Testimony of

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Introduction

Good morning, Chairman Guthrie, Ranking Member Eshoo, and other members of the Subcommittee. My name is Kristin Bass, and I am the Chief Policy and External Affairs Officer for the Pharmaceutical Care Management Association (PCMA). PCMA is the national association representing America's pharmacy benefit companies, which administer prescription drug plans and operate home delivery and specialty pharmacies for more than 275 million Americans with health coverage through public and private employers, labor unions, retiree plans, Medicare, Medicaid, the Federal Employees Health Benefits (FEHB) program, and the exchanges established by the Affordable Care Act (ACA). Our members work closely with health plans and health insurance issuers to secure lower costs for prescription drugs and achieve better health outcomes.

I appreciate the opportunity to testify before you to share the thoughts and concerns of the pharmacy benefit industry regarding the legislative proposals under consideration. Pharmacy benefit managers (PBMs) have always focused on lowering prescription drug costs for patients and a wide range of health plan sponsors – specifically by:

- Negotiating rebates from brand drug companies and discounts from drugstores to reduce costs for patients, their families, and health plans – saving payers and patients an average of $1,040 per patient per year.[i]
- Encouraging the use of more affordable alternative brand drugs, such as generics and biosimilars.
- Offering services that benefit patients, such as home delivery, which saves patients time and money while increasing access and care coordination.
- Managing and helping patients access high-cost specialty medications.
- Reducing waste, preventing potentially harmful drug interactions, and improving adherence.

Today, in addition to discussing the legislative proposals that have been introduced, I will review the policies that PCMA members support to encourage a competitive market for prescription drugs, highlight some of the ways pharmacy benefit companies currently work to lower costs for patients and reduce health benefit costs for employers and other plan sponsors, and explain how PBMs support meaningful, actionable transparency to further enhance market competition. Just like PCMA's members, the PBM market is dynamic, diverse, and continues to grow. As of March 2023, there are 73 full-service PBMs in the U.S., with six new PBMs entering the market since 2021.[ii]

As an industry, we welcome any opportunity to discuss and advance ways to improve the prescription drug marketplace so Americans can better afford their prescription drugs. There are many bills before the Committee today, all intended to lower health care costs and improve consumers' ability to make informed choices; however, some of these well-intended proposals will have unintended consequences that would do the exact opposite, increasing costs and reducing choice.

PCMA's testimony today considers mainly the bills and discussion drafts addressing prescription drug costs filed for this committee's consideration, which are limited in scope and focus almost exclusively on the role of PBMs, rather than the companies responsible for setting the prices of the drugs they make and sell. We believe any attempt at understanding the factors driving drug costs must include a look at the entire supply chain, including drug companies, large pharmacy collectives known as Pharmacy Services Administrative Organizations (PSAOs), wholesale distributors, employer benefit consultants, pharmacies, and all others with impact on the cost of prescription drugs. For instance, there is irrefutable evidence of certain drug companies repeatedly abusing the patent system to keep more affordable alternatives from entering the marketplace, which allows those companies to arbitrarily set and increase prescription drug prices.

As it assesses how best to improve the prescription drug market, we encourage the Committee to review all these entities, their business models, profit incentives and underlying motives for pushing or attempting to block certain pieces of legislation as it assesses how to improve the prescription drug market.

Pharmacy Benefit Companies Support Policies to Encourage Competition as the Best Way to Lower Prescription Drug Costs

PBMs work to improve prescription drug affordability by providing prescribers with information about less expensive generic alternatives, setting performance standards for pharmacies to encourage generic fills and adherence, and ensuring patients are aware of lower cost alternatives. Due in large part to these efforts by PBMs, 90 percent of prescriptions are filled with generics.[iii] Pharmacy benefit companies also support increased uptake of biosimilars by preferring both the brand and a biosimilar to ensure patients and providers have the incentive to choose lower-cost options and the choice to continue with a drug from which they may be reluctant to switch. Our industry supports policy proposals to increase biosimilar uptake, including eliminating the interchangeability designation to reduce costs and confusion, stopping abuse of the patent system, and making it easier for Medicare Part D plans to update formularies as new biosimilars come to market.

