APhA
American Pharmacists Association

AMERICAN PHARMACISTS ASSOCIATION
STATEMENT FOR THE RECORD

BEFORE THE U.S. HOUSE BUDGET COMMITTEE

BREAKING UP HEALTH CARE MONOPOLIES: EXAMINING THE BUDGETARY EFFECTS OF HEALTH CARE CONSOLIDATION

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Chair Arrington, Ranking Member Boyle, and Members of the Committee:

On behalf of our nation's over 340,000 pharmacists, the American Pharmacists Association (APhA) is pleased to submit the following Statement for the Record to the U.S. House Budget Committee Hearing, "Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation."

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists and pharmacy personnel in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA applauds the Committee's ongoing leadership and recognition of the need to improve competition in the highly concentrated healthcare marketplace,[1] where over 80% of all equivalent prescription claims are processed by only three vertically merged companies, which has increased barriers to market entry, raised prescription drug costs, and reduced choice for consumers, purchasers, and the U.S. taxpayer.[2]

APhA also looks forward to gaining further insights into this consolidated marketplace with the Federal Trade Commission's (FTC) potential release of its expanded[3] and ongoing pharmacy benefit manager (PBM) study this summer.[4]

As stated by Chair Comer during a recent House Oversight and Accountability congressional hearing,[5] heavy consolidation in the healthcare marketplace "means when PBMs negotiate with a pharmacy or a health insurer, they are either negotiating with themselves or one of their direct competitors. They own pharmacies to which they steer patients who have branded drug therapies for which they can maximize the fees and rebates they charge the pharmaceutical companies, and then turn around and charge the self-insured employer or the U.S. government

[1] https://www.drugchannels.net/2024/05/mapping-vertical-integration-of.html
[2] https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html
[3] https://www.ftc.gov/news-events/news/press-releases/2023/06/ftc-further-expands-inquiry-prescription-drug-middlemen-industry-practices
[4] https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry
[5] https://oversight.house.gov/release/hearing-wrap-up-pharmacy-benefit-managers-push-anticompetitive-drug-pricing-tactics-to-line-their-own-pockets%ef%bf%bc/

the full price of the medicine."[6] They play shell games with rebates, causing employers and our government to think they are getting a deal, when, in fact, they are continuing to hide billions of dollars in undisclosed fees. If the prescription is something that is filled at the local pharmacy, they charge the pharmacy a monthly fee just to be part of their network, then reimburse the pharmacy below their cost of the drug, often times even forcing the pharmacy to dispense a more expensive brand name drug with a higher out of pocket copay for the patient so that the PBM can collect the rebate.

Vertically integrated healthcare companies and their PBMs increase the costs of rivals in either the upstream or downstream market.[7] Such a foreclosure effect can raise prices and require that firms seeking to enter one of the markets enter both markets which significantly increases the difficulty of entry. As a result, vertical PBM mergers that reduce the actual or potential number of competitors create serious competitive concerns. Whenever the statement is made that there are 73 full-service PBMs in the marketplace, the next question to ask is what does that represent of the total market share? As indicated earlier in our statement, 70 smaller PBMs only garner less than 20% of the marketplace. This consolidation has created large oligopolies in the healthcare marketplace that engage in destructive, anticompetitive conduct.

Similarly, in the case of Change Healthcare, a serious vulnerability was exposed that industry consolidation and vertical integration have led to only a few vendors owning nearly all the market share of business for pharmacies and other providers to transact healthcare claims. While precise data are not publicly available, several sources estimate that Relay Health and Change Healthcare together control over 95% of the switch aspect in the pharmacy industry. Had an attack simultaneously occurred on Relay Health, the consequences to our healthcare system could have been catastrophic.

Take-it-or-leave-it contracts by entities that dominate the marketplace include provisions that require them to be the sole contractor for certain products and services. This locks pharmacies in without the ability to switch to a new provider or have a backup plan. Change Healthcare also held sole contracts for many pharmaceutical manufacturer discount cards and compassionate use programs. This meant that not only was the cyberattack disruptive on our healthcare system, but it also negatively impacted individuals in our society with health disparities who are particularly vulnerable. Clearly, these issues have significant budgetary impacts for our nation's healthcare system.

[6] https://x.com/GOPoversight/status/1704136650610049056
[7] https://www.crowell.com/a/web/rvRQKSU3eAs7xxCzx6d5A9/4Ttkch/20200401-antitrust-analysis-of-vertical-hc-mergers.pdf

**Vertically Integrated Healthcare Companies are Costing Medicare, the Federal Government and the U.S. Taxpayer:**

- Between 2010 and 2020, CMS reports that pharmacy direct and indirect remuneration (DIR) fees increased by more than 107,400 percent![8] The increase in point of sale and retroactive DIR fees did not go to Medicare or the taxpayer, it went to PBMs.
- The Medicare Payment Advisory Commission's (Medpac) March 2023 report found that pharmacy DIR payments to PBMs in Medicare Part D were an astounding $12.6 billion for 2021—which represents a $3.1 billion (+33%) increase from the 2020 figure of $9.5 billion.[9]
- It's also important to note that despite PBM claims, CMS found that "actual Part D program experience has not matched expectations" "less than 1 percent of plans have passed through any price concessions" and "the amount passed through is less than 1 percent of the total price concessions those plans receive."[10]
- The U.S. Office of Personnel Management (OPM) recently released the findings of a 2018–2021 Office of Inspector General (OIG) audit of the American Postal Union Health Plan's pharmacy operations, which found that its PBM overcharged the health plan and the Federal Employee Health Benefits Program (FEHBP) by "$44,882,688…by not passing through all discounts and credit related to prescription drug pricing" that was required under the PBM's contract with OPM.[11]

