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Introduction

Good morning, Chairman Grassley, Ranking Member Durbin, and other members of the Committee. My name is Juan Carlos "JC" Scott, and I am the President and Chief Executive Officer of The Pharmaceutical Care Management Association (PCMA). PCMA appreciates the opportunity to testify at today's hearing on competition in the drug supply chain. The Pharmaceutical Care Management Association (PCMA) is the national association representing America's pharmacy benefit managers (PBMs). Employers and other plan sponsors, like unions, have unique needs and sponsor health insurance for very different groups of Americans. In a free and open market, they choose whether to contract with a PBM and what they want out of that service. They choose how to set up their contract and how to pay for the services, and they choose how best to use the savings delivered by their PBM. Employers and unions choose to hire PBMs to secure lower costs for prescription drugs and achieve better health outcomes for patients. While employers could negotiate directly with drug companies and pay the prices each pharmacy charges the general public, nearly all choose to work with PBMs because of the value our companies provide to them and the patients they cover. Over the next 10 years, PBMs will save employers, health plans, labor unions, state and federal governments, and patients more than $1.2 trillion.[i] In alignment with the theme of this hearing, we strongly believe that competition is key to lower drug costs. That said, the quickest, clearest, least prohibitive path to lower drug costs is for drug companies to simply lower their prices.

PBMs focus on enabling access and lowering prescription drug costs for patients and the wide range of health plan sponsors who choose to hire them – specifically by:

- Negotiating manufacturer rebates from brand drug companies and discounts from drugstores to reduce costs for patients, their families, and health plans – saving an average of $1,154 per patient per year.[ii] These savings are fully under the control of the PBM client in every aspect.
- Encouraging the use of more affordable alternative drugs, such as lower-cost brands, generics, and biosimilars.
- Offering services that benefit patients, such as home delivery, adherence programs, and drug reviews.
- Managing and helping patients access high-cost specialty medications.
- Identifying and rooting out fraud, reducing waste, and preventing potentially harmful drug interactions.

Today I will review the policies PCMA members support to encourage a competitive market for prescription drugs and discuss ways PBMs work to generate value for the U.S. health care system.

Congress is focused on lowering drug costs and improving care for patients. So are PBMs. In this statement, we share how PBMs have proactively sought business solutions to address changing demands and patient needs, review policies that PCMA members support to encourage a competitive market for prescription drugs, and explain how many policies under active consideration that would limit employer choice and PBMs' ability to drive down costs could lead to harmful unintended consequences for patients.

PBMs are not waiting for government intervention or unnecessary mandates to address what the market demands. Our companies are already, and rapidly, adapting, evolving, and innovating to meet demand in the marketplace to lower out-of-pocket (OOP) costs for patients – and improve transparency for plan sponsors and consumers.

The adaptations PBMs are pioneering in the prescription drug market are focused on five patient-centric areas:[iii]

1. Lowering out-of-pocket costs for patients.
2. Providing more transparent information about pharmacy benefits, costs, and access.
3. Working with health plans to break down barriers around biosimilars.
4. Strengthening the retail pharmacy market and giving patients access to pharmacies regardless of where they live.
5. Supporting lower list prices and comprehensive coverage options for GLP-1s and other prescription drugs.

It is crucially important that as policymakers consider proposals to intervene in the commercial market with PBM mandates and limitations, they do so with a more complete understanding of the numerous ways the market continues to change and adapt, and its competitive characteristics.

The PBM market is highly competitive. When a PBM does not perform as expected, employers and unions have choices. There are more than 70 full-service PBMs in the market and new entrants are continually emerging, with an 18% increase in the total number of PBM businesses over a five-year period. There are dozens more companies offering subsets of PBM services. PBM business models are structured in a variety of ways, adding to the choice and optionality for employers and plan sponsors when choosing a PBM. Some PBMs are stand-alone companies, some stand-alone companies focus only on certain therapeutic areas and categories of medications, and other PBMs may have an affiliated mail, specialty or retail pharmacy or be part of a larger health care company, which can add to the ability to offer a total care package to patients enrolled in a plan. The choice is up to the employer or plan sponsor to determine what will deliver the highest quality, best health outcomes, and lowest costs for the enrollees they are serving.

