March 29, 2023

The Honorable Chairman Ron Wyden
Senate Finance Committee
United State Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ranking Member Mike Crapo
Senate Finance Committee
United State Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Pharmacy Benefit Managers (PBM) Recommendations

Dear Chairman Wyden and Ranking Member Crapo:

Pharmacy Benefit Managers (PBM) play an important role in managing participants, beneficiaries, and enrollees' individual and group plans, as well as Medicare Advantage and Medicaid Managed Care plans, and prescription drug benefits. However, some PBM practices have put participants, beneficiaries, and enrollees' health and safety at risk, as well as restricted underserved individuals' access to safe and affordable prescription drugs. ASHP is the largest association of pharmacy professionals in the United States, representing over 60,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies. Our members have seen firsthand how PBM practices can limit and put at risk patient care.

Bring Transparency to PBM Rebates: Manufacturer drug rebates for patient out-of-pocket (OOP) expenses that are being taken by PBMs are opaque and need greater transparency. At a minimum, rebates intended for patients' OOP expenses should be provided at the point-of-sale (POS) and instituted in a manner designed to simplify reimbursement and promote transparency for both patients and pharmacies. Often the negotiated rate between a PBM and a manufacturer so adversely impacts a pharmacy's ability to cover its acquisition cost for a product, the cost to the pharmacy is greater than a dug's acquisition cost. POS reimbursement should, in all cases, be sufficient to cover a pharmacy's acquisition cost for a drug. Additionally, we recommend that all contracts clearly outline prescription and pharmacy performance measures, fees, and expectations, as they relate to reimbursement. There should be complete transparency about expectations and comparator benchmarks related to performance and outcomes.

Pharmacy Fees: Pharmacy fees have increased exponentially over the last few years. According to data released by CMS, "performance-based pharmacy price concessions, net of all pharmacy incentive payments, increased, on average, nearly 170 percent per year between 2012 and 2020 and now comprise the second largest category of DIR received by sponsors and PBMs, behind only manufacturer rebates"[1] These fees were originally created to incentivize quality. However, they have become arbitrary in nature and purpose and quite extensive. For instance, many times the quality metric a pharmacy fee is based on is irrelevant to the setting and medical condition a drug is used to treat. Pharmacy fees are also usually unknown until a drug is dispensed and the claim adjudicated. Until recently, these fees were enforced retroactively, placing pharmacists in financial peril. While the retroactive collection of fees is expected to terminate based on CMS's recent ruling, vague administrative fees and unclear performance measures may not be impacted.[2] We recommend that no administrative, prescription, quality, performance, or other care-related fees be collected retroactively, but clearly outlined at the POS. We also recommend an individual or group plan, and its PBM, be prohibited from enforcing pharmacy fees except when the quality measure on which a fee based is directly relates to the condition a patient is being treated and is appropriate for the setting the patient is being treated in. Lastly, we recommend that any fee to be collected and related to performance be clearly outlined in scope and magnitude within the contract with a pharmacy, allowing pharmacies to properly forecast budgeting and understand expectations.

Prohibiting White and Brown Bagging: White bagging occurs when a PBM requires patient medications be distributed through a narrow network of specialty pharmacies that are often affiliated with the PBM before the pharmaceuticals are then sent to a site of care, such as a hospital, where they will be dispensed by a provider. Hospitals have strict quality controls and by circumventing the traditional and regulated hospital supply chain, white bagging raises patient safety risks by enabling diversion and heightening the possibility of drug spoilage/wastage. Brown bagging occurs when a PBM ships medications to a patient, who then must take the pharmaceutical to the provider for administration. These medications typically require special storage and handling. White bagging and brown bagging put pharmaceuticals at risk of spoilage, contamination, and diversion, putting patients' health at risk. We recommend Congress prohibit PBMs from imposing white and brown bagging.

Protecting the 340B Program and Providers Against Discrimination: Safety net hospitals rely on the 340B Drug Pricing Program to provide healthcare services, including care for uninsured and underinsured patients. However, PBMs have been discriminating against 340B providers, including excluding them from networks or making them use their software and other services at additional costs with the intent of reducing reimbursements for 340B purchased drugs. We recommend Congress prohibit PBMs from discriminating against 340B providers with the intent of reducing reimbursements for 340B purchased drugs, including such practices as excluding 340B providers from networks or requiring payment of fees or the use of specific claims software as a means of increasing drug costs beyond 340B levels.

[1] Federal Register / Vol. 87, No. 89 / Monday, May 9, 2022 / Rules and Regulations; page 27834).
[2] *Id.*

Expanding Access to Biosimilars: Uptake of biosimilars lags behind coverage of small molecule generic drugs. Insurers and their PBMs typically only cover one preferred brand of any given biologic product, excluding all other biosimilar products. This is contrary to how plans cover small molecule drugs where they are required to cover all commercially available generics. We recommend Congress require that an individual or group plan, and its PBM, that covers multiple generic small molecule drugs in a formulary, treat biosimilars in a similar fashion. Thus, an individual or group health plan, and its PBM, that cover a reference (brand name) biologic or any biosimilar of the reference product, must cover *all* biosimilars of that product.

ASHP thanks you for considering these recommendations regarding PBMs, which will ensure participants, beneficiaries, and enrollees have access to safe and effective drugs. We look forward to continuing to work with you on this issue. If you have questions or if ASHP can assist in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,

Tom Kraus
American Society of Health-System Pharmacists
Vice President, Government Relations