APhA submitted the following comments to aid in the FTC's ongoing study of vertically integrated companies that may assist the Committee's work[12]:

- **Vertically merged healthcare companies rely on "fake prices" to maximize arbitrage:** Vertically integrated PBMs use "list prices," or average wholesale price (AWP), also known in the industry as "ain't what's paid," as the basis for their pricing guarantees to pharmacies and plan sponsors. AWP does not include buyer volume discounts or rebates often involved in prescription drug sales and is subject to manipulation by manufacturers or even wholesalers.[13] Brand name drugs have high AWPs that are offset by negotiated rebates and discounts that make those net prices much lower. Generic drugs have high AWPs (derived from brand drugs[14]) that in no way reflect the actual

[8] https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and
[9] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf#page=427
[10] https://www.federalregister.gov/documents/2018/11/30/2018-25945/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocket-expenses
[11] https://www.oversight.gov/sites/default/files/oig-reports/OPM/2022-SAG-029.pdf?utm_source=MarketingCloud&utm_medium=email&utm_campaign=Leg-Reg+4-26-24&utm_content=Leg-Reg+4-26-24
[12] https://www.pharmacist.com/DNNGlobalStorageRedirector.ashx?egsfid=zypK-JcWrxw%3d
[13] https://www.ncbi.nlm.nih.gov/books/NBK561162/?msclkid=7ef624c5d13811ec916c6800ded152e1
[14] https://www.46brooklyn.com/research/2019/10/11/three-two-one-launch-rfmyr

prices pharmacies pay to acquire those drugs. In both regards, the "actual" prices of both brand and generic drugs are hidden by the vertically integrated companies.

- **Vertically merged practices: Spread Pricing-Increased Costs for Medicaid (States and the Federal Government)**: "Spread pricing," is the difference between the reimbursements paid to pharmacies and the rates reported back to the payer where the PBM retains the difference. For an example, an Ohio Medicaid audit revealed $244 million from PBM "spread pricing" from Q2 2017 to Q1 2018.[15] Ohio's state Auditor conducted his own audit and found that spread equated to 31.4% of gross generic spending in Ohio Medicaid managed care.[16] Spread pricing also allows pharmacy-affiliated vertically merged PBMs to shift traditional pharmacy margins to the PBM side of their enterprise.

- **Vertically merged practices: Patient Steering:** Another practice of vertically merged PBMs is drug "steering," which is the pushing of particular medications by vertically merged PBMs to their owned pharmacies. An analysis of a percentage of brand drug claims filled by four affiliated pharmacy Florida Medicaid managed care plans (excluding 340B) found that, in Florida, specialty drugs (<$2,000 per prescription (brand drug AWP discount) are not only steered to affiliated pharmacies, they are also filled at more expensive PBM-affiliated pharmacies. For example, the analysis reveals that one brand specialty drug, with 80% filled at a PBM-affiliated pharmacy would have resulted in over $1.5 million in savings on that drug alone if Florida Medicaid would have recognized the non-affiliated pharmacy cost on the claims within the affiliated pharmacies. Additional analysis shows that, in 2017, when a vertically merged PBM became the provider of a Medicaid health plan's PBM services in Florida, that month, the vertically merged PBM dramatically increased the rates reported on claims dispensed at its PBM-affiliated pharmacies on Florida Medicaid's #1 spend generic antipsychotic. At the same time, it dramatically reduced the rates paid to all other Florida pharmacies. Overall, in 2018, 94% of the margin (revenue above acquisition cost) reported on all generic drug claims by the Medicaid health plan was reported on claims dispensed at the vertically merged PBM-affiliated pharmacies.

- **Vertically Merged practices: Specialty Steering:** In Medicare Part D, this is accomplished through a "loss leader" strategy, where: 1) vertically merged PBMs price generic maintenance drugs very cheaply for patients at preferred and/or PBM-owned pharmacies to pull patients over from standard pharmacies 2) charging inflated prices on specialty drugs to Part D after patients have been lured in with cheap generics and 3) "clawing" back considerable DIR fees from community pharmacies that have chosen to remain "preferred."

[15] https://www.pharmacist.com/CEO-Blog/the-pbm-fire-that-started-in-ohio-is-spreading-across-the-statesand-apha-is-fanning-the-flames-updated-6
[16] https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf

APhA strongly urges the Committee to work with and fund the FTC to break up the vertical healthcare conglomerates and divest from their consolidated services which lack competition in the healthcare marketplace. Congress should also work with FTC to conduct a retrospective analysis of industry consolidation to measure the effectiveness of past enforcement over monopolies and oligopolies and the budgetary impacts on both the federal and state governments and the downstream healthcare costs to pharmacies, other healthcare providers, and patients.

APhA would like to thank the Committee for the opportunity to comment on this important issue. APhA looks forward to working with the Committee to restore transparency, accountability, competition, and equity to our nation's supply chain and healthcare marketplace. Please contact Doug Huynh, JD, APhA Director of Congressional Affairs, at dhuynh@aphanet.org if you have any additional questions or additional information.