American Pharmacists Association

TESTIMONY OF
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BEFORE THE U.S. SENATE COMMITTEE ON THE JUDICIARY

"PBM POWER PLAY: EXAMINING COMPETITION ISSUES IN THE PRESCRIPTION DRUG SUPPLY CHAIN"

TUESDAY, MAY 13, 2025

APhA
American Pharmacists Association

Good morning, Chairman Grassley, Ranking Member Durbin, and members of the committee.

Thank you for inviting me to testify this morning on behalf of my patients. I would also like to express my gratitude to Chairman Grassley for your years of leadership on pharmacy benefit management (PBM) reform.

My name is Randy McDonough, I live in Iowa City, Iowa, and I am Co-Owner and CEO of Towncrest Pharmacy Corporation for the past 19 years, and, since March of this year, I have served as the President of the American Pharmacists Association, or APhA, representing our nations over 300,000 pharmacists at every site of care.

I want to begin my testimony by providing you with a real patient case. A case that provides an example of the egregious business practices of pharmacy benefit managers, or PBMs, and the time, effort, and risk I endured to help a patient. The patient is a young man in his early twenties. He has struggled with obsessive-compulsive disorder, or OCD, to the point where it was so debilitating that he had to be hospitalized. Finding the "right' medication for this patient took some time and effort, and we worked closely with their physician during that time. Unfortunately, the medication that finally "worked" cost us $728.35. Our reimbursement from the PBM was only $10.33. I followed all the appropriate processes of the PBM to dispute the reimbursement amount, but it resulted in no change and a lack of response from the PBM. After several months of losing over $700.00 with each refill and no response from the PBM, I took more drastic measures and went against my contract with the PBM to contact the health plan directly to see if they could help me with this dire situation. I told the health plan, similarly to what I told the PBM, that I am being put into an ethical dilemma with this case. As a business, I cannot afford to fill this medication for this patient, but as a caring health care provider, I recognized that this patient was benefiting greatly from the treatment, so I chose the latter to advocate on behalf of the patient. It was only because of my tenacious persistence that I got a partial resolution. Due to the health plan's pressures, in addition to my advocacy with my state legislators, the PBM relented and finally increased the amount of reimbursement, but never to the level where the reimbursement exceeded my cost.

Now, perhaps you are thinking that this is an extreme example, but I challenge you that it is not. Community pharmacists and their staff across this country are being forced into this ethical dilemma multiple times a day with multiple patients, to the point where decisions are made to even carry or stock medications, especially name brands. And this is not just a brand medication

problem as our reimbursement for generics is based on a nebulous, non-transparent, and supposedly proprietary maximum allowable cost or MAC pricing in which the reimbursement for the drug is many times below our cost, and there is minimal or no professional fee to offset the cost of dispensing. In essence, it has become the rule that there is a net negative reimbursement for a large percentage of medications filled in community pharmacies across the country. So, what does this business model do to the infrastructure of community pharmacies in this country, to be candid, Closures!

And this leads me to my own practice challenges. Towncrest Pharmacy Corporation, which has been in existence since 1963, is comprised of five community pharmacies and a closed-door long-term care pharmacy. Last year, our total net income for these six pharmacies was over a negative $116,000.00 (>-116,000.00). This has forced us to make some hard decisions. At the beginning of the year, we were deciding to close a pharmacy in one of our rural communities because of its financial challenges. Still, we were also concerned (another ethical dilemma) that it was the only pharmacy within a 15-mile radius, which is an issue for access for some of our older and sicker patients who may have physical limitations and transportation challenges. Instead of closing it, we converted it to a hybrid telepharmacy in which a pharmacist is physically present two days per week, and the other three days it is managed by a technician and pharmacists remote in to provide clinical services. Even in this model, our first quarter numbers indicate almost a negative $100,000.00 (-$100,000.00), challenging our decision not to close. More recently, on May 1st, we decided to close another one of our rural pharmacies because there was no viable financial path for us to keep this pharmacy open, given the current reimbursement model. This pharmacy will be closed at the end of this month. So, now my corporation has become one of the statistics. In Iowa alone, more than 200 pharmacies have closed since 2014, and a record 31 pharmacies closed in 2024 alone.

Spread pricing, underwater MACs, DIR fees, clawbacks, true-ups, rebate opacity, take or leave it contracts, generic effective rates, and patient steering are terms that we have become familiar with or heard about when talking about PBMs and their harmful business practices. Many of these issues stem from a lack of competition and transparency by the PBMs. But, at the end of the day, I just call it a broken system. A system where I want to provide care, but it has become financially unfeasible. A system where community pharmacies were an access point for patients, and now more and more pharmacy deserts are emerging. A system in which profits are emphasized over patients. And a system that is about ready to implode upon itself. The race to the bottom has ended—and I, along with my community pharmacy colleagues, can no longer survive.

Thank you again for the opportunity to testify at this very important hearing. APhA is committed to working with the Committee to enact meaningful federal PBM reforms that will safeguard community pharmacies and ensure patient access to essential care, particularly in rural and underserved areas like mine in Iowa, which need it most. I am happy to answer any questions.