PCMA supports numerous pieces of legislation that have been introduced and advanced by this committee in previous Congresses that would address tactics that undermine competition in the pharmaceutical market. We also support policies to address drug companies' abuses of the patent system that allow them to extend monopoly pricing well beyond their products' original patent expirations. Drug companies too often block competition and are responsible for setting and increasing prices. Improving competition in the marketplace by cracking down on this abuse will help lower costs for patients and families.

We encourage the Committee to consider these and other proposals to improve competition in the prescription drug market.

PBMs Support Meaningful, Actionable Transparency to Enhance Market Competition

Transparency that helps patients and payers is necessary across the entire prescription drug supply and payment chain. PBMs support and practice actionable transparency that empowers patients, their physicians and pharmacists, those sponsoring health coverage, and policymakers to make informed decisions that can lead to lower prescription drug costs. Actionable transparency encourages consumers to shop for coverage that best fits their health needs and budgets, and through their health coverage, use the most cost-effective, highest-value health care goods and services. It enables prescribers and patients to avoid pharmacy-counter surprises and helps ensure that physicians can prescribe drugs that are affordable for patients. To that end, PBMs provide patients and prescribers with real-time benefit tools, which provide information about a patient's progress through a deductible or another benefit phase, what drugs are on the patient's formulary, and exactly what cost sharing to expect for a given drug at the pharmacy. PBMs also provide patients with information on in-network pharmacies, premiums, general cost-sharing, and benefits for their prescription drug coverage.

PBMs provide health plans, employer plan sponsors, and consumers with a broad array of accurate, actionable information on price and quality to make efficient purchasing decisions. As part of their requests for proposals (RFPs) when putting their pharmacy benefits out to bid, PBMs' customers lay out the terms of the transparency and information they want to receive, as well as their audit rights, and those are memorialized in their contracts.

In recent years, Congress has added more requirements for PBMs to report to federal agencies, as well as public reporting in more aggregated form. In both cases, these bills included appropriate protections for confidential data to avoid encouraging tacit collusion, and PCMA supported these efforts. We have also supported legislation that is now law, which provides Congressional support agencies, including Congressional Budget Office (CBO), Government Accountability Office (GAO), Medicare Payment Advisory Commission (MedPAC), and Medicaid and CHIP Payment and Access Commission (MACPAC), with access to Medicare and Medicaid claims-level data to ensure you are able to perform appropriate oversight.

We have very significant objections, however, to **H.R. 2691, *the Transparent PRICE Act,*** which requires public disclosure of drug-specific information, including the average amount paid by a plan (net of rebates, discounts, and price concessions) for each specific drug dispensed or administered by each participating provider. With this information, each pharmacy and drug manufacturer will know its competitors' price concessions and will be able to determine whether it could have gotten the same business with a lesser price concession. Thus, we believe public disclosure of this too granular, too recent information creates a very high risk for tacit collusion and that patients and plan sponsors will pay more for prescription drugs as a result.

While we support the aim of **H.R. 2679, *the PBM Accountability Act,*** to provide detailed utilization and cost information to plan sponsors, we strongly believe that it is unnecessary to legislate provision of this information as employers can request these data as part of their RFPs.

We appreciate that the bill's sponsors have included a provision that would avoid giving drug-specific confidential information on discounts and rebates to manufacturers, wholesalers, pharmacies, and others in the supply chain who could use it in an anti-competitive manner.

However, the bill still includes a requirement for PBMs to provide information to which they are typically not privy, namely detailed information about drug copay coupons and other forms of manufacturer direct financial assistance to patients. To comply with this requirement, we ask that the bill include a requirement for manufacturers to provide the required drug copay coupon and patient assistance program information to PBMs.

As the Committee considers these proposals, we want to caution against another unintended consequence that could arise from the enactment of either or both bills. Extensive, unharmonized but duplicative reporting requirements create administrative burdens to which larger PBMs may be able to adapt, but smaller PBMs may find overly burdensome or wholly unworkable, forcing them to either close their doors or consolidate, reducing the competitive market for PBMs. It is also important to note that while larger PBMs may be able to adapt, these added reporting burdens on top of the existing requirements outlined below could lead to higher costs for consumers.