Companies like Amazon Pharmacy, MCCPD, Navitus, Civica, and others are introducing fresh business models, including cost-plus reimbursement and full pass-through options, that reflect growing innovation and dynamism in a competitive marketplace.

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. But we continue to emphasize the need to focus on the true cause of high drug prices, and that is the prices that brand drug manufacturers independently set and independently raise. During the September 19, 2023, House Oversight Committee hearing, Dr. Rena Conti of Boston University noted, “Drug prices are set high in the United States because, simply, drug manufacturers can charge them, and we will pay them.” This statement continues to be true.

We want to immediately clarify any misunderstanding about how PBMs work: our industry supports choice and flexibility for clients; maintains robust competition in the market; provides transparent, actionable information to employers, plan sponsors, patients, prescribers, and policymakers; and maintains a healthy pharmacy market to serve patients. In addition, and to be clear, our companies support and advocate for lower list prices on all prescription drugs. Our mission is to negotiate for lower net costs for employers and clients, which means lower costs for patients. Lower list prices mean a better starting point for those negotiations, and PBMs are actively calling on big drug companies to lower their prices.

Understanding the factors driving drug costs must include a look at the entire supply chain, including drug companies, wholesalers, pharmacies and all others with an 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 maintain higher profit margins than nearly any other industry at the expense of patients. This is why we support Chairman Grassley's Prescription Pricing for the People Act.

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

Restricting Pharmacy Benefit Manager (PBM) Affiliates Will Harm Patients and Impact Health Plan Design

Policies that single-out or limit certain business models will only lead to fewer options for plan sponsors, fewer ways to serve plan enrollees, and a less diverse and competitive marketplace. For example, restrictions on PBM affiliation with pharmacies negatively impact patient access, care coordination, clinical outcomes, and costs. PBM-affiliated pharmacies make lower-cost pharmacy options like home delivery and specialty pharmacies accessible to millions of Americans. In fact, just recently, Dennis Carlton, Ph.D., professor emeritus at the University of Chicago Booth School of Business and former chief economist at the U.S. Department of Justice Antitrust Division, wrote an extensive report that disproves the notion that PBM-affiliated pharmacies somehow increase prescription drug costs.[iv] Additionally, based on Dr. Carlton's findings, **plan sponsors and patients would not realize substantial savings if they used only non-affiliated pharmacies**. At the prices shown in the data, total drug expenditures (by plan sponsors and patients combined) would be about the same whether the basket of all drugs was purchased at non-affiliated pharmacies or at PBM-affiliated pharmacies. This counters the idea that overall drug expenditures could be significantly reduced if drugs were no longer purchased at PBM-affiliated pharmacies.

Forced pharmacy fragmentation would cause many specialty pharmacies serving high-risk patients with complex conditions to be forced to surrender their pharmacy licenses and cease operations due to the limitations placed on PBM pharmacy affiliate licensures. PBM-affiliated mail-order programs serve hundreds of thousands of lives in each state and would be prohibited from operating, forcing patients to find an alternative source for accessing their medications. Patients with complex conditions receiving limited distribution specialty drugs or infusion medications would need to find pharmacies or facilities that have access to their medications. Further, pharmacy closures could lead to gaps in care that would reduce patient adherence.[v,vi]

Forced disintegration would also disrupt pharmacy networks. Employers, unions, and other plan sponsors who choose to use PBM-affiliated mail and specialty programs in their benefit design will see increased costs and reduced competition in the marketplace. These limitations would also force many retail pharmacies to close, challenging the ability to develop strong pharmacy networks. The result of forced closure of these pharmacies is the elimination or reduction of programs for patients. More specifically, adherence programs and supportive care, foundational and financial assistance programs, and Risk Evaluation and Mitigation Strategies (REMS) reporting will fall to local pharmacies, who may not be equipped to provide the necessary services at all and may not be prepared to scale up in order to meet certification requirements.[vii]

Closing or disallowing the use of specific pharmacies, particularly in places where there are very few, could create problems for plans as they try to comply with Medicare, Medicaid, and federal and state commercial market compliance mandates.[viii,ix,x] This type of law not only impacts licensure for retail pharmacies, mail order pharmacies, and specialty pharmacies, but could also impact infusion, hospital, grocery store, and long-term care pharmacies.

