House Committee on Oversight and Accountability
Role That Pharmacy Benefit Managers (PBMs) Play in the Pharmaceutical Market
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Chairman Comer, Ranking Member Raskin, and distinguished members of the House Committee, I would like to thank you for the invitation to speak to your committee on the necessity of PBM (Pharmacy Benefit Manager) reform in the United States.

My name is Greg Baker. I, first and foremost, am a pharmacist. I am also the CEO of AffirmedRx which is a transparent PBM I founded and is headquartered in Louisville, KY. I began my pharmacy career 30 years ago as a pharmacy technician for an independent pharmacy in Fort Wayne, IN that not surprisingly is no longer in business – for many reasons we will touch on today. Beyond that I have 11 years experience working directly with jumbo self-funded employers to help define and develop their pharmacy programs. Our goal at AffirmedRx is to partner with self-funded employers to deliver patient-centric pharmacy benefits with a mission to improve health care outcomes by bringing clarity, integrity and trust to pharmacy benefit management.

Currently, a handful of large PBMs control up to 80% of the market in the USA. This is problematic for every employer in the country. These PBMs are not constrained by any obligation to be transparent on their pricing or methodology and this has caused an extreme escalation of cost to all employers using a traditional PBM. This problem is also costing taxpayers significantly since some of the biggest health plans in the country are run by local, state and federal government entities. Medicare and Medicaid programs throughout the country are also deeply affected by the practices of traditional PBMs. And perhaps most importantly, it is also incredibly frustrating for practicing pharmacists who have a

professional duty and deep personal obligation to their patients to provide the best care possible and for the patients themselves who can no longer afford their medication which they need in order to live productive lives.

In August 2022, the American Bar Association published an article explaining trends and developments in price gouging at the state attorney general level. They define price gouging as the practice of raising prices of essential goods, services, or commodities to an unreasonable, unfair, or excessive level typically during a declared state of emergency. While only 37 states have price gouging laws other states can still bring about lawsuits as a violation of state consumer protection or similar laws. Most of these laws are only triggered by a declared state of emergency, the occurrence of a natural disaster, or an "abnormal market or economic disruption." I contend, based on current PBM practices and the state of the pharmacy industry in America, every attorney general should be actively pursuing pricing gouging lawsuits.

Let us consider some facts that make me believe we are in a state of emergency and at a minimum are dealing with "abnormal market or economic disruption."

- Medications can be a key component to reduce health risk, control chronic disease and treat illnesses. In the U.S., illness and death from non-optimized medication therapy cost $528.4 billion annually – equivalent to 16% of total U.S. healthcare expenditures
- Patients starting new prescriptions as prescribed by their physicians abandoned 94 million prescriptions at pharmacies in 2022 with increasing frequency as costs rise
- A JAMA article published in June 2021 suggest that while drug manufacturers may increase list prices in order to offer larger rebates to insurers, such increases were associated with increased out-of-pocket costs to patients
    - It found that between 2014-2018 list prices from manufacturers grew 13.3% while rebates paid to PBMs increased 24.4%.

- With the manufacturers raising list prices they also found that for every $1 increase in list price equated to an increase of $2.09 in patient out of pocket costs. While we have had much debate over the list price increases by pharmaceutical manufactures, these numbers clearly show how PBMs are retaining the most value and the American public continues to suffer greater drug affordability issues
- Finally, the report sadly pointed out that every $10 increase in patient out of pocket costs led to lower adherence rates. This is particularly concerning amongst individuals with lower incomes and among older adults as increasing prescription cost sharing can be associated with increased emergency department use, more frequent hospitalizations, and other poor health outcomes

While these numbers illustrate at a high-level overview how current market behaviors can have negative impacts on the entire system I have a specific example I would like to share with the committee. This points to the problem, but please understand this is just one out of the thousands of ways PBMs create profit for themselves at the detriment of our American society.

