Statement for the Record: National Community Pharmacists Association

United States House Energy and Commerce Health Subcommittee Hearing:

"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients."

February 26th, 2025

Chairman Guthrie, Ranking Member Pallone, Subcommittee Chairman Carter, Vice Chairman Dunn, Ranking Member DeGette and Members of the Committee:

On behalf of the National Community Pharmacists Association, thank you for holding this hearing regarding pharmacy benefit managers (PBMs) and their effect on the prescription drug market. NCPA represents America's community pharmacists, including 18,900 independent community pharmacies across the country, and together our members employ 205,000 individuals, and provide an expanding set of health care services to millions of patients every day. Our members are small business owners who are among America's most accessible health care providers. We commend your bipartisan leadership on this issue and thank you for prioritizing PBM reform in the 119th Congress.

PBMs are largely unrecognized by most patients and misunderstood by many employers and payers (including governmental entities and taxpayers), but they profoundly influence U.S. health care decision-making and drug spending. They have the power to determine which drugs patients may have, which pharmacies patients may use, and, through their affiliations with or ownership of pharmacies, control how much their competitors can be reimbursed for prescription drugs and other pharmacy services. They also determine the drug price patients pay at the counter. They use this influence to increase their outlandish profits at the expense of taxpayers, patients, and local, independently run pharmacies. Due to vertical integration, the three largest PBMs (representing over 80 percent of covered lives in this country) are owned by or own the three largest health insurance companies and they each have their own pharmacy, whether it is mail order or retail. PBMs' anticompetitive practices, opaque reimbursement models, and restrictive contract terms have created an environment in which they can use their overwhelming market power to steer patients away from their competitors to their own pharmacies and pay themselves higher prescription reimbursement rates. They also limit access to the marketplace similar to major tech firms that run app stores.

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A recent Federal Trade Commission (FTC) interim report found that the top three PBMs generated more than $7.3 billion in revenue from patients by steering "specialty drugs" to their affiliated pharmacies.[1] Such practices not only limit independent pharmacies' reimbursements but also inhibit patients' ability to pay for critical medications. These and other PBM abuses have led to the net loss of over 450 independent community pharmacies since June 2023, and we are on track to continuing losing one a day.[2] The closures of these irreplaceable community pharmacies harm tens of thousands of patients, many of whom rely on their local pharmacy for first-line medical care, particularly those who live in rural or medically underserved areas.

In addition, pharmacists have recently been subject to financial burden in several forms, including: the Change Healthcare cybersecurity attack, Express Scripts' (ESI) violation of the recent direct and indirect remuneration (DIR) rule for their own profit, as described in more detail below, and lower reimbursement overall for prescriptions. The cyberattack on Change Healthcare affected roughly a third of the country and led to pharmacies dispensing patients' medications in good faith after the system went down.[3] However, reimbursements for those medications were delayed by months, severely cutting into pharmacies' already low bottom line. In the aftermath of Hurricane Helene in September 2024, pharmacies had to operate without access to their records or electricity, and when they acted in good faith to serve patients, PBMs hit them with audits in the middle of the crisis. PBMs skirt the rules and play games all too frequently. In January 2024, the Medicare Part D rule on DIR fees went into effect and pharmacists immediately noticed overall lower reimbursement on medications, as well as new fees from PBMs. Those new fees and games took the form of ESI's "bonus pool" where fees were not being calculated at the point of sale and thus violated the restriction on retroactive DIR fees. NCPA notified the Centers for Medicare & Medicaid Services (CMS) of the violation on January 8. We sent a letter in April to ESI calling out their stifling business practices, including the unlawful bonus pool program[4] We followed up with CMS in May with a letter and with a meeting the following week between CMS and NCPA's Regional Chain Advisory Group, which represents over 700 pharmacies in 20 different states. CMS informed us that ESI was violating the rule[5] and by June 10, ESI announced they would be discontinuing[6]

These practices should not be a surprise. In June 2024, 3 Axis Advisors released a report detailing spread pricing in employer-based health plans in the state of Washington.[7] The results show that many mail-order pharmacies' prescriptions cost significantly more than brick-and-mortar pharmacies, with the price of generics three times higher, and brand-name drugs three to six times more expensive at a PBM-affiliated mail-order pharmacy than a chain and **35 times more expensive** than at independent pharmacies.[8] During the four-year period of the study, plan sponsor costs went up by 30 percent, and pharmacy reimbursements decreased by three percent.

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[1] FTC Releases Second Interim Staff Report on Prescription Dug Middlemen
[2] Local Pharmacies on the Brink, New Survey Reveals | NCPA
[3] NCPA Timeline of Change Healthcare Cyberattack and Response
[4] NCPA Letter to ESI, April 2024
[5] ESI Fees Violate Federal Policy; NCPA Pushes CMS for Clarity, Accountability
[6] ESI blinked and vows to accelerate reimbursement for bonus pool fees
[7] 3AxisAdvisors Report - Understanding Drug Pricing from Divergent Perspectives
[8] WSPA PBM Study Results Released

We often hear that PBMs claim they save money for state-funded health plans like Medicaid managed care programs, yet numerous reports have found that this is not the case. Instead, you can see that excessive amounts of taxpayer dollars have been funneled to PBMs. Here are a few examples:

- West Virginia and North Dakota both eliminated spread pricing and moved to a transparent cost-based reimbursement system, saving their Medicaid programs $54.4 million and $17 million respectively.[9]
- Kentucky identified $123 million of spread pricing annually, precipitating wholesale changes to their Medicaid pharmacy model.
- The auditor general in Ohio identified more than $224 million of spread pricing.
- Illinois found $220 million in spread pricing waste in its Medicaid program.
- The Commonwealth of Virginia and Maryland have found smaller yet still egregious sums of spread pricing.