Legislation Aimed at Drug Pricing Should Address the Drugmakers That Set Prices

Big drug companies determine the price, decide when to increase the price, block competition to keep the price high, and increase sales by spending billions of dollars each year advertising high-priced products to consumers. In 2023, drug companies launched new U.S. drugs at prices 35% higher than the previous year.[xi] Between 2008 and 2021, new drugs launched at prices that increased exponentially, by 20% each year.[xii] Drug companies also continue to increase prices on existing products, with an average increase of 5.44% in 2024[xiii], significantly outpacing the general rate of inflation.[xiv]

Efforts to lower drug costs must start with an understanding that prices are set by drug companies. When a drug company sets its initial price, that price dictates costs throughout the supply chain – from the wholesaler's negotiation for discounts from the manufacturer to the markups paid by pharmacies as they stock their stores, to the amount ultimately paid by the insurance plan sponsor and the patient and the amount paid to each pharmacy.

Policymakers and others who have called out the fact that drug companies charge Americans much higher prices than the rest of the world have it right. They increase drug prices year in and year out, including increasing the price of 556 drugs in just the first week of 2024[xv], with a median increase higher than the rate of inflation.[xvi] A recent analysis[xvii] found that pharmaceutical companies' price increases on five top-selling drugs cost U.S. patients and the health care system $815 million in 2023, despite a lack of innovation to justify those price increases. While another report from AARP[xviii] found that manufacturers "consistently" hiked prices above inflation on 943 top-selling drugs in all but one year between 2006 and 2020.

While there are numerous drug supply and payment chain participants, only one is responsible for setting and raising drug prices. Brand and generic drug manufacturers always exercise full control over the pricing of their products. In recent years, we have seen brand manufacturers exercise this ability by lowering prices in response to policies that motivate them to do so. For example, when insulin manufacturers were faced with the looming threat of removal of the Average Manufacturer Price cap – which would have required companies that chose to raise prices at a rate outpacing inflation to pay Medicaid rather than simply supply the drug to Medicaid at a deeply discounted price – they dramatically decreased list prices on several popular insulin products by 70–80%.[xix, xx, xxi] Prior to this move, insulin accounted for a significant percentage of rebates in Medicare Part D,[xxii] and because we always stand for lower drug prices that result in reduced drug costs, not only did PCMA applaud this move, but we also encouraged other manufacturers to follow suit. Lower list prices for drugs can decrease costs throughout the supply chain, lowering the net cost for employers and, often, patient cost-sharing. PCMA will always celebrate lower list prices because PBMs strive for lower drug costs.

Drug Companies' Anti-Competitive Practices

PCMA applauds and strongly supports the bipartisan work of this committee to address brand name manufacturers' anti-competitive tactics, especially patent abuse, including the recent passage of several solutions that would substantially support greater competition in the

prescription drug market, and stop drug companies from wrongfully extending monopoly pricing on top-selling drugs, imposing billions of dollars in higher costs on American patients and taxpayers. These anti-competitive practices cost U.S. consumers an additional $40.07 billion[xxiii] on drug spending in just one year. One of those anti-competitive tactics is the practice of filing dozens or even hundreds of patents on just one drug to create a patent thicket to keep competition out of the market. This strategy netted $158 billion[xxiv] on just four top selling biologic drugs between primary patent expiration and biosimilar launch.

These tactics lead to Americans paying the highest prescription drug prices in the world. Across brand drugs, pharma list prices are 422%[xxv] higher in the U.S. than in other countries.