This example compares the cost of a medication provided transparently from Mark Cuban and his Cost Plus Drug Company. Mark posts all his invoices online so everyone can see what he is paying for the medications he sells. Traditional PBMs tell their clients they use their size and scale to get a better deal that smaller companies cannot compete with. We do know these large PBMs buy thousands of times more drugs than Mark Cuban and they very likely get a better acquisition cost, but they do not always use that purchasing power to help their clients. Below is one example which illustrates that the largest PBMs are likely making decisions in the best interest of their shareholder and not in the best interest of the patient. This is inexcusable at best in my opinion.

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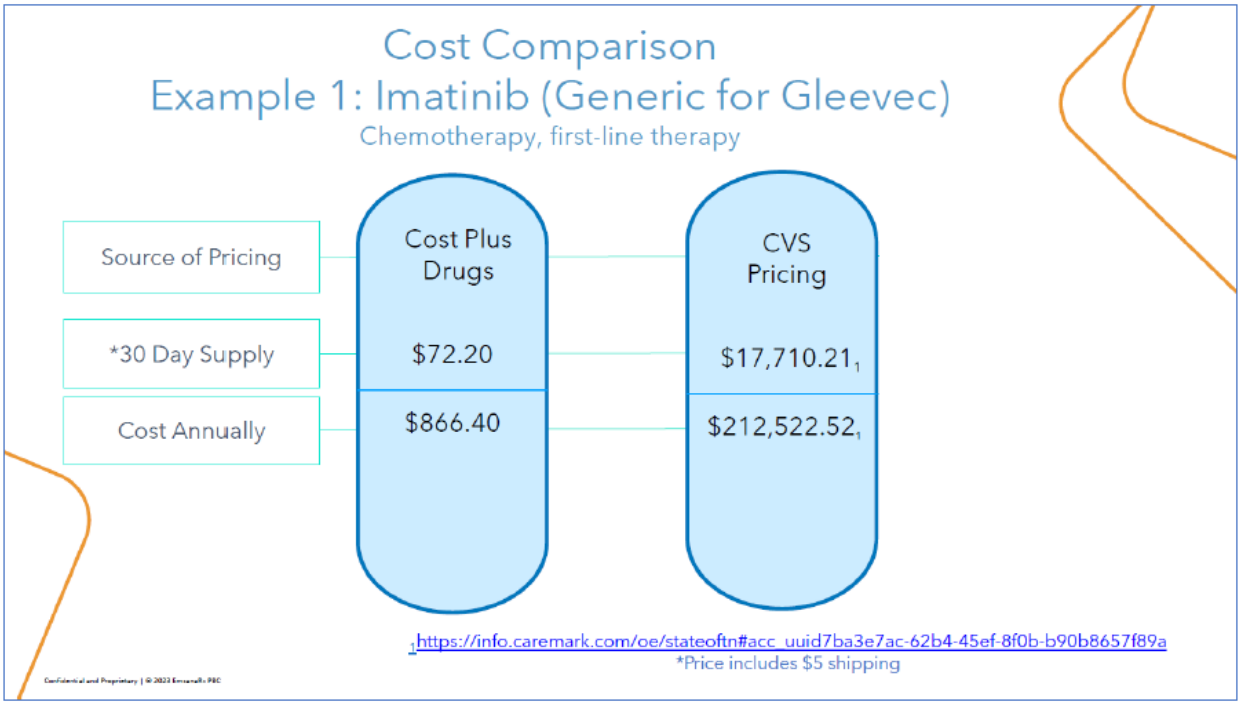
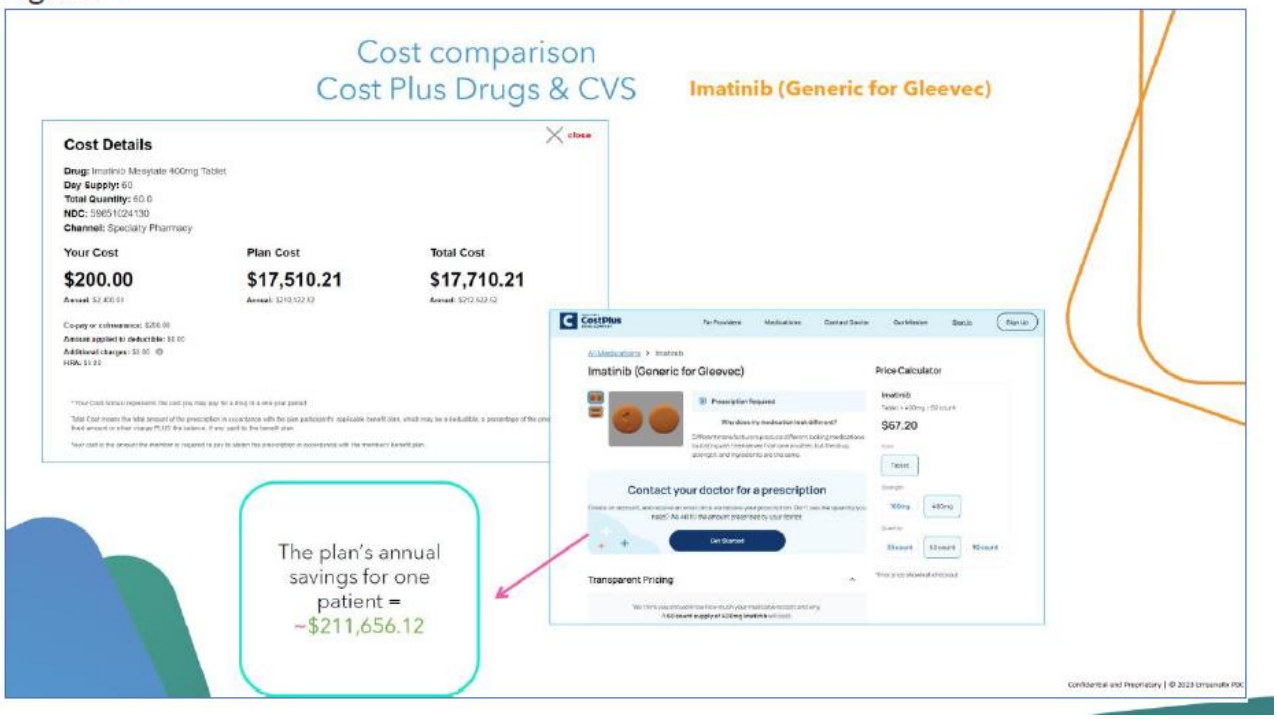
PUBLIC BENEFIT CORPORATION