PBMs Already Comply with Numerous Disclosure Requirements

As noted in PCMA's written statement in response to the Committee's hearing on this subject last month, "Examining Transparency and Competition in Health Care," pharmacy benefit companies already operate under federal transparency requirements and adhere to myriad contractually required transparency provisions imposed by their own business and government partners.

PBMs are subject to transparency regulations promulgated by the Departments of Health and Human Services (HHS), Labor, and Treasury, the Office of Personnel Management, and states. PBM practices are overseen by state Medicaid agencies, state-based consumer protection agencies, private accreditation organizations, and their own customers – health plan sponsors. PBMs are also directly regulated by state departments of insurance or other state agencies.

Exchange plans must report data to CMS on numerous administrative processes such as coverage determinations and prior authorization in a way that both enrollees and potential enrollees can access and understand them. Exchange plans must also report data confidentially to CMS regarding generic dispensing rates for retail and mail order pharmacies; aggregate amounts and types of rebates, discounts, price concessions, and service fees; total prescriptions covered; and the difference between the amount the health plan pays the PBM and the amount that the PBM pays retail and mail order pharmacies.

Medicare Part D plans must make available to enrollees and potential enrollees all relevant aspects of their benefit design, and report confidentially to CMS the same information as exchange plans, through annual reporting. Part D plans also submit to CMS Prescription Drug Event (PDE) data, which is a summary of Part D claims activity with additional data elements including pharmacy dispensing fees. As part of the annual bid and reconciliation processes, PBMs (via the Part D plans) must report to CMS estimated pharmacy and manufacturer Direct and Indirect Remuneration (DIR), including rebates and other price concessions.

It is important to note that government reporting by PBMs is not static but an ongoing, evolving construct. Indeed, CMS routinely updates required Medicare Part D filings to encompass more information, including with respect to PDE and DIR filings. For example, new pharmacy DIR rules take effect on January 1, 2024. Under these new rules, the negotiated price for a Part D covered drug must reflect the lowest possible reimbursement a network pharmacy will receive for a drug and must include all pharmacy price concessions. CMS has already issued detailed guidance on how these changes are to be included in PDE and DIR filings, including changes related to calculating beneficiary cost sharing taking into account the application of pharmacy price concessions at point of sale.[iv] Also, CMS has several other major expansions underway to the PDE submissions for 2025 related to Inflation Reduction Act implementation, and we expect to see more for 2026.

Moreover, reporting is not limited to federal health care programs and exchanges. For commercial plans, the Departments of Treasury, HHS, and Labor as well as the Office of Personnel Management (OPM) require PBMs to report:

- The 50 most frequently dispensed brand prescription drugs.
- The 50 costliest prescription drugs by total annual spending.
- The 50 prescription drugs with the greatest increase in expenditures from the previous year.
- Prescription drug rebates, fees, and payments by drug manufacturers in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates.
- The premium and out-of-pocket cost impact of prescription drug rebates, fees, and other payments.

PBMs may report these data directly to the government or to their customers. The customers (plan sponsors, issuers, and the FEHB program carriers generally) are required to submit this information, along with some of their own data regarding premiums, aggregated at the state/market level, rather than separately for each plan. The Departments must biannually issue a report based on the data, but otherwise must keep the data confidential and may not release proprietary information. The first such report will be issued in June 2024.

PBMs may report these data directly to the government or to their customers. These customers (including plan sponsors, issuers, and the FEHB program carriers generally) are required to submit this information aggregated at the state/market level, rather than separately for each plan.

Beyond government reporting requirements, much of the PBMs' operational specifics are available to plan enrollees through other provisions of the Affordable Care Act and Social Security Act, including the Summary of Benefits and Coverage, Medicare Plan Finder, and real-time benefit tools that provide current information on prescription drug benefits.

Finally, the Securities and Exchange Commission (SEC) also requires publicly traded health plans and PBMs to report quarterly and annual financial information to the SEC.