- The list price for a pair of autoinjectors for Dupixent, a biologic used to treat COPD, asthma, and eczema among other conditions, is $3,993[xxvi] in the U.S. – including a 5% increase on January 3, 2025, and is more than twice that of France ($1,453).[xxvii]
- The list price for a 30-day supply of Invokana, a drug used to treat Type 2 diabetes and kidney disease, is $500 in the U.S., which is over eight times higher than in Canada ($64).[xxviii]
- The list price for a 30-day supply of Opsumit, a drug that treats pulmonary arterial hypertension, is nearly $13,000 after a 2.5% price increase on January 3, 2025, which is six times higher than in Australia ($1,971).[xxix]
- Of the 356 drugs approved by the FDA between 2010-2019, 99.4%[xxx] included research funded by the National Institutes of Health.

Further, Pharma's direct-to-consumer (DTC) advertising encourages Americans to take expensive blockbuster drugs they may not even need. Ten[xxxi] of the largest drug companies spent $36 billion – or 37% – more on sales expenses and marketing than on research and development, spending 17.8 billion[xxxii] on DTC ads alone from 2016 to 2018. This is why pharma companies should be required to disclose their high prices in commercials and be banned from writing off the ads that push these huge and often unnecessary expenses onto American consumers. Federal tax revenue could increase by up to $1.7 billion annually if DTC ads from the ten largest pharmaceutical companies were taxed or banned.[xxxiii]

Accountability Within the Health Care Supply Chain

In almost every industry – and especially health care – the most effective way to lower costs is through leveraging increased competition. That is why we must ensure that patent protections and market exclusiveness meant to balance rewarding innovation with securing affordable access for patients do not block competition and keep prices high.

PCMA's policy platform calls on Congress to take steps to address competition in the prescription drug market, including the following:

1. Reform patent laws and regulations to accelerate competition.
2. Ensure market exclusivity is used to incentivize innovative drug research and is capped at the interval Congress deems appropriate.
3. Penalize abuse of the citizen petition process.
4. Promote generic and biosimilar competition.

PBMs negotiate $148 billion in savings from manufacturers and pharmacies annually,[xxxiv] and those savings directly benefit employers, unions, retirees, and patients.

Rebates have never been the cause of high drug prices. Rebates are simply the mechanism PBMs are required to use in order to achieve savings. This is because of a 1936 law called the Robinson-Patman Act and subsequent court rulings.[xxxv] PBMs are primarily concerned with maintaining the ability to negotiate discounts from drug companies on behalf of employers, unions, taxpayers, and patients. If the law allowed for it, those savings could be achieved through different approaches. Since we are currently required to comply with this system, it is important to note that numerous reports have shown that rebates are not correlated with list prices or price increases. For example, an HHS OIG report from 2019 noted, "Even when brand-name drugs had increases in both unit reimbursement and unit rebates, the increase in rebates was not always the same magnitude as the increase in reimbursement."[xxxvi] Another expert analysis found that price increases for rebated and non-rebated drugs were essentially the same,[xxxvii] and PCMA's research demonstrates that list price increases "are not correlated with changes in prescription drug rebates."[xxxviii]

A little-known truth is that most drugs do not have rebates at all. One analysis found that nine out of 10 prescription drugs with the highest price increases since 2018 did not have rebates.[xxxix] Another analysis of 2016 data found that 89% of prescriptions written in 2016 had no rebates, 81% of all Part D drugs analyzed did not have rebates, and 64% of brand drugs analyzed did not have rebates.[xl]

Directing Reform Efforts at PBMs Will Lead to Unintended Consequences

Just like Congress and the Center for Medicare and Medicaid Services (CMS) have full control over government health care programs, employers and unions should have the right to determine the structure of their benefit designs with equal choice and flexibility. They should have the option of determining how they would like to pay the PBM they select to provide services. Policies that prevent employers and unions from paying for value or incentivizing optimal performance are misguided – they do nothing to improve patient affordability or improve the competitive market for drugs. As changes are considered, it will be important to prioritize patients, preserve employers' and unions' choices, and maintain balance so the private market can continue to control costs.

