minute.

So, we see that Americans don't have many choices usually among which insurers to pick or providers to see or PBMs to use or even pharmacies to go to. So, that drives the result that Americans pay more for prescription drugs and healthcare generally than nearly every other advanced economy.

We also see that conglomerates own the pharmacy networks as you have suggested, and when we look at this whole picture and incredibly the thicket of interrelating operations here, we see why the patient often loses out in the fight between the pharmaceutical companies, the insurers, and the PBMs over who has to pay what.

I am encouraged by this bipartisan work by our colleagues here and other Committees to produce legislation to promote transparency and rein in some of this sector's worst practices. I would be pleased to see this Committee advance serious legislation to combat these problems.

I am concerned about the counterproductive attempts we are seeing by the House Majority to repeal provisions in the Inflation Reduction Act that have been lowering drug prices for seniors and saving taxpayer dollars. That bill allowed, as you know, Medicare for the first time ever to negotiate directly with drug manufacturers to lower and cap the prices that seniors pay, and my senior constituents are really concerned about the prospect that we might see the significant progress we have made there rolled back somehow. So, don't want to see that.

I did want to pick up on a couple of the issues that Mr. Bentz raised, and also some of the issues raised by our witnesses. Dr. LoSasso, what was your suggestion with respect to enforcement I think it was of Robinson–Patman? How would that address the issues we are talking about today?

Dr. LOSASSO. Well, I guess I should point out, first, that I am not a legal scholar, nor do I claim to be, but my better-informed colleagues tell me that the reason behind the somewhat clumsy rebate mechanism is because of restrictions in Robinson–Patman around price discrimination policy. So that is probably the extent of my understanding of Robinson–Patman Act.

Ms. SCANLON. OK. So, more research for us.

Dr. LOSASSO. Indeed.

Ms. SCANLON. OK. Dr. Mattingly, you noted that the concessions that PBMs get from pharmacies are contributing to consolidation

of pharmacies, essentially squeezing the independents out of the market. What could Congress do to remedy this?

Dr. MATTINGLY. When we are evaluating legislation, especially things like NADAC—or, sorry, National Average Drug Acquisition Cost, or cost-plus-type pricing, because we know those kind of things have been thrown out there—when we are talking about what the cost of the drug should be and the cost of the dispensing fee, we need to really understand, what is the value of the service that the pharmacist is providing?

When I was a pharmacist—I guess I am still a pharmacist, but I was a real pharmacist before—I wasn't incentivized to tell the patient not to take a drug, right? Like my revenue is based on you filling a prescription. If I say we talk and we figure out your history, and it is like, hey, maybe you shouldn't take this medication, I get zero revenue. Now, we swear an oath, like we would do that.

Maybe that shouldn't be the case. Like maybe we should figure a way for the care that I provide that I am compensated for, and then there could be a combination of that fee for service in combination with a capitated kind of model.

Ms. SCANLON. Interesting. Dr. Frank, I was interested in your comments about the pharmacy deserts in rural areas. We see a similar thing in the very economically distressed urban areas that I represent. I have limited time, so I was going to ask Dr. Van Nuys, you suggested that the savings that PBMs are negotiating are being absorbed by them rather than being passed along to patients or insurers or other payees and suggested that one way to better align the PBMs' incentives with patients and payers would be to impose fiduciary duties on PBMs. What would that look like?

Dr. VAN NUYS. It is a good question. It is a very complex fix to a very complex system. Right now, PBM—the only fiduciary responsibility that PBMs have is to their shareholders. That is not necessarily how we want our healthcare to operate. So, requiring PBMs to act as fiduciaries, either to their health plan clients or to the employees and beneficiaries of those health plans, changes the focus of what is required of them.

Ms. SCANLON. OK. Thank you. I see my time has expired. I yield back.

Mr. MASSIE. The gentlelady yields back.

I recognize the gentleman from North Carolina for five minutes.

Mr. BISHOP. Thank you, Mr. Chair. This is an intimidating kind of witness—or hearing in which to ask questions, especially given the way Congress is, you have got to run out to do a little speech and get back in, so I missed Dr. LoSasso, I missed Dr. Mattingly, I missed Dr. Frank. I got to hear Dr. Van Nuys' testimony. Then, I have heard the questions and the answers.

I will say it all seems like a Rube Goldberg contraption, and so you have got a lot of really smart experts, and they do a lot of research, and we never really get to the point where everybody feels like pharmaceutical costs are about right. We never get a lot of satisfaction there. You have got some arguments, and then you have got—Dr. LoSasso, do I get the basic essence of your position that you think this is really driven by pharmaceutical manufacturers and the patent system and the fact that you have got to sort of have a heavy counterweight to them, somebody that can negotiate

with them, and that is what—PBMs kind of help that function get carried out? Is that right?

Dr. LOSASSO. In brief, sir, yes, I do believe that PBMs are not only the tip of the spear when it comes to engaging in price competition and enforcing price competition, they probably are the entirety of the spear.

Mr. BISHOP. OK. Because of the rest of the way the system is composed, right? Because you have got pharmaceutical manufacturing and you have got the patents associated with those, and things like that. Is that—and you have got all the consolidation in the healthcare industry through payers, payors, and all those kinds of things.