Exposing Proprietary Pricing Information Can Raise Drug Prices

PCMA continues to be concerned about potential unintended consequences of bills that expose proprietary pricing and contract information. The Federal Trade Commission (FTC) has historically spoken out against over-exposing information about private business dealings because such an approach is deeply damaging to a competitive marketplace, stating, "If pharmaceutical manufacturers learn the exact amount of the rebates offered by their competitors (either because the safeguards on subsequent disclosure by purchasers and prospective purchasers are insufficient or because the mandated disclosure to prescribers provides sufficient information for pharmaceutical manufacturers to calculate these amounts) then tacit collusion among manufacturers is more feasible. Consequently, the required disclosures may lead to higher prices for PBM services and Pharmaceuticals."[v]

Likewise, the FTC has noted that there are limits to the benefits of transparency and unintended consequences can result.[vi]

The FTC is not alone in this assertion. Recently, in speaking about concerns related to anticompetitive information exchanges, Principal Deputy Assistant Attorney General Doha Mekki noted on behalf of the Department of Justice (DOJ) that, "Courts have long recognized that the exchange of competitively sensitive information can subvert the competitive process and harm competition." Attorney General Mekki also spoke of the United States Supreme Court's concern that sharing current pricing information risks greater harm than sharing old, stale information, and specifically stated that, "transparency in the health care arena may lead to tacit collusion and higher prices."[vii] She went on to say:

> *Courts also have looked at the degree to which the exchanged data has been aggregated. These decisions considered how, in light of the facts and market realities at the time, the information could facilitate and result in the type of behavior that the antitrust laws condemn. The Second Circuit explained in Todd that "[p]rice exchanges that identify particular parties, transactions, and prices are seen as potentially anticompetitive because they may be used to police a secret or tacit conspiracy to stabilize prices. . .. Courts prefer that information be aggregated in the form of industry averages, thus avoiding transactional specificity." But facial aggregation of data alone has been held to be insufficient to save otherwise problematic information exchanges. In Todd, the Second Circuit looked beyond data that appeared to be somewhat aggregated to conclude that the defendants had the ability to effectively disaggregate it, raising serious antitrust concerns.*[viii]

For these reasons, it is important to carefully protect data that helps to maintain a competitive market and ensure it is never released publicly. As Mekki warns, such information sharing would likely damage the private market, "A softening of competition through tacit coordination, facilitated by information sharing, distorts free market competition in the process."

Additionally, the Congressional Budget Office has framed the transparency and disclosure considerations clearly in this often-quoted statement:

> *The disclosure of drug rebates could affect Medicare spending through two principal mechanisms. First, disclosure would probably make rebates less varied among purchasers, with large rebates and small rebates tending to converge toward some average rebate. Such compression, for reasons discussed below, would tend to reduce the rebates that PDPs received and thus would raise Medicare costs. Second, for a range of medical conditions, drugs appropriate for treatment are available from only a few manufacturers; disclosure of drug-by drug rebate data in those cases would facilitate tacit collusion among those manufacturers, which would tend to raise drug prices.*[ix]

PCMA encourages the Committee, as it reviews how to improve the prescription drug market to help lower costs for patients and businesses, to focus its efforts on actionable transparency that reduces drug costs versus transparency that raises them.

Pharmacy Benefit Companies Support Plan Sponsors' Ability to Choose What Works for Them

Public and private health plan sponsors vary dramatically in size, resources, and function, serving diverse populations. Employers, union and retiree plans, states, and others who provide health care coverage know more about their financial resources and plan participants than any other entity, and they need the ability to design plans tailored to the unique needs of their participants. No public or private employer, union, retiree health plan, pension fund, or other health plan is required to hire or use a PBM, but virtually all do, and the vast majority are happy with the services their PBMs provide, with employers reporting about 80 percent satisfaction with the cost-saving, health-improving services provided by their PBM. As health plan sponsors strive to create accessible, affordable benefits that meet the needs of the populations they cover, policymakers should avoid mandates that could increase costs and decrease quality.

Health plans, including those serving federal programs, rely on PBM expertise to secure savings through price concessions from pharmaceutical companies, administer medication adherence and health coaching programs, and provide overall guidance and expertise on pharmacy benefit design and coverage. PBM clients choose their PBMs through a transparent and highly competitive bidding process. With more than 70 full-service PBMs in the market – including new entrants – health plan sponsors have an opportunity to evaluate the differentiated value propositions of multiple PBMs and select the one that best meets their needs.[x] Some may base selection criteria on PBMs' scale, ability to negotiate deep discounts, or effectiveness managing the risk of price changes. Others may base selection criteria on PBMs' innovative care management programs or different levels of service. For small employers, many of whom may struggle to provide health insurance to employees, PBMs both lower their overall drug costs and provide cost predictability, enabling them to stretch their benefit dollars even further.