Many bills under consideration eliminate important choices, such as "spread pricing," a tool used to efficiently manage costs. Today, employers and unions have choices on how to reimburse pharmacies. They can choose "pass-through" contracting, in which the plan sponsor pays the PBM a fee as well as whatever the pharmacy charges, or "spread pricing," in which the sponsor lets the PBM hold the risk that plan participants may use more expensive pharmacies to fill their prescriptions – and 34% of employers choose spread pricing.[xli] While larger employers may select pass-through contracts, as they have the scale to deal with the variability of pharmacy charges, smaller employers may choose spread contracts because of the pricing predictability and savings they derive. Spread pricing is not, as some stakeholders have described, simply charging the pharmacy one rate and then marking up the price and charging the employer or union a higher rate to produce a profit. Banning this contract provision eliminates an option employers and unions use to gain greater predictability. States that have banned spread pricing have seen drug costs increase in Medicaid, including in the Ohio Medicaid program, which paid an additional $38 million for prescriptions after moving away from spread-based contracts.[xlii]

Employers and unions should also continue to have the option of encouraging beneficiaries to use higher quality, lower-cost pharmacies to get their drugs. This is a benefit to the patient, the

employer or union, and taxpayers. A ban on the use of pharmacy networks that promote steering would further increase costs. Studies have demonstrated that encouraging the use of lower-cost options like home delivery results in savings. Mail delivery is expected to save Medicare Part D and Medicaid Managed Care programs over $100 billion over the next 10 years.[xliii]

One of the key tenets of the PBM industry is to prefer the drugs that cost the least after all discounts. In coordination with independent clinical experts on a pharmacy and therapeutics committee, PBMs typically develop a recommended formulary for plan sponsors, who may customize it. Government mandates that dictate formulary design and force plans to cover more expensive drugs would increase premiums for patients (and increase program costs for taxpayers) and reduce leverage in negotiations with manufacturers. The resulting higher drug costs would be a direct result of limiting the necessary PBM tools used to control costs.

PBMs are the private market solution to managing drug costs and are equipped to harness market competition to lower drug costs. Recently, CMS released its selected drug list for 2026 Medicare price negotiations. In selecting drugs for negotiation under the Inflation Reduction Act's direct negotiation provision, CMS chose several drugs that already have competition that the private market can and does leverage. CMS will need to be mindful of the effect of these selections on other drugs in the same market and be sure to provide a clear off-ramp to remove selected drugs to avoid suppressing competition from biosimilar and generic manufacturers.

A number of economists and health policy experts have written about their research-based views that certain anti-PBM bills will do more harm than good in terms of increasing costs, stifling economic growth, and limiting the choices and contracting flexibility that employers and unions appreciate today when it comes to health benefit design and coverage, including the following:

- Economist George Ford published a theoretical model and cited empirical evidence concluding that PBMs reduce drug costs for employers and other health plan sponsors.[xliv]
- Dennis W. Carlton, economist at the University of Chicago, analyzed data from the three largest PBMs, concluding that industry criticisms around rebates, pharmacy reimbursements, and profits are unfounded.[xlv]
- AEI Senior Fellow Alex Brill published a report on the unintended consequences and increased costs of misguided proposals for PBM reform.[xlvi]
- Former chief economist for the Council of Economic Advisers in the prior Trump administration and University of Chicago Professor of Economics Casey Mulligan published findings on the economic impact of ending pay-for-PBM performance and the massive $32 billion financial windfall to pharma.[xlvii]
- In 2023, Competitive Enterprise Institute (CEI) published a study written by newly appointed Special Assistant to the President for Economic Policy at the National Economic Council Joel Zinberg, MD, on how PBMs drive down the cost of prescription drugs, which concludes that "PBMs are a pro-competitive creation of the market for prescription drugs that improve consumer welfare" and that current legislative proposals are "likely to be counterproductive, resulting in reduced competition, higher costs, and an end to the natural evolution in the market of terms and arrangements which benefit the actors in the drug distribution system."[xlviii]
- The Brookings Institution released a new analysis that provides an overview of recent legislation targeting PBMs being considered by Congress and how the policies will not effectively lead to lower costs. The analysis concludes that eliminating rebates and spread

pricing could actually have the opposite intended effect by weakening PBMs' negotiating power against Big Pharma – the root cause of high prescription drug prices.[xlix]