Dr. LOSASSO. In my view, they are the only entity that really has an incentive to try to pass along savings, because what they are ultimately selling is insurance. The lower the premium, the better. If you can bring down the premium, then you get more business.

Mr. BISHOP. Do I understand, then Dr. Van Nuys, again, I heard your testimony. So, all you believe that PBMs play an important role, and they are—on balance, they are a net plus. Is that correct? Anybody differ from that point of view?

Dr. Van Nuys, what I heard you say specifically in your testimony, if you will, you told us about a lot of things that are problematic, but you also—I thought there was a premise in there that they are really important—they provide important benefits. Did I get that correct?

Dr. VAN NUYS. Yes. They play an important role. You need somebody negotiating drug prices. You need somebody designing formularies. You need somebody managing pharmacy networks.

The second half of your question was, on balance, are we seeing those benefits or are we seeing greater costs because of this sort of countervailing forces?

Mr. BISHOP. The gentleman from Georgia, Mr. Johnson, said something that probably came at one of your testimony—that 90 percent of the drugs are generics. Is that correct?

So, I am sort of left surprised by that. If the pharmaceutical manufacturers and the monopoly they are provided—and I am aware of the games they play in terms of trying to preserve patent for a longer period of time and reformulate, and so forth, and there is a lot of scams in there maybe.

If it is 90 percent driven by generics, and that is supposed to be—that shouldn't be operating, then why are we having to set up the whole Rube Goldberg contraption for the sake of 10 percent of the market? Dr. LoSasso?

Dr. LOSASSO. It is not 90 percent of the dollars.

Mr. BISHOP. OK.

Dr. LOSASSO. OK. So just to be clear.

Mr. BISHOP. It is interesting and revealing. It is like reading Bork's Antitrust—no, it is like having to read the CliffsNotes to Bork's Antitrust Paradox and then come in and try to ask intelligent questions about it.

So, given the limitations I am facing on that score, I am going to yield to the Chair the balance of my time.

Mr. MASSIE. I thank the gentleman from North Carolina.

Dr. Frank, I think you were centering on what might be a solution or an improvement, which was these independent PBMs. You said there is some hope there. There is consolidation. There is three or four that are controlling everything, but there are some trying to get into the market.

What could we do to make them more competitive? Or is there something we could unshackle to make them more competitive?

Dr. FRANK. I think that is a really important question. I think it is one that I have been thinking about a lot. I don't have a great answer.

Mr. MASSIE. Give me your best answer. Best effort.

Dr. FRANK. My best answer is that the government now, one way or another, is involved in about half the insurance purchases around the country. Right? So, there is probably—and I don't know a better way to put it, but there is probably some ways to, as we have done in other areas, like when we started Medicare Part D, is to put our thumb on the scale a little bit to make the market work better.

How exactly to do that I haven't figured out yet, but I think that given what an important role the government has in procurement of prescription drugs and working through PBMs and PDPs, there may be some ways there to advantage some of these independent entities.

Mr. MASSIE. The gentleman's time from North Carolina has expired, which means my time has expired. I may come back and ask some of the other witnesses the same question, so be thinking about it.

I now yield to Mr. Ivey—or, sorry, recognize Mr. Ivey for five minutes.

Mr. IVEY. Thank you, Mr. Chair. I want to commend you for this hearing. I think this is a great example of a bipartisan effort, and I appreciate the panel as well, very interesting and provocative answers.

I do want to—if the clerk could put up the exhibit. This is—are you able to see that? OK. This is from the FTC Staff Report "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies." I wanted to ask you some questions about this.

Dr. Frank, I think you touched on some of this already in talking about how difficult vertical integration antitrust cases can be. Man, this sure looks like one to me. You have got the concentration of the PBMs, which is around 80 percent. I didn't realize until I saw this graphic the extent of the vertical integration. This is pretty significant.

I want to ask you two questions, though. So, even if it is a complicated or difficult case to make, and it is sort of touches on what the Chair asked a moment ago, isn't this the type of thing that FTC/DOJ antitrust should be trying to break up in some way?

If we want to try and figure out a way to give the other three PBMs, which I guess is—what is that, Humana, MedImpact, and Prime? Are those the three? A chance to try and break into that 80 percent wall, wouldn't sort of breaking up the relationship between the PBMs, CVS, Express Scripts, and Optum, which the rest

of their vertical integrated columns, wouldn't that be the way to do it? Not sure, but, yes, Dr. Frank, what is your take on that?

Dr. FRANK. It certainly is tempting target. As I said, I am reluctant just because the economics aren't worked out. We don't have super great evidence on that, and it would take us—you and I would probably be somewhere else by the time that those things got worked out.

I do think that there are other things that we can do in the interim that can be done either administratively or regulatorily that would sort of move the ball ahead and it is for that reason that I—

Mr. IVEY. OK. Well, let me ask you a quick followup, and then I am going to yield some time.

So, one of the things when I asked unknown—unnamed PBMs about this issue, and they said: Well, Mr. Ivey, but the relationships between the PBMs and the other entities in that vertical column are all those transactions are done at arm's length. So, it is all done at fair market value.

I said—well, I didn't say it. I thought it. Come on.

[Laughter.]

Mr. IVEY. Come on. I think one of you referenced a minute ago about the possibility of sharing benefits up and down the stream. That creates the problem of overpricing at that level, and also distorts the information that we are trying to get at from the transparency piece.