PBMs also manage pharmacy benefits for state Medicaid programs with both Medicaid managed care organizations (MCOs) and fee-for-service (FFS) coverage. Nationally, PBMs saved Medicaid $22 billion from 2013 to 2018 combined; however, the potential for additional savings remains untapped.[xi] In the commercial market, PBMs have the flexibility to:

- drive use of the highest therapeutic quality, lowest-cost drugs and shift utilization from brands to generics as clinically appropriate;
- develop preferred pharmacy networks;
- advance evidence-based, clinically effective utilization; and
- leverage data analytics to detect and prevent fraud, waste, and abuse.

As drug prices continue to increase and expensive gene and cell therapies come to market, state Medicaid programs will face increasing budgetary pressures. Optimal use of PBMs tools in state Medicaid programs would save a total of $112 billion over 10 years, $43 billion for states, and $69 billion for the federal government. [xii]

Plan sponsors, including state Medicaid programs, should continue to have the option of determining how they would like to pay the pharmacy benefit company they select for their services. “Spread pricing” is a risk-based contracting model in which the client (in this case, a state Medicaid program) may choose to contract for predictability. Under a spread pricing model, a state would let the pharmacy benefit company hold the risk that Medicaid recipients may use more expensive pharmacies to acquire drugs. In exchange for that risk, the state lets the PBM keep the savings when a patient uses a less expensive pharmacy, but the PBM takes a loss when patients use costlier pharmacies. Today, states and other plan sponsors can choose spread pricing or, alternatively, “pass-through” contracting, in which the plan sponsor pays whatever the pharmacy charges. While some may select pass-through contracts because they have the scale or budget to deal with the variability of pharmacy charges, others, including a number of state Medicaid programs, choose spread contracts because of the pricing predictability and savings they derive. It is important to note that while this type of risk-based contracting has been portrayed as drug-by-drug difference between what a plan pays for an individual drug and what is paid by the PBM to the pharmacy, spread contracts are based on a plan sponsor’s overall drug spend. In contrast, under administrative, or pass-through, contracts, plan sponsors bear financial risk for their total drug spend. Many employers, including small businesses, prefer the price predictability of spread contracting.

Among the bills offered for consideration today is **H.R.1613, *the Drug Price Transparency in Medicaid Act of 2023***, which prohibits the use of spread pricing in Medicaid, limiting state choice. State Medicaid programs are never required to select risk-based contracting models. State Medicaid programs that do not wish to use spread pricing can – and do – select other payment arrangements. We believe states should have that flexibility.

We are further concerned that the proposed legislation’s application of the Medicaid equal access protection at section 1902(a)(30) of the Social Security Act to PBMs appears to give the Centers for Medicare & Medicaid Services (CMS) direct rate setting authority with respect to pharmacy

reimbursement. The equal access protection, a federal directive imposed on states as the primary administrators of the Medicaid program to ensure sufficient payments providers, should not be repurposed and imposed on PBMs who generally have no contractual privity with the state Medicaid agency. We are unclear whether the intent of the Committee is to broaden Medicaid's rate setting authority, or otherwise bypass MCOs in contracting with PBMs. We oppose making this change and urge the subcommittee to appropriately consider this potential consequence.

CMS' May 15, 2019 guidance on Medicaid's Medical Loss Ratio (MLR) already ensures that PBMs are not excessively profiting from state Medicaid programs by requiring that pharmacy spread is included in the plan's 15 percent non-claims administrative expense, in addition to eligibility and coverage verification, claims processing, utilization review, or network development, expenditures, and profits. As explained in the guidance:

> *The PBM is required to classify and report revenues and expenditures associated with the administration of the Medicaid covered outpatient drug benefit to the managed care plan in the same manner that the managed care plan would be required itself to classify and report this information if the managed care plan had administered the covered outpatient drug benefit directly. Even if the managed care plan pays the PBM a capitated amount in a risk-based arrangement, the managed care plan and PBM must classify and report revenues and expenditures associated with the administration of the Medicaid covered outpatient drug benefit consistent with 42 CFR 438.8. That is, the managed care plan may not use the entire capitated payment to the PBM as incurred claims. Rather, the PBM must calculate incurred claims as the amounts paid to the retail or mail-order pharmacy.*[xiii]

As part of this reporting process, states are able to make informed decisions about their Medicaid drug benefits. They should continue to have that choice.