Similarly, lawmakers should beware of misguided approaches meant to give handouts to pharmacies at the expense of employers, unions, taxpayers, and patients. Bills that focus on restricting the practices of PBMs fail to understand the importance of negotiating discounts from drug manufacturers and pharmacies. Restricting PBMs' abilities to negotiate with pharmacies by mandating inclusion of all pharmacies into pharmacy networks, preventing performance-based accountability programs, and mandating reimbursement floors, would result in much higher drug costs for plan sponsors, including in federal health care programs.[l] PBMs use credentialing, audits, and performance-based contracts to do things like ensuring that pharmacies are appropriately equipped to meet the needs of specific patient populations, requiring pharmacies to demonstrate appropriate financial stability, and ensuring patient safety.

Further, recent proposals in Congress have suggested prohibiting PBMs from being compensated based on a drug's list price or utilization, thereby ending a pay-for-PBM performance model that has effectively delivered savings to employers and unions for years. This drastic change in how PBMs work will cost employers, taxpayers, and patients exorbitantly – and will provide a massive $32 billion financial windfall for drug companies who are able to avoid discounting their products, keeping what otherwise would be rebates as profit.[li]

Throughout the U.S. economy, people and businesses are incentivized to perform well through the opportunity to benefit from the effects of their labor. Delinking would work in a manner contrary to established economic principles known to produce better outcomes. As one paper notes, "pay for performance is one of the most cited conclusions in economics, where it is frequently noted that 'incentives matter.'"[lii] Thus, delinking would not correct misaligned incentives as alleged; instead, it would shift incentives away from driving down drug costs – PBMs' stated mission. Lawmakers should be wary of this policy, as it "has the potential to significantly (i) increase drug prices, (ii) reduce drug utilization, and (iii) redistribute billions of dollars annually from patients and taxpayers to pharmacy companies and drug manufacturers."[liii]

When these economic principles play out in numbers, we see that delinking in Medicare alone would result in much higher costs: "Annual federal spending on Medicare Part D premiums would increase $3 billion to $10 billion plus any concomitant increase in Medicare subsidies for out-of-pocket expenses. … [And additional] Medicare spending would require the federal government to tax more, spend less outside of Medicare, and/or borrow more, which has additional effects on the broader economy."[liv] In addition to these substantial economic harms, delinking PBM compensation from a drug's list price singles out one supply and payment chain participant, while all others continue to be paid based on that long-standing standard. Drug companies, wholesalers, pharmacies, and even physicians (in the case of physician-administered drugs) are compensated on a basis that ties back to the list price of a drug.

Drug rebates are used to lower drug costs. When a PBM capitalizes on a competitive drug market and negotiates deeper discounts or rebates, that equates to lower drug costs for patients and plan sponsors. The ability to pay a differential for exceptional performance incentivizes better performance. Preventing PBMs from being rewarded for doing a better job runs counter to the efforts made to shift the health care system toward paying for value. Some current policy proposals even seek to prevent compensation based on covered lives or processed claims, further exacerbating the problem by not only preventing rewards for exceptional effectiveness in negotiating lower drug costs but also prohibiting rewards for efficiently processing high numbers of claims.

Specialty drugs have continued to rise in price. Specialty drugs represented 54% of total drug spending in 2024, up from 47% in 2019, driven by growth in immunology and oncology drugs.[lv] For specialty drugs launched in 2024, the median cost at launch for non-oncology specialty medicines was $40,450, while oncology therapies had a median annual cost at launch of $411,855.[lvi] PBMs play a vital role in managing these costs. By encouraging the use of mail-service and specialty pharmacies, PBMs will help generate more than $274 billion in savings over the next 10 years, with savings from mail-order pharmacies projected to be over $23.5 billion and savings on specialty medications projected to generate more than $250 billion.[lvii] For all these reasons, Congress must carefully evaluate proposals to understand the intended effects.