I can't think of another way to address it, but I do want to yield the balance of my time to the gentlelady from North Carolina.

Ms. ROSS. Well, thank you very much, Mr. Ivey.

I have been working on bipartisan PBM legislation that has been going through Energy and Commerce, and you are probably familiar with a lot of it. A lot of it, given—and I love the setup from my colleague. A lot of the problem is this vertical integration, because the savings are not going to the patients.

So, yes, there might be some savings, but they are either going back to the insurance company or they are going to the PBM. That doesn't accomplish the goal, and that is the antitrust problem. The antitrust problem isn't that there is a PBM trying to find efficiency. The antitrust problem is that the PBM is either self-serving or serving the people that they are contracting with and not serving the patient. That is the fundamental thing here.

I love what Dr. Van Nuys said about having some kind of fiduciary responsibility, but I think what we should be thinking about is, if you are going to get into the business of having vertical integration with PBMs, that the beneficiary cannot be the vertical integration. That is the antitrust problem, and we need to figure out, maybe it is not breaking it up. Maybe it is more regulation for how that vertical integration can work.

That is the nub of it, because the vertical integration is not helping the patient at all, and it is not reducing drug prices to the patient at all.

Thank you, and I yield back.

Mr. IVEY. Thank you. I yield back the balance of my time.

Mr. MASSIE. The gentleman yields back.

I now recognize the gentleman from Virginia for five minutes.

Mr. CLINE. Thanks, Mr. Chair. This is a great hearing, timely topic, and I appreciate the bipartisan nature of it.

With the rise in premiums and deductibles and the ever-increasing costs of prescription drugs, it is clear something needs to change, and I am a firm believer that free market solutions are the best solutions, and to truly have a free market we need competition. When you have 95 percent of the prescriptions in the hands of six PBMs, you don't have competition.

This hearing is so important, because we are seeing clear anti-competitive growth in our healthcare system. The FTC has said that they are going to be taking action in court, but we do want to examine, in terms of our Article 1 powers, what Congress can do about that.

Last year, *46brooklyn Research* released a report on how PBMs define brand, generic, and specialty. They found that those definitions—brand, generic, and specialty—differ from PBM to PBM. In other words, instead of using the FDA drug application designation of NDAs and biologic license applications for defining brand and abbreviated new drug applications, ANDAs, for defining generic, PBMs essentially make up their own definitions.

Similarly, the analysis found that a surprisingly large portion of the drugs on the specialty list were generics, 42–54 percent. Dr. Mattingly, in your testimony, you mentioned drug price definitions and how that can impact what is paid. Have you done any research or work regarding how PBMs define drugs in their contracts?

Dr. MATTINGLY. That is a great question. One of the things I kind of joke about with specialty is that it is not really—it is expensive, and that seems to be the biggest part of the definition that leads to that. It causes a lot of problems, so, no, I think you are keen to pointing that out, that maybe we need to have a more clear definition of what breaks things into these tiers.

Mr. CLINE. I saw a couple of other heads nodding. Does anyone else want to weigh in on that?

Dr. VAN NUYS. I will also add that I think the *46brooklyn* folks have also demonstrated that sometimes drugs are reclassified and from regular to specialty, and then, because of the PBM contract, the patient is required to use the specialty pharmacy that is affiliated with the PBM. So, that is another—it is not just that the price is different, but now you also have to buy it from my pharmacy.

Mr. CLINE. Dr. Frank?

Dr. FRANK. What she said.

[Laughter.]

Mr. CLINE. Thank you. Dr. Frank, actually, you spoke a lot about vertical integration in your testimony. When it comes to the big three, which side of the business makes the most cash, insurance or PBM?

Dr. FRANK. A huge amount of the profit comes from the specialty and the mail order. A disproportionate part. I haven't sort of allocated it all out, so I can't give you a precise answer, but it is a disproportionate amount coming from the PBM, those two pieces of the PBM industry.

What is important here is also that because of the regulations on medical loss ratios in the health insurance side of things, it is very convenient for the PBMs to overcharge the insurers to avoid regu-

lation because the revenues still go back to the parent company and so do the profits, that they are out of the reach of the regulators.

Mr. CLINE. Does anyone else want to weigh in on that? Well, that we have got a lot of questions that have—and some legislation moving forward that may or may not address the concerns. I am glad this Committee is exercising its jurisdiction, and I think there may be some answers that lie in this Committee.

So, with that, I yield back. Thank you, Mr. Chair.

Mr. MASSIE. Would the gentleman yield his remaining—

Mr. CLINE. Yes, I yield back.

Mr. MASSIE. So, may I—

Mr. CLINE. I yield to the Chair.

Mr. MASSIE. OK. Thank you very much. Didn't want to take anything that wasn't mine, but I will take it.

So, what I hear from small mom-and-pop pharmacists is, "I am paying $25 for this drug and that CVS or the hospital is paying $5 for it," or "I am filling a prescription, and even before I consider my labor or my employees, I am filling it for less than—they are paying me less than it costs me."

What scale would they have to operate at to make money if they are paying more than they are getting reimbursed? Like is there any scale that that works? Dr. Van Nuys?

Dr. VAN NUYS. Well, no. What you have laid out, there is no scale. You don't make it up on volume. It is true that if you are larger, you can get better pricing from a wholesaler.