Figure 1



And the screenshots directly from each website…

Figure 2



These practices provide massive payouts to the traditional PBM while creating disadvantages for the employers and taxpayers utilizing their services. The worst part is the fact that this example exists because PBMs define where medications can and cannot get filled. In this situation they tell the market that because this is an oncology product it needs to be filled only at their own specialty pharmacy. Because the PBM – as a for-profit company – gets to decide what it pays itself, bad things happen.

Additionally, there has been much discussion about rebates and the relationship between the pharmaceutical manufacturers and PBMs. I am not here to defend or hold manufacturers harmless when we are talking about why we have a drug affordability issue in our country. They are by no means innocent, but the PBMs bear a significantly larger responsibility to the problem. There are hundreds of brand manufacturers and only three main rebate aggregators. These three aggregators are each owned by one of the big three PBMs. They not only negotiate rebates for those traditional PBMs, but they now provide these rebates services to almost every other PBM in the industry. These aggregators are Ascent which was created in Switzerland by Express Scripts in 2019 and now owned by Cigna, Zinc which was created by CVS in 2020, and Emisar which was started in Ireland in 2022 and is owned by United Health Care. Ascent and Zinc each contract for over 100 million American lives and Emisar contracts for 65 million. They use their scale to create competition between manufacturers.

Let's look at insulin as there has been much talk about insulin pricing. Using Novo Nordisk as the example – they know if they lose access to the formulary controlled by one of these PBMs their medications will no longer be available to tens of millions of lives. So, the PBMs use this to their advantage and continue to extract more and more rebates because if Novo does not want to pay the higher rebate amounts the GPO will find one of the other manufacturers willing to do so. The massive market consolidation is why – as I previous mentioned – rebates are going up faster than list prices.

There are numerous reasons why costs go up, but the PBMs are at the heart of many of them. They are creating "abnormal market and economic disruption" at a time of national crisis when people can no longer afford their medications. When patients are not adherent to their medication overall health care costs increase significantly. If every American could afford their medication and had convenient access to a community pharmacy I believe we could remove hundreds of billions of waste for what we have today in a $1.4 trillion health care system. This price gouging and other negative practices need to be exposed and halted.

The practices being engaged in by these PBMs are inherently harmful to pharmacies throughout the country, especially independent pharmacies for several reasons. The first example of this is steering patients away from their local pharmacies to large mail-order organizations owned by these traditional PBMs themselves. Another example is these large PBMs also have the ability to make anything a "specialty drug" and not allow local pharmacies to dispense the drug regardless of what is best practice as shown in the Figure 2. Finally, even when these independent pharmacies are included in PBM networks, often the reimbursement of drugs to the pharmacy is less than their acquisition cost. In the end, this harms patients and their care. It is possible to operate a PBM, restrain costs for the employer and taxpayers while still providing the best pharmacy care available. But changes must be made to require greater transparency and allow for greater competition for this to happen.

While this testimony has illustrated numerous ways PBMs hurt American society there are unfortunately still many more. These include:

- Formularies are built preferring high-cost drugs over generics or drugs with lower cost
    - This results in high costs for members at the pharmacy counter when they are on high deductible or coinsurance plan
    - This increases PBMs' profits via retention of manufacturer fees
- Narrow/Preferred networks are used to drive patients to more profitable pharmacy locations for the PBM while also limiting patient access which can be particularly harmful in lower income areas

- Self-funded employers are not allowed access to their pharmacy data which limits their ability to understand costs or make better decisions on behalf of their plan participants that could lower premiums and out of pocket costs
- Most self-funded employers use consultants they believe to be unbiased. These consultants may be compensated by the PBM with monies that are never disclosed to their clients – creating a conflict of interest and inhibiting competition. This concept is expressly called out in several SEC filings as illustrated on pages 22-23 of the 10-K filed by Willis Towers Watson calling out "market derived income"

In closing, I would like to point to William Deming who is acknowledged to be the foremost thought leader in total quality management. He has two disparate quotes I would like to leave the committee with. His first quote states "Every system is perfectly designed to get the results it gets." I know there has been much discussion that the PBM system is broken. My contention is that the industry has created a system to enrich corporate executives and create the opportunity to buy back hundreds of billions worth of corporate stock. This in turn massively increases shareholder value at the expense of the American corporation and taxpayer. The system is not broken – it is working perfectly. The problem is we have the wrong system.

With that said I point to my second Deming quote. While we consider a better system through our conversation today Deming also said that systems need to be "a network of interdependent components that work together to try to accomplish the aim of the system. The aim for any system should be that everybody gains, not one part of the system at the expense of any other."
I commit to you that AffirmedRx will continue to work with employers, state and federal health plans and pharmacies throughout the country to find solutions to the challenges faced by those employers trying to just make sure their employees have access to the drugs they need while keeping down unnecessary costs.

Thank you, members of the committee, for the opportunity to speak today and I look forward to your questions.

For more information here are links to articles aimed at educating purchasers about the PBM industry:

https://affirmedrx.com/how-gpos-work/

https://affirmedrx.com/how-pbms-make-money/

https://affirmedrx.com/what-is-a-pbm/

https://affirmedrx.com/8-things-every-employer-should-know-about-their-pharmacy-benefit-manager/

https://affirmedrx.com/how-do-pharma-pbm-contracts-play-role-in-rebate-leakage-part-1/

https://affirmedrx.com/how-do-pharma-pbm-contracts-play-role-in-rebate-leakage-part-2/