PBMs Are Innovating to Create a More Transparent Market with Even More Options While Prioritizing Patients

In response to client and consumer demands in this competitive market, PBMs are continually innovating and adapting to either carve out a new niche or to gain or maintain market share. No employer, union, or plan sponsor is required to use a PBM. Should their needs change or the services not be delivered, employers are always free to choose a different PBM. PBMs must compete in a rigorous request for proposal (RFP) process on a regular basis that requires PBMs to constantly innovate to retain existing customers and grow with new business. As part of this process, when putting their pharmacy benefits out to bid, PBMs' customers lay out the terms of the benefits they intend to provide, the transparency and information they want to receive, and the audit rights they require to ensure those terms are met. Once they select a PBM that meets all of their requirements, these details are formalized in their contracts. In a May 2022 letter to the FTC, the School Employees Retirement System of Ohio described this dynamic, stating, "SERS' PBM contracts are on a transparent pricing basis, with 100% pass-through of rebates and pharmacy pricing. All rebates and pricing discounts are applied directly to SERS members as reduced pharmacy premiums every year. The pass-through contract provision is independently audited biannually, confirming that all monies related to the retiree prescription drug benefit are passed back to SERS."[lviii]

Addressing demands for more transparency

PBMs are innovating by developing new programs that lower drug costs and increase affordable access for patients. Recently, large and small PBMs across the industry have rolled out new, innovative programs including ones that provide more actionable transparency for patients, lower out-of-pocket costs at the pharmacy counter, and improve access to needed drugs.[lix]

- One PBM recently announced actions to lower out-of-pocket costs for more patients, including ensuring patients don't pay more out-of-pocket for their medications than the amount that the PBM negotiated.
- Several PBMs have implemented programs that enhance transparency and simplify pharmacy benefits for patients and their providers – underscoring our longstanding commitment to supporting transparency measures that lower drug costs.
- More programs are now available to employers that limit to $0 or a low dollar amount what is paid by patients out-of-pocket for many common prescription drugs.
- New, more transparent pharmacy reimbursement models, enhanced pharmacy networks, increased reimbursement in rural areas, and expansion of clinical services

through partnerships with pharmacies are all helping evolve the pharmacy market and move toward a more patient-centered future.
- And across the industry, PBMs of all sizes support and continue to call for drug manufacturers to lower the list prices on all prescription drugs.

PBMs are doubling down on their work to support transparency and provide actionable information to our clients. The market is demanding it, and our companies are responding. Many PBMs are offering new programs that make pharmacy benefits easier for employers and unions and their plan participants to understand. Efforts are underway to bring more detailed visibility to employers through additional options for reporting mechanisms. Updates to plan sponsor reporting include offers of better pricing transparency through drug level details,[lx,lxi] cost-plus pricing models with a simplified reimbursement structure, and value-based models that promote efficient care and better patient outcomes.[lxii] The choice always belongs to the client and PBMs work to provide whatever level of data and information the client puts in their contract.

PBMs are also providing tools that offer patients more transparency to help facilitate convenient access to information that empowers patient savings and improves adherence. PBMs have online web portals and digital apps for patients that provide real-time, actionable information, allowing them to search for the lowest-cost prescription alternatives, find or compare across pharmacies, or access their prescription histories.[lxiii,lxiv]

PCMA has worked with policymakers and is committed to continue working with policymakers to engage on policies that enhance this type of actionable transparency.