Mr. MASSIE. That doesn't speak—that is not saying that the employees are not working as hard at the small pharmacy or that there is no scale at which when you are paying more than you are getting for the drug, there is no scale at which that works.

So, there is something wrong there in the pricing. Maybe these small pharmacies are twice as efficient. Maybe the employees are more motivated. It is a scale thing, and that is a problem.

Let's see, I recognize the gentlelady from Vermont now for five minutes.

Ms. BALINT. Thank you, Mr. Chair.

I represent Vermont, and it is a very rural State. We are a collection of small, tight-knit communities, and in many towns and villages there are small businesses like independent pharmacies that are often the bedrock of communities.

I can tell you I had the same independent pharmacy for 20 years. It closed recently. I can tell you there were times when I went into my independent pharmacist. If things had gone haywire with my insurance, Frank would literally say to me—because I have asthma,

> You know, I know you, you have been my person for 20 years, we will get it straightened out, I know where you live, it is going to be OK.

They recently closed after decades of serving my community. They are not the only one, and I am very concerned. Mr. Bentz talked about this in Oregon as well, that we do see independent pharmacies closing, and it is a very serious concern, not just because of the level of care that you get from these pharmacies, but also, in a rural State, you have got to drive then farther to get that prescription or to get that counsel.

We have an aging population, and you can just imagine, and it is snowy, and it is icy, and it is dirt roads, and so it does materially affect us when these independent pharmacies close.

Now, the FTC conducted an in-depth study in PBM practices, and one part of their report really stood out to me. The FTC used a case study of two generic cancer drugs to find that non-big three pharmacies—so those independent pharmacies like the ones that have closed in Vermont in the last few years—they pay 20–40 times the average national price for those drugs.

So, it goes to what you were saying just now, Mr. Chair. On top of that, the retail chain outlets seem to be doing pretty well actually. So, the FTC found that pharmacies affiliated with the big three PBMs retain nearly $1.6 billion in dispensing revenue above the national average.

So, I really appreciate you are all here. I am glad this is a bipartisan hearing where we are really trying to dig in.

Ms. Van Nuys, I really would like to dig in a little bit on this piece of the independent pharmacies. Why are independent pharmacies at such a disadvantage, in particular, when it comes to the generic drugs? Or are they? What are the disadvantages that independent pharmacies come up against in pricing?

Dr. VAN NUYS. So, the report that I was referencing earlier, there is some evidence to suggest that the large PBMs who have integrated pharmacies are reclassifying drugs to then require them to be purchased at their mail-order pharmacy or at their specialty pharmacy. There is also, in that same report, evidence that they are doing that strategically in the sense that the more profitable prescriptions are more likely to be sent to the integrated pharmacy than they are to independent pharmacies. So, I think that is one element here.

These sorts of behaviors—again, back to the FTC report—we would love to know more about how this is happening and what the aggregate results of these actions are.

Ms. BALINT. So, can you explain just to make it as clear to us as possible, we have heard a lot about the dangers of the vertical integration as it relates to consumers and being able to actually see any value from the PBMs, right?

Can I just see that slide? Do we still have that slide available that was at—OK. So, this is bringing me back six years to when I was on the Finance Committee in my State Senate. OK? It is just as confusing now as it was then.

It makes no sense to the average person, to the average consumer, and certainly for those of us who are the eyes and ears for average consumers, you can't explain this stuff. We are not seeing the benefit from PBMs. Somebody is, but it is not us. So, can you also just tell me, how does vertical integration really impact negatively independent pharmacies and consumers from your perspective?

Dr. VAN NUYS. So, again, specifically, these vertically integrated PBMs are taking their profitable business and directing it toward other parts of their own organization rather than allowing the independents to benefit from it.

Ms. BALINT. So, basically, what we are saying is our independents just don't have a shot.

Dr. VAN NUYS. They are not on a playing field that they can compete on. They are up against a very formidable adversary.

Ms. BALINT. Appreciate it. Sorry for going over. I yield back.

Mr. MASSIE. No problem. Thank you for yielding back.

I now recognize the gentleman from New Jersey for five minutes.

Mr. VAN DREW. Thank you, Mr. Chair. Mr. Chair, thank you for having this hearing. It is valuable. It is worthwhile, and I know it is only the very, very rudimentary beginning, but it is still good. You have got to begin somewhere. Hopefully, we can get something done.

I am a dentist. I was a practicing dentist for 30-some years, and I practiced through even being in the State Senate, State Assembly, and the Mayor of my town. I had a partner and was able to do it, and it is a wonderful profession.

I will tell you; people assume because I am a dentist that I have the—I know it is where I am going to go with this—that I have the answers to healthcare. They go, "Jeff, you are in Congress now." Of course, I sold my practice when I got in Congress. "We need you to settle the healthcare program. I have a problem."

I have people that actually come up to me and say that all the time, we do have some other dentists and physicians, et cetera. I know of no problem, quite frankly, in general—and I know we are talking the specific subject now—but that is more difficult, more complex, and harder to solve at so many levels, because every time you do something there is a ripple effect somewhere else, and it is a really difficult issue.

I am actually candid about it when I am in a debate or a discussion and people say, "Well, what are you going to do about healthcare?" I will talk about some ideas, don't get me wrong, and we all know the political talking points. We also know those aren't going to be the answers at the end of the day. This is a really difficult issue.