Medicare Part D Pharmacy Network Requirements Support Robust Beneficiary Access to Prescription Drugs

Maintaining a competitive market for prescription drugs requires participation from all participants in the supply chain. Where a patient acquires a drug can impact its cost significantly. Policies that restrict pharmacy benefit companies' ability to develop pharmacy networks drive costs up, while well-managed pharmacy networks offer savings to both plan sponsors and enrollees. Health plan sponsors may select – or in the case of Medicare Part D, prefer – specific networks of pharmacies to provide drugs to their enrollees at competitive prices. Nationally, 76% of employers report using a tailored pharmacy network, and employees typically save about 38% out-of-pocket using in-network vs. out-of-network pharmacies.[xiv] To preserve the benefits of pharmacy networks, it is important to understand the critical role of pharmacy services administrative organizations (PSAOs) in supporting pharmacies.

Pharmacies large and small are important partners in delivering care to patients. Most pharmacy networks are designed to provide patients with a variety of options allowing them to get the drugs they need where they need them. Approximately 83% of independent pharmacies use large

PSAOs to negotiate favorable contracts with pharmacy benefit companies. Data shows the independent pharmacy market is stable, growing 0.4% over the last year,[xv] and it is the only sector of retail pharmacy that has experienced growth over the last 10 years. By leveraging the power of large PSAOs to negotiate with pharmacy benefit companies on their behalf, independent pharmacies can secure favorable contract terms and, on average, higher reimbursements than chain drugstores.[xvi] PSAOs and PBMs also provide pharmacies with software, such as Pharmacy Quality Solutions' Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP), which allow pharmacies to access their contracted pharmacy measures and compare benchmark measures of their contracts across plans and against other pharmacies.

There are many types of pharmacies – retail, specialty, hospital, clinic, home care, mail order pharmacy, compounding, and assisted living or long-term care – to name a few. These pharmacies vary and not all pharmacies can or should do all things because they offer differing levels of expertise and services to ensure patients are getting what they need to secure the best health outcomes. In fact, there are more than 60,000 retail pharmacies in the United States, including large chains, mass merchants, grocery stores, and 23,000 independent community pharmacies.

Health plans with a variety of sites of care in their networks are able to promote access, affordability, and value. For example, the right mix of brick-and-mortar, mail, and specialty pharmacies improves adherence to therapy and patient safety.

The discussion draft legislation ***to amend title XVIII of the Social Security Act to promote transparency of common ownership interests under Parts C and D of the Medicare Program*** may disincentivize business model efficiencies and be a disservice to beneficiaries and the broader PBM market by increasing administrative burdens. The excessive reporting requirements imposed by this proposal on vertically integrated plans could also impair the ability of Part D plans to meet the program's standards for network adequacy. Further, other members of the prescription drug supply chain may be impacted as they are vertically integrated as well. For example, wholesalers often own PSAOs and or pharmacies, as well as operating the equivalent of pharmacy franchises.

PBMs Help Patients Afford Their Drugs

As we understand it, the legislative proposal before the Committee ***to establish patient protections with respect to highly rebated drugs*** attempts to prevent patients from paying out-of-pocket cost sharing that exceeds the net cost of their drug. This is a scenario outside the norm because the market already offers solutions to prevent it from happening. PBMs support efforts to address high out-of-pocket costs for patients and offer health plans' myriad programs in the commercial market, including benefit design options that allow up to full rebate pass-through at the point of sale. The bill also proposes a complicated requirement to base cost sharing on the net price of a drug from the previous calendar year, which is impractical because rebate contracts change every year. For example, a rebate could drop precipitously from one year to the next, as

is likely to happen with respect to the insulins for which manufacturers just dropped prices. To minimize operational complexity, cost sharing should be based on a good faith estimate of net price for the current year, as rebates are not known until well after a year's end.