Innovating for patient affordability and access

Many challenges with patient affordability result from exposure to drug companies' high list prices. Ensuring patient access and affordability and improving clinical outcomes are core functions of PBMs. PBMs work with employers and unions to understand how best a PBM can effectively meet the needs of their populations and drive down costs. While benefit design and cost-sharing decisions always belong to the employer or plan sponsor, PBMs are offering them programs that limit what is paid by patients to $0 or a low-dollar amount for many common prescription drugs.[lxv]

Addressing the climbing list prices set by manufacturers for specialty drugs, PBMs are creating strategies that improve affordable access to these medications. Using clinical teams, PBMs help plan sponsors and plan participants manage specialty drug costs, such as by providing disease-specific estimates to predict future drug costs and spending,[lxvi] adding multiple manufacturers for the same reference product and biosimilars to their formularies while achieving reduced net cost to the plan sponsor,[lxvii] offering $0 cost-share for select biosimilars,[lxviii] and addressing access for high-cost drugs such as glucagon-like peptide 1 (GLP-1) weight loss medications.

PBMs are responding to the evolving GLP-1 drug class to support employers and patients.[lxix] PBMs offer plan sponsors comprehensive programs that combine weight loss aids (such as GLP-1s) and lifestyle changes[lxx,lxxi] and are encouraging the use of best practices around GLP-1s to contain costs and promote access to patients in need.[lxxii] Using all tools available, PBMs recommend coverage and formulary placement of GLP-1s for weight management to employers and unions when appropriate, allowing them to design benefits that work for their populations.[lxxiii]

Evolving pharmacy reimbursement models and advancing clinical care

Pharmacists are a part of communities across the country, and they have frequent face-to-face interactions with patients – "roughly twice as frequently as [patients] visit primary care physicians" and even more often for those who live in rural areas.[lxxiv] Pharmacies are integral to a PBM's success in helping patients access their medications. PBMs want a better partnership with all pharmacies and need a healthy pharmacy market to serve our clients and their patients. For this reason, PCMA supports policies such as the Equitable Community Access to Pharmacist Services Act, which grants pharmacists the ability to serve patients in response to COVID-19 or during public health emergencies in specific ways so there will be no delay in pharmacists' ability to assist and be paid.

As the practice of pharmacy evolves, so should the payment models for pharmacist services. Many PBMs are revising the traditional reimbursement models used for many years to bring more transparency and reflect the value delivered by pharmacists. Starting this year, there will be new offerings to employers and unions in the commercial market that reimburse pharmacies based on drug acquisition cost, a set markup, and a fee to reflect the quality of pharmacy services provided.[lxxv,lxxvi,lxxvii] PCMA's members are also taking note of the market shift to paying for value and innovating current models to expand pharmacist reimbursement for clinical services offered in retail settings.[lxxviii]

PBMs support pharmacists in rural communities by offering increased reimbursement to true independent pharmacists.[lxxix] Reimbursement models are evolving with the health care market to include enhanced performance and better health outcomes from pharmacists, allowing a pharmacist to apply their clinical knowledge and practice at a level commensurate with their training and licensing.[lxxx,lxxxi]

PBMs are innovating their offerings, and the private market is addressing many of the issues Congress is debating. Any legislative changes to the health care system, including additional limitations placed on employers, unions, and their PBMs, should be designed to lower drug costs. Limiting PBM tools that drive down costs would increase costs by reducing competition and giving drug companies and pharmacies greater leverage to the detriment of patients, taxpayers, employers, and unions.

Conclusion

PBMs exist to reduce drug costs for plan sponsors and, most importantly, for the patients our companies serve. Much of this value is generated by the savings PBMs negotiate with pharmaceutical manufacturers and pharmacies. PBMs are enabled to negotiate most effectively when there is a competitive prescription drug market.

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.[lxxxii] As a result, PBMs will lower the cost of health care by $1.2 trillion over the next 10 years.[lxxxiii]

America's businesses know the needs of their employees best and value choice and flexibility when it comes to making decisions on pharmacy benefits. More than 90% of employers say it's critical to have the flexibility and choice PBMs provide in determining how best to offer prescription drug benefits to their employees and we urge Congress not to disrupt the commercial market by removing choices from employers and unions and mandating a one-size-

fits-all approach to pharmacy benefits. 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, unions, patients, and taxpayers.

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