So, thank you—all of you—for the work that you do.

So, the first question I am going to ask is about the PBMs, the insurance companies, and the manufacturers. Again, you heard it today, and my colleagues asked excellent questions. Some folks think it is the manufacturers. Some think it is the PBMs. Some think it is insurance companies. It is probably all of them.

I will start by picking on Dr. Mattingly. What would you do—I am going to ask this question a couple of times. You are king of the world, man. You are king of the country, and your one task in life is to fix this thing. I call you up. I am Jeff Van Drew. I want to write some bills. What should I do? You are in control. What should I do?

Dr. MATTINGLY. Well, first, thank you for the promotion. One of the challenges that we have is we don't have a process to really value any of these things that you have listed out. Like we don't—we, I say "we," like society, like we struggle to value, what is the value we should place on a brand-name pharmaceutical? What is the value we should place on a generic pharmaceutical?

Mr. VAN DREW. Do you mean the financial value?

Dr. MATTINGLY. Economic value. No. What is it if an employer, it is important that your employees are healthy, so they come to

work and they are productive. Right? So, that is why health insurance is valuable to an employer.

For patients—so, we don't know what the—how do we truly come to an agreement on what a drug price should be? Some drug prices are too low. I keep hearing that it is all about drug prices being too high. Some generic prices have gone so low that we run into supply chain shortages. So, like, it is more complex on the other side, too.

Mr. VAN DREW. By the way, try to explain that to the public. Gee, this drug is too cheap, and it is hurting us. So, you know what? That is not easy. Go ahead.

Dr. MATTINGLY. Yes. I am not the most popular sometimes in trying to explain these things. Also, then, when you flip to the side with the insurance or the PBM, what is the value that they are providing? So, I have heard a lot about vertical integration.

Well, why would we vertically integrate? Like why would Apple build a $3 trillion company off the vertical integration with their software and hardware all under one roof? So, is there value from a vertically integrated chain or is the cost of the vertical integration problematic, like where it is anticompetitive?

So, that is why—I struggle because I want to know, like, we can't agree on when the insurance company is doing us a good job and we should pay them, like managing a formulary or setting up a pharmacy network and evaluating the pharmacy network.

Then, the pharmacists, we don't value—we don't have a good way of valuing the pharmacists' services. Again, with you as a dentist, you probably recognize there were things in your practice that you felt like, well, I did not get paid well for this, but I got paid well for that, and so sometimes it is mind blowing to think, as a provider, what do I need to do? Like what do you want me to do? How do you value what I do?

Mr. VAN DREW. OK. So, it would be exploratory in nature, and we are not even there to really determine, to factually try to find out the best route to go.

Dentistry changed a lot for a lot of reasons, partly because of the debt of the students coming out now. So, you all have noticed, wherever you live, that you are seeing larger facilities that are corporate in nature. In my day, you went out, you put your shingle up, you started out, and you might have some debt from school, but it wasn't so overburdening that you couldn't also have more debt to start your practice.

The same thing—and I want to associate with the remarks of my friend on the other side of the aisle from Vermont. I am in New Jersey, admittedly, the more rural part of New Jersey, down in the Southern half of the State. Nevertheless, people do—and I don't know what the answer to this is at all. Nobody does. We miss the independent pharmacy. There is nothing wrong with the CVSs, the Walgreens, et cetera.

Dr. LoSasso, you said something about they are inefficient providers, and therefore they go. I get it. There is something to providing healthcare that is more than just being a Walmart. I know we can't define that fiscally, but it is a real issue.

They are just going to go away, to be honest with you. There is nothing I am going to say at this hearing that is going to stop that.

How much—I am going to ask you all really quickly on this, and then I will yield back. How much of the cost of all of it—and I won't even say all of healthcare, but of pharmaceuticals, just like in healthcare, we can do surgeries and things we never ever could do before. Everybody is getting dental implants now. Years ago, man, nobody would ever spend that kind of money or get implants.

In pharmaceuticals, how much is due to the new types of drug therapy that we can give people that is very, very expensive? When we inhibit that, if we put such price controls in, that it was no longer effective for companies to say, "We want to pursue more new and innovative drugs"?

I am going to start with you, Dr. Van Nuys. I love somebody that has got a "Van" in their name. Just go right down the row, and we have got to be quick, I know.

Dr. VAN NUYS. I don't have those numbers, but I do know that what we are overpaying on, like, the generic side of the market is not going to support that kind of innovation.

Mr. VAN DREW. Do you agree that some generics are too cheap or no?

Dr. VAN NUYS. Sure. I am sure there are some.

Mr. VAN DREW. OK.

Dr. VAN NUYS. In general, no.

Mr. VAN DREW. We are overpaying, you believe, in—

Dr. VAN NUYS. Medicare is, 21 percent.

Mr. VAN DREW. OK.

Mr. MASSIE. The time has expired.

Mr. VAN DREW. I know. Can they just finish answering or no?

Mr. MASSIE. We will let one more answer.

Mr. VAN DREW. OK. One more of you. We will go to you. You are next.

Dr. FRANK. I think that there is a balancing act here, and the—right now we pay too much for brand name prescription drugs some—a lot of times, particularly ones where there are multiple other drugs that do more or less the same thing for the same illness.