We are also concerned about the likely significant market distortion that would result from the provisions of the bill prohibiting health plans from receiving from drug manufacturers a rebate, reduction in price, or other remuneration for a highly rebated drug that was not covered in a previous year, unless the reduction in price is reflected at the point of sale to the enrollee; and any such other remuneration is a flat-fee-based service fee not contingent on the total volume of sales. For example, this provision essentially requires a point-of-sale rebate if a PBM negotiates to a lower overall cost of a competitor's drug and puts it on the formulary. This would lead to premium increases. In addition, manufacturers would know that PBMs would want to avoid premium increases, and it would strengthen manufacturers' hands in negotiations for drugs that already have patent protections and monopoly pricing. We urge the subcommittee to eliminate this provision from the legislation to avoid this unintended market distortion.

In addition to offering programs to keep out-of-pocket costs low, PBMs work with those providing insurance to encourage patients through formulary design and cost-sharing incentives to use the most affordable drugs, which are usually generics. Generic dispensing has grown over the past decade as more generics have entered the market and patients have responded to health plan designs encouraging their use.[xvii] PBMs also employ other tools designed to deliver high-quality drug benefits while bringing down costs.[xviii] For many brand drugs, PBMs negotiate directly with drug manufacturers who compete for formulary placement by offering rebates.[xix] For drugs on a preferred tier of a plan's formulary, patients typically have lower cost sharing.[xx] As competing products enter the market, PBMs gain the flexibility to leverage competitor products to negotiate deeper drug discounts for patients and employers.[xxi]

PBMs have also led the industry in creating contracts that account for the value of specialty and high-cost medications.[xxii] Value-based arrangements are at the forefront of new drug payment designs and will be critical to managing the costs of next-generation therapies such as cell and gene therapies, orphan drugs, and ultra-expensive specialty drugs. Value-based contracts will better allow plans to manage these high costs, and plan sponsors will need broad flexibility to craft and employ value-based contracts.

The Medicare Part D program, where older Americans and those living with disabilities can choose among private plans to get their drug benefits, is a great example of how PBMs' support for plans impacts patients. PBMs support Part D plans by negotiating rebates and discounts and promoting better pharmacy quality, passing 99.6 percent of the savings from those negotiations to the Part D plans, which in turn use them to enhance drug benefits and keep premium costs reliably low for beneficiaries.[xxiii] We applaud the introduction of **H.R. 2666, the *Medicaid VBPs for Patients (MVP) Act,*** which could reduce the barriers to innovative contracting models in Medicaid, hopefully allowing Medicaid programs to better control program costs.

Savings from PBMs benefit health plans, employers, retirees, and patients directly. Prescriptions cost health plans and employers an average of $1,040 per person per year, with patients paying an average of $166 for their prescriptions, or 12 percent.[xxiv] Without PBMs and the savings they generate, drug costs could be over $2,300 per person per year.[xxv]

Conclusion

Thank you for inviting me to appear before the Committee today. PBMs exist to reduce drug costs for plan sponsors and, most importantly, for the patients for whom those health plan sponsors provide coverage. In doing this work, PBMs generate tremendous value, estimated at $145 billion annually for society,[xxvi] and, when taking Medicare savings into account as well as other programs and the commercial market, save payers and patients an average of $1,040 per person per year.[xxvii] Much of this value is generated by the savings PBMs negotiate with pharmaceutical manufacturers and pharmacies. PBMs also lower prescription drug costs by promoting the use of generic medications, encouraging better pharmacy quality, and offering things like home delivery of medications. Through their work, PBMs lower the cost of health coverage, reduce drug costs, and support better and more affordable prescription drug access for patients, which means more people can get on and stay on the medications they need. For many years, evidence has shown a return of 10:1 on investments in PBM services for their private sector and government partners.[xxviii] As a result, PBMs will lower the cost of health care by $1 trillion this year alone.[xxix]

PCMA looks forward to working collaboratively with Congress and other stakeholders to build on the existing private market framework to address prescription drug affordability challenges and improve functionality for patients. As this process moves forward, we would be happy to work with you to minimize unintended consequences that would lead to higher costs for employers, patients, and taxpayers.

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