Further, according to an NCPA survey of our members in January 2025, over 80 percent of respondents said the financial health of their business declined in 2024, and 20 percent are considering closing their doors this year.[10] Half of all respondents stated that Medicare Part D makes up over 40 percent of their business by prescription volume, and we found that community pharmacies are being under-reimbursed on 75 percent of the Part D prescriptions they fill, when taking into consideration the cost to acquire and dispense a medication.[11] If pharmacies continue to face challenges like these, more and more will shut their doors. In the last four years we have lost almost 2,700 retail pharmacies (chain, mass merchants and independents) — an overall 4.7 percent decrease of pharmacy choices for patients — and that pattern of pharmacy closures is increasing. Independent pharmacy net closures continue at approximately one store per day.

It is for these reasons that Congress must enact the bipartisan, bicameral legislation that was negotiated and agreed to at the end of last year to address these issues and hold PBMs accountable. The Congressional Budget Office (CBO) scored the PBM reform policies included in the legislation as saving taxpayers nearly $5 billion, as can be seen in the chart below. Included in the legislative measures are policies that would enhance transparency and eliminate spread pricing in Medicaid managed care programs, as well as requirements of CMS to define and enforce reasonable and relevant contract terms in Medicare Part D, improving patient access to medications.

[9] NCPA Explainer – State Medicaid Managed Care Reform
[10] Report for January 2025 Survey of Independent Pharmacy Owners/Managers
[11] Report for February 2024 Survey of Independent Pharmacy Owners/Managers

Provision	Latest Public CBO Score
NADAC	$2.046B in savings (CBO)
Medicaid spread	$306M in savings (CBO)
Commercial PBM transparency	$1.872B in savings (CBO)
Part D delinking/transparency	$719M in savings (CBO)
TOTAL	**$4.943B in savings**[12,13]

Furthermore, we believe the recent push to improve efficiency in government and save taxpayers money is a natural fit for these reforms and the above-mentioned savings that would follow. As we outlined in a December 2024 letter to the incoming administration,[14] the PBMs' blatantly anticompetitive behaviors prevent the overall health care market from operating efficiently for consumers, resulting in higher drug costs. The increasing dominance of PBMs poses a significant threat to consumers' convenient access to prescription medications, while at the same time raising costs for government programs like Medicare Part D, Medicaid, Tricare, and the Federal Employees Health Benefit Plan.

This can be seen in a recent report from the Government Accountability Office, which called for additional oversight of the Department of Defense's (DOD) Tricare program.[15] The DOD's Defense Health Agency (DHA) oversees the Tricare contract, and oversight plans within the contract call for audits of the program. However, since 2009 when ESI took over the contract, DHA has never implemented an audit, instead relying on monthly reports from ESI, which GAO found to have inaccuracies. Specifically, there were two months of missing information on beneficiaries impacted by network changes, during which time roughly 200 pharmacies had left the network.

Additionally, the Office of Inspector General (OIG) released a report in March 2024[16] finding the PBM – once again ESI – overcharged the United States Postal Service health plan by nearly $45 million dollars. This included such acts as overcharging pharmacy claims, failing to implement pass-through transparent drug pricing, withholding drug pricing discounts when filling prescriptions with the PBM's own mail-order and specialty pharmacies, failing to return retail pharmacy transaction fees the carrier had been credited for, and failing to pass on a portion of – or outright withholding – the drug manufacturer rebates. We continue to encourage the committee to use their power of oversight and policymaking to find creative ways to save money for patients and taxpayers while ensuring independent pharmacies are reimbursed fairly.

Further delay of legislative action would be catastrophic to community pharmacies and their patients. Increased vertical and horizontal consolidation of PBMs and health plans has caused severe inequities

[12] CBO Estimated Budget Effects of the Beter Mental Health Care, Lower-Cost Drugs and Extenders Act and Certain Provisions of the MEPA Act
[13] CBO Cost Estimate of S.1339, Pharmacy Benefit Manger Reform Act
[14] NCPA Letter to DOGE December 2024
[15] GAO Report - DOD Should Improve Monitoring of TRICARE Beneficiaries Access to Prescription Drugs
[16] OIG Report – Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021

for pharmacies and Medicare Part D beneficiaries alike. Community pharmacies are under-reimbursed on 75 percent of Part D claims, and PBM practices cause further harm to patients by impeding access to medications through limited formularies and networks, letting insurance companies – not patients and doctors – decide when a drug works for a patient. We applaud the bipartisan, bicameral efforts to address PBM reform, and we urge lawmakers on both sides to continue to work in a bipartisan manner to pass these reforms that save $5 billion. Congress must not miss this opportunity to pass comprehensive and meaningful PBM reforms, and we hope that this hearing will provide the necessary momentum to provide legislative relief in the coming days.