There are certainly some places where paying a high price has been well worth the price. I think of the Hepatitis C drugs, for example. High price, good deal, and so the question is which ones—and that is going back to Dr. Mattingly's point, which spay for value. A lot of times we are not getting a lot of value.

Mr. VAN DREW. Thanks. Thank you for your answer.

Mr. Chair, I yield back. Could you ask the question as Chair, is this worthy of antitrust action?

Mr. MASSIE. We may get to that, but now I need to recognize the gentlelady from Wisconsin for five minutes. Or, sorry, Wyoming.

Ms. HAGEMAN. Wisconsin?

Mr. MASSIE. I am so sorry.

[Laughter.]

Mr. MASSIE. There is somebody on the Committee from Wisconsin.

Ms. HAGEMAN. Yes. They are both W.

Mr. MASSIE. Just don't say I am from Tennessee, please.

Ms. HAGEMAN. PBMs may be the best example of the adage that the government is always trying to fix its last solution. Let that sink in for just a minute.

Dr. Frank, in your testimony, you said that, quote,

> Retail pharmacies face an array of challenging economic conditions threatening the survival of some of those operating in rural America, yet much of what threatens those enterprises is not tied to PBMs.

Then, you highlight a number of potential contributing factors in your testimony, but I would like to seek some clarity on your conclusions as I am from Wyoming and I represent the least populated State in the Nation and the ninth largest land-wise. So, obviously, we have a lot of rural areas in Wyoming that need to be served by pharmacies.

I want to discuss what the top contributing factors are. You even summarize your testimony by saying that, quote,

> There is little reason to believe that PBMs are the main economic force creating these risks.

In your opinion, what factors contribute the most to rural America's problems with access to pharmaceuticals?

Dr. FRANK. I do think that—well, let me start by saying that the independent pharmacy issue is really different between rural areas, urban, and metropolitan areas. The point I was trying to make was this is a problem, because pharmacy deserts are growing in this country, and about half of all places—rural areas are served primarily by independent pharmacy.

So, there is a problem here. I am just not sure that the blame or the solution is PBMs. To me, there are other things that can be done in policy that, unfortunately, it doesn't relate to antitrust necessarily, but are important fixes for keeping rural places healthy.

We do it in a variety of other parts of our public programs. We do it in Medicare for hospitals, we do it in just a whole variety of areas, and I think that there are lessons to be imported into—

Ms. HAGEMAN. Such as?

Dr. FRANK. Such as making payment adjustments for rural pharmacies. So, for example, again, you add a bump to an independent rural pharmacy when they are this little community provider, or something like that. So, I think there are policies like that this can preserve these things because even though there are potentially efficiency disadvantaged, as a community resource, they have an efficiency advantage in that they keep people healthy in important ways.

Ms. HAGEMAN. Right. I think that we only have a couple of Walgreens in the entire State of Wyoming. We have one Whole Foods in Jackson. We don't have the access to some of these chains that other places have.

Dr. FRANK. Right.

Ms. HAGEMAN. Dr. Van Nuys, turning to you quickly, you provide a number of policy recommendations, which include increasing transparency, reevaluating the rebate system, scrutinizing vertical integration, and better aligning PBM incentives with patient and payer interests. There have been efforts in recent years at the State level to make reforms to the PBM structure.

Have any of these efforts been successful?

Dr. VAN NUYS. I know that the State legislation has been—some of it has been relatively recently passed and is only now being implemented. I have not seen the data that lets us evaluate how that is working. I do know what they did in Ohio when they audited their PBM and fired them for that 31 percent spread pricing margin and hired a single PBM to administer their whole Medicaid managed care program, that has been saving them $150–$200 million a year.

Ms. HAGEMAN. So, there is one State that has successfully done some reform in this area.

Dr. VAN NUYS. Other States have done similar, I think.

Ms. HAGEMAN. OK. Do you think that this is something that could be accomplished at the State level? Or is it your conclusion that Congress needs to act as well?

Dr. VAN NUYS. I do think that some progress can be made at the State level. I do think because these are national organizations it is maybe more efficient to have them subject to a single set of rules. I don't know.

Ms. HAGEMAN. So, do you have any particular State that you would recommend that we look to what they have done to determine whether that is something that could be implemented on a national basis or that other States ought to be looking to for addressing this issue?

Dr. VAN NUYS. So, most of the State legislation that I have seen is kind of piecemeal, right? They go after spread pricing, or they go after registration or something like that. So, I don't think there is any State that has accomplished the big—

Ms. HAGEMAN. What about the rest of you? Do you have any examples of where there are States or areas that they have successfully addressed the PBM issue?

Dr. LOSASSO. Well, I can speak to at least one situation that I studied is probably more of an example of what not to do, and that was the comparison of Michigan and Illinois, where Michigan thought that it could carve out specialty and specifically carve out those aforementioned curative therapies for Hep C, Sovaldi, and so forth, back in 2012.

What happened was that Illinois kept PBM model in place. The market evolved. The market changed. Sovaldi and other drugs went off patent. Cheaper generics came available. The lack of a PBM in Michigan's context meant that they were not nimble enough to move toward the cheaper generics that became available and cheaper substitutes that were available from other manufacturers. They wound up spending about $50 million more than they otherwise would have compared to Illinois.

Ms. HAGEMAN. OK. Thank you.

I yield back.

Mr. MASSIE. I thank the gentlelady from Wyoming.

I now recognize the gentleman from Texas for five minutes.

Mr. MORAN. Thank you, Mr. Chair. Chair, thank you for holding this hearing today, and thank you to the witnesses for taking time to testify.

One of the really great things I like about this hearing is I feel like we are hearing a very balanced testimony on both sides of this issue. It is very complicated, so thank you for truly an informative

gathering opportunity today for those of us that are still forming our opinions about the PBM issue and what we need to do legislatively, if anything, to fix the rising cost for drugs for Americans today.

Mr. Chair, I would ask unanimous consent to introduce the dissenting statement of Commissioner Melissa Holyoak in the matter of the Pharmacy Benefit Managers Report, July 9, 2024, into the record.

Mr. MASSIE. Without objection.

Mr. MORAN. All right. I want to play devil's advocate for a couple of you here today on some of the things you have talked about. Dr. LoSasso, if I got that correct, I want to come to you and ask you, first, so Dr. Frank, just a second ago, mentioned about pharmacy deserts. I am in a very rural area, just like Ms. Hageman is. I represent Northeast Texas, 17 counties, larger than the State of New Jersey, the entire State of New Jersey, Mr.—yes.

[Laughter.]

Mr. MORAN. I know. You can fact check that if you would like to.

The point is, I have got some counties that don't even have a pharmacy at all in my county—in my district. So, there is pharmacy desert there.

As a county judge before I came here, I actually saw the benefit of Pharmacy Benefit Managers. I hired one in our county that came in and said,

> Hey, here is what you can do in your self-insured plan to replace the higher cost drugs with more generics. We have saved a lot of money for our employees. We kept the benefit to their health high in the process.

Then, as I visited with my independent pharmacies around the district, in particular, I found that they were struggling because of, really, the vertical integration issue of the PBM. So, I don't think that this is a widespread "all PBMs are bad" situation. It is just there are some unintended consequences here that I think are devastating to rural communities in particular. So, I want to go back to you, Mr. LoSasso, and ask, there was a proposed fix over here by Dr. Frank. He said payment adjustments for rural pharmacies. What do you think about that?

Dr. LOSASSO. Well, it is certainly a very interesting and potentially beneficial solution to the problem that has been brought up. I would never contradict Dr. Frank. So, it will probably be gamed, like all these types of adjustments and set-asides and add-ons invariably result in.

Again, like you actually gave a great example there. You were in a situation where you wanted to save some money, you brought it into a PBM. They were aggressive. They gave you the savings you wanted. So, you got what you wanted.

However, then you realized that there were these—what you viewed as spillover effects that impacted the pharmacists, the local pharmacies. So, I wonder if you could have it both ways.

Mr. MORAN. Yes. I don't know, because I know the pendulum swings, and the reason I am concerned about it is because, in some circumstances, you mentioned about the inefficiencies of smaller pharmacies. If they can't basically live up to a certain quantity of drugs that they are going to actually dispense, and maybe they

can't be part of the PBM network, well, that becomes problematic because now my people in East Texas don't have access to that because there is not a large enough population base in certain areas to have a CVS or a Walgreens.

So, now they are not taking their drugs. They are not following up the way they should, and now they have bigger, worse outcomes, health outcomes, that we are all going to have to pay for. We don't want to have to do that.

So, there is a real benefit to having the smaller independent pharmacies in all these markets, and we are seeing them disappear. We are also seeing a lot of our consumers driven to pharmacies they don't want to necessarily have.

So, I would love to find a solution that works for the consumer but still stays true to free market principles, because, quite frankly, I am always starting in that stance to say, "I am a free market guy. Let the market work it out."

We have screwed this market up already, and so there is the other pushback I would have on both sides of the argument is we are already, as a government, intruding on the free market here. Because we have screwed it up, so how do we fix it a little bit better without further intruding on the free market? In the last 30 seconds, am I off base in my comments here? Does anybody disagree? Dr. Van Nuys?

Dr. VAN NUYS. I don't disagree.

Mr. MORAN. OK. Dr. Frank?

Dr. FRANK. Yes. I don't think we should blame ourselves quite as much. The whole pharmaceutical supply chain is a creation of nature of man, of government, an patents, FDA, Medicare, just all the way down the line, and to not have any consequences from having built something from the ground up, so go easy on yourself.

Mr. MORAN. I have got—well, thank you. You are the only one in America that is going to tell me that, by the way.

I have got a lot more questions, and I won't ask them, but I do want to say I think there is space for us to have discussion on the patent reform as well, in particular, as it regard pharmaceuticals, because I think that could be a driving factor to bring down costs as well.

So, thank you all for your testimony today. Very important, very difficult. We need to work together, both ends of this spectrum, to find a good solution for the consumers and the United States and preserve the free market.

Thank you. I yield back.

Mr. MASSIE. Thank you, Mr. Moran.

We are up against votes, so if anybody leaves and doesn't hear my questions, I won't be offended. I have five minutes remaining. I saved it for the end to try and cover things that haven't been covered.

Dr. LoSasso, what is the radical free market solution to this? Just clear out all the underbrush, and what would get rid of all the history? How do we fix this? You have got like a minute to solve it all.

Dr. LOSASSO. Oh, that is all. Yes.

Mr. MASSIE. From scratch.

Dr. LOSASSO. Yes. Well, boy, geez. If we just didn't—if we are just in the PBM—I guess—

Mr. MASSIE. I was told you are a free market guy.

Dr. LOSASSO. Right. So, of course, the original sin was allowing for no tax on employer-sponsored health insurance benefits. So, that weakens the—

Mr. MASSIE. I agree with you there.

Dr. LOSASSO. That weakens that the pay—the incentives that the payers have to even really think about in pushback, because a lot of what we talked about here today that I think troubles me is that we tend to be ignoring the role of the payers. The payers are the ones sitting there looking at the proposals from multiple insurance companies, vertically integrated or not. They still have choice. If I don't like T-Mobile, I will go to AT&T. Right?

So, I can't really be ripped off that much, right? Even with the 80 percent that the three vertically integrated insurance chains—

Mr. MASSIE. What if Apple owned AT&T?

Dr. LOSASSO. Sorry?

Mr. MASSIE. What if Apple owned AT&T? That is my concern. That might be a better analogy.

Dr. LOSASSO. Well, yes. Then I could still go back to T-Mobile.

Mr. MASSIE. OK.

Dr. LOSASSO. Yes.

Mr. MASSIE. With an Android.

Dr. LOSASSO. So, OK, I don't want to monopolize your time here. If you want to just, it is—

Mr. MASSIE. OK.

Dr. LOSASSO. You get the idea.

Mr. MASSIE. The original sin was telling employers that they should provide this, and then giving them the government benefit to make and then not extending that same benefit to individuals who tried to go out and buy healthcare. So, I agree with you on that.

Dr. Frank, or maybe it was Dr. Mattingly—I don't know—one of you was asked about antitrust action, and it didn't seem like there was a clear-cut case here, given the existing laws. So, I don't want to relitigate that question.

I want to ask a question. Is there one piece of law that we could pass? Since the existing law doesn't seem to be actionable or clearly actionable in this situation, is there a rule that we could pass that would fix this, the anticompetitive nature of it?

Dr. FRANK. Well, I have at least an idea about how you could get rid of some of the—attenuate some for the game playing, the regulatory avoidance. So, what you might do there is sort of handle it the way we handle multinationals, which is insist on transfer pricing, that you have transfer pricing rules that somehow reflect something close to fair market value, because right now Dr. Van Nuys and I both made the point that there is a lot of game playing that can be done within that vertical structure to avoid regulations, to avoid—

Mr. MASSIE. What is transfer pricing? What do you mean by that?

Dr. FRANK. So, transfer pricing is—I am a PBM, and I sell services to the insurance company. Well, if my insurance company has

their profits regulated, then I am going to charge them a lot, because that is on the books as a cost. Even though it is revenue to the PBM, that goes back to the parent company. So, those second set of revenues are not regulated. They are not subject to margin regulation in health insurance.

So, by doing transfer prices, which insists on constraining what can be done in terms of who can charge the other one what, you eliminate or you reduce the ability to play games to avoid regulation, taxes, and things like that.

Mr. MASSIE. OK. One minute remaining. Dr. Van Nuys, you had four suggestions. If you could implement just one of those in legislation, what would it be?

Dr. VAN NUYS. Transparency.

Mr. MASSIE. What would that look like, transparency? How would we impose it?

Mr. MASSIE. In pricing?

Dr. VAN NUYS. So, what I want is aggregate benchmarks, average prices at different points in the transaction system. So, CMS already publishes a series called the National Average Drug Acquisition Cost, NADAC. They collect with surveys, and they aggregate it, and they publish it monthly, and anybody can get it. I can get it. You can get it.

That gives us a benchmark to evaluate one particular transaction. That is the transaction between the—sorry, the pharmacy and the wholesaler, the prices between the pharmacy and the wholesaler. I want something like that at the different transactions in the chain. So, I want to know what PBMs are charging health plans to settle a claim, what PBMs are paying pharmacies to settle a claim, what PBMs are negotiating with manufacturers. I want an average benchmark like NADAC, high quality, net—

Mr. MASSIE. What would you do with that information? Who would use it?

Dr. VAN NUYS. I think market participants would use it to understand whether the prices that they are being offered by whoever their counterparty is, the PBM, are fair, and are reasonable. Right? So, any of those market participants could use that benchmark. They don't have anything like that now.

Mr. MASSIE. All right. Thank you very much.

My time has expired, and that means we are done with the hearing. I appreciate the indulgence of the Ranking Member here. Did you want to say anything before we close?

Mr. CORREA. Just, Mr. Chair, I want to thank you very much for handling this—handling this Committee hearing in a nonpartisan way. America is much better off with the information we got today. Barely scratched the surface, but we have some work to do, and I want to thank our witnesses for your good testimony today. Much appreciate you all.

Mr. MASSIE. That concludes today's hearing. We thank our witnesses very much for appearing before the Committee.

Without objection, all Members will have five legislative days to submit additional written questions for the witnesses or additional materials for the record.

Without objection, the hearing is adjourned.

[Whereupon, at 4:39 p.m., the Subcommittee was adjourned.]

All materials submitted for the record by Members of the Subcommittee on the Administrative State, Regulatory Reform, and Antitrust can be found at: *https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=